

CHAPTER ONE – INTRODUCTION

Statement of the Problem

The American Association for Marriage and Family Therapy (AAMFT) is the primary professional organization for the field of marriage and family therapy. It was founded in 1942 and currently represents over 23,000 marriage and family therapists. Since its inception, AAMFT has served many purposes including: facilitating understanding, education, theory development, and research in the field of marriage and family therapy; developing standards for education, training, clinical supervision, professional ethics, and clinical practice; and ensuring that the public's needs are met by trained practitioners (American Association for Marriage and Family Therapy [AAMFT], 1998). One of AAMFT's tenets is that "therapists with specific education and training in marriage and family therapy provide the most effective mental health care to individuals, couples, and families," (AAMFT, 1998). To this end, AAMFT states its "members meet rigorous standards for the education and training and are held to the highest ethical standards of the profession," (AAMFT, 1998). Therefore, AAMFT takes an active stance in developing the field of marriage and family therapy, not only representing the needs of the profession and the therapist, but also representing the needs of the consumer.

One major way that AAMFT represents the needs of both consumers and therapists is through the development and enforcement of a code of ethics. The code of ethics is a set of standards, guidelines, and rules that all members of the profession are required to follow. Huber (1994) describes the purpose of mental health codes of ethics in the following manner:

"They provide a position on standards of practice to aid members in deciding how to act when conflicts arise. They assist in clarifying professionals' responsibility to clients and society. They give society some guarantee that professionals will demonstrate a sensible regard for the mores and expectations of the society. Finally, they give professionals themselves a means of safeguarding their freedom and integrity." (p. 5).

Brock (1994) maintains the AAMFT code serves three preventative functions: 1) it establishes practice guidelines that prevent harm to consumers, members, and the profession; 2) provides guidelines for safe and effective practice; and 3) establishes the perception among members, consumers, and the public that AAMFT therapists practice safely and with client interests foremost in their minds. Therefore, AAMFT and the therapist have a responsibility to know what the clients' interests are and to be able to practice according to the tenets of the code of ethics. These interests not only change with each individual client, but they are affected by changes in society.

Over the more than fifty years that AAMFT has existed, therapists' responsibilities to clients have increased as the profession has embraced the growing consumer movement in the mental health field. "As Western society became increasingly dependent upon professionals, it holds these persons more accountable for how they conduct themselves in their work," (Preister, Vesper, & Humphrey; 1994, p. 11). Issues such as informed consent, duty to protect, duty to warn, standard of care, client right to know, and currently the client's Bill of Rights have affected the growth, standards, and responsibilities of marriage and family therapists. For example, in the 1970's, the Tarasoff ruling held a therapist at fault for not warning the potential victim that his client had threatened to (and in fact did) kill her (Huber, 1994). Although the Tarasoff ruling was a California case, many states now mandate that a therapist must break confidentiality and warn a potential victim if the client threatens to harm that person. This mandated issue became a part of the AAMFT code of ethics in 1982. Another issue, informed consent, has also been incorporated into the code of ethics. Not only does the principle of informed consent protect the client by requiring discussion of the risks and benefits of therapy, it also protects the therapist from a possible malpractice suit. These issues and changes in the code of ethics, laws, and standards of practice, illustrate the changing recognition over time of the responsibilities of the profession and the therapist to the client.

One reflection of changes in therapist responsibilities is the evolution of the AAMFT code of ethics. Since the first version was developed in 1962, the AAMFT code

of ethics has been revised nine times. Many revisions reflect the changing needs of society and the mental health consumer movement. In 1975, revisions were added to the code explicitly prohibiting client exploitation or other harm, demonstrating AAMFT's (and society's) growing concerns in this area (Preister, et al., 1994). Also in the 1975 revision, the aspects of duty to protect and duty to warn from the Tarasoff case were introduced. Section II, 3d states, "Information is not communicated to others without consent of the client unless there is clear and immediate danger to an individual or to society, and then only to the appropriate family members, professional workers, or public authorities." (Preister, et al., 1994, p. 198). This tenet was further strengthened in the 1985 revision, which specified that confidentiality could be broken to prevent clear and immediate danger to a person; as mandated by law; when the therapist is a defendant in a civil, criminal, or disciplinary action arising from therapy; and when there is a waiver (Preister, et al, 1994). The addition that therapists could break confidentiality when mandated by law reflected changes in state laws. Many states had begun to mandate that a therapist must break confidentiality not only when there is a threat of personal harm through suicidal or homicidal actions, but also in cases of child or elder abuse or neglect. The 1985 code was the first to specifically allow confidentiality to be broken when mandated by governing laws.

In the late 1970's and early 1980's, the code went through further revision to keep up with the changes in society, in family life, in the profession, and in the Association (Preister, et al; 1994). In 1982, a section on "responsibilities to clients" was added which states, "Family therapists are dedicated to advancing the welfare of families and individuals, including respecting the right of those persons seeking assistance, and making reasonable efforts to insure that their services are used appropriately," (Preister, et al., 1994, p. 198). The code further broadened the specific responsibilities the therapist has to a client in 1988 when the topic of informed consent was added to this section, a reflection of the growing consumer movement.

The eighth revision occurred in 1991. This code has eight basic principles: 1) responsibility to clients; 2) confidentiality; 3) professional competence and integrity; 4)

responsibility to students, employees, and supervisees; 5) responsibility to research participants; 6) responsibility to the profession; 7) financial arrangements; 8) advertising. Preister, et al. (1994) state “...the AAMFT Ethics Code is a living document that reveals the development of a profession. In the context of the evolution, the code embodies the values of the profession, the principle one being to advance the welfare of clients and their families,” (p. 25). As the code evolved, it became more specific and incorporated society’s movement toward protecting client welfare. This, in turn, increased the therapists’ responsibility to clients. The final revision that occurred in 1998 mainly addressed issues in advertising.

The AAMFT Code of Ethics is enforced by the National Ethics Committee. The ethics committee is composed of six members: four clinical AAMFT members and two public members. The committee members are appointed by the AAMFT president, with the approval of the Board of Directors. Each member serves a three-year term, but cannot serve for more than two consecutive terms. The responsibilities of the Ethics Committee are to “review the AAMFT code of ethics and interpret it to the membership and to the public, and consider allegations of ethical standards made against members” (American Association for Marriage and Family Therapy [AAMFT], 1995). The grievance procedure was developed so complaints from a client, supervisee, or other professional regarding the violation of the code by a therapist or supervisor could be filed. Specifically, if a client feels that their welfare is not being advanced and that a violation of the ethics code has occurred, that person can contact AAMFT and file a grievance, beginning the complaint process. The national ethics committee has a specific responsibility to conduct investigations of alleged violations of the code and to resolve the matter (AAMFT, 1995). The complaint procedure begins when a person files a written grievance with AAMFT. The ethics department determines if the person named in the complaint is an AAMFT member. Once it has been determined that the person is a member, an investigation is opened. The Chair of the ethics committee can close the case if the allegation, if proven factual, is not a violation of the AAMFT code of ethics. However, the Chair can also determine that the allegation, if proven factual, is a violation of the code and charge the member with a specific violation. If sufficient information is

found, the case goes to the Ethics Committee for deliberation. The case can either be closed, with no violation found, or the committee can make a formal finding of specific violation. If a violation is found, the case can either be mutually settled between the parties or the committee can recommend sanctions towards the member. Sanctions against the member can include: no action because the member has been adequately sanctioned elsewhere, such as in a civil law suit; suspension or termination of membership; mandated additional supervision or education; community service, etc.

While the complaint procedure exists in order to give clients an arena to ask that their therapist be sanctioned, a client would have to know to contact AAMFT in order for the procedure to be initiated. However, it is unclear how a client becomes aware of the code of ethics and/or the complaint procedure. Two questions that arise from this ambiguity are 1) does the client have a right to know this information and, if so, 2) whose responsibility it is to inform the client that the code of ethics and the grievance procedure exists?

Corey and Corey (1989) believe that clients are often unaware that they have rights and that most professional codes of ethics require that clients be given adequate information to make informed choices regarding therapy. They also state, “Although most professionals agree on the ethical duty to provide clients with relevant information about the helping process, there is not much consensus about what should be revealed and in what manner.” (p. 183). Even Corey and Corey (1989), who believe that the best way to safeguard the rights of clients is to develop procedures to help them make informed choices, do not include information about a code of ethics in their model of a client informed consent form for therapy. The AAMFT code itself makes no direct mention of the therapist’s duty to inform clients of either the code of ethics or the grievance procedure. Some authors contend that the informed consent form should delineate parts of the code of ethics and/or state laws that requires the therapist to take action such as breaking confidentiality in cases of reporting child abuse and duty to warn. Leslie (1996) states that psychologists should ensure that clients are fully aware of the psychologist’s code of ethics and are fully apprised of all the options open to them.

However, there is no direction on how to inform clients of the code or whose responsibility it is to inform them.

In 1995, AAMFT revised the “Procedures for Handling Ethical Matters” manual to include descriptions of two duties of the state divisions and the Ethics Committee. In section 1.00, the manual states, “It is the policy of AAMFT that the primary role of divisions in regard to ethics is to educate AAMFT members and the public about the AAMFT Code of Ethics and about the procedures for filing complaints,” (AAMFT 1995, p. 1). Yet the only specific actions divisions are directed to take are: 1) to answer inquiries from the press about the code and 2) to suggest that divisional officers may facilitate, educate, and inform persons about how to follow the procedures for filing an ethical complaint. There is no mention of how the public becomes aware of the code of ethics or the complaint procedure. There also are no specific guidelines on how to educate the public, except to answer questions if they arise. If the consumer does not know that the code or the complaint process exists, how would they know to call the state division to get “educated?” Even with regard to educating division members about the code, the only guideline for the state divisions provided by this manual is to disseminate copies of the code and provide workshops on the code. There is no indication that the state divisions should help members to inform their clients of the code and grievance procedure. In regard to the responsibilities of the Ethics Committee to the public, section 1.10 under the role of the Ethics Committee states that the committee should, “Review the AAMFT Code of Ethics and interpret it to the membership and to the public...” (AAMFT 1995, p. 3). Again, there seems to be no clear indication on how the public becomes aware of the code.

Clearly, there is much confusion about who is responsible for informing the public of the AAMFT Code of Ethics and the complaint procedure. Therapists have to provide clients with enough information to give informed consent to treatment, but there is ambiguity on what information needs to be included, and if the existence of a code of ethics and grievance procedure needs to be part of that information. Those authors who do state that the consumer should be informed do not suggest whose responsibility it is to inform. The AAMFT state divisions and the ethics committee each have a responsibility

to the public, to educate and interpret, respectively, the code of ethics, but there is no clear indication if their responsibility includes informing all clients of the code and grievance procedure.

Does the ambiguity about informing clients about the code have any real effect? According to AAMFT, at any given time marriage and family therapists treat over 1.8 million people (AAMFT, 1998). Doherty and Simmons (1996) found that 98.1% of clients are satisfied with the treatment they receive from MFT's. In the Doherty and Simmons study, 526 AAMFT clinical members from 15 states returned anonymous surveys regarding their practice of marriage and family therapy. Four hundred ninety-two of these therapists' clients also reported on their satisfaction with the treatment they received and 98.1% of these clients indicated they were satisfied with their treatment. However, there are problems with the Doherty and Simmons study. It is unclear how these particular clients were selected to report on their satisfaction level. It is possible that the therapists self-selected the clients and could have chosen clients they felt would give a positive report. Also, clients could have felt pressure to report positively, since the therapist was the one asking them to fill out the survey. Doherty and Simmons (1996) acknowledge that one cause of the high percentage of satisfied clients could be that, with a response rate of 62.3%, unsatisfied clients may have been less likely to return the questionnaire. However, assuming that 98.1% of clients are satisfied with therapy, 34,200 clients of the 1.8 million people treated by AAMFT members would be dissatisfied with the treatment they received. In 1993, when the number of ethics complaints was the highest, 94 clients filed a grievance, only .005% of the 1.8 million who were being treated. Obviously, not all the 34,200 clients who are unsatisfied will have an ethical violation occur, but the number of clients who did file is minute compared to the treatment population. In addition, not only could the number of unsatisfied clients may be even larger given the limitations of the Doherty and Simmons study, but ethical violations could have occurred in the 98.1% of the population who are satisfied with treatment, but the clients may not know. The overriding question is: Is the number of ethical complaints small because few ethical violations occur, or is it because few clients know of their right to file a grievance? Furthermore, the small number of

complaints is not only specific to AAMFT. In 1996, the American Psychological Association received only 89 complaints against its 84,000 membership (APA, 1997), approximately one tenth of one percent (.01%) of the membership.

Locke (1996) surveyed 24 clinical members of AAMFT from Virginia regarding therapists' perceptions of client knowledge of the AAMFT organization, code of ethics, and grievance procedure. Ninety percent of the therapists believed that 25% or fewer of their clients knew that AAMFT, the code of ethics, and the grievance procedure even existed. This adds some evidence to suggest the low number of complaints may be due to clients' lack of information. The proposed study is designed to more thoroughly investigate this situation.

Theoretical Framework

The theoretical framework used by this study is Action Science (Argyris, Putnam, & Smith, 1985). Since there is a fair amount of ambiguity about what information should be given to clients and by whom, Action Science's views on Espoused Theory and Theory-in-Use will help to frame the examination of this issue. Action Science examines the connection between what a person believes or values (espoused theory) and what a person actually does or their actions (theory-in-use). Espoused theories are those that a person claims to follow where as theories-in-use are those that can be inferred from a person's actions (Argyris et al., 1985). There may be differences between what a person believes and what the person does, and a person's actions (theory-in-use) may or may not be consistent with his/her beliefs (espoused theory). Argyris, et al. (1985) believe that, "what people do is not accidental...rather their action is designed; and, as agents, they are responsible for the design" (p. 82).

Even though a person's espoused theory and theory-in-use may be inconsistent, the person may not be aware of that inconsistency. Argyris, et al. (1985) state that individuals are aware of their espoused theory, because it is the one they claim to follow; it is a conscious statement. However, a person may not be aware of their theory-in-use because these theories are not always consciously articulated. They are reflected in the

actions one takes. A person's theory-in-use can be made explicit through self reflection. The theory of Action Science leads this study to ask what people think should be done (espoused theory) regarding the issue of what to inform clients and whose responsibility it is, as well as what they actually do (theory-in-use). Locke (1996) found that 41.7% of the therapists she surveyed stated it was their belief that the therapist working with a client has an ethical duty to inform them of the AAMFT code of ethics. However, when asked what their perception of client knowledge of the AAMFT code of ethics, over 90% of the therapists stated that less than 25% of their clients knew about the code. In this sample, there seemed to be a discrepancy between what therapists believe is their responsibility (their espoused theory) and the actions therapists actually take (their theory-in-use). The proposed study will examine the discrepancy, or the congruency, between family therapists' espoused theory regarding informing clients and family therapists' theory-in-use. It is designed to be a larger, more representative sample of the field of marriage and family therapy than the Locke study (1996) and can begin to acquire information to possibly clarify the ambiguity in the field.

Objectives

Based upon the aforementioned ambiguities, this study is designed to ascertain what the professional marriage and family therapy community, as represented by AAMFT members and officers, thinks about the following questions:

1. Should clients be informed that AAMFT, the code of ethics, and the grievance procedure exist?
2. Whose responsibility is it to inform the client of what AAMFT is, the code of ethics, and the grievance procedure?
3. Do therapists specifically have a responsibility to inform their clients of AAMFT, the code of ethics, and the grievance procedure?
4. What are the therapists', state division officers', and AAMFT national ethics board members' perceptions of client knowledge of AAMFT, the code of ethics, and grievance procedure? What percentage are aware?
5. Are there differences between therapists, state division officers, and the ethics board members in regards to questions 1-4?

6. Specifically, what do therapists currently do in their practice to inform clients about AAMFT, the code of ethics, and the grievance procedure?
7. Are therapists' actions regarding informing clients of AAMFT, the code of ethics, and the grievance procedure consistent with their beliefs?
- 8.

Rationale of Study

This study is designed to begin to resolve the ambiguities of policies covering who is responsible to inform clients of the code of ethics and grievance procedure. It may provide information to develop more specific policies in the AAMFT organization and/or the informed consent forms used by therapists, and may add to the mental health consumer movement. This study will collect data on policies, perceptions, and actions. It will also help to determine if there are differences of perceptions, policies, and values between therapists, state division officers, and AAMFT ethics board members. Finally, it may provide information about the consensus in the field regarding who is responsible for informing clients of the existence of AAMFT, the code of ethics, and the grievance procedure.

CHAPTER TWO: LITERATURE REVIEW

This section will present a review of literature relevant to the research in the area of codes of ethics and clients' right to know as they pertain to the current study. Specifically, this chapter will examine codes of ethics and critiques, client rights, the increase of therapists' responsibility over time, informed consent, and the theoretical framework of Action Science.

Codes of Ethics

The code of ethics for the American Association for Marriage and Family Therapists (AAMFT) has been in existence nearly 40 years. Brock (1998) states that the code is

“much more than a mere listing of rules, it is the collected wisdom of the profession that strengthens and supports the Association and the field of marriage and family therapy in several important ways.” (p.3).

Brock (1998) believes the code serves three preventative functions: describing safe and effective practice; preventing already bad situations from getting worse by taking action to stop exploitive and harmful practices; and establishing and maintaining the perception to members, consumers, and the community that members practice safely and with client interests foremost in their minds. To this end, “the code requires therapists to confine their behavior to what will benefit clients first and themselves only secondarily,” (Brock, 1998, p. 4). Larsen and Rave (1995) believe, in general, that the primary focus of professional ethics should be first on the welfare of the client and society, leaving the welfare of therapists or their profession a secondary focus.

Most professional organizations in the mental health field have a code of ethics that provides guidelines and standards for practice. Although codes vary dependant on the organization, all of these codes have as one of their purposes to protect the welfare of the client (American Association for Marriage and Family Therapy, 1998; American Psychological Association, 1997; American Psychiatric Association, 1995; American

Counseling Association, 1988; National Association of Social Workers, 1996). Codes of ethics from American Association for Marriage and Family Therapy, the American Psychology Association, the American Psychiatric Association, the American Counseling Association, and the National Association of Social Workers, all contain similar themes concerning how to protect the welfare of the client. These general themes include: respecting the rights of clients to make choices; providing informed consent; practicing within the therapist's area of competence; protecting the privacy and confidentiality of the client; avoiding dual relationships, etc. The codes vary in the specificity of the guidelines they provide to the therapist to fulfill the purpose of protecting the client's welfare, although most of the guidelines are general and ambiguous. None of the codes communicate ways that the therapist can proactively promote client welfare. For example, the NASW code, which this author found to have the most information of all the codes reviewed, states under Section 1, "Social Workers' Ethical Responsibilities to Clients" that, "Social workers' primary responsibility is to promote the well-being of clients," (1.01 Commitment to Clients) and "Social workers respect and promote the right of clients to self-determination" (1.02 Self-Determination). Although these statements call for some action from the therapist, the NASW code only describes exceptions to the code. For example Article 1.01 asserts that the social workers' responsibility to society or specific legal obligations may supersede the loyalty to the client (i.e., mandated reporters of child abuse and duty to warn). There is no indication in the definition in this section regarding how a therapist can proactively promote the client's welfare, just cases when they can't. In fact, the NASW code states,

Some of the standards that follow are enforceable guidelines for professional conduct, and some are aspirational. The extent to which each standard is enforceable is a matter of professional judgement to be exercised by those responsible for reviewing alleged violations of ethical standards. (p. 7).

With no clear indication in the code, each individual social worker is left to determine which standards are aspirational and which are enforceable. This opens the practitioner to other influences, such as, personal gain which can affect their ethical judgement. Brock (1998) warned of therapists using rationalizations to support a therapist's self-serving behavior, which almost always leads to the clients being harmed.

Critiques of Codes of Ethics

Despite the positive aspirations of professional codes of ethics, there have been critiques of codes in general. The most vocal has come from the feminist movement, which will be reviewed later in this chapter. Outside of the feminist movement, professionals tend to view codes as vague, paternalistic, conflicting, and unclear. Woody (1990), for example, stated that professional codes have ambiguous terms, encompass conflicting obligations for the therapist, and do not provide any indication of how to weigh the importance of duties when they conflict. Vesper and Brock (1991) note that there are oversights and inclusion of less germane material due to the make-up of the ethics committees who design the codes. These committees consist of members who volunteer their time and have opinions on which issues are most important. Therefore, because of the personal biases of committee members, a given ethical issue may be included, not included, or given more emphasis than other issues. Also, Vesper and Brock state that codes are written in general terminology, which can lead to confusion and unclear guidelines.

Lerman and Porter (1990), delineate seven concerns with professional codes including: lack of proactive ways to promote and establish optimal ethical behavior; grievance procedures being too paternalistic and demeaning to consumers; complaint procedures developed to legally protect the profession rather than out of compassion for the client; and additions being added to the codes in an ad hoc fashion rather than through an examination of the values and premises of the code. They also add “existing codes rarely state their rules within a conceptual context that would aid a practitioner in understanding how a particular action or inaction on a therapist’s part might harm a client,” (p. 7). Another critique of codes is that the interests of clients cannot be systematically included in the construction process of the code (Neukrug, Lovell, and Parker, 1996). They also assert that there are:

“...possible conflicts associated with codes: between two codes, between the practitioner’s values and code requirements, between the code and ordinary morality, between the code and institutional practice, and between requirements within a single code.” (p. 100).

Coale (1998) believes the current rule-based codes of ethics have inherent problems. She states that rule-based ethics do not fit every situation because of the variability of human need. Also, Coale believes that the present codes privilege professionals' needs over the clients'. Because mental health professions have traditionally favored the therapist-as-expert, Coale quotes Ballou, "The 'rights' may be the client's but the therapist holds the power to define the client's reality and to set the terms of the therapeutic relationship...Nowhere is the concept of shared power encouraged, or even discussed," (Ballou, 1990, p.240). Lastly, Coale (1998) considers ethics rules as having a hidden agenda to protect the therapist, though framed in terms of client protection, and criticizes the mental health profession for, "increasingly deferring to attorneys for the establishment of their ethics rules," (p. 13).

Finally, Pope, Tabachnick, and Keith-Spiegel (1987) believe that ethics in general have been neglected in the professional literature, which leaves therapists without adequate guidelines and information. With codes being unclear and a lack of information provide by the literature, the burden of adhering to the code depends on the individual therapist's sense of ethical integrity and responsibility. Given the ambiguous nature that is sometimes created by the therapist-client relationship, the context in which ethical decision is made is ambiguous as well (Coale, 1998). "What is ethical in one situation is not ethical in another. Ethical meanings vary," (Coale, 1998, p.4).

A question derived from these concerns is how does a therapist practice ethically without clear guidelines for action from the codes or from the professional literature? The mental health professions have begun to recognize the need for more specific guidelines on some ethical issues. For example, therapists having sex with clients is one action that codes explicitly prohibit, and that has received much attention in the professional literature. Each of the five codes reviewed have a statement specifying that the therapist shall not engage in sexual contact with current (and, in some codes, former) clients (American Association for Marriage and Family Therapy, 1998; American Psychological Association, 1997; American Psychiatric Association, 1995; American Counseling Association, 1988; National Association of Social Workers, 1996). Despite

specific guidelines in some areas like sex with clients, however, there still are major gaps in the information, guidelines, and resources available for therapists concerning ethics. The area of focus for this study - whether clients should be informed of the existence of the code of ethics and grievance procedure - is particularly vague. In the five professional codes of ethics reviewed, none stated that the client should be informed either of the code of ethics, or of the procedures for filing a complaint to the ethics committee of the organization. Even in the professional literature, the topic of informing clients about codes of ethics and grievance procedure is almost entirely ignored. Three articles, two of which focused on other ethical issues, [neutrality of therapy, Leslie (1996), and a model for resolving ethical dilemmas, Woody (1990)] contained one sentence statements that the therapist should disclose that they follow their national professional association's code of ethics. However, neither paper gave any indication of why or how this should be done.

Hare-Mustin, Marecek, Kaplan, and Liss-Levinson (1979) called for therapists to take responsibility for incorporating ethical standards into their practices so that client rights would be an integral part of therapy. They noted that historically, "protecting the rights of clients was of secondary importance" (p. 3) for ethical standards. Primarily, standards were developed to protect the profession and maintain professionals' integrity. "It is unfortunate that statements of ethical standards represent more of a 'salute to the flag' for therapists rather than a bill of rights for clients," (Hare-Mustin, et al., 1979, p. 3). The authors noted that therapist are as responsible as the client with client rights in a number of areas, including freedom of choice, disclosure of information about treatment, and protecting human dignity. In addition, by informing clients of these rights, therapists would be encouraging healthy functioning in clients by helping them accept their rights and responsibilities in these areas. Hare-Mustin, et al., state three reasons why it is the therapist's responsibility to inform clients of their rights:

First, persons entering therapy do so in a help-seeking posture, not a self-protecting one...Second, the therapy situation is a novel one for most clients. They do not know their rights. Mystification of the therapeutic process intensifies clients' dependence on their therapists and lowers their ability to assert

their rights. Finally, some clients entering psychotherapy may not be capable of protecting their rights. They may be members of groups that have historically been denied power...Such clients may be resigned to having their rights denied and their complaints unheeded. (p. 4).

Hare-Mustin, et al. (1979) review three areas in which they believe therapists have a responsibility to inform clients of their rights. These three areas include: assuring that clients make informed choices; establishing a contract; and responding to clients' challenges to the therapist's competence. It is under the last section that the issue of providing the client information about channels of protest arises. Though the authors suggest including information about filing grievances orally or in writing at the beginning of therapy, they believe this approach warrants caution. They argue that clients may not be interested in the information and the information is biased because it is the therapist's version of what information clients need rather than the clients' view and information given at the beginning of treatment about grievances may undermine clients' trust in therapeutic process. The authors also ponder the therapist waiting until the client needs the information. This approach is dependent on the therapist's ethical integrity, on his/her opinion that it was needed, and on the therapist recognizing the need first, if the client does not. Hare-Mustin, et al. (1979) acknowledge,

...it may be difficult for therapists to suggest means of protest when the client is complaining about the therapist's own practices. Paradoxically, at this point, when the information is most needed, it may be least useful because the client no longer trusts the therapist. (p. 15).

Although the authors state that there may be no optimal time to provide the information, they are clear that it is the therapist's responsibility to provide the client the information as one of the rights of clients. However, the article makes no mention of providing information about the code of ethics or how a client would know if they had something to complain about (i.e., ethical violation). The authors note that the client may not know their rights or be used to having their rights denied or unheeded. And although they make a case for increased therapist's responsibility, how would a client

who comes to therapy in a “help-seeking posture” even know what to complain about or that a violation has occurred if they are not informed of the code of ethics?

Leslie (1996) states that it is the therapist’s responsibility to inform clients and organizations about the psychologist’s professional ethics. Leslie asserts that changes in societal attitudes make it increasingly important for psychologists and the profession to pay attention to ethical issues. Leslie acknowledges that there are complex and unavoidable ethical issues facing psychologists, but contends that malpractice will be avoided if psychologists, as a professional group:

1. We should attach greater importance to ethical issues in education and training at all levels, up to and including professional development.
2. We should ensure that individuals and organizations that receive services from psychologists are fully appraised of the code of professional ethics of psychologists.
3. Psychologists should provide their clients, whether individuals or organizations, with a written contract. (p. 93).
- 4.

Leslie is clear that it is the therapist’s responsibility to inform the client of the code of ethics, but does not include the complaint procedure. While some authors over the years have called for taking more action, they have been few and far between. Specific guidelines about what action to take has been ignored, with one exception.

Feminist Approach to Ethics

The Feminist Therapy Institute addressed the topic of therapist informing clients of the complaint procedure by specifically including it in their own code of ethics. The Feminist Therapy Institute believes in the equal valuing of all people and in social, economic, and political equality, with an emphasis on women, due to the fact that women have been oppressed (Larsen and Rave, 1995). The tenets of feminism include equalizing power in interpersonal relationships, recognizing that each person deserves respect and has equal right to personal power in relationships, therapists being a role model for clients, and engaging in social action to change society. These tenets apply to

professional relationships as well as others. As the feminist movement grew, it became increasingly critical with the current professional codes of ethics. Lerman and Porter (1990) summarize the Feminist critique of current professional codes as follows:

- (1) most ethics codes are reactive rather than proactive – they list the lowest common denominator of acceptable behaviors rather than establish standards that promote and establish ethical behavior that reaches toward the optimum;
- (2) behavior is described in terms of ‘good-bad’ dichotomies rather than more accurately reflecting the extreme complexity of actual human experience. Often ethical codes do not recognize that extremes in either direction have the potential to result in harm; thus they fail to do justice to the full complexities of interpersonal relationships;
- (3) the dichotomous nature of ethical principles does not lead to understanding of the contexts or circumstances that lead to violations among practitioners and how they can be prevented;
- (4) most codes have usually ignored issues pertaining to the special circumstances of minorities and women;
- (5) the procedures for redress of grievances frequently tend to become paternalistic and demeaning toward the consumers whose interest they purport to protect;
- (6) the complaint procedures have frequently been developed with an eye more toward legally protecting the professions than out of compassion for the client; and
- (7) the codes themselves have been added to in a piecemeal fashion, usually without further examination of the values, premises, and assumptions that originally motivated their formulation. They thus tend to become over-detailed, concrete, labyrinthine, ponderous, and impersonal in form as well as tending to lose whatever clear focus with which they began. (p. 6-7).

Lerman and Porter (1990) add that professional codes do not prescribe actions for the therapist that would be beneficial for the client nor state rules within a conceptual framework to aid therapists in understanding how a particular action or inaction might harm the client. With these critiques in mind, members of the Feminist Therapy Institute developed a code of ethics in 1987 to provide more guidance for therapists on issues not

addressed in traditional professional codes. The intention of the feminist code is to be an adjunct to traditional codes and was triggered by the need to provide more direction to therapists and reduce oppression, especially for women clients, through therapists' either deliberate or inadvertent behavior.

Feminist therapists wanted and needed a code that would go beyond their professional codes in acknowledging feminist tenets, to deal more extensively and specifically with overlapping relationships, recognize the power differential between client and therapist, incorporate concerns about diversity, increase access by all to both knowledge and treatment, require therapist self-monitoring and self-care, and encourage therapist and client proactive behavior for social change.

(Larsen and Rave, 1995, p.6).

Larsen and Rave go on to state the need for clear ethical statements to provide proactive direction and include issues not addressed in traditional codes. Lerman and Porter (1990) add that the feminist code attends to values, tries to prevent misguided efforts from therapists, and recognizes the need for therapists to be aware of power differentials so power is not abused.

The feminist therapy code of ethics is divided into five sections: cultural diversities and oppressions, power differentials, overlapping relationships, therapist accountability, and social change. Section two, power differentials, specifically addresses the issue of informing clients about the grievance procedure. Feminists focus on how power inequities exist in the client's life, especially for women and minorities, and strive not to reenact these inequities in the therapeutic relationship. Therapists try to understand how power inequities contribute to the client's problems and they try to empower the client through this understanding and action. Therefore, "the tasks of therapists, then, are to be sensitive to power issues, to use power responsibly in the service of clients, and to assist the clients in gaining perspective on how power affects them individually," (Larsen & Rave, 1991, p. 7). There are four tenets regarding power differentials included in the Feminist code of ethics:

- A. A feminist therapist acknowledges the inherent power differentials between client and therapist and models effective use of personal power. In using the

power differential to benefit the client, she does not take control of power which rightfully belongs to her client.

- B. A feminist therapist discloses information to the client which facilitates the therapeutic process. The therapist is responsible for using self-disclosure with purpose and discretion in the interests of the client.
- C. A feminist therapist negotiates and renegotiates formal and/or informal contracts with clients in an ongoing mutual process.
- D. A feminist therapist educates her clients regarding their rights as consumers of therapy, including procedures for resolving difference and filing grievances. (Rave & Larsen, 1995, p.40).

Although this code does not specify exactly what information a therapist should provide to satisfy Section D, it does clearly indicate it is the professional's responsibility to inform the client. This code provides more guidance to the therapist than any other.

In summary, the professional codes and literature largely ignores the issue of informing clients of the code of ethics and grievance procedure. Except for the code of ethics of the Feminist Therapy Institute, this practice falls under the context of therapist discretion. But are mental health clients being told about the code their therapist follows and the grievance procedures available to them? The answer to this question is currently unknown. As described in Chapter One, only a small number of ethical complaints filed each year in the AAMFT and APA organizations compared to the number of clients served. There could be many reasons about why the number of complaints is so small. Professionals may be practicing ethically. Clients may be using other means such as courts and state regulation boards to voice their discontent. Clients may not know that an ethical violation has occurred, or they may be unaware that they can file a complaint with the professional organization. If clients are not cognizant that a violation has occurred, or that there are grievance procedures available to them through the therapist's organization, they will not use the very procedures developed to protect their welfare.

Increasing Therapist Responsibility

Compared to the lack of direction by professional organizations, society today places more and more responsibility for the client's welfare on the therapist. Over the past 15 years, the therapist's responsibilities to the client have increased due to the consumer movement, a change that has been part of many other professional relationships apart from therapy. The consumer movement focuses on the rights and needs of the consumer, rather than the provider. Woody (1990) states the consumer movement has "brought skepticism toward authority, the assertion of health as a basic civil right, and a civil liberties view of mental health," (p. 142). This results in professionals losing some autonomy and authority.

Many of the changes brought about by the consumer movement are reflected in state laws and regulations. While each state has its own unique set of laws governing the conduct of therapists, there are some nearly universal requirements that a majority of states mandate therapists to abide by. Examples of such laws are duty to warn and mandated reporting of child abuse. In addition, many states now require therapists to be licensed to practice. Each state may differ on the requirements therapists are asked to meet, but many of the state licensing laws have been derived from professional codes of ethics (Vesper and Brock, 1991) or from professional organizations' membership requirements. Licensing laws often overlap professional discipline boundaries, adding to role confusion and possible ethical conflicts. For example, in Virginia, a therapist can be licensed as a professional counselor, clinical social worker, clinical psychologist, or marriage and family therapist. Therefore, a therapist must adhere not only to the code of ethics of their professional organization, but also to the state laws and particular state license regulations. While potentially confusing for therapists, this gives consumers of therapy more avenues to file complaints with state licensing boards or through the legal system.

While the trend toward state regulation of therapy has increased the therapist's responsibilities and provided accountability to the profession, it has also created some pitfalls. Inconsistencies within state laws can complicate treatment and the ethics codes

and legal standards can be at odds with one another (Vesper and Brock, 1991). There is no uniform code or overarching legal standard for the therapist to follow, which can lead to confusion about what to do when codes of ethics and laws conflict. A therapist could be faced with the dilemma of choosing between following the code of ethics to protect the client's welfare or following a state law that contradicts that aspect of the code. Without clear guidelines, a therapist is left with the responsibility to decide which course to follow. According to Vesper and Brock (1991):

“Practicing marriage and family therapy is both challenging and perplexing. A therapist is required to fully engage in the client's world, while being detached enough to conduct effective intervention strategies. This dual reality that the therapist encounters with every client demands an active mind, one capable of balancing the work that takes place in the office with the development and facilitation of acceptable strategies to intervene in a dysfunctional system. In addition, the marriage and family therapist must add at least two more levels of awareness to every therapeutic interaction: ethical practice and the legal ramifications of that practice.” (p. 9-10).

Like state laws, professional codes of ethics have changed to reflect the growing responsibilities of therapists and the profession, along with the demands of society. The codes for the American Association for Marriage and Family Therapists, American Psychological Association, American Counseling Association, and the National Association of Social Workers were initially developed in the 1950's and 1960's. While these codes are relatively new, they have each gone through a number of revisions to reflect society's changing values (Neukrug, Lovell, and Parker; 1996). Haas and Malouf (1995) believe that codes have become less abstract and more detailed over the years as statements of professional principles are articulated more clearly and ramifications better explored. However, they also acknowledge that codes have shifted from professional conduct to legalistic practice guidelines. Brock (1998) describes some of the changes in the AAMFT Code of Ethics that resulted in more specific and clearer definitions regarding the issues of boundaries, confidentiality, and duty to warn. But, while the codes have gotten more specific in some areas, they still are unclear, vague, ambiguous,

or silent about other topics. The responsibility for deciphering the code still lies largely with the therapist. However, two ways the mental health profession has tried to help therapists and clients resolve this ambiguity is by setting guidelines for informed consents and by providing a Mental Health Consumer's "Bill of Rights."

The principle of informed consent is a development in the efforts to protect client welfare. The purpose of informed consent is to provide the client with sufficient information about the proposed course of treatment, risks and benefits, and other alternatives available to them. The client should receive enough information to make an informed decision regarding treatment. Haas and Malouf (1995) state that obtaining informed consent from a client implies respect for the dignity of the client, a belief that the client can make reasonable judgements, and enhances trust between the therapist and the client. They also acknowledge that while the duty to obtain informed consent is clear, the specifics of obtaining it are not.

In part, this is a result of the fact that providing informed consent is both a moral obligation and an exercise of technical skill which will vary depending on the specifics of the case at hand. That is, the manner in which the practitioner provides information and the timing with which he or she provides it can affect whether the information is helpful or harmful. (Haas & Malouf, 1995, p. 52).

There have been many articles about the technical side of informed consent, usually focusing on what to include in an informed consent document (Reamer, 1987; Schultz, 1982; Stromberg, Haggarty, Leibenluft, McMillian, Mishkin, Rubin, & Trilling, 1988). Most of the authors agree on general areas to include, such as risks and benefits of treatment, confidentiality, alternatives to treatment, etc. Manning and Gaul (1997) contend that the focus of the legal requirements of informed consent has overridden the true intent, or "spirit" of the principle informed consent - to elicit the participation of the consumer. Manning and Gaul (1997) define the "spirit" of informed consent as, "...a partnership between provider and client. Partnerships are based on egalitarian relationships that respect and appreciate the different strengths each bring to the decision process," (p. 111). In order for this to occur, according to Manning and Gaul, power

must be shared between the provider and the client through information and decision-making processes. Many practitioners resist the “spirit” of informed consent for many reasons: sharing information increases the possibility of the therapist being challenged; the provider must be informed and open to consider options suggested by the client; the therapist needs to be able to explain information, including information about the proposed treatment, fully and clearly so the client can understand; and sharing power in this mode takes time and effort (Manning & Gaul, 1997). However, providing the “spirit” of informed consent as well as the legal aspects promotes client rights, self-determination, and autonomy.

The issue of informed consent is one that is continually debated in the professional literature. Corey and Corey (1989) describe the debate as follows, “Although most professionals agree on the ethical duty to provide clients with relevant information about the helping process, there is not much consensus about what should be revealed and in what manner, “ (p. 183). Because informed consent increases the likelihood that a client will challenge what the therapist offers, it can be uncomfortable for some therapists. Corey and Corey (1989) believe that obtaining a client’s informed consent involves the therapist balancing providing too little information and overwhelming the client with too much. Haas and Malouf (1995) state, “Therapists, too, need to resolve the question of when they are simply being withholding because they feel restricted in their practice,” (p. 62). In fact, Manning and Gaul (1997) state, “When [client] rights interfere in the usual mode of practice, the [therapist’s] support decreases,” (p. 112). The question then arises, where does informing the client of the professional’s code of ethics and procedure to file a grievance fall? Is it part of information that provides clients the ability to make an informed decision or is it too much information that may overwhelm the client? Do therapists resist providing that information because they may have to further explain their actions or because it interferes with the usual mode of practice? Without clear guidelines, it is left up to the therapist’s discretion.

Another step the mental health profession has taken to empower the client and become more rule-oriented is through the establishment of the client “Bill of Rights.”

The Bill of Rights is a collaborative document by nine different mental health organizations to protect the rights of individuals seeking treatment. The document grew out of concern by the organizations that clients were not being well-served by the health care system. As stated by Daw (1997),

“The Bill of Rights marks the first time that diverse professional organizations have come together to develop a shared set of principles that declare Americans’ right to quality mental health care. The principles cover the individual’s right to full information about an insurance or managed care plan, confidentiality, choice of mental health professional, insurance equal to that available for other illnesses, a role in determining treatment, and plan accountability.”

The Bill of Rights is a document that challenges the roles of insurance and managed care companies in determining client treatment for mental health issues. The crux of the document is that clients are being harmed due to these companies denying client treatment, confidentiality being broken, and clients not being told of all the treatment options available to the client to control costs (“A Mental Health Bill of Rights,” 1997).

The Bill of Rights covers ten principals for the provision of mental health services, which include: right to know, confidentiality, choice, determination of treatment, parity, discrimination, benefit usage, benefit design, treatment review, and accountability. The “right to know” section addresses the notion of appeals and grievances by stating, “Individuals have the right to receive information about the methods they can use to submit complaints or grievances regarding provision of care by the treating professional to that profession’s regulatory board and to the professional association,” (“A Mental Health Bill of Rights,” 1997). This section goes on to discuss receiving benefit utilization decisions. However, it does assert that clients do have a right to know about the grievance procedures open to them, a point agreed upon by nine mental health organizations, including the five mentioned in this section. While the Bill of Rights does not state who is responsible to inform the client of this information or any specific information regarding this matter, it does clearly state that the client has a “right to know.” This reflects a movement toward clients receiving greater knowledge and having their rights promoted by the professional organizations. Although it is limited to

the managed care system, it does make the statement of clients being informed of the grievance procedure. However, this is a first step in acknowledging the client's right to know about grievance procedures and a collaborated effort of the mental health profession to protect clients' welfare.

The weight of responsibility for therapist is great and, with society moving towards increased responsibility, the weight grows. Unfortunately, there are many ways that a therapist can compromise their professional duty to act ethically. Lack of moral commitment, haphazard practice, failure to keep abreast of educational development, employing inappropriate theoretical frameworks, practicing for personal gain, and exploiting clients are all ways that can contribute to a therapist acting unethically (Vesper & Brock, 1991). Neukrug, Lovell, and Parker (1996) express concern about therapists' ethical decision making capabilities, stating four difficulties a therapist may face. "The counselor may (a) misinterpret or fail to see the need for moral action, (b) be incapable of making a principled moral judgement in the face of a complex dilemma, (c) be unable to plan a course of action, and (d) lack the will to act," (p. 101).

Therapists not only have to grapple with their own moral and professional integrity, they also have the responsibility to, "assess the client's psychological needs, employ the necessary therapeutic strategies, respect the dignity of the client, empower the client to be self-determinant, and terminate treatment upon attainment of therapeutic goals," (Vesper & Brock, 1991, p. 19). Add to this increased therapist accountability, duty to follow ethics codes and state laws, and, as called upon by feminists, a responsibility to improve society, and the responsibilities of therapists have grown exponentially.

One way to solve the ambiguity and conflicts the therapist experiences is to become more rule-oriented. While this provides clear guidelines in some areas, it also has serious consequences. The increase in therapists' responsibilities and the changes in professional codes of ethics and laws impact the service provided to the client and the dynamic of the therapeutic relationship. Coale (1998) believes that the move to more

rule-based ethics disempowers the client and encourages the profession's needs and definitions of reality over the client's. She states:

While giving lip service to client protection, the mental health professions are equally concerned with risk management, i.e., with protecting the therapist from threats of litigation and ethics complaints by clients. This pits clients and therapists against one another and exacerbates the vulnerability of both. (Coale, 1998, p.1).

Coale believes that rule-based ethics minimize healing possibilities and do not look at the uniqueness of each client nor the therapeutic relationship. In addition, clients have had little input in the formulation of professional codes of ethics. Coupled with the increased responsibilities from the changes in society, these have strained the therapeutic relationship, which victimizes both the client and the therapist. The therapist does not have the ability to be flexible or creative in order to understand the client's context and problems because of the regulations and increased accountability the therapist is bound by. Coale (1998) strongly asserts that the very nature of therapy has been colored by rule-based ethics which disempowers the client, creates an adversarial relationship between client and therapist, and increases a therapist's anxiety about litigation and risks.

Action Science

The concept raised by Manning and Gaul (1997) earlier in this section, regarding the practitioner's contradiction between intellectual support of rights of clients and demonstrating that support in actual practice, accentuates the discrepancies between beliefs and actions. Wilkins, McGuire, Abbott, and Blau (1990) examined the differences between what practitioners should do (beliefs) versus what they would do (actions) in a variety of ethical conflict situations. Results found that the practitioners' actions were not consistent with their beliefs. "Clinicians indicated that they would be unwilling to follow through in response to the ethical violation to the same degree that they previously had indicated they should," (p. 544). This study is related to the broader theory of Action Science which forms the theoretical basis for the current study.

Action Science (Argyris, Putnam, & Smith, 1985) examines how people design and implement action in relation to one another. As such, it is an outgrowth of social psychology. Common wisdom suggests that “actions speak louder than words.” Indeed, the relationship between actions and words is at the heart of Action Science. Schon (1983), in an effort to understand professional practice, found that what professionals say they do is often different than what they’re observed to do. What people say they will do is their “espoused theory.” It is the theory the person acknowledges he/she believes in. However, the professional’s actions provide clues to his or her “theory-in-action.” This is the theory underlying what the professional actually does. It may be conscious or unconscious, though the person is usually not aware of his/her theory-in-use. The espoused theory may or may not be consistent with the theory-in-use, thus, the words and the actions may or may not be the same. The individual may not even know whether both are consistent with each other. One of Action Science’s goals is to examine the espoused theory and the theory-in-use for consistency. This entails becoming aware of one’s theory-in-use. When one becomes aware of it, it can lead to a reconciliation of the two (espoused theory and theory-in-use). The goal of this study is to examine the consistency between therapists espoused theory (words) and theory-in-use (actions) regarding whether clients should be informed of AAMFT, the AAMFT code of ethics, and the AAMFT grievance procedure. By examining the consistency, the study will determine the professions’ espoused theory and theory-in-use, and whether or not they are consistent.

CHAPTER THREE: METHODS

The purpose of this study is to examine the AAMFT professions' beliefs and actions regarding if clients should be informed of the AAMFT code of ethics and the grievance procedure, and who is responsible for informing the client, with a specific emphasis on the therapist's role. This chapter describes the research methods used for the study.

Sample

This study is a descriptive study design with a stratified sample of American Association for Marriage and Family Therapy (AAMFT) members. The three strata sampled were AAMFT clinical members, AAMFT state division officers, and AAMFT national ethics committee members. In the first strata subsample, five hundred AAMFT clinical members were randomly selected through a computer program from five states chosen to be geographically representative of the AAMFT organization. One hundred members were chosen from each of the following states: New York, Georgia, Kansas, Minnesota, and Colorado. Of the 500 clinical members, a total of 137 (27.4%) returned the survey. The largest return came from Minnesota with 40 out of 100 surveys returned; followed by Kansas with 27 out of 100, New York with 26 out of 100, Colorado with 23 out of 100, and finally Georgia with 21 out of 100.

The second strata subsample consisted of AAMFT state division officers including the current state division president, the two most recent past-presidents, the president elect, and the state division's ethics chair from the fifty-three active states and Canadian AAMFT divisions. The names and addresses of potential participants were retrieved from the AAMFT organization's web page or through personal phone calls to the division president. Not all state or Canadian divisions had the five division positions, so a total of 190 surveys were sent. Eighty-six (45.3%) surveys were returned from this subsample. Of the surveys returned, 53 were from presidents, 38 from presidents-elect, 79 from past presidents, and 20 from ethics chairs.

The present and past members (within the past ten years) of the national AAMFT ethics committee comprised the third strata subsample. Their names and addresses were solicited from the AAMFT national organization office. A total of twenty-four surveys were sent and eight (33.3%) were returned.

Overall, a total of seven hundred and fourteen surveys were mailed to the three sub-samples. The total number returned from the three samples was 231, with a response rate of 32.4%.

Demographic Information

The demographic information provided here combines all three strata sub-samples. The participants averaged between 40-60 years of age and included 108 males and 118 females. Two hundred and fifteen (93.9%) participants described themselves as Caucasian, four (1.7%) as African American, 3 (1.3%) as native American, 3(1.3%) as Hispanic, and 3 (1.3%) as Asian. The highest level of education for this sample included 55% with Master's degrees and 44.6% with Doctorate degrees. When asked their primary academic background, 51.5% indicated they were trained as marriage and family therapists, 12.6% as psychologists, 10% as social workers, 4.8% as professional counselors, 8.2% as clergy, and 0.9% as clinical nurse specialists. Three-and-a-half percent marked the "other" category, which included law, medicine, or another form of counseling. Some of the participants (8.7%) marked more than one answer, with the most common combining marriage and family therapy with professional counselor, psychologist, or social worker. The primary professional field the participants identified with varied slightly from the academic field with 70.1% as marriage and family therapist, 9.1% as psychologists, 5.2% as social workers, 2.6% as professional counselors, 3.9% as clergy, 1.3% as clinical nurse specialist. Again, three-and-a-half percent identified with the "other" category and described fields such as medicine or administration. A few participants (4.3%) marked more than one category, with the most common combining marriage and family therapist with either professional counselor or clergy. Participants were then asked to indicate what type of practice they were engaged in. The sample is made up of professionals working in individual private practice (36.8%), group private

practice (14.7%), state or community agencies (8.2%), employee assistance programs (0.4%), non-profit agencies (11.7%), university training programs (11.3%), schools or education facilities (3.0%), or in another field (8.2%). Three percent of the sample stated they were not in practice.

The participants were asked to describe their AAMFT status. This question asked for participants to mark all that applied for the following categories: 95.2 percent described themselves as clinical members of AAMFT, 19.0% as state division past presidents, 11.7% as state division presidents, 7.8% as state division president elects, 6.5% as state division ethics chair, 0.4% as present national ethics committee members, 3.9% as past national ethics committee members, and 12.1% marked "other." The most common position specified under the other category was AAMFT approved supervisor. The most common number of years the participant had been a clinical member of AAMFT was six-to-ten years (27.7%). Nine (3.9%) participants stated they were not a clinical member of AAMFT, which could reflect public members of the national ethics committee or participants whose clinical membership has expired.

Procedures

A letter (Appendix A) was mailed to potential participants asking them to volunteer to complete an anonymous survey (Appendixes B & C), sign an informed consent form (Appendix D), and return both in a self-addressed, stamped envelope. The informed consent form provided an explanation of the study, the subject's rights as voluntary participants in the study, names and phone numbers of contact persons, and how the researcher would ensure confidentiality. Participants were expected to read the informed consent form, sign it, and return it with the survey. The surveys were color-coded to indicate which state the clinical member was from, and to distinguish between clinical members, state division officers, and ethics board members. Otherwise, there was no identifying information on the survey itself.

The survey was divided into 3 sections: 1) basic demographic information; 2) information regarding the participants' AAMFT status and professional history in the

field of marriage and family therapy; and 3) questions related specifically to the research questions. Clinical members and state division officers were sent a 35 question survey (Appendix B) and ethics committee members were sent a 29 question survey (Appendix C). The clinical members and state division officers survey consisted of 27 multiple choice questions and 8 short answer questions. The national ethics committee survey consisted of 24 multiple choice questions and 5 short answer questions. The additional six questions were added to the clinical member and state division officer survey to ask specific questions related to their practice of informing their clients of their membership in AAMFT, the AAMFT code of ethics, and the AAMFT grievance procedure. The national ethics committee sample did not have these questions in their survey, since the ethics committee consists of public members as well as clinical members. Instead, they were asked three questions which elicited their opinions on the overall client population's knowledge of the AAMFT organization, the code of ethics, and the grievance procedure. A postcard was sent four weeks after the survey had been originally mailed to remind the potential participants to complete and return the survey. When a survey was received, the informed consent form was separated from the survey and stored in a separate, locked location to ensure confidentiality. Quantitative data from each survey was entered into the SPSS statistical software package for analysis.

Short answer questions were used to generate both qualitative and quantitative data. Qualitative information obtained through the short answer questions was coded and categorized using content analysis (Marshall & Rossman, 1989). Content analysis allows the researcher to identify patterns and to obtain an objective and quantitative description of the content (Marshall & Rossman, 1989). Pre-determined categories were applied to the data gathered from the survey responses. The information was then coded into quantitative data in two ways. Subjects were asked questions regarding their beliefs if therapists, state divisions, and/or the national ethics committee had a responsibility to inform clients about the AAMFT organization, the AAMFT code of ethics, and the AAMFT grievance procedure. Clinical members and state division officers were also asked the actions they took to inform the client. First the data was categorized into "yes" or "no" answers based on the reply. If the subject indicated there was any level of

responsibility or if they took any action to inform, no matter how small, the answer was coded “yes.” If the subject indicated there was no responsibility or took no action to inform, it was coded “no.”

Secondly, the answers were then coded according to how active an effort the participant made to inform their clients of their AAMFT membership, the code of ethics, and grievance procedure. The level of action was coded into predetermined categories: proactive, semi-active, passive, do nothing, and no responsibility/do not inform.

"Proactive" was defined as taking direct action to inform the client. It was defined as the therapist (or state division or national ethics committee) doing something actively to inform or take responsibility for informing. It is a direct action from the person or organization to inform the client. Examples include the therapist tells the client verbally, information is provided in the informed consent form which the client is given to read and sign, or, advertising directly to the public (for state division and AAMFT national ethics committee only), e.g., public service announcements, newspaper articles, etc.

"Semi-active" was defined as taking indirect action or having indirect responsibility to inform the client – making information easily available but not actively drawing the client’s attention to it. Examples include hanging the AAMFT clinical membership certificate on the wall; providing information in a brochure or business card in the waiting room; using the AAMFT logo in their advertisement; or, in the case of state divisions and national ethics committee, when action is taken through the therapist to inform the client (i.e., provide workshops to therapists on ethics, provide brochures to the therapist to distribute, etc.). The third category is "Passive." This was defined as providing information is only when the client inquires. Another category was "Do Nothing." This category was used in cases where the subject believed there was a responsibility to inform but would make no effort to do so, not even answering questions when asked. The final main category was "No responsibility/Do not inform." This category was used when the participant believed there was no responsibility and therefore did not inform their clients of any information regarding AAMFT, the code of ethics, or the grievance procedure. Specific quantitative questions regarding how the participant informs his/her own clients were also used to determine if the subject informed his/her

client and to determine the level of action. The participant's short answers were read, and using a content analysis method, it was decided by the researcher in which category the answer belonged. The most active response the subject gave on both items was used as the basis for categorizing the answer. For example, a participant may have indicated that he/she did not inform his/her clients of AAMFT in the short answer question. However, the subject indicated in the quantitative, multiple-choice question that he/she uses the AAMFT logo on business cards. The short answer question would be coded as “yes” the subject does inform clients on a semi-active level, based on the quantitative answer. This was used to clarify ambiguity in answers and to provide consistency.

During the coding process, answers that were unclear as to which category they belonged in (either yes/no or the level of activity) were discussed with the faculty advisor and a consensus was reached. Rules for coding were developed from these discussions. The faculty advisor also independently coded a sub-sample of 29 (21.2%) randomly selected surveys. The researcher and advisor agreed on the coding on all but two of the sample selected to cross code. The items that were disagreed upon were discussed and the researcher and advisor came to a consensus. Short answer questions coded by the two methods just described were also entered into the SPSS package.

The short answer data was also categorized into major overriding themes by using a modification version of Glaser and Strauss’ (1967) constant comparative method. Short answers were read again by the researcher. Since theory development was not the goal of this analysis, major themes were identified from the responses and categorized accordingly by comparing each response with the others. The categories were then used to more completely understand the participants’ meanings and the quantitative findings.

Measures

A questionnaire was constructed by the researcher to ascertain information from AAMFT clinical members, state division officers, and national ethics committee members regarding their opinion on if clients should be informed of the AAMFT code of ethics and grievance procedure and whose responsibility it is to provide that information.

The questionnaire was divided into the following categories: demographic information, knowledge of the code and grievance procedure, beliefs, actions, and perception of client knowledge.

Demographics Questions

The survey requested participants to provide demographic information including gender, age, ethnic background, and education level. The participants were also asked to indicate their primary academic background, professional field, and type of practice. The categories that form the answers to these questions were derived from Doherty and Simmon's (1996) survey. Participants were also asked their AAMFT status and number of years as an AAMFT clinical member. See questions 1-9 in Appendixes B and C.

Knowledge of AAMFT Code of Ethics and Grievance Procedure

Questions 10-14 (in Appendixes B and C) inquired about the participant's knowledge of the AAMFT code of ethics and grievance procedure. Participants indicated the most recent time they had read the code and grievance procedure, how knowledgeable they felt they were with regard to the code and procedure, and what the primary sources of their ideas regarding professional ethics were.

Beliefs on Informing Clients

Eleven questions (questions 15-25 in Appendixes B and C) were used to assess the participant's beliefs on informing clients about AAMFT, the AAMFT Code of Ethics, and the AAMFT Grievance Procedure. Questions 15-17 specifically asked if clients should be informed in the three areas. Questions 18-20 provided categories for the participant to indicate who, in their opinion, had the primary responsibility to inform clients in the three areas. Finally, five short answer questions (21-25) were used to ascertain the participant's belief with regards to specific responsibilities for the therapist, state divisions, and the national AAMFT ethics committee to inform clients.

Actions on Informing Clients

State division officers and clinical members were asked what actions they took to inform their clients of AAMFT, the AAMFT code of ethics, and the AAMFT grievance procedure (questions 27-32 in Appendix B). Three multiple choice questions were used to determine how the participant informed his/her client of the three areas. Three short answer questions were asked to further describe the specific information the participant provided to clients.

Perception of Client Knowledge

State division officers and clinical members were asked to indicate their perception of their current caseload's awareness of AAMFT, the AAMFT code of ethics, and the AAMFT grievance procedure (questions 33-35 in Appendix B). The national AAMFT ethics committee members were asked to indicate their opinion of overall public knowledge of the three categories (questions 27-29 in Appendix C).

Data Analysis

Demographics and Knowledge of AAMFT Code of Ethics and Grievance Procedure

Frequencies were calculated for the demographic information (questions 1-9) to provide a description of the survey sample. Also, frequencies were done to describe the sample's knowledge of the AAMFT code of ethics and grievance procedure on questions 10-14.

Beliefs on Informing Clients

Research Question One: Should clients be informed that AAMFT, the code of ethics, and the grievance procedure exist?

Research Question Two: Whose responsibility is it to inform the client of what AAMFT is, the code of ethics, and the grievance procedure?

Research Question Three: Do therapists specifically have a responsibility to inform their clients of AAMFT, the code of ethics, and the grievance procedure?

Research questions one, two and three asked for information regarding the participant's beliefs on informing clients of AAMFT, the AAMFT code of ethics, and the AAMFT grievance procedure, whose responsibility it is to inform clients of this information, and if therapists had a specific responsibility to inform. Frequencies were calculated for the participants' responses to questions 15-25 on the surveys and results examined.

Actions on Informing Clients

Research Question Six: Specifically, what do therapists currently do in their practice to inform clients about AAMFT, the code of ethics, and the grievance procedure?

Frequency statistics were also completed on the clinical members and state division officers' responses to survey questions 27-32 (Appendix B), which asked what action therapists took to inform clients of AAMFT, the AAMFT code of ethics, and the AAMFT grievance procedure. The results were examined and provided information to answer research question six.

Perception of Client Knowledge

Research Question Four: What are the therapists', state division officers', and AAMFT national ethics board members' perceptions of client knowledge of AAMFT, the code of ethics, and the grievance procedure? What percentage are aware?

Additionally, frequencies were calculated for questions 33-35 (Appendix B) and questions 27-29 (Appendix C), which examined the participants' perceptions of client knowledge of the AAMFT organization, the AAMFT code of ethics, and the AAMFT grievance procedure (research question four) and results examined.

Other Research Questions

Research Question Five: Are there differences between therapists, state division officers, and the ethics board committee members in regards to questions 1-4?

Research question five asked to determine if differences existed between therapists, state division officers, and the AAMFT national ethics committee members regarding research questions 1-4 (should clients be informed, whose responsibility it is to inform clients, do therapists have a specific responsibility to inform, and perceptions of client knowledge). First, frequency statistics were performed and results were compared between the three groups. Since the ethics committee sample was so small, it was combined with state officials to create one sub-sample of “AAMFT officials.” Second, a cross tab analysis was then performed to further compare the data.

Research Question Seven: Are therapists' actions regarding informing clients of AAMFT, the code of ethics, and the grievance procedure consistent with their beliefs?

A bi-nominal test (Roscoe, 1969) was used to determine if therapists' actions were consistent with their beliefs regarding informing clients of AAMFT, the AAMFT code of ethics, and the AAMFT grievance procedure. For each question (AAMFT, Code of Ethics and grievance procedure) participants were first divided into two groups -- those who believe the therapist is responsible for informing the client, and those who do not believe the therapist is responsible. A binomial test was then used to see if the results in each group met the criterion for consistency. Consistency was arbitrarily defined as 80% or more of the participants acting in a way that matched their belief. For example, the group that believe the therapist is responsible for informing the client about the existence of AAMFT would be judged consistent in their actions if 80% or more of the participants did something to inform their clients about AAMFT. Since the binomial test only indicates whether or not the observed value is equal to the expected value (in this case 80%), when a significant difference was found, it was further examined to determine the direction of the difference. Significant differences that fell below the criterion for consistency were judged inconsistent (e.g. a 50% observed result was judged inconsistent given the 80% criterion) while those that fell significantly above the criterion was judged to be consistent.

CHAPTER FOUR: RESULTS

The data in this chapter comes from the analysis performed on the participants' answers to the survey regarding whether clients should be informed of the AAMFT code of ethics and grievance procedure, as well as who is responsible for informing the client. Most of the results come from quantitative data which were analyzed using the SPSS statistical software package. A few short answer questions were coded into general themes to provide a better understanding of participants' opinions. The survey questions were divided into five sections: demographic information, knowledge of AAMFT code of ethics and grievance procedures, beliefs on informing clients, actions on informing clients, and perception of client knowledge. The demographic information has already been described in Chapter Three. This section begins with a brief description of the participants' knowledge of the code of ethics and grievance procedures. Results from the remaining three sections are described in terms of the guiding research questions.

Knowledge of AAMFT Code of Ethics and Grievance Procedures

Participants were asked to indicate the last time they read the AAMFT code of ethics and the grievance procedure. Participants were asked to choose from seven multiple choice options. A frequency statistic was performed for each question. Twenty-nine percent indicated they had read the code of ethics within the past three months; 31.2% within the past year; 19.5% within the past two years; 12.1% within the past five years; 4.8% within the past ten years; 0.4% over ten years ago; while 2.2% indicated they had not read the code of ethics, as shown in Figure 1. Eight-and-seven-tenths percent indicated they had read the grievance procedure within the past three months; 22.1% within the past year; 18.6% within the past two years; 15.6% within the past five years; 4.3% within the past ten years; 1.3% over ten years ago. Finally, 29% of the participants indicated they had never read the AAMFT grievance procedure (see Figure 2). While the results indicate that participants are familiar with the code of ethics, almost one third of the sample said they have not read the grievance procedure.

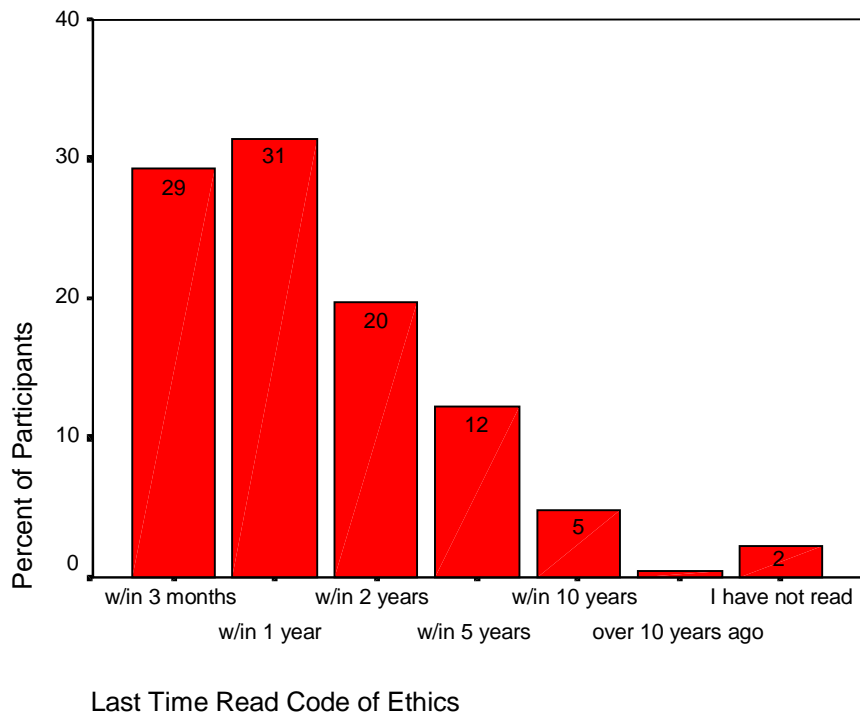


Figure 1: Participants' familiarity with the AAMFT Code of Ethics.

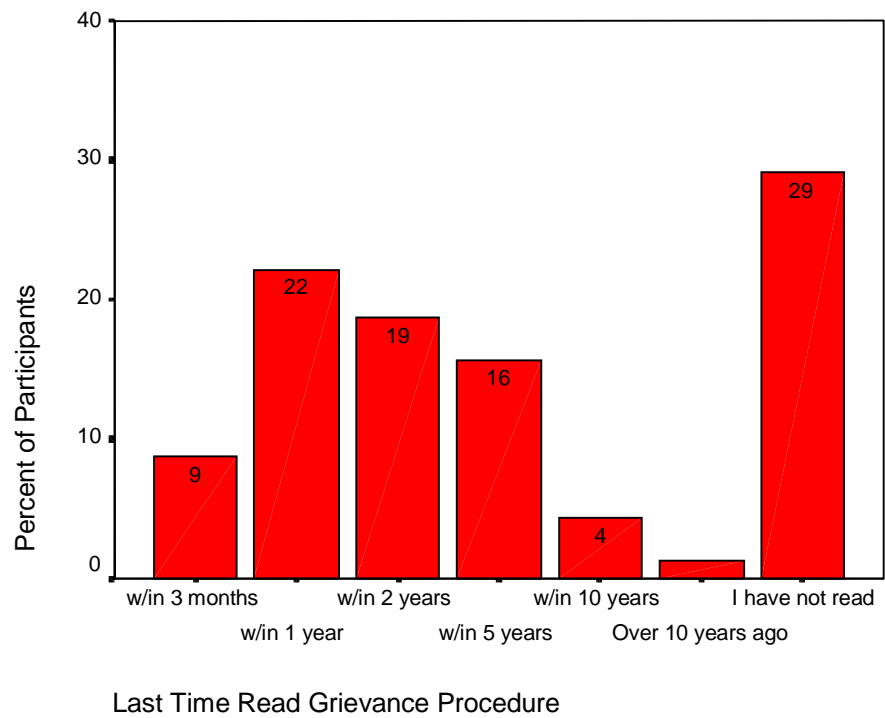


Figure 2: Participants' familiarity with the AAMFT grievance procedure.

Next, the participants were asked to indicate their level of knowledge of the code of ethics and the grievance procedure. Concerning the code of ethics, three percent stated they were not knowledgeable at all; 35.5% felt they were somewhat knowledgeable; 35.9% felt knowledgeable; 17.3% indicated they were very knowledgeable; and 7.8% were extremely knowledgeable (see Figure 3). In regard to the grievance procedure, 35.5% indicated they were not knowledgeable at all; 42.9% felt somewhat knowledgeable; 12.6% felt knowledgeable; 5.6% indicated they were very knowledgeable; and 3.0% stated they were extremely knowledgeable (see Figure 4). The results indicate that most participants report moderate levels of knowledge about the code of ethics. However, in regard to the grievance procedure, most participants report their level of knowledge as low, as illustrated in Figure 4.

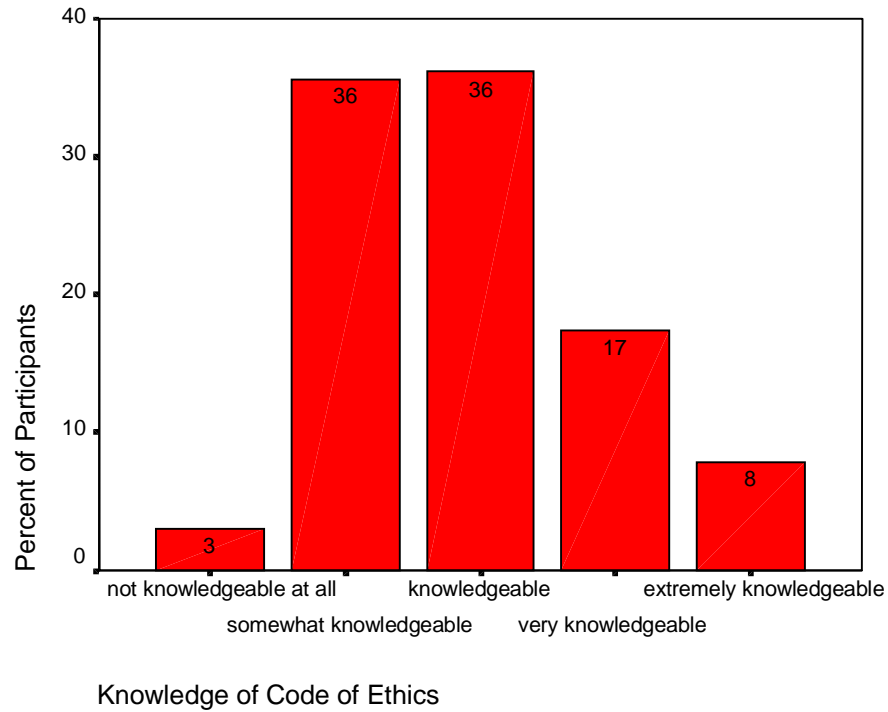


Figure 3: Participants' self-reported knowledge of the AAMFT code of ethics.

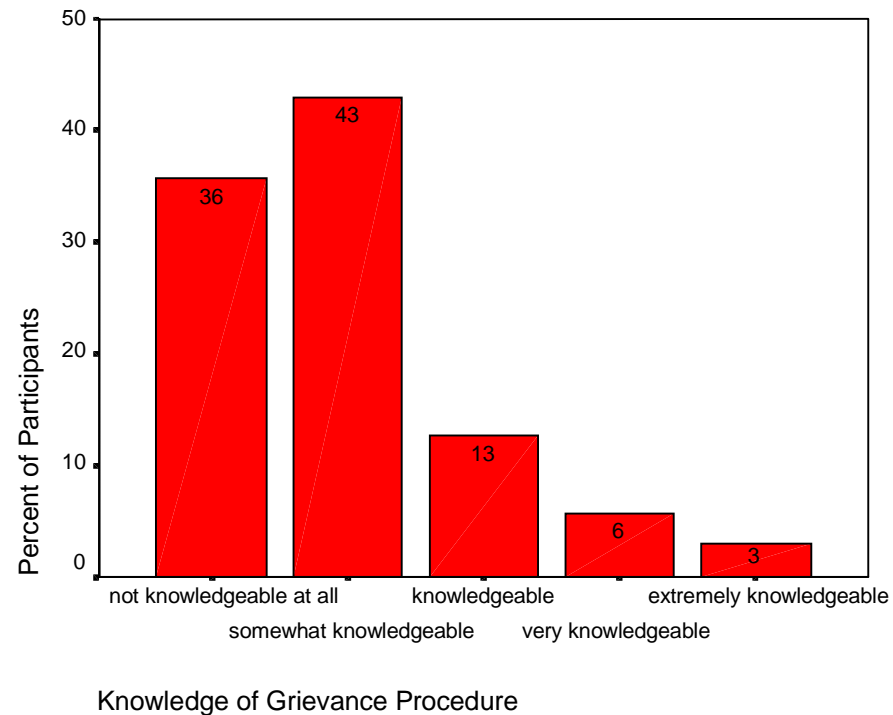


Figure 4: Participants' self-reported knowledge of the AAMFT grievance procedure.

Finally, participants indicated where their ideas about marriage and family therapy ethics came from. The two largest contributors to the participants' ideas about ethics came from core personal values (58.9%) and training program/graduate coursework (57.8%). Other influences included the AAMFT national organization (41.6%), AAMFT state divisions (29.4%), supervisors/supervision (42.4%), other colleagues (33.8%), state licensing board regulations (43.7%), scholarly articles/workshops (35.9%), and theoretical background (22.5%). The results indicate that a wide range of mediums influence participants' ideas about ethics.

Table 1

Influences for Ideas About Marriage and Family Therapy Ethics

Influences	Percentage
Core Personal Values	58.8%
Graduate Coursework	57.8%
State Licensing Board Regulations	43.7%
Supervisors/Supervision	42.4%
AAMFT National Organization	41.6%
Scholarly Articles/Workshops	35.9%
Other Colleagues	33.8%
AAMFT State Division	29.4%
Theoretical Background	22.5%

Note. Participants could choose more than one answer.

Beliefs on Informing Clients

Research Question One: Should clients be informed that AAMFT, the code of ethics, and the grievance procedure exist?

The participants were fairly consistent in their belief that clients should be informed. One hundred and eighty-four of the participants (79.7%) indicated that clients should be informed about AAMFT, while 41 (17.7%) felt clients should not be informed (see Figure 5). In regard to the code of ethics, 191 (82.7%) stated that clients should be

informed and 35 (15.2%) participants felt clients should not (see Figure 6). The number of participants who feel that clients should be informed about the grievance procedure was slightly lower. One hundred and sixty of the participants (69.3%) indicated clients should be informed about the procedure and 63 (27.3%) thought clients should not be informed (see Figure 7). While the results indicate a consensus in beliefs about informing clients about AAMFT and the code of ethics, fewer participants believe clients should be informed of the grievance procedure.

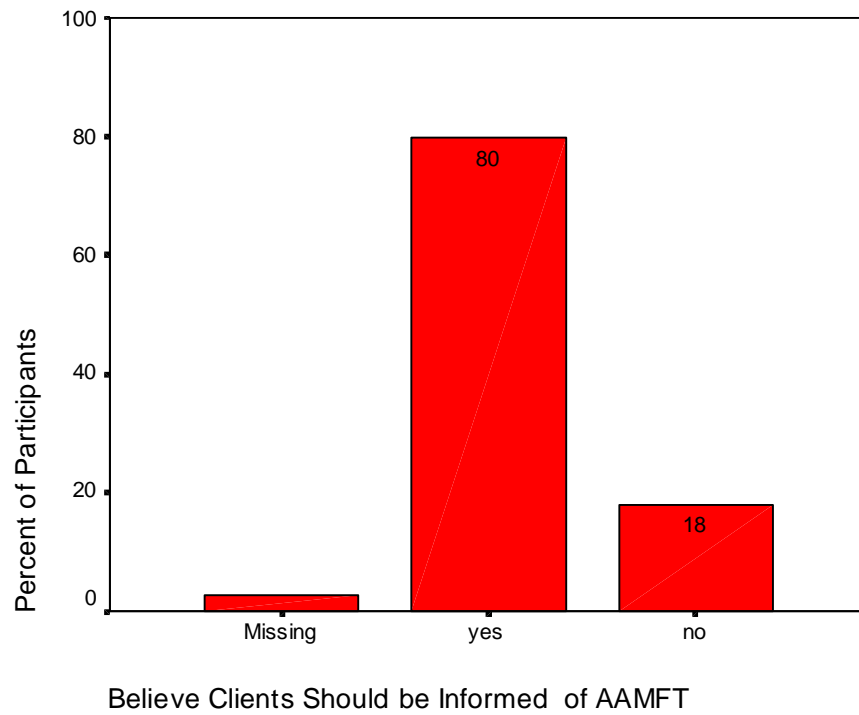


Figure 5 Participants' beliefs on informing clients of AAMFT.

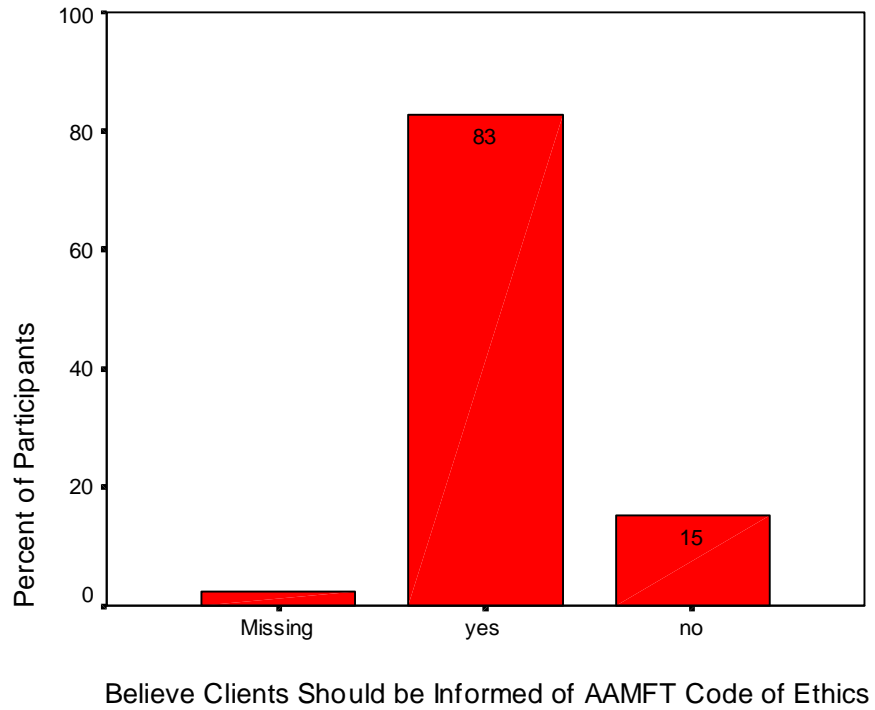


Figure 6: Participants' beliefs on informing clients of code of ethics.

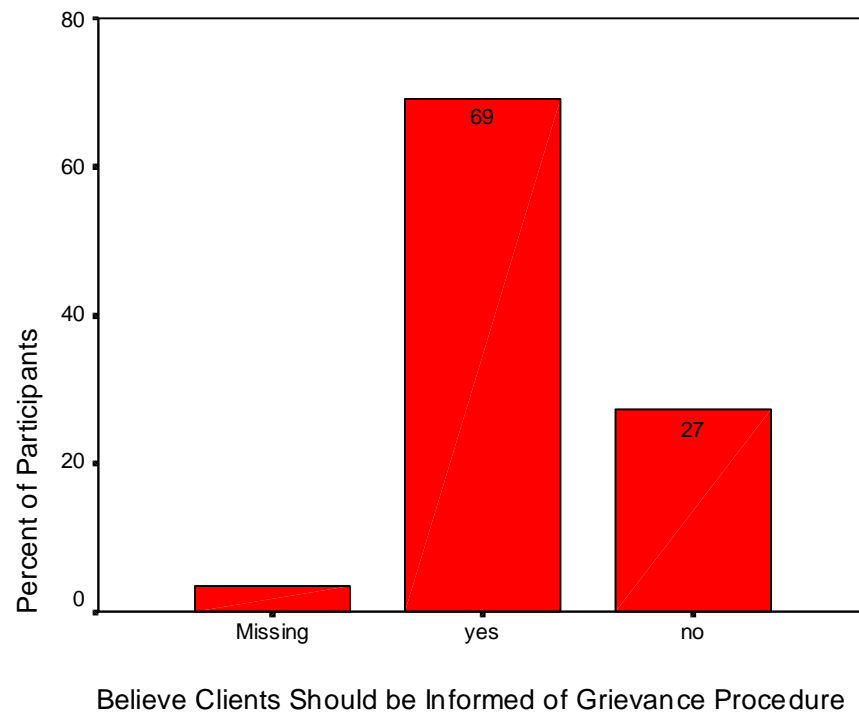
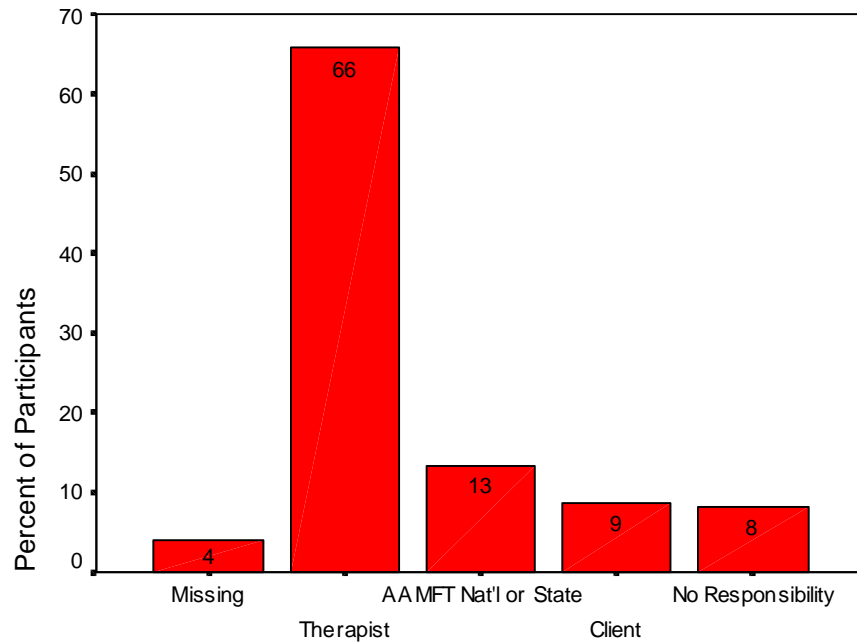


Figure 7: Participants' beliefs on informing clients of grievance procedure.

Research Question Two: Whose responsibility is it to inform the client of what AAMFT is, the code of ethics, and the grievance procedure?

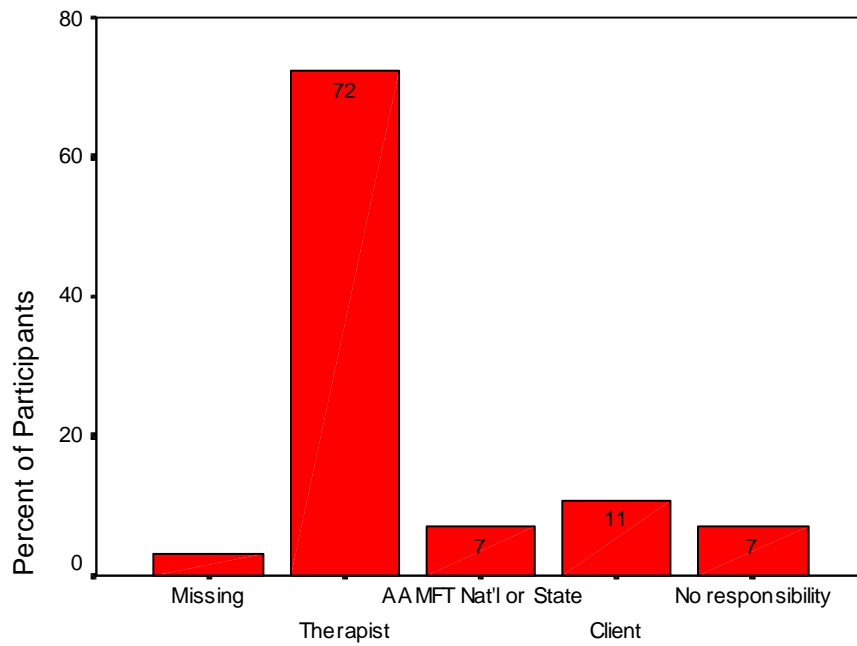
A majority of the sample believe it is the therapist's responsibility to inform the client of AAMFT (65.8 %), the code of ethics (72.3%), and the grievance procedure (59.7%). In each category, approximately ten percent of the sample felt the client should investigate for him/herself if the client wants the information. Some participants indicated that no responsibility existed to inform the client of AAMFT (8.2%), the code of ethics (6.9%), nor the grievance procedure (7.8%).

The AAMFT national or state organization was considered by 13.4% of the participants to have the responsibility to inform clients about the organization, but only 6.9% of participants believed it was the national's or states' responsibility to inform clients about the code of ethics. However, 14.3% indicating it is the national or state organization's responsibility to inform the client about the grievance procedure. Figures 8, 9, and 10 detail the results, which indicate the participants believe the therapist has the primary responsibility to inform the client of AAMFT, the code of ethics, and the grievance procedure.



Responsible to Inform Client of AAMFT

Figure 8: Participants' beliefs regarding who is responsible to inform clients of AAMFT.



Responsible to Inform Clients of Code of Ethics

Figure 9: Participants' beliefs on informing clients of code of ethics.

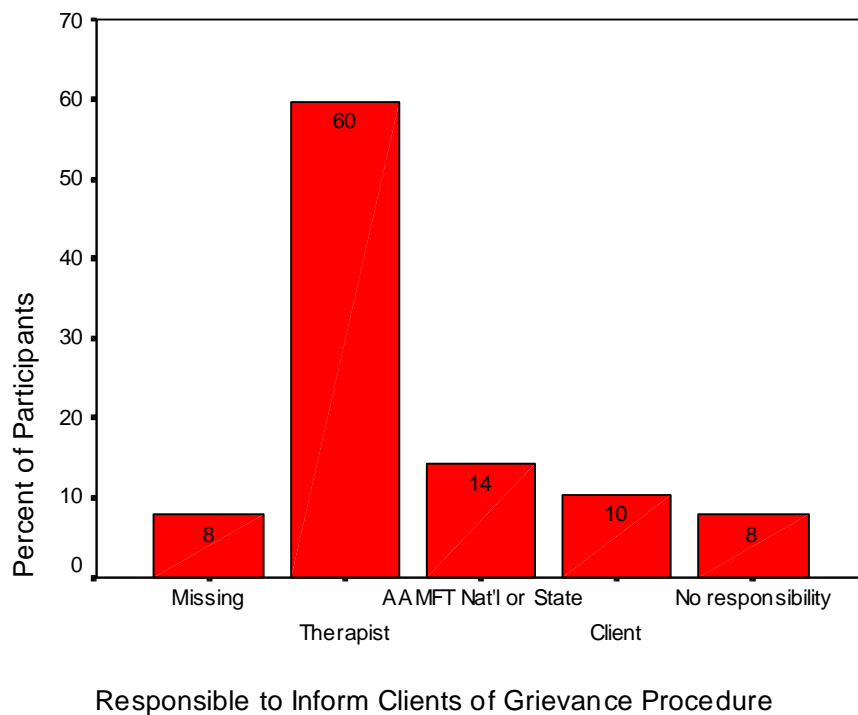
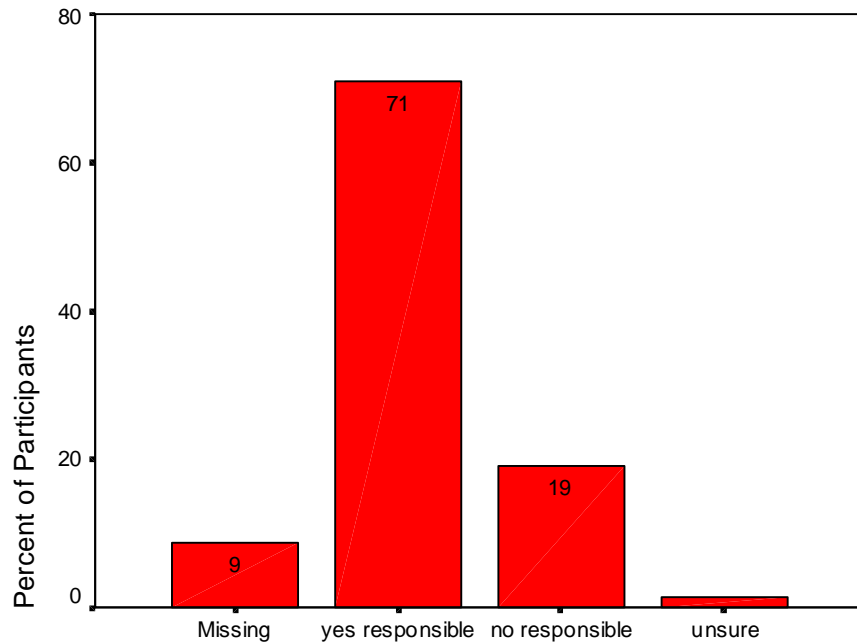


Figure 10: Participants' beliefs on informing clients of grievance procedure.

Research Question Three: Do therapists specifically have a responsibility to inform their clients of AAMFT, the code of ethics, and the grievance procedure?

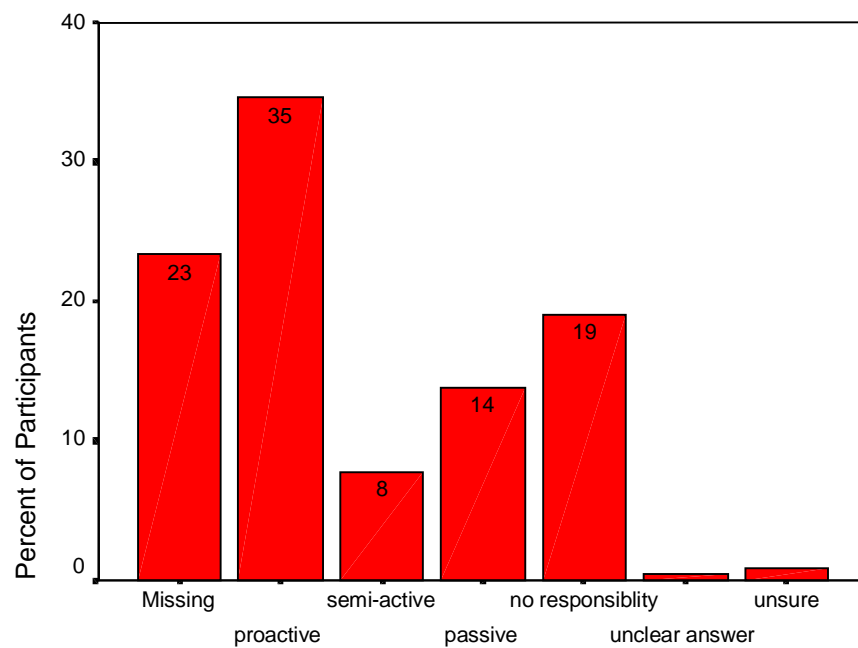
When asked specifically if therapists have a responsibility to inform the client about the AAMFT organization, 71.0% of the participants said yes. Nineteen percent did not believe the therapist had a specific responsibility and 9% of the answers were coded as missing data (see Figure 11). The level of action that participants believed the therapist should take varied in the following manner, as indicated in Figure 12: 34.6% believed the therapist should be proactive (therapist takes a direct actions to inform the client); 7.8% semi-active (information is easily available but therapist does not actively draw attention to it); 13.9% passive (provide information only when asked). Interestingly, when asked specifically if the therapist is responsible to inform (as compared to research question two which asked who was responsible and gave different options), the percentage in support rose from 66% to 71%. One-third of these participants believed the therapist had a responsibility to be proactive to inform clients,

while another third believed the therapist should either act passively or has no responsibility.



Believe Therapist Responsible to Inform Client of AAMFT

Figure 11: Participants' beliefs regarding therapist responsible for informing the client of AAMFT.



Level of Belief for Therapist Responsible to Inform Client of AAMFT

Figure 12: Participants' belief about the level of informing clients of AAMFT.

Participants were asked to provide a short answer description of what they felt a therapist should do to inform his or her clients of AAMFT. Those who felt the therapist does have a responsibility to provide information described the actions a therapist might take in a variety of ways. Some felt that giving this information should be part of the beginning of treatment – a regular routine beginning with a new client. This information would be presented as part of the informed consent or disclosure statement signing process. Others felt that the information should be given selectively – when the client asked directly about it, to build trust between the client and the therapist, or when the therapist judged the client needed the information. Unfortunately, no participants gave examples of situations that would lead the therapist to make a decision that the client needed such information. Finally, some participants felt that giving information about AAMFT was the therapist's responsibility only in states that did not have state licensure for marriage and family therapists. In states with licensing, informing clients about the licensing laws and state grievance procedures overrode the therapist's responsibility to inform them about AAMFT.

There were five main themes for understanding why some participants believed the therapist is not responsible to inform the client about the AAMFT organization. One theme that emerged included AAMFT is a voluntary organization. Some of the responses for this theme included, “None. AAMFT is a professional organization and has little to do with direct service,” and “None. AAMFT is a trade organization. Why should clients care about what trade organizations I belong to?” One participant stated her belief that the AAMFT is for therapists, not clients. She states,

The organization is the guild for the therapist. The ethics committee can and does address issues regarding members' behavior. Only through Principle 6, responsibility to the profession, is there a hint of the need to inform clients of AAMFT. Our guild is more for us than for clients.

Another theme came forth was therapist judgement. Many respondents felt the information was not relevant to therapy, was too overwhelming for clients, or the clients were not interested in information about therapist. One respondent wrote, “No

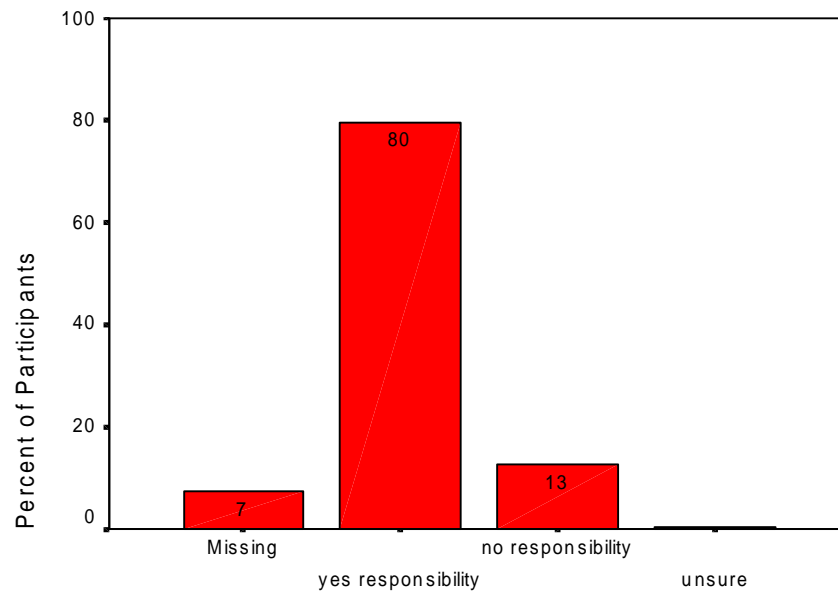
responsibility. Most clients don't care about national membership." Another participant spoke to the information being too overwhelming for clients:

When I consider all the things we have to do upon initiating contact/clinical work with a client, I can't imagine adding more to the plate. Most client's don't hear half of the "necessary information" we give them now. Their pain is too great.

The last three themes from the participants' responses included: divulging information is a choice and not a responsibility, no responsibility exists unless the client specifically asks, and marriage and family therapy is regulated by the state licensing boards.

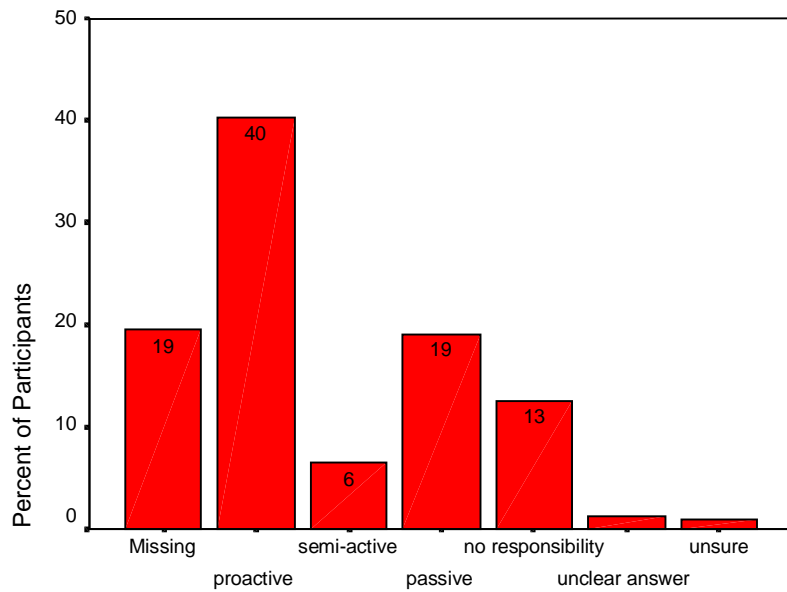
The results from the short answer indicate there are a number of perceptions that participants have about their responsibility to inform clients of AAMFT. There seems to be no consensus in the beliefs, as shown by the number of themes that emerged either for or against the therapist being responsible.

The belief that the therapist is responsible for informing the client of the code of ethics increased in comparison to the percentage who believed the therapist is responsible to provide information about the organization. A total of 79.7% from this sample believe it is the therapist's responsibility to inform while 12.6% believe it is not (see Figure 13). Over forty percent (40.3%) believed the therapist should be proactive (take direct action to inform the client), 6.5% semi-active (make information easily available but does not draw attention to it), and 19.0% passive (provide information only when asked) in providing the information about the AAMFT code of ethics (see Figure 14). Over half of the participants believed the therapist should either be proactive or passive, which seems to indicate either a be forthright approach or a "don't ask, don't tell" approach to informing clients about the code of ethics.



Believe Therapist is Responsible to Inform Client of Code

Figure 13: Participants' beliefs about the therapist being responsible to inform clients about the code of ethics.



Level of Belief Therapist Responsible to Inform Client of Code of Ethics

Figure 14: Participants' belief about the level of informing clients of the code of ethics.

The short answer question regarding the therapist's responsibility to inform the client about the code of ethics yielded many themes. Seven categories emerged from the answers of those who believe the therapist is responsible to inform the client. The beginning of treatment and to build trust in the therapeutic relationship again spoke to the therapist actually doing something. A participant wrote, "New client information sheets should state that the therapist is bound by AAMFT professional code of ethics." Another respondent felt, "If it is needed to increase confidence in therapist-client relationship, it should be described and/or shown." The themes of in therapist's judgement, if the client initiates, and in a non-licensed state were again derived from the responses in support of the therapist being responsible. Two new themes emerged from the data: stating only parts of the code, such as those items that apply specifically to clients or are mandated by law, and the information being part of client rights. One respondent reported, "Clients have the right to know what ethical code we follow and should be informed by the therapist and/or intake worker."

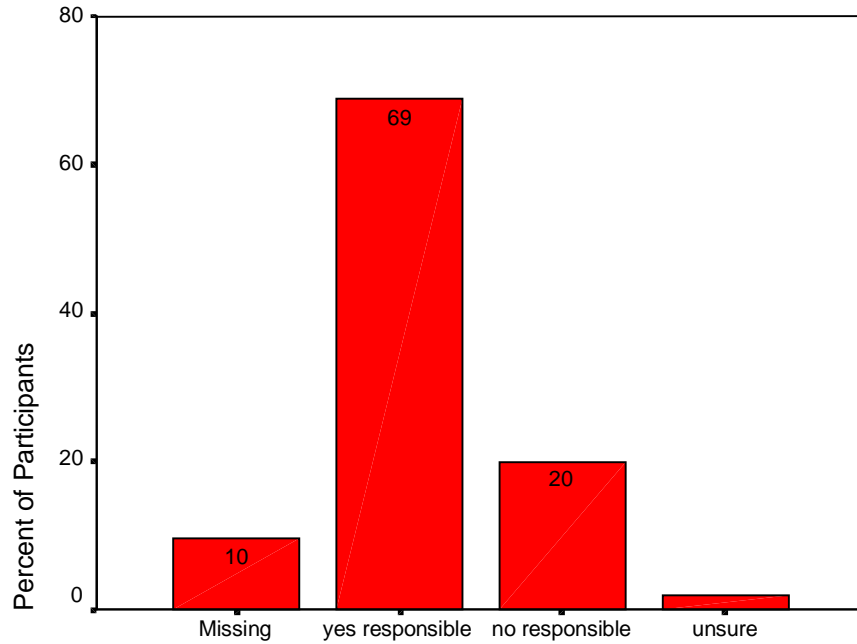
Five themes emerged from the answers of those who felt there was no responsibility to inform clients about the AAMFT code of ethics. Again, if client initiates and therapist judgement were two dominant themes. One respondent combined the two and stated,

I believe the [code of] ethics only needs to be provided when the client requests info or when the therapist believes the client needs to know in order to respond to a situation. I do not believe it is necessary to automatically provide every client.

Another participant's response reflected the theme of therapist's judgement. The answer stated, "If it [information about the code of ethics] would unsettle a client and make him/her fearful of therapist by raising questions he/she doesn't have, skip it." The remaining three themes included: marriage and family therapy regulated by state licensing boards, AAMFT is a voluntary organization, and the code only provides guidelines and isn't mandatory.

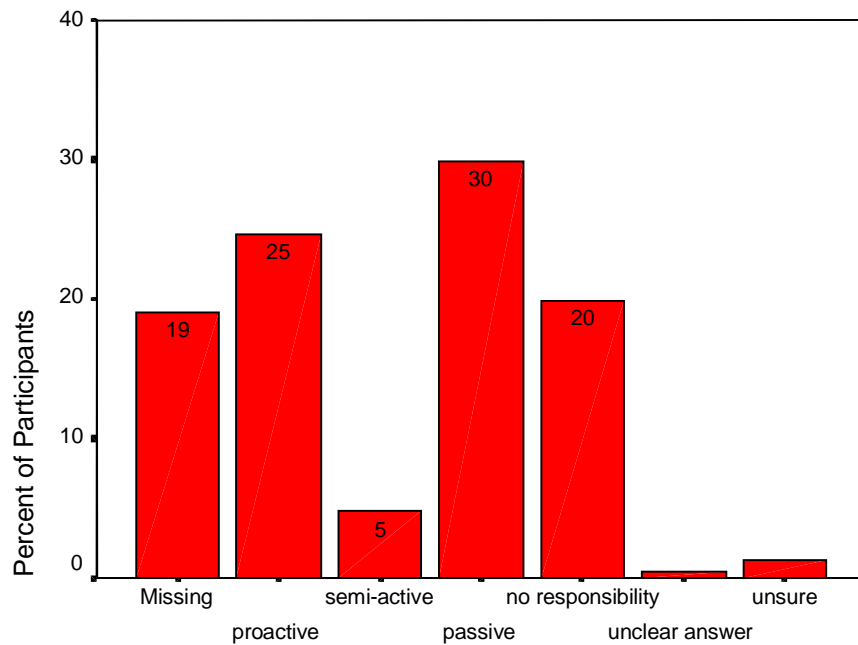
The results from the short answer responses again reflected the lack of consensus for the reasons why the therapist is responsible or not responsible to inform clients of the code of ethics. Although participants may agree that the therapist is or is not responsible, the answers seem to indicate a variety of reasons why, suggesting a sense of ambiguity in the field on this topic.

Support for the therapist being responsible to inform the client of the grievance procedure dropped to 68.8% in comparison to the beliefs the therapist was responsible to inform clients of the AAMFT organization and the code of ethics. Almost twenty percent (19.9%) believed the therapist is not responsible. The level of action the participants believed the therapist should take included: 24.7% believing the therapist should be proactive (direct action to inform the client), 4.8% semi-active (information easily available but does not actively draw attention to it), and a majority (29.9%) believing the therapist should be passive (provide information only when asked). Figures 15 and 16 display the results, which again indicate an increase in support that the therapist is responsible to inform the client of the grievance procedure when participants were asked specifically. Interestingly, half of the respondents believed the therapist either should be passive or had no responsibility to inform clients and only one-fourth believed the therapist should be proactive.



Believe Therapist Responsible to Inform Client of Grievance Procedure

Figure 15: Participants' beliefs regarding therapist responsible to inform of grievance procedure.



Level of Belief Therapist Responsible to Inform Client of Grievance

Figure 16: Participants' beliefs the level of informing clients of grievance procedure.

The short answer question generated common themes in support of both the therapist being responsible and not being responsible in informing the client of the AAMFT grievance procedure. Six themes arose to support the belief that the therapist is responsible. One theme that emerged was it is the client's right to know the information. "Clients need to know that we are held accountable and that they have the right to hold us accountable through a specific grievance procedure," stated one participant. Therapist's judgement is another theme that was stated by participants. One example of therapist judgement included how to determine the client's need for such information: "If a conflict arises, I think the therapist has an obligation to inform the client of the procedure." Another theme that emerged was when the client initiates wanting the information. The belief of one respondent was, "If client inquires, inform them of general [grievance] process, then give AAMFT number. They can call there, get assistance, and learn specific grievance procedure." Three additional themes that kept recurring were: in the beginning of treatment; in a non-licensed state; and to build trust in the therapeutic relationship.

Four main themes emerged from the responses of those who believed the therapist is not responsible to inform the client of the AAMFT grievance procedure. The four themes include: marriage and family therapy regulated by the state licensing boards; introduces doubt into the therapy process (i.e., implies reason to file, anticipates violations, no trust); therapist's judgement, and client initiates (i.e., respondent believes there is no responsibility with the exception of if the client asks). The theme of introducing doubt seemed to be echoed by many participants. Some of the responses included: "...to describe this [grievance] procedure during initial session may imply that there may be a reason during the therapist's work to file a grievance," and "None – in any profession, inherent that people (consumers) have recourse...but I think it's unnecessary to anticipate such." Again, the results from the short answer questions indicated a lack of consensus and ambiguity in the field because of the wide range of themes that emerged.

An interesting observation when reviewing the results is the apparent differences in level of action the therapist should take to be responsible to inform the client of AAMFT, the code of ethics, and the grievance procedure. For both informing clients of AAMFT and the code of ethics, the support for being proactive is high. However, there seems to be less support for informing clients about the grievance procedure.

Finally, although not a research question, participants were asked their opinion regarding whether the state divisions and/or national ethics committee had any responsibility to inform clients about the code of ethics and the grievance procedure. Sixty-seven percent indicated that the state division and 64% felt the national ethics committee had some level of responsibility. About 20% of the sample felt neither the state division nor the national ethics committee had any responsibility (see Figures 17 and 18). The beliefs about the level of responsibility for each varied (see Figures 19 and 20). Twenty-seven percent believed the state divisions should be proactive (direct action from the organization to inform the client), 6.9% semi-active (indirect action from the organization to inform the client), and 12.6% passive (provide information only if the client inquires). The beliefs about the role of the national ethics committee informing clients were 20.3% believing the committee should be proactive, 8.7% semi-active, 13.4% passive, and 0.4% believe the committee should do nothing (responsibility exists but organization would make no effort to inform at all).

The results indicate that participants believe that both the state divisions and the national ethics committee either need to be proactive in informing clients or they have no responsibility at all.

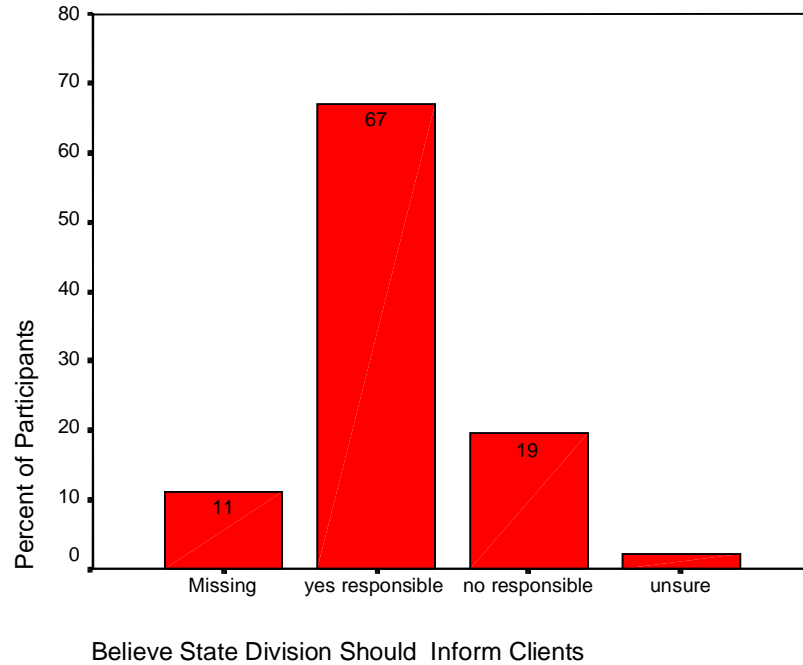


Figure 17: Participants' beliefs the state division should inform clients about code of ethics and/or grievance procedure.

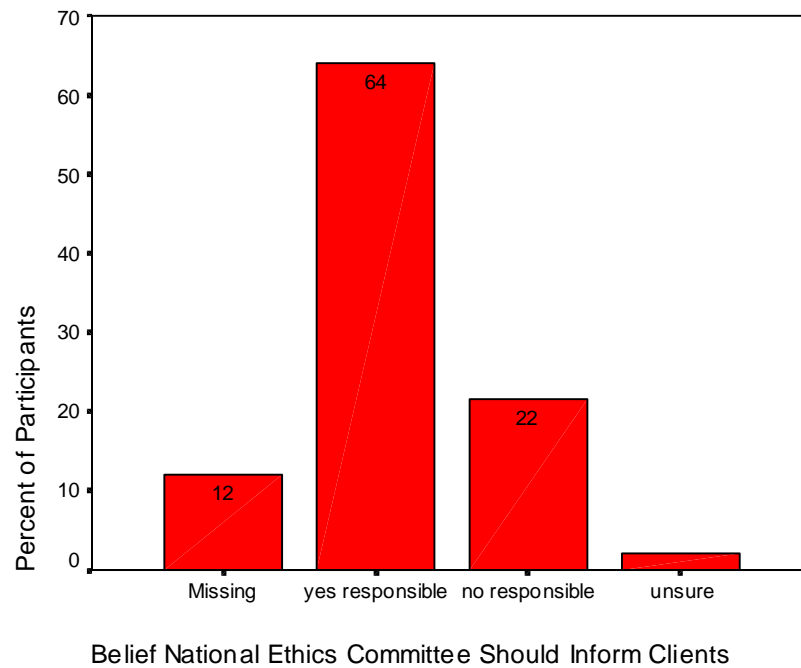


Figure 18: Participants' beliefs national ethics committee should inform clients about code of ethics and grievance procedure.

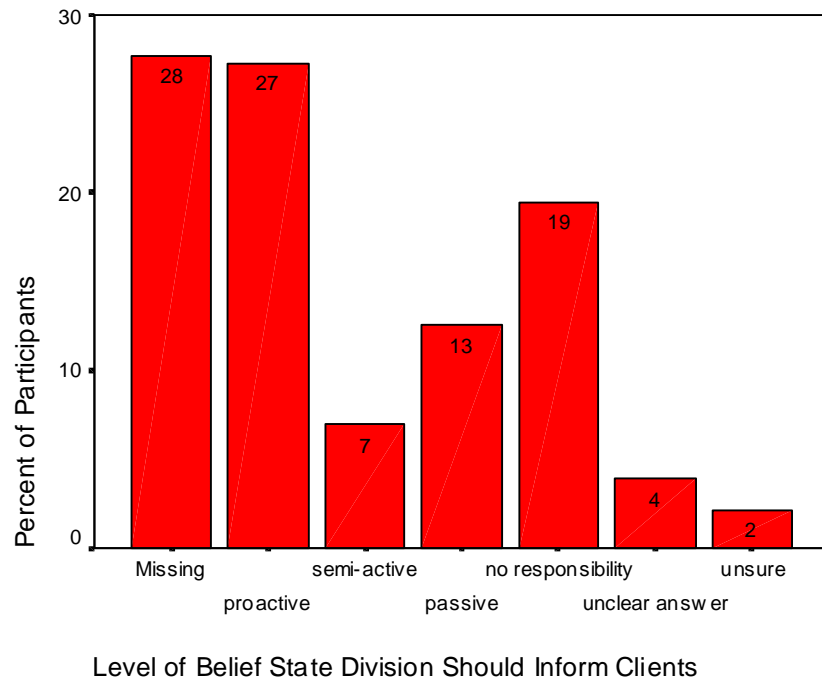


Figure 19: Participants' beliefs about the level of informing clients by the state divisions.

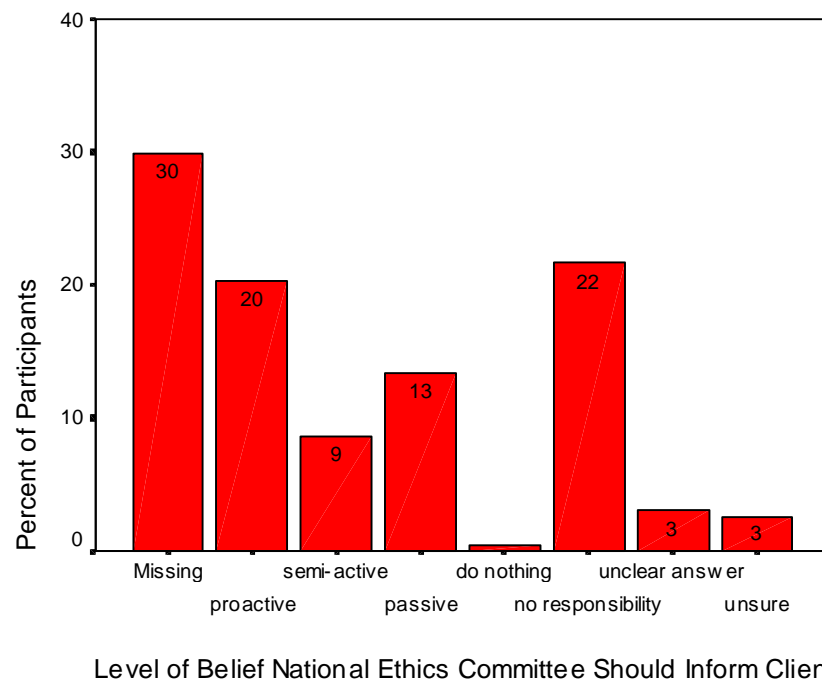


Figure 20: Participants' belief about the level of informing clients by the national ethics committee.

The themes that emerged from the participants' responses to the short answer questions asking if the state divisions and the national ethics committee had a responsibility to inform the client/public about the code of ethics and the grievance procedure were almost identical. The themes supporting the state division or national ethics committee having a responsibility included: promoting AAMFT (including the code and grievance procedure) through advertising, media, and internet; educating the public and therapists about AAMFT, the code of ethics, and the grievance procedure; if the client initiates (contacts the division or the national committee directly); influencing state licensing boards; and in non-licensed states where state regulations do not exist. The three themes that emerged from the responses who believe the state divisions and national ethics committee do not have a responsibility included: AAMFT a voluntary organization; state licensure boards regulate marriage and family therapy; and no responsibility exists unless specifically asked by client. The only theme that emerged that was unique to the national ethics committee indicated that the committee did not have responsibility because participants' believed the only job of the committee was to review complaints.

Again, a number of themes emerged from the short answer questions. This may, again indicate a lack of consensus in the professional community. In all, there seems to be no clear consensus of who is responsible to provide what information, or, more specifically, what is the role of the therapist, state division, and national ethics committee to inform clients. While there is a clear indication that clients should be informed, the results indicate the question of who should inform and how actively the information should be given remains unanswered.

Perception of Client Knowledge

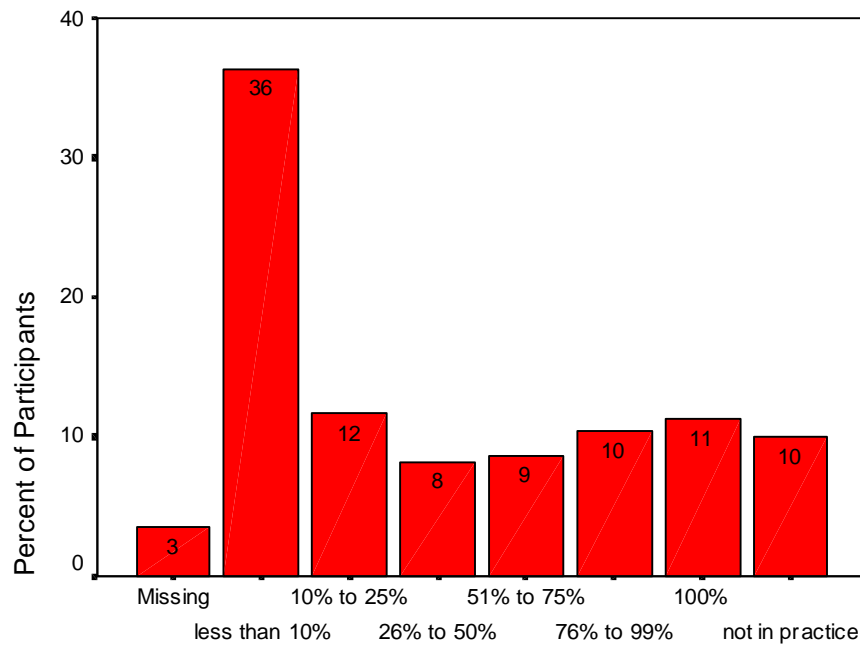
Research Question Four: What are therapists', state division officers', and AAMFT national ethics committee members' perceptions of client knowledge of AAMFT, the code of ethics, and grievance procedure? What percentage are aware?

Clinical members and state division members were asked to indicate how knowledgeable they felt the clients in their own caseload were of the AAMFT organization, code of ethics, and grievance procedure. The national ethics committee was asked to indicate how knowledgeable the general public was about these things. However, since there was a small number of returned surveys from the ethics committee, their responses were condensed into the responses from the clinical members and state division members. Participants' reported perceptions of clients' knowledge of the AAMFT organization, code of ethics, and grievance procedure are indicated by Tables 2, 3, and 4(see also Figures 21, 22, and 23). Ten percent of the respondents indicated they were not in practice for each question. The results indicate that as the level of risk to the therapist increases, the level of knowledge by the client decreases. Almost 50% of the participants indicated that less than one-fourth of their clients knew what AAMFT was. That number increases to 60% for the code of ethics, and 70% for the grievance procedure.

Table 2

Perception of Client Knowledge About AAMFT Organization

Percent of Caseload Knowledgeable	Percent of Participants who indicated answer
Less than 10% aware	36.4%
10% - 25% aware	11.7%
26% - 50% aware	8.2%
51% - 75% aware	8.7%
76% - 99% aware	10.4%
100% aware	11.3%



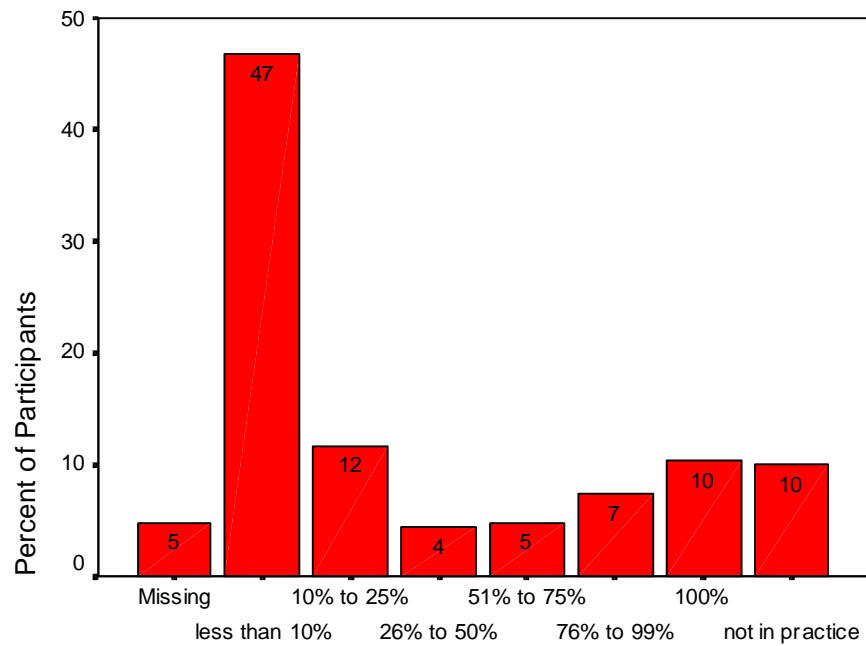
Perception of Caseload Aware of AAMFT

Figure 21: Participants' perceptions of caseload aware of the AAMFT organization.

Table 3

Perception of Client Knowledge About AAMFT Code of Ethics

Percent of Caseload Knowledgeable	Percent of Participants who indicated answer
Less than 10% aware	46.8%
10% - 25% aware	11.7%
26% - 50% aware	4.3%
51% - 75% aware	4.8%
76% - 99% aware	7.4%
100% aware	10.4%



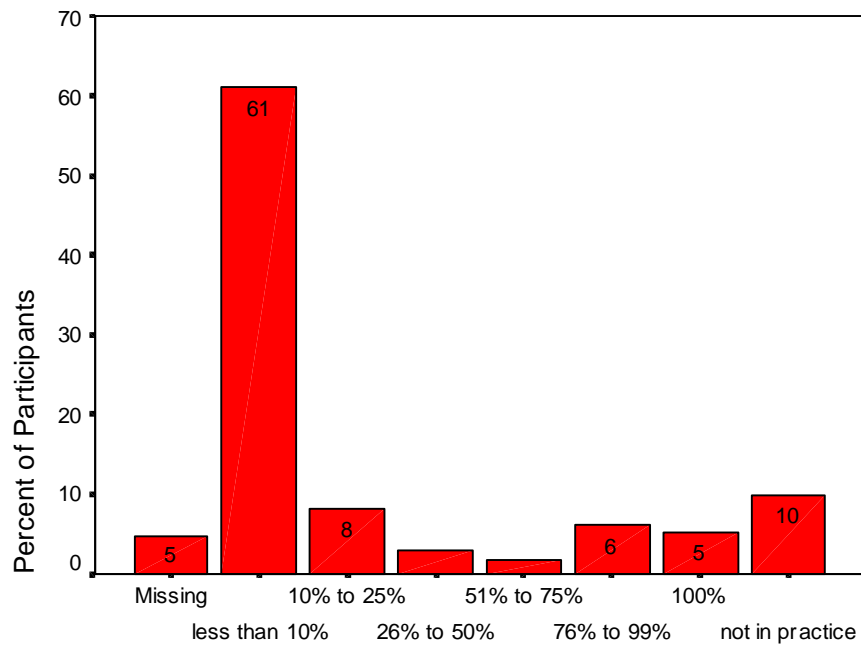
Perception of Caseload Aware of Code of Ethics

Figure 22: Participants' perception of clients aware of AAMFT code of ethics.

Table 4

Perception of Client Knowledge About AAMFT Grievance Procedure

Percent of Caseload Knowledgeable	Percent of Participants who indicated answer
Less than 10% aware	61.0%
10% - 25% aware	8.2%
26% - 50% aware	3.0%
51% - 75% aware	1.7%
76% - 99% aware	6.1%
100% aware	5.2%



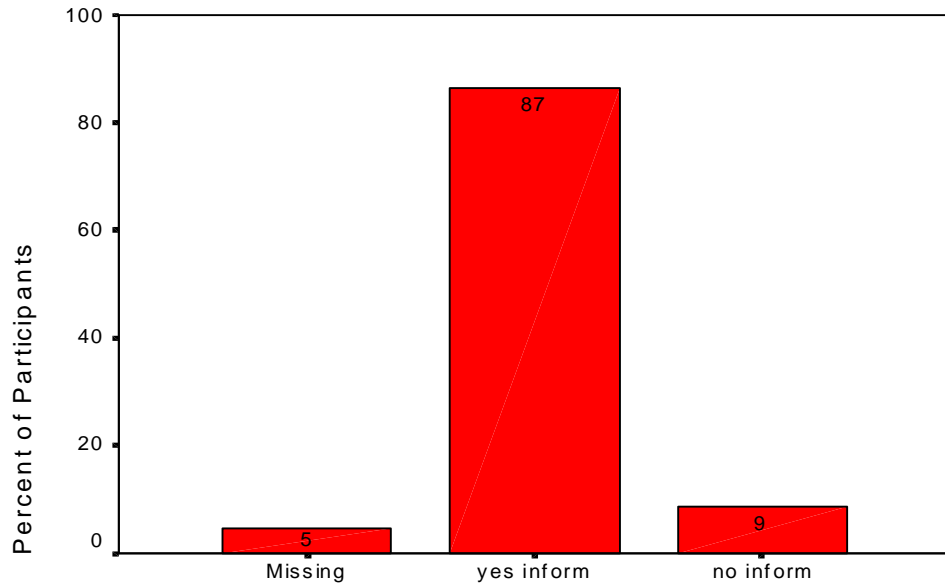
Perception of Caseload Aware of Grievance Procedure

Figure 23: Participants' perception of clients aware of AAMFT grievance procedure.

Actions on Informing Clients

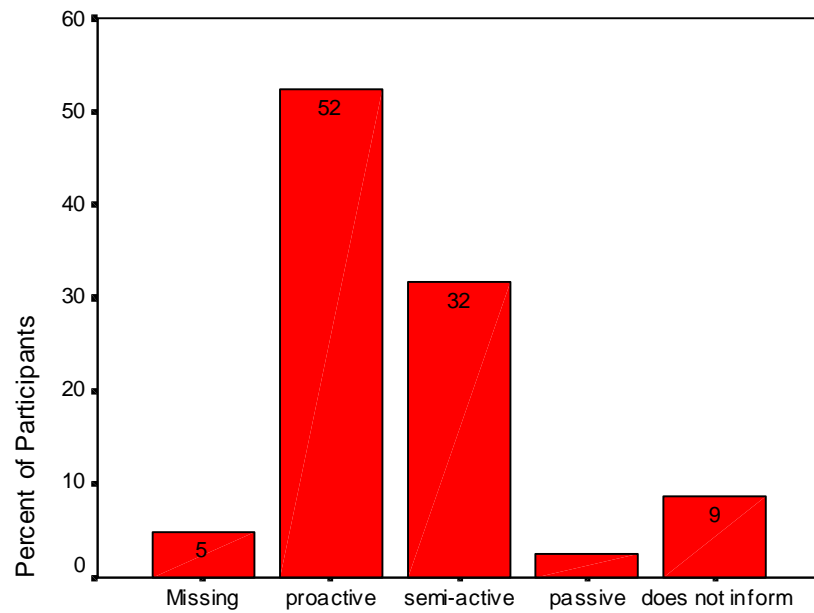
Research Question Six: Specifically, what do therapists currently do in their practice to inform clients about AAMFT, the code of ethics, and the grievance procedure?

A large number of participants (86.6%) specifically inform clients of the AAMFT organization in some manner while 8.7% do not inform them (see Figure 24). Over fifty percent (52.4%) inform their clients in a proactive fashion (direct action on the part of the therapist to inform the client), 31.6% are semi-active (information is easily available but the person does not actively draw client's attention to it), and 2.6% are passive (provide information only when asked). Figure 25 details these results. The most common method of informing clients of AAMFT was having the certificate of membership visible to the client (67.1%). This was followed by telling the clients verbally (40.3%), having information in a brochure or business card (38.1%), in the informed consent form (27.3%), and through advertisements (20.8%). Almost seven percent (6.9%) of participants indicated they inform clients through other means. Table 5 denotes the method of informing. The results indicate that almost all of the participants inform their clients about AAMFT, most by a proactive or semi-active method. The most common methods are either verbally or hanging their membership certificate on the wall so clients can read it if they want to.



Take Action to Inform Clients of AAMFT

Figure 24: Participants' actions about informing clients of AAMFT.



Level of Action to Inform Clients of AAMFT

Figure 25: Participants' level of action on informing clients of AAMFT.

Table 5

Methods Used by Participants to Inform Clients of AAMFT

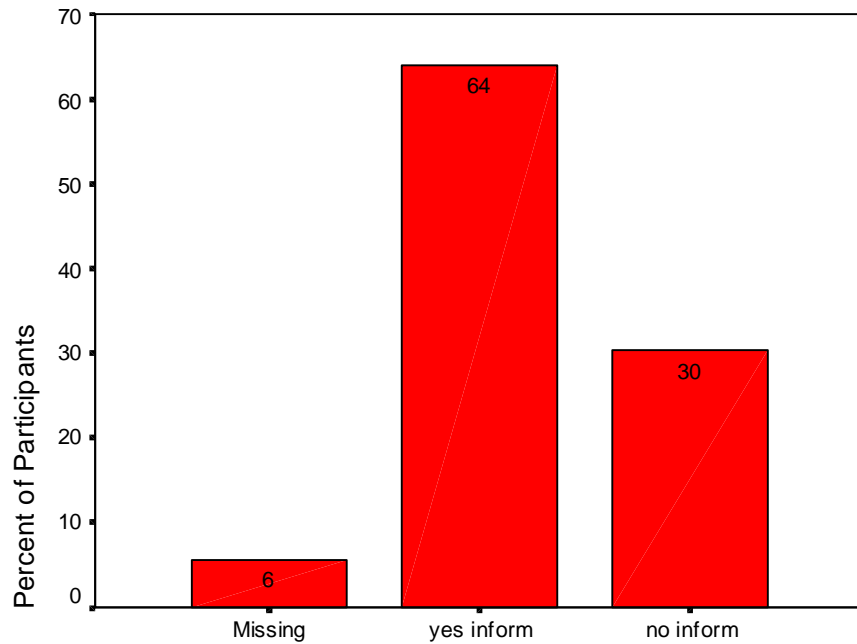
Method of Informing	Percent
Certificate Visible	67.1%
Verbally	40.3%
Brochure/Business Card	38.1%
Informed Consent Form	27.3%
Advertisement	20.8%
Other Means	6.9%

Note. Participants could chose more than one answer.

The participants' written short answers about informing clients of AAMFT were coded into themes taking action or not taking action to provide the information. Four themes emerged from the responses of those who took action to inform clients of AAMFT. One theme was to inform clients of the role of AAMFT. Responses included, "AAMFT is a governing body. AAMFT dictates clear protocol for ethical treatment. Members agree to adhere to these principles," and "[AAMFT is a] national organization that governs this profession and protects clients' rights." Another theme was AAMFT indicating a level of training of the therapist. One participant wrote in regard to what she tells clients, "Just that I'm a clinical member which means that my training included an emphasis on marriage, family, sexual issues, divorce and other relationship issues." The last two themes, when client initiates and at the beginning of treatment (in informed consent, explanation of services, or a disclosure statement), indicate the timing of providing information.

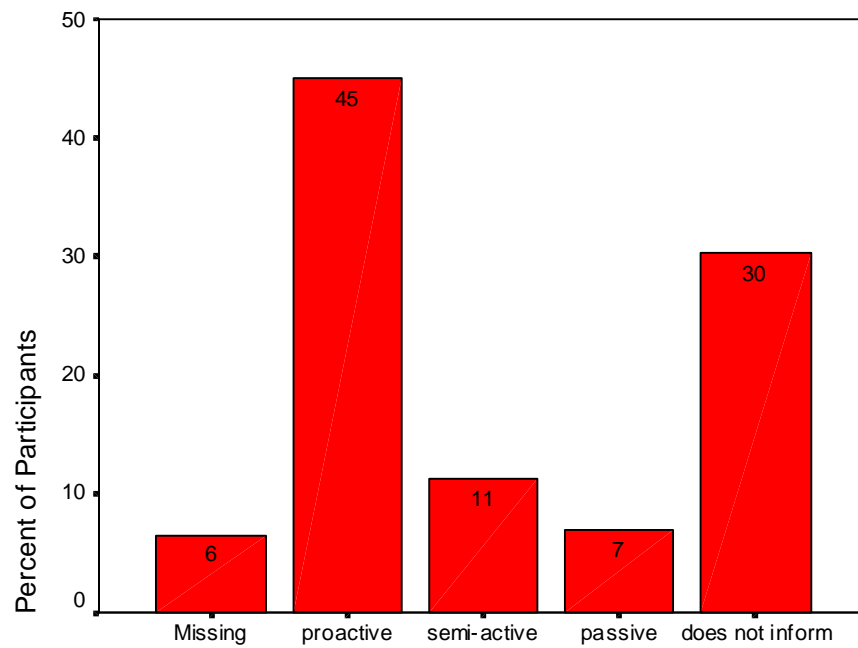
Only two themes emerged in regard to the therapist not taking action to provide information about AAMFT. One theme was that state licensing boards govern marriage and family therapy. The other theme was therapist judgement. As one participant wrote, "I don't spend their [the client's] money on long discussions about me." Another respondent stated, "They [the client] are not interested in my professional organizations."

The percentage of participants who do inform their clients of the AAMFT code of ethics decreased from the percentage who inform clients of the AAMFT organization to 64.1% and those who do not inform increased to 30.3% (see Figure 26). Of the number who do inform, 45.0% inform proactively (direct action from the person to inform clients), 11.3% semi-actively (information is easily available but the person does not actively draw client's attention to it), and 6.9% passively (provides information only when client inquires). Figure 27 further illustrates the level of action. The methods used by participants to inform clients of the code of ethics included: verbally (27.7%), available in office (26.8%), informed consent form (19.9%), included in information packet given to client (14.3%), brochure (9.1%), give a copy (7.8%), and other means (8.7%). The results indicate a decrease in actions to inform the client of the code of ethics. However, those participants who indicated they do inform clients, do mainly in a proactive manner, most commonly by verbally telling the client.



Take Action to Inform Clients of Code of Ethics

Figure 26: Participants' action on informing clients of AAMFT code of ethics.



Level of Action to Inform Clients of Code of Ethics

Figure 27: Participants' level of action on informing clients of AAMFT code of ethics.

Table 6

Methods Used by Participants to Inform Clients of AAMFT Code of Ethics

Method of Informing	Percent
Verbally	27.7%
Available in Office	26.8%
Informed Consent Form	19.9%
Information Packet	14.3%
Brochure	9.1%
Other Means	8.7%
Give a Copy	7.8%

Note. Participants could chose more than one answer.

Five themes emerged from coding the short answers of those participants who felt the therapist should take action to inform clients of the AAMFT Code of Ethics. One major theme was to inform the client of parts of the code. These were mostly parts that were either applicable to clients or were mandated by state laws. Examples of parts of the code participants discuss with clients include, "Confidentiality. The exceptions to confidentiality according to state law (child abuse and threats of harm to self and others)," "Sexual intimacy between client and therapist not appropriate. Therapy is a professional, not a personal relationship," and "Dual relationships not permitted – no socializing, trading for services." Another theme that emerged was to develop trust between the therapist and client by informing client of the code. A participant described this theme as, "Basics about ethical professional behavior as part of developing trust and providing safe environment for treatment." The last three themes addressed the timing of taking action to inform the client and echo themes discussed earlier: at the beginning of treatment (informed consent form or statement of understanding), when the client initiates (asks or voices concern), and in the therapist's judgement.

Three themes emerged from the answers of those participants who did not feel the therapist should take action to inform. Some felt there was no specific action that should be taken, except if the client asks. Another theme was that the state licensing boards

regulate the practice of marriage and family therapy and it is the state code that should be discussed, not the AAMFT code. The third theme that emerged was that, in the therapist's judgement, the client did not need to know. One example of this theme was recorded by one participant as, "The code of ethics is for me, not for my clients." The results from the short answers seemed to indicate ambiguity about how much or when information about the code of ethics should be shared.

Participants' support for taking action to inform clients of the AAMFT grievance procedure was dramatically less than the support for informing clients about the organization and the code of ethics. Fifty-five percent of the participants indicated they do not take any action at all, while 36.8% took some form of action to inform clients of the grievance procedure (see Figure 28). Figure 29 displays the level of action participants take to inform the client, which ranged from 23.8% being proactive (direct action from the person to inform the client), 6.1% semi-active (information easily available but does not actively draw client's attention to it), to 6.9% passive (provides information only when client asks). The methods taken to inform the client of the AAMFT grievance procedure include: 17.7% verbally discuss, 14.3% make it available in the office, 9.1% include it in the informed consent form, 7.8% include it in an information packet given to the client, 3.5% in brochure, 1.7% give a copy and 5.2% by some other means (see Table 7). The results indicate that clients are not receiving information from the therapist about the grievance procedure. However, the therapists who do inform clients do so in a proactive manner, mainly by verbally telling the client.

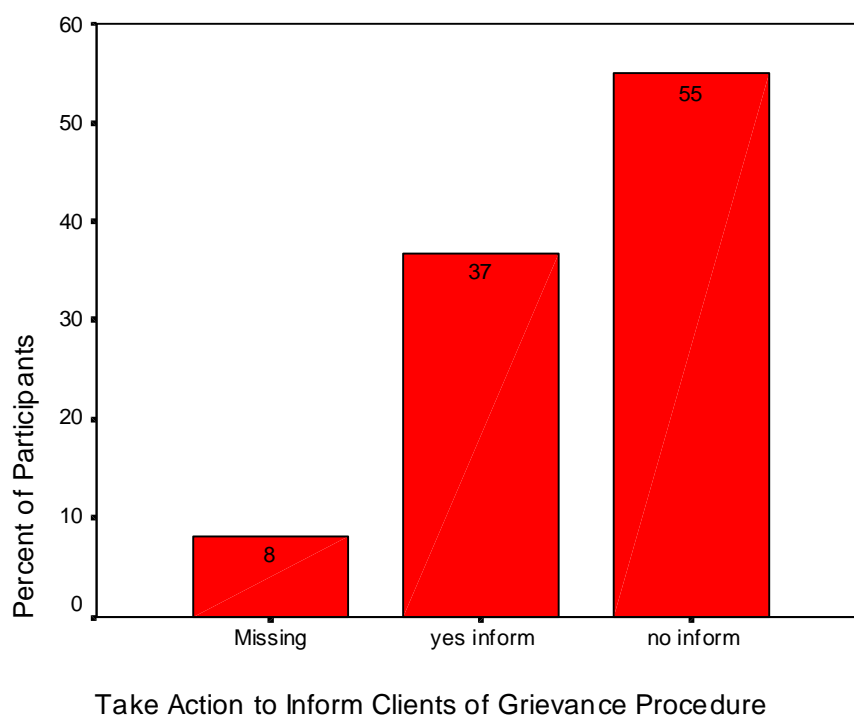
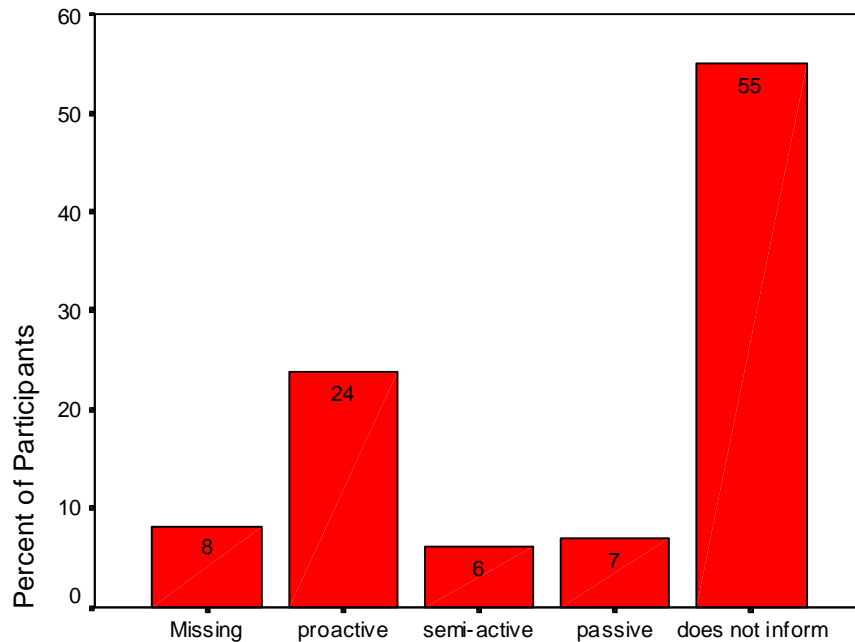


Figure 28: Participants' actions to inform clients of AAMFT grievance procedure.



Level of Action to Inform Clients of Grievance Procedure

Figure 29: Participants' level of action to inform clients of AAMFT grievance procedure.

Table 7

Methods Used by Participants to Inform Clients of AAMFT Grievance Procedure

Method of Informing	Percent
Verbally	17.7%
Available in Office	14.3%
Informed Consent Form	9.1%
Information Packet	7.8%
Other Means	5.2%
Brochure	3.5%
Give a Copy	1.7%

Note. Participants could chose more than one answer.

The themes that were generated by the coding of the short answer question supporting or not supporting the participant taking action to inform the client of the AAMFT grievance procedure were more concise and less varied than in regard to informing clients of AAMFT and the code of ethics. Only two themes emerged from

those participants who took action to inform the client, both addressing the timing: at the beginning of treatment (informed consent and statement of understanding) and if the client initiates (asks for procedure or voices a grievance). Three themes emerged for the participant not to share information: the state licensure board governs the practice of marriage and family therapy (state grievance procedure discussed or given), in therapist's judgement (no need to give specific information), and therapist themselves not knowing the grievance procedure. The results from the short answer question seem to indicate that clients are not informed about the grievance procedure unless they ask, mainly because it is the participants' perception that grievances are handled through the state licensing board.

Other Research Questions

Research Question Five: Are there differences between therapists, state division officers, and the national ethics committee members in regards to research questions 1-4?

Due to the small number of returned national ethics committee members' surveys, state division officers and national ethics committee members responses were combine in order to perform the statistical tests needed to examine the results. The combined category will be referred to as "AAMFT officials." This was applied to all analyses done for research question five.

Research question one asked if clients should be informed that AAMFT, the code of ethics, and the grievance procedure exist. As reported earlier, 79.7% of participants believed clients should be informed and 17.7% believed they should not be informed. A chi-square was performed and found no significant difference ($\chi^2=.045$, $p=.832$) between clinical members and AAMFT officials. Approximately 80% of clinical members and AAMFT officials believe clients should be informed of AAMFT, while 18% believe clients should not be informed (see Figure 30). The results indicate that there is a consensus between the two groups.

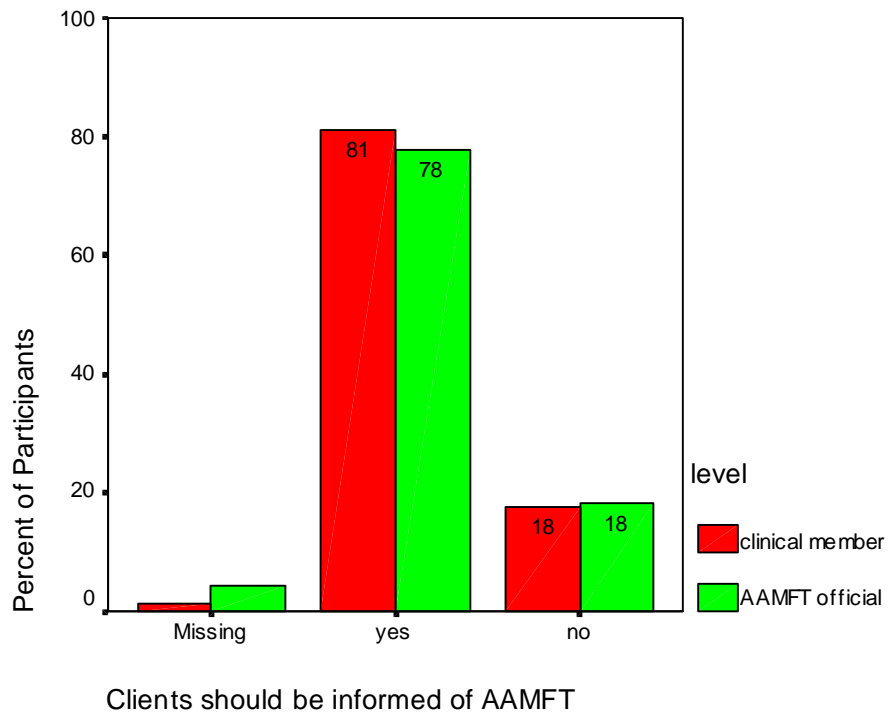


Figure 30: Comparison of clinical members and AAMFT officials beliefs on informing clients of AAMFT.

In regard to the belief that clients should be informed of the AAMFT code of ethics, 82.7% of participants believe clients should be informed while 15.2% believed they should not be informed. The chi-square analysis found no statistically significant ($\chi^2=3.385$, $p=.066$) difference between clinical members and AAMFT officials. Eighty-seven percent of clinical members believed the client should be informed of the code of ethics, compared to 77% of AAMFT officials. Twelve percent of clinical members and 20% of AAMFT officials did not believe the client should be informed (see Figure 31). However, the results indicate a slight trend that more clinical members believe clients should be informed of the code of ethics than AAMFT officials.

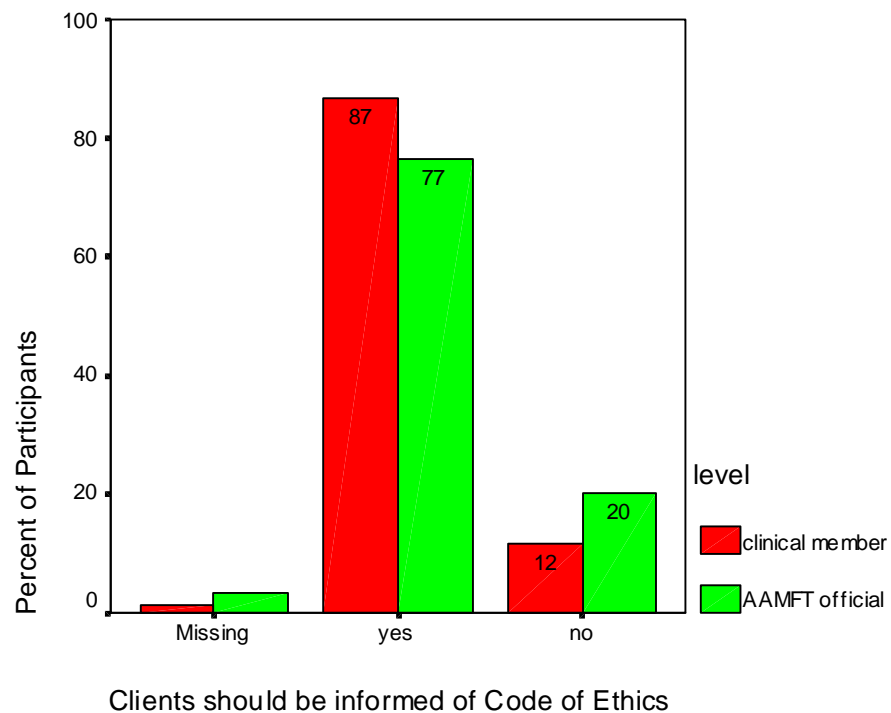


Figure 31: Comparison of clinical members and AAMFT officials beliefs on informing clients about the AAMFT code of ethics.

Finally, as reported earlier, the belief that clients should be informed of the AAMFT grievance procedure was 69.3% and that clients should not be informed was 27.3%. Chi-square analysis found a significant difference ($\chi^2=7.409$, $p=.006$) between clinical members and AAMFT officials on this question. Seventy-five percent of clinical members believed clients should be informed as compared to 61% of AAMFT state officials. While only 20% of clinical members believed clients should not be informed, 37% for AAMFT state officials (see Figure 32). The results indicated a difference between the two levels regarding their beliefs. Three-fourths of clinical members believe the client should be informed while less than two-thirds of AAMFT officials believe the client should be informed of the grievance procedure.

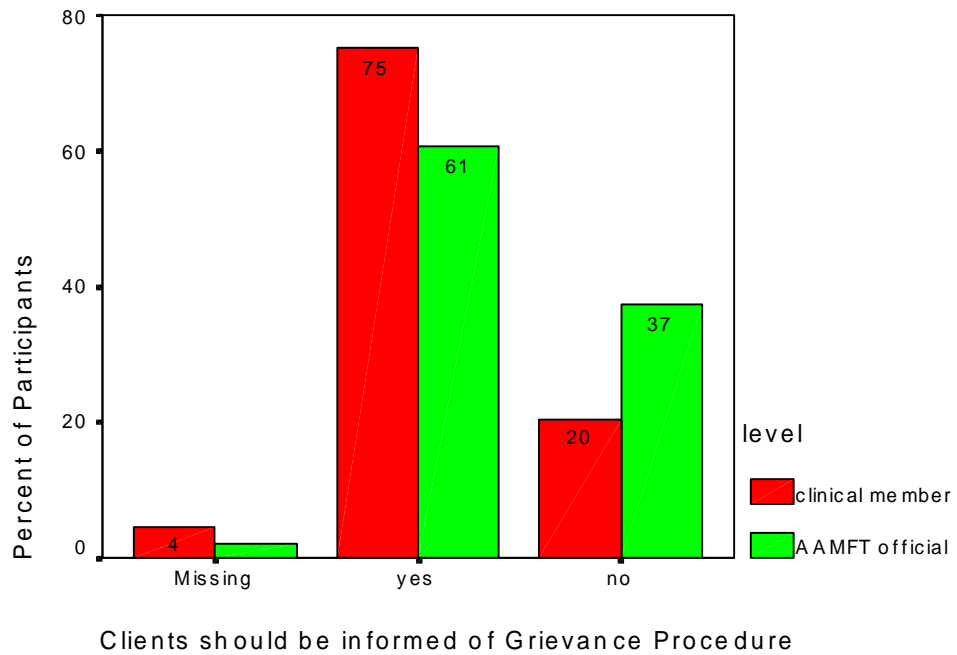


Figure 32: Comparison of clinical members and AAMFT officials beliefs about informing clients of the AAMFT grievance procedure.

Research question two asked whose responsibility it was to inform the client of what AAMFT is, the code of ethics, and the grievance procedure. The results from question two for the entire sample are summarized in Table 8.

Table 8

Summary of Results for Research Question Two for Entire Sample

	<i>Therapist responsibility</i>	<i>Client investigate for self</i>	<i>National or state organizations</i>	<i>No responsibility exists</i>
AAMFT	65.8%	10%	13.4%	8.2%
Code of Ethics	72.3%	10%	6.9%	6.9%
Grievance Procedure	59.7%	10%	14.3%	7.8%

In comparing the clinical members with the AAMFT officials in regard to whose responsibility it is to inform clients of AAMFT, the chi-square found no significant difference ($\chi^2=4.451$, $p=.217$) was found between groups. Seventy-two percent of clinical members and 57% of AAMFT officials believe the therapist working with the client is responsible; 11% of clinical members and 17% of AAMFT officials believe it is the national or state organization's responsibility; 9% of clinical members and 7% of AAMFT officials believe clients should investigate for themselves; and 7% of clinical members and 11% of AAMFT officials believe no responsibility exists (see Figure 33). The results indicate there is no significant difference between the two groups in regard to the beliefs on who should inform the client about AAMFT.

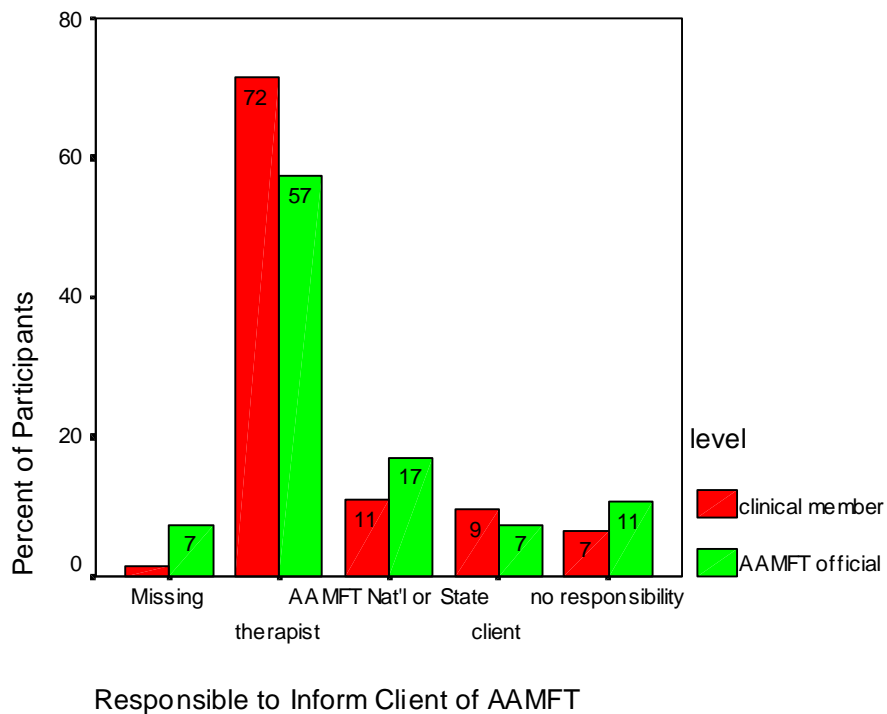


Figure 33: Comparison of clinical members and AAMFT officials beliefs regarding who is responsible to inform clients about AAMFT.

A chi-square was performed on the responses from clinical members and AAMFT officials in regard to the beliefs about who is responsible to inform clients of the code of ethics. Again, no significant difference was found between the two groups ($\chi^2=2.601$, $p=.457$). Seventy-four percent of clinical members believed it was the therapist working with the client's responsibility to inform, 7% believed it was the national or state organization's responsibility, 12% believed the client should investigate for self, and 5% believed there was no responsibility. The AAMFT officials varied slightly with 69% believing it is the therapist's responsibility, 7% the national or state organization, 9% believed the client should investigate for self, and 10% felt there was no responsibility. Figure 34 compares the results in which the beliefs between the two groups are consistent.

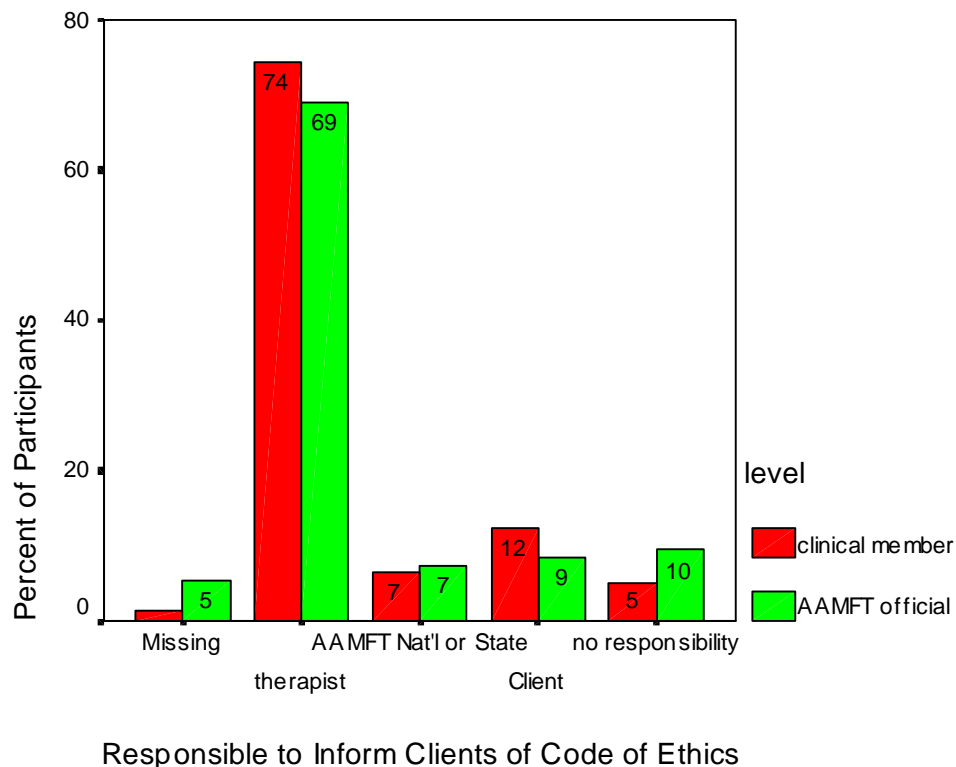
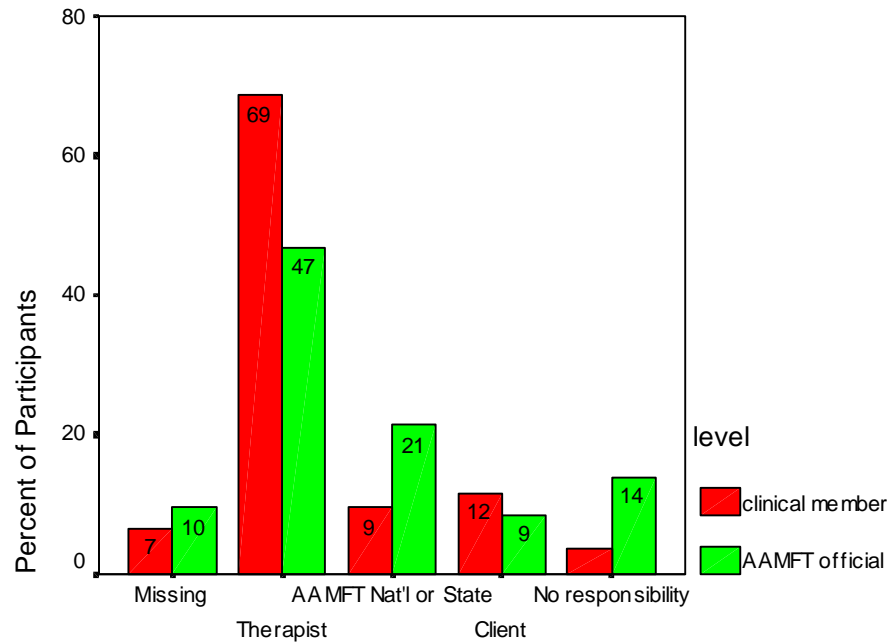


Figure 34: Comparison of clinical members and AAMFT officials beliefs about who is responsible to inform clients about the AAMFT code of ethics.

A significant difference was found comparing the two groups about whose responsible for informing clients about the AAMFT grievance procedure ($\chi^2=17.871$, $p<.001$). Sixty-nine percent of clinical members as compared to 47% of AAMFT officials believed it was the therapist working with the client's responsibility to inform the client about the grievance procedure. Nine percent of clinical members believed it was the national or state organization's responsibility while 21% of AAMFT officials believed the national or state organization had the responsibility. The two groups answered similarly regarding the belief the client should investigate for self, with 12% of clinical members and 9% of AAMFT officials responding. However, the two groups differed about no responsibility existing. Fourteen percent of AAMFT officials believed there was no responsibility, as compared to 4% of clinical members (see Figure 35). The results indicate a difference in beliefs between clinical members and AAMFT officials

about who is responsible to inform clients about the grievance procedure. Interestingly, clinical members place the responsibility almost entirely on the therapist while AAMFT officials were more varied in their belief about who is responsible.



Responsible to Inform Clients of Grievance Procedure

Figure 35: Comparison of clinical members and AAMFT officials beliefs about who is responsible to inform clients of AAMFT grievance procedure.

Research question three asked participants if therapists specifically have a responsibility to inform their clients of AAMFT, the code of ethics, and the grievance procedure. As reported earlier, 71.0% of the participants felt the therapist had a responsibility and 19% believed the therapist did not have a responsibility to inform the client about AAMFT. In regard to the code of ethics, 79.7% believed the therapist had a responsibility and 12.6% believed the therapist did not have a responsibility to inform. Lastly, 68.8% believed the therapist had a responsibility and 19.9% believed the therapist did not have a responsibility to inform clients of the grievance procedure. No significant differences were found when clinical members were compared to AAMFT officials on the beliefs that the therapist had a specific responsibility to inform clients about AAMFT ($\chi^2=3.035$, $p=.219$), code of ethics ($\chi^2=1.349$, $p=.509$), and grievance procedure ($\chi^2=2.908$, $p=.234$). See Figures 36, 37, and 38 for a summary of the findings. The results indicate that clinical members and AAMFT officials share similar beliefs regarding the responsibility of the therapist to inform clients about AAMFT, the code of ethics and the grievance procedure.

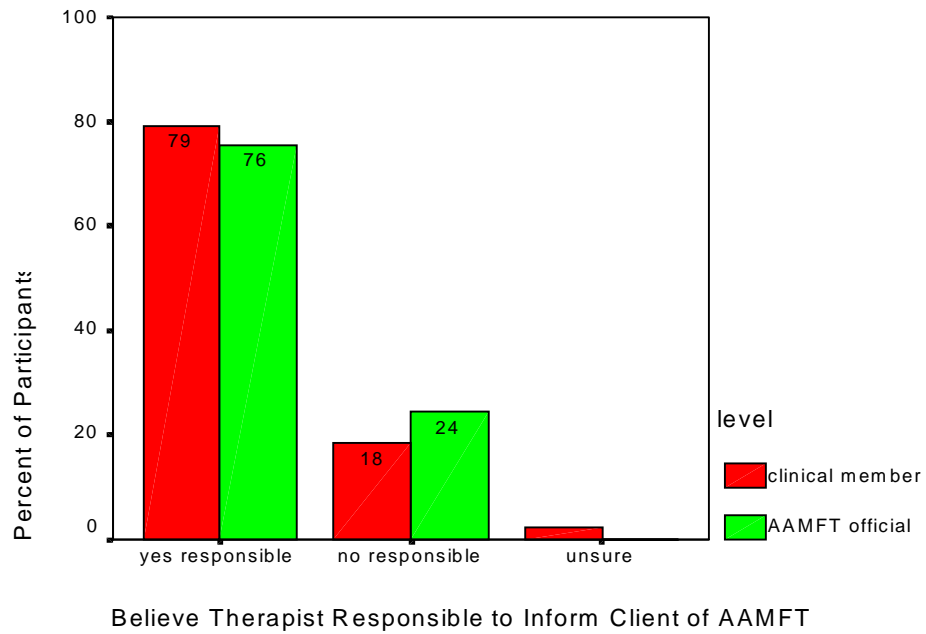


Figure 36: Comparison of clinical members and AAMFT officials about therapist being responsible to inform clients of AAMFT.

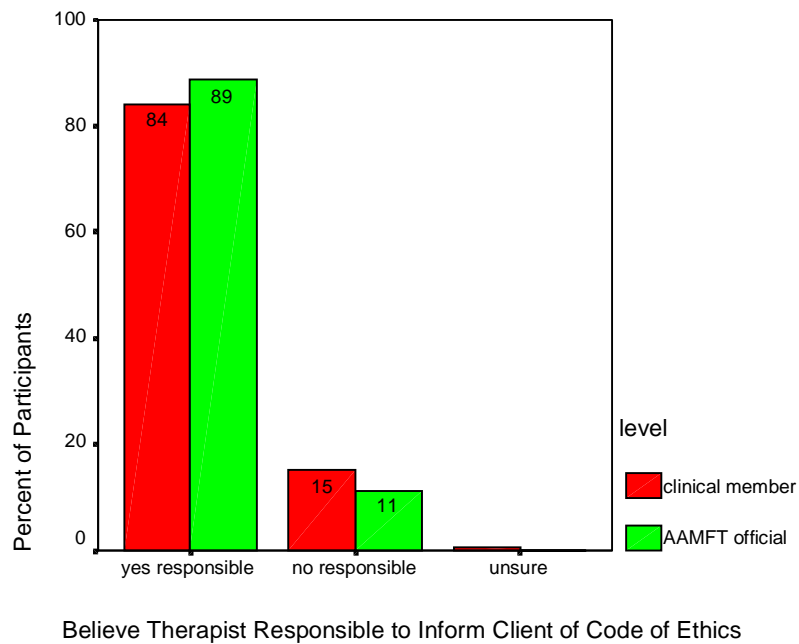
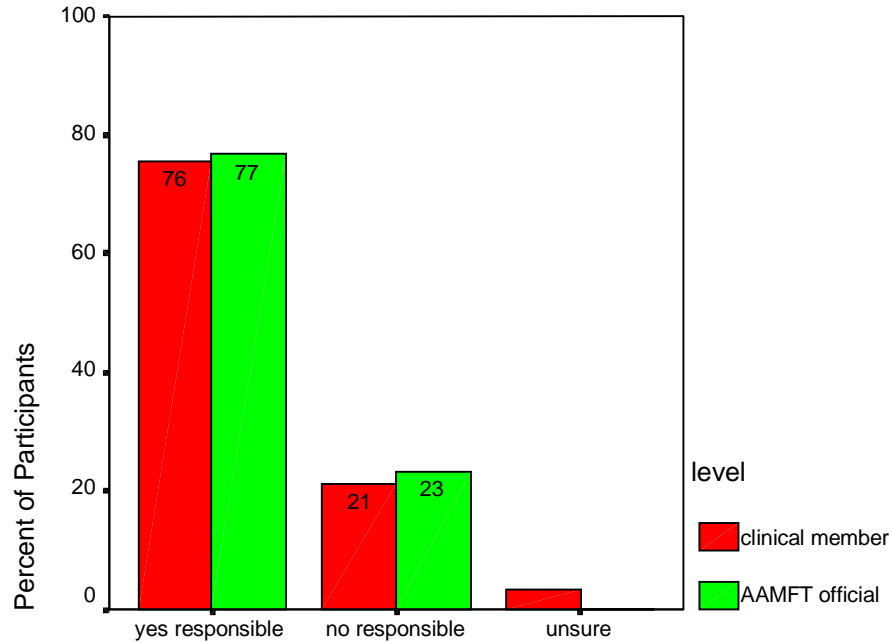


Figure 37: Comparison of clinical members and AAMFT officials beliefs about therapists responsible to inform clients of AAMFT code of ethics.



Believe Therapist Responsible to Inform Client of Grievance Procedure

Figure 38: Comparison of clinical members and AAMFT officials beliefs about therapists responsible to inform clients about the AAMFT grievance procedure.

Research question four asked participants for their perceptions of client knowledge. It specifically asked what percentage of their caseload is aware of AAMFT, the code of ethics, and the grievance procedure. Refer to Tables 2, 3, and 4 for a review of the results. Notably, most participants perceived less than ten percent of their caseloads were aware of AAMFT (36.4%), the code of ethics (46.8%), and the grievance procedure (61%). Chi-square statistics found no significant differences between clinical members and AAMFT officials in regard to percent aware of AAMFT ($\chi^2=8.818$, $p=.184$), code of ethics ($\chi^2=8.373$, $p=.212$), and grievance procedure ($\chi^2=4.499$, $p=.610$). Tables 9, 10, and 11 report the results which indicate that clinical members and AAMFT officials have similar beliefs about the level of client knowledge.

Table 9

Comparison of Clinical Members to AAMFT Officials About Perception of Clients

Aware of AAMFT

Percent of Caseload Aware	Level	
	Clinical Members	AAMFT Officials
Less than 10%	43%	29%
10% to 25%	11%	13%
26% to 50%	6%	12%
51% to 75%	7%	12%
76% to 99%	10%	11%
100%	10%	13%
Not in Practice	12%	8%

Table 10

Comparison of Clinical Members to AAMFT Officials About Perception of Clients

Aware of AAMFT Code of Ethics

Percent of Caseload Aware	Level	
	Clinical Members	AAMFT Officials
Less than 10%	54%	42%
10% to 25%	8%	18%
26% to 50%	3%	7%
51% to 75%	5%	6%
76% to 99%	8%	8%
100%	11%	11%
Not in Practice	12%	8%

Table 11

Comparison of Clinical Members to AAMFT Officials About Perception of ClientsAware of AAMFT Grievance Procedure

Percent of Caseload Aware	Level	
	Clinical Members	AAMFT Officials
Less than 10%	59%	71%
10% to 25%	8%	9%
26% to 50%	3%	2%
51% to 75%	2%	1%
76% to 99%	7%	6%
100%	7%	3%
Not in Practice	12%	8%

Research Question Seven: Are therapists' actions regarding informing clients of AAMFT, the code of ethics, and the grievance procedure consistent with their beliefs?

To examine the consistency of participants' beliefs and actions regarding informing clients about AAMFT, the participants were divided into two subsets, those who do believe it is the therapists responsibility and those who do not believe it is. A binominal test was performed on each group to examine if the participants' reported actions were consistent with their beliefs. The results found a significant difference ($p < .001$) from the 80% criterion used to indicate consistency. In examining the results further, 97% of participants report doing what they say they believe, thus these participants are consistent with their beliefs and actions. Surprisingly, the results show that those who believe clients should not be informed tend to behave inconsistently with their beliefs ($p < .001$) because 77% reported they inform clients about AAMFT, even when they believe it is not their responsibility to do so. However, the results from both tests indicates that clients are being informed about AAMFT. Figure 39 compares the results.

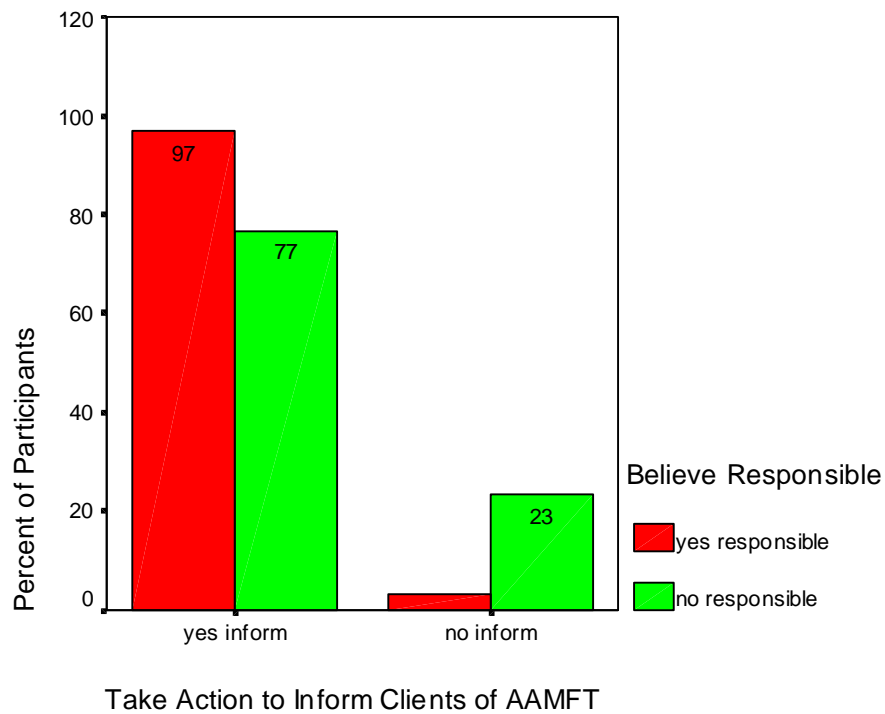


Figure 39: Comparison of participants' beliefs and their actions about informing clients of AAMFT.

Bi-nominal tests were also calculated to examine if the participants' beliefs regarding the therapist being responsible to inform clients about the AAMFT code of ethics against their actions on informing clients. The results for the subset who believe the therapists are responsible found no significant difference ($p=.149$) from the 80% criterion. Thus these participants are consistent with their actions. Seventy-seven percent of those participants who believe the therapist is responsible take some level of action to inform the client about the code of ethics. No significant difference ($p=.481$) was found for those who believe the therapist is not responsible to inform clients and their actions. Most of the participants who do not believe the therapist is responsible, do not take any action (82%) and are therefore consistent with their beliefs and actions. Figure 40 displays the results, which indicate participants are consistent with their beliefs and actions in regard to informing clients about the AAMFT code of ethics.

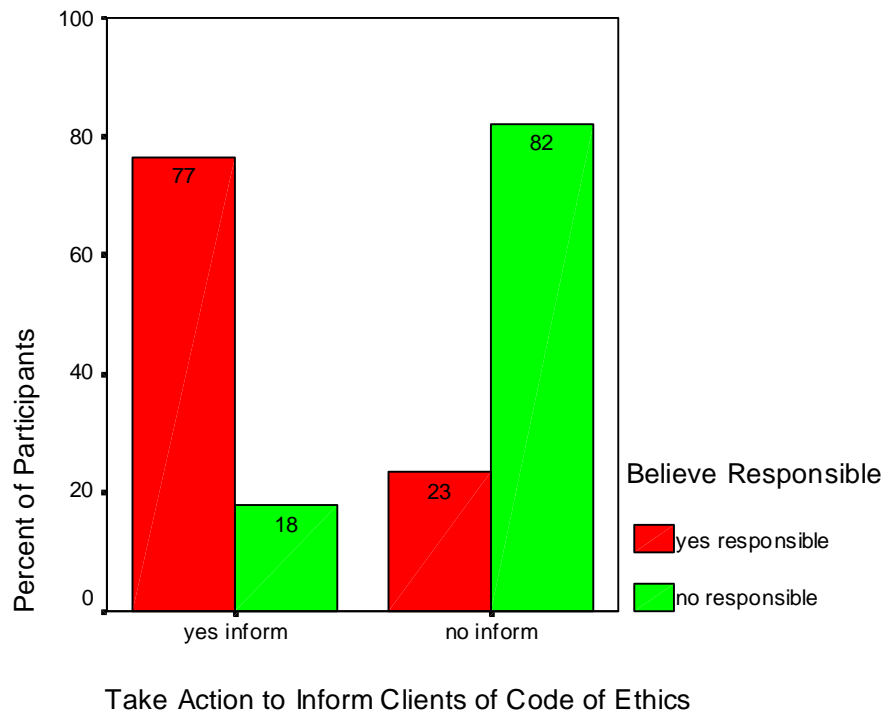


Figure 40: Comparison of participants' beliefs and their actions about informing clients of AAMFT code of ethics.

Finally, bi-nominal tests were performed to compare participants' beliefs and actions concerning the therapist being responsible to inform clients of the AAMFT grievance procedure. In reviewing the results for participants who believe the therapist is responsible, a significant difference was found ($p < .001$) from the 80% criterion. Further examination indicated that this subset was inconsistent with their beliefs. While fifty-one percent of participants who believe the therapist is responsible to inform the client also take action to inform, 49% do not. Thus, the difference is in the direction of not meeting the criterion. The bi-nominal test for those participants who do not believe the therapist is responsible to inform clients about the grievance procedure found no significant difference ($p = .146$) from the 80% criterion. Participants who believe the therapist is not responsible are consistent with their actions. Eighty-eight percent do not take action to inform, while 12% do. Figure 41 display the results, which indicate the actions of those who believe the therapist is responsible are inconsistent to their beliefs compared to the actions of those who do not believe the therapist is responsible to inform clients of the grievance procedure.

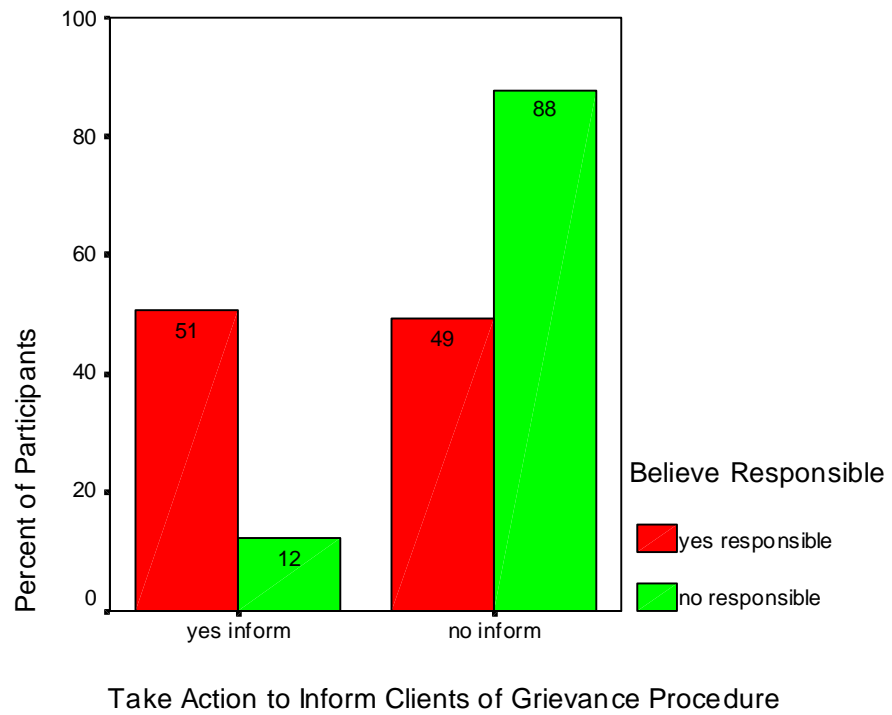


Figure 41: Comparison of participants' beliefs and their actions about informing clients of AAMFT grievance procedure.

CHAPTER FIVE – DISCUSSION

Introduction

The purpose of this research was to obtain information about AAMFT members' beliefs and actions regarding informing clients of AAMFT, the code of ethics, and the grievance procedure. AAMFT clinical members, state division officials, and the national ethics committee board members were surveyed. As reported in chapters one and two, discussion about giving clients this information is almost non-existent in the professional literature and is unclear or missing in the codes of ethics themselves. This situation leads to confusion for therapists about whether or what to tell their clients. This study begins to examine and understand this ambiguity. In this section, the findings will be discussed as well as how they might effect the ethical decision making process. Kitchener's (1991) components of moral action will be used as the framework for the discussion. Finally, limitations of the study, implications for practice and policy, and suggestions for further research will be explored.

Summary of Findings

The majority of participants in this study believe that clients should be informed of AAMFT, the code of ethics, and the grievance procedure. Further, they believe the responsibility to give this information generally lies with the therapist. However, their actions are not always consistent with their beliefs. Interestingly, participants' beliefs about how the therapist should be in informing clients varies depending on the information given. Approximately 80% of participants believe clients should be informed about AAMFT and the code of ethics. The belief clients should be informed of the grievance procedure drops slightly (approximately 70%). Most participants indicated that the therapist should be proactive when sharing information about AAMFT and the code of ethics – actively making sure the client gets the information. However, a majority of the participants believe that the therapist need only take a passive stance when it comes to providing information about the grievance procedure – making the information available only if the client needs or wants it. Informing clients about the grievance procedure seemed to generate the most ambivalence for the study participants.

It was the only area of difference between the Clinical Members in the sample and the AAMFT officials. More clinical members (75%) than AAMFT officials (61%) believe the client should be informed about the grievance procedure and that therapists have a responsibility to inform them (69% clinical members as compared to 47% AAMFT officials).

Almost all of the participants (87%) inform clients about their membership in AAMFT in one way or another. This number decreases to two-thirds of the participants when asked if they inform their clients about the AAMFT code of ethics. However, the grievance procedure continues to be the source of controversy. Only 45% of the participants indicated they inform their clients of the AAMFT grievance procedure. Clients, generally, are not being informed of the grievance policy by therapists in this sample.

The results indicated that participants believe clients should be informed of AAMFT, the code of ethics and the grievance procedure, but their actions are not always consistent with the beliefs. Consistency, as defined as 80% or greater of the participants within a belief took action to match, existed within all of the subsets except one – the belief that the therapist is responsible to inform clients about the grievance procedure and taking action to support this belief. Only half of these participants took action to inform clients about the grievance procedure. Kitchener (1991) described four components of moral action that influence the ethical behavior of therapists: ethical sensitivity, deciding on a moral course of action, valuing the ethical choice, and ego strength. This next section will discuss how each of Kitchener's components might explain the discrepancy between therapists' beliefs and actions.

Ethical Sensitivity

Kitchener (1991) describes ethical sensitivity as interpreting the situation as requiring moral action – being aware that an ethical issue exists. One of the questions raised in this study was whether or not clients should be informed about AAMFT, the code of ethics, and the grievance procedure. Overwhelmingly, therapists recognize that

clients should be informed. Therefore, therapists in this sample seem to be sensitive to the ethical issue of clients' rights to have knowledge about the therapist's professional association, and its regulations for practice.

Deciding on a Moral Course of Action

The next component of Kitchener's (1991) model "involves thinking through the situation and deciding what is the right or fair course of action." (p. 240). Even though the clinician may be aware that a ethical issue exists, awareness does not automatically indicate how to act. Kitchener (1991) describes three levels of understanding that impact the therapist's ethical decision making: the facts of the situation, ethical rules (codes of ethics), and ethical principles from which ethical codes are derived. It is the second level that the findings from this study indicate a possible short-coming. As discussed earlier, almost no professional literature discusses informing clients about AAMFT, the code of ethics, and the grievance procedure, nor prescribe what action to take. Interestingly, more AAMFT officials than clinical members believed the clients should not be informed about the grievance procedure. Perhaps this is why no clear policy exists regarding informing clients of the grievance procedure. The people in charge of the policy-making are less likely to believe clients should be informed and that a responsibility to do so exists – i.e., officials are less likely to interpret informing clients about the grievance procedure as a situation requiring moral action. However, those "in the trenches" (clinical members) do believe they are responsible, yet do not have policies to guide them on when or how to do this.

A variety of themes emerged from the short answer responses in this study showing that therapists use a variety of rationales to support their actions (or lack of action). The existence of so many different rationales may indicate a lack of consensus and guidance in the field regarding informing clients of AAMFT, the code of ethics, and the grievance procedure. While there is a belief that the client should be informed and that the therapist is responsible to inform the client, the therapist is left without clear guidance regarding what actions, if any, to take. The therapist may look to the professional codes of ethics for guidance. However, these codes are ambiguous and the

issue of informing clients is not even addressed. The findings add partial support to Corey and Corey's (1989) assertion that, "Although most professionals agree on the ethical duty to provide clients with relevant information about the helping process, there is not much consensus about what should be revealed and in what manner." (p. 183).

An unanticipated finding of this study was the impact of state licensure on the beliefs and actions taken by participants on whether or not clients should be informed, who should inform them and what information should be shared with clients regarding AAMFT, the code of ethics, and the grievance procedure. Many participants feel that licensure supersedes duty imposed by their professional organization. Participants' responses seem to indicate that AAMFT, its code of ethics, and its grievance procedure are irrelevant in states with licensure and only are important in states without licensure. For example, one respondent stated, "In a licensure state, none [responsibility to inform client of AAMFT]. In a non-licensure state, the therapist should make visible his/her accreditation by AAMFT." Many participants who were in states with licensure had responses that addressed the irrelevance of AAMFT to their clients. "I don't see the need to inform clients of the organization. My clients are informed of my license and grievance procedures in our state," "AAMFT is a voluntary code. The state code of ethics is the one with teeth due to licensure revocation possibilities," and "Therapy in [my state] is regulated by the state, not AAMFT. The state code of ethics is the only code which might be relevant." State licensure codes and the professional codes may or may not conflict with each other. However, the therapist is left to decide which one to follow and which one is the more influential in regard to deciding on a moral course of action.

Valuing the Ethical Choice

Kitchener (1991) describes the third component of ethical decision making as the therapist being influenced by numerous values other than ethics, such as ambition, money, prestige, self-protection, and so forth. These values may compete with the value of the ethical action therapists decide to take. In this study, the findings seem to indicate that as the information to be provided increases the perceived risk to the therapist (telling

a client that one is a member of AAMFT feels less risky than explaining to the client that the organization has a formal procedure for filing a grievance against the therapist), how actively the information is shared decreases. One major influence on this component of moral action was revealed in the findings from the short answer responses. Many of the beliefs and actions a therapist stated he or she would believe in/take fit the theme of “in therapist’s judgement” – when the therapist make the judgement about whether or not the client needs the information rather than providing it automatically. For example, one participant stated, “I don’t think clients are interested in AAMFT, they just want good therapy to solve their problems.” Another participant responded, “I believe the ethics, grievance and AAMFT only needs to be provided when the client requests info or when the therapist believes the client needs to know in order to respond to a situation. I do not believe it is necessary to automatically provide to every client.” This theme was found in almost all the short answer responses, from agreeing or not that responsibility exists, to taking or not taking action to inform clients of AAMFT, the code of ethics, and the grievance procedure. It appears that therapist use this rationale often, especially in terms of the grievance procedure. The result is that therapists, not clients, have the power to determine, in large part, if a grievance will be filed. To this end, the lack of guidance about informing clients of AAMFT, the code of ethics, and grievance procedure seems to be contradicting Brock’s interpretation of the code of ethics function as helping “...therapists to confine their behavior to what will benefit clients first and themselves only secondary.” (Brock, 1998, p. 4). Therapist’s judgement seems to be a major obstacle in all three of Kitchener’s (1991) components that have been discussed in regard to deciding the responsibility and action a therapist takes to inform clients. This finding revives the concern stated in chapter two of the many influences that can compromise the therapist’s professional duty to act ethically. Many participants made sweeping statements that their clients do not care about the therapist’s professional organization, are too overwhelmed by their own problems to care, or simply do not need to know unless a violation or issue arises. One is left to wonder whether this stance rises out of genuine care for the client, or is a reflection of personal gain, lack of moral commitment, or a failure to see the need for action? Brock (1998) stated the need for guidelines as:

There is a notion among some psychotherapists that practice guidelines interfere with good therapy. Adherents to this policy, or lack of one, believe they need a high degree of freedom to serve their clients. Unfortunately, such thinking often leads to strange rationalizations in support of a therapist's self-serving behavior. Most always when therapists fool themselves this way, clients are harmed. (p. 4).

Some of Brock's "strange rationalizations" are evident in themes participants reported. Examples of these "rationalizations" include: "Our guild is more for us than for clients," "Most clients don't care about national membership," and "The code is for me, not for my clients." Therapists are indeed using their own judgement to determine the client's need for information. Whether or not this leads to client harm cannot be determined from this study. However, it does indicate that there are a number of influences that impact the therapist's decision making and that "each by itself or in combination may lead mental health counselors to choose an action that ignores their ethical decisions." (Kitchener, 1991, p. 242).

The therapist's actions may also be negatively influenced by competing values. Those participants who do inform, may do so in a way that influences the client not to pursue a complaint. One respondent wrote what she tells her clients about the grievance procedure: "That it [grievance procedure] is not to be taken lightly. They should consider carefully because they must share intimate information with strangers. The therapist's career and reputation are effected." It is hard to decipher if the participant is being clear about the process of the grievance procedure, or if the way she presents the information might inhibit her clients from using it.

Ego Strength

Kitchener's (1991) last component that influences ethical decision making is the individual's character strength. Though a therapist may be aware of the ethical dilemma, develop a plan, and value the choice, he/she still may not follow through with the decision because they lack the strength to deal with the consequences of such action. Such consequences might be to precipitate a grievance against themselves, suffer

economic and legal sanctions, and endure censure from colleagues. This study did not address the participant's character, therefore it is difficult to know what influence strength of character had on the discrepancies found.

Limitations

The results and conclusions from this study begin to clarify the perceptions in the field of Marriage and Family Therapy about informing clients of the AAMFT code of ethics and grievance procedure. However, several limitations should also be considered.

One caveat to the Kitchener (1991) model is that this study addressed clients being informed about AAMFT, the code of ethics, and the grievance procedure. While this study suggests that there are many ways in which a therapist could be influenced during the ethical decision making process, this does not imply that clients are not necessarily being informed of ethics and grievance procedures. This study did not take into account the impact of the shift to state licensing boards in the practice of marriage and family therapy. The survey only asked specifically about AAMFT, the AAMFT code of ethics, and the AAMFT grievance procedure. It seems many respondents believe the state is the primary and AAMFT is either irrelevant (as mentioned above) or secondary. Therefore, where many responses seem to indicate a lack of responsibility or action, this may not reflect the respondent's belief that the client should be informed or that the respondent does take action to inform. For example, "Nil [responsibility to inform of AAMFT grievance procedure]. My responsibility is to inform clients about the state grievance procedure – even if they don't ask," "There is a state grievance board here and I believe the client should know that he/she can inform the board if there is an ethical problem," and "I believe it is critical to inform clients of code of ethic. Right now with shift, AAMFT is more secondary and state ethics are more pertinent to client." Clients may be being given information about state regulation that serves the same function as the AAMFT code of ethics and grievance procedure.

To truly understand the impact of licensure, the survey could have asked more specific questions, and selected a balance of states with and without state licensing boards. New York was the only state in the study that was a non-licensed state.

The small return rate (32%) may also be a limitation of the study. The range of responses from the returned surveys may over-represent people who are consistent with their beliefs and actions. Those who did not return the survey may not be concerned with ethics. This study only asked for the perceptions of the professional field. It did not survey clients to discover if they believe they should be informed, whom they believe is responsible, and what action should be taken. It may be discovered that clients truly do not care about this information or that they already know it. Also, this study did not find out from clients what they know.

Lastly, since the author also coded and interpreted the survey answers herself, there may exist researcher bias. Bias have been introduced in choosing the categories to code, interpreting and coding the participants' answers, definitions of categories, and the selection of themes. However, action was taken to reduce researcher bias by weekly meetings with the research advisor and his independent coding of a random sample of surveys.

Clinical Implications

Despite the limitations of the study, there are several potential implications to consider for practice and policy. There needs to be some clarity in the field about who is responsible to govern the practice of marriage and family therapy. AAMFT could take a stand that it is turning such regulation over to the states. This would at least clarify some of the ambiguity about who is responsible to govern. Then the AAMFT organization could shift its purpose from direct regulation to influencing state licensing boards about what to include in codes of ethics and grievance procedures, perhaps even trying to have all state licensing boards be congruent. One respondent wrote the following:

If AAMFT is depending on state licensure boards to protect the consumer and govern the profession, than we'll get to the place where this may not be

important. I personally happen to disagree. I believe AAMFT should set the standard and adopt an updated code that will set expectations for licensure boards.

Another implication is the clear need for some guidelines regarding the responsibility to inform clients and what information to give clients about codes of ethics and grievance procedures. It seems that some state licensing boards may be already doing this, but it needs to become a “standard of practice” for all marriage and family therapists. AAMFT could encourage and expect these standards from all of its members, and also influence state licensing boards who currently do not include this in their licensing laws to do so.

Two actions that AAMFT could take to help clarify the ambiguity is to produce a simplified version of the code and send out grievance procedures to members. A brochure that included information about the code of ethics that pertain to clients in layman’s language could be given to clients by members, perhaps as an introduction to therapy. Additionally, many respondents stated they had never read the grievance procedure. Perhaps this needs to be sent to members in their information packet when they join. Simply providing descriptions of the code and grievance procedure suitable for distribution to clients might result in more therapists providing this information to the people they service.

Future Research

There is a need for more research addressing the impact of state licensure. The findings in this research about the influence of state licensing board regulations indicates a need for this to be further explored. Perhaps if this research had asked about other avenues of information that therapists are informing clients about, the results may have been different, especially regarding the congruency between beliefs and action about grievance procedures. Also, another area for future research is to survey clients themselves for their perceptions and beliefs about the topics this research addressed.

Today's therapist is caught in a shift of policy and procedures from AAMFT governing and certifying marriage and family therapists to state governments doing so. This shift only fuels the confusion that exists about what information to share with clients and who is responsible to share it. Not only could the therapist be confused as to which (the AAMFT organization or the state licensing board) he/she is governed by and accountable to, but the client may also be confused.

A new question then arises – if clients do not know about AAMFT, do clients know about the state licensing boards codes of ethics and grievance procedures? Is information about one being substituted for information about the other or are clients simply receiving no information about therapy regulations? More research in this area will provide information and literature for therapists who are struggling with this ethical dilemma and could possibly influence the moral course of action they decide to take.

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Appendix A
Sample Letter
Lisa D. Locke
Family & Child Development Department
Virginia Tech
7054 Haycock Road
Falls Church, VA 22043

May 15, 1998

Dear AAMFT Clinical Member;

I am in the process of completing my thesis towards a Masters degree in Marriage and Family Therapy at Virginia Tech. I am contacting you to participate in the research for my thesis, which is entitled: AAMFT Ethics Code and Grievance Procedure: Should clients be informed? I have enclosed a completely anonymous survey to determine the opinions of AAMFT clinical members, state division officials, and the national ethics committee members on the subject of whether or not there is a responsibility to inform clients. I am asking that you fill out the enclosed survey and return it to me by June 15, 1998 in the self-addressed, stamped envelope provided. It should take approximately 20 minutes to complete and your name will not be associated with your feedback. There are not foreseeable risks involved with filling out this survey. As a benefit, I am hoping that your feedback will provide useful information in determining the responsibility, if any, of informing clients. It may also help to clarify your own beliefs on the subject. If you have any questions, you may contact me at (703)538-8470 or my thesis advisor, Dr. Eric E. McCollum at (703)538-8463. Thank you for your participation.

Sincerely,
Lisa D. Locke
Masters' Degree Candidate

Appendix B
Survey for Clinical Members and State Division Officials

Demographics

1. Gender

- 1) Male
- 2) Female

2. Age:

- 1) 20 - 29
- 2) 30 - 39
- 3) 40 - 49
- 4) 50 - 59
- 5) 60 - 69
- 6) 70 or older

3) Ethnic Background

- 1) Caucasian
- 2) African American
- 3) Native American
- 4) Hispanic
- 5) Asian
- 6) Other (please specify) _____

4) Education (highest level)

- 1) Master's
- 2) Doctorate

5) Academic Background (mark primary)

- 1) Marriage and Family Therapist
- 2) Psychologist
- 3) Social Worker
- 4) Professional Counselor
- 5) Clergy
- 6) Clinical Nurse Specialist
- 7) Other (please specify) _____

6) What professional field do you most identify with? (mark primary)

- 1) Marriage and Family Therapist
- 2) Psychologist
- 3) Social Worker
- 4) Professional Counselor
- 7) Clergy
- 8) Clinical Nurse Specialist
- 7) Other (please specify) _____

AAMFT Information

- 7) AAMFT Status (circle all that apply)
- 1) AAMFT Clinical Member
 - 2) AAMFT State Division Past-President
 - 3) AAMFT State Division President
 - 4) AAMFT State Division President-Elect
 - 5) AAMFT National Ethics Committee Member – Present
 - 6) AAMFT National Ethics Committee Member – Past
 - 7) AAMFT State Division Ethics Chair
 - 8) Other (please specify) _____
- 8) Number of Years as an AAMFT Clinical Member
- 1) 0 - 5
 - 2) 6 - 10
 - 3) 11 - 15
 - 4) 16 - 20
 - 5) more than 20
 - 6) not a clinical member
- 9) Type of Practice (choose one that best describes your primary position)
- 1) Individual - private practice
 - 2) Group - private practice
 - 3) State or Community agency
 - 4) Employee Assistant Program
 - 5) Private non - profit agency
 - 6) University training program
 - 7) School/Education
 - 8) Other (please specify) _____
 - 9) Not in practice

AAMFT, Code of Ethics, & Grievance Procedure

- 10) Please rate yourself on how knowledgeable you are about the AAMFT Code of Ethics.
- 1) Not knowledgeable at all
 - 2) Somewhat knowledgeable
 - 3) Knowledgeable
 - 4) Very knowledgeable
 - 5) Extremely knowledgeable

11) Please rate yourself on how knowledgeable you are about the AAMFT Grievance Procedure.

- 1) Not knowledgeable at all
- 2) Somewhat knowledgeable
- 3) Knowledgeable
- 4) Very knowledgeable
- 5) Extremely knowledgeable

12) The last time I read the AAMFT Code of Ethics thoroughly was

- 1) Within the past 3 months
- 2) Within the past 1 year
- 3) Within the past 2 years
- 4) Within the past 5 years
- 5) Within the past 10 years
- 6) Over 10 years ago
- 7) I have not read the AAMFT Code of Ethics

13) The last time I read the AAMFT Grievance Procedure thoroughly was

- 1) Within the past 3 months
- 2) Within the past 1 year
- 3) Within the past 2 years
- 4) Within the past 5 years
- 5) Within the past 10 years
- 6) Over 10 years ago
- 7) I have not read the AAMFT Grievance Procedure

14) Where do your ideas regarding ethics mainly come from?

- 1) Training program/Graduate coursework
- 2) AAMFT National Organization
- 3) AAMFT State Division
- 4) Supervisor/Supervision
- 5) Other colleagues
- 6) State licensing board
- 7) Scholarly articles/workshops
- 8) Theoretical background
- 9) Core personal values
- 10) Other (please specify) _____

15) Should clients be informed of the AAMFT organization?

- 1) Yes
- 2) No

16) Should clients be informed of the AAMFT Code of Ethics?

- 1) Yes
- 2) No

- 17) Should clients be informed of the AAMFT Grievance Procedure?
- 1) Yes
 - 2) No
- 18) Who, in your opinion, has the primary responsibility to inform clients about the AAMFT organization? (Mark only one).
- 1) Therapist working with client
 - 2) AAMFT National organization
 - 3) State AAMFT division
 - 4) Client should investigate for self
 - 5) Insurance company
 - 6) AAMFT National Ethics Committee
 - 7) Other (please specify) _____
 - 8) There is no responsibility
- 19) Who, in your opinion, has the primary responsibility to inform clients about the AAMFT Code of Ethics? (Mark only one).
- 1) Therapist working with client
 - 2) AAMFT National organization
 - 3) State AAMFT division
 - 4) Client should investigate for self
 - 5) Insurance company
 - 6) AAMFT National Ethics Committee
 - 7) Other (please specify) _____
 - 8) There is no responsibility
- 20) Who, in your opinion, has the primary responsibility to inform clients about the AAMFT Grievance Procedure? (Mark only one).
- 1) Therapist working with client
 - 2) AAMFT National organization
 - 3) State AAMFT division
 - 4) Client should investigate for self
 - 5) Insurance company
 - 6) AAMFT National Ethics Committee
 - 7) Other (please specify) _____
 - 8) There is no responsibility
- 21) What responsibility, if any, does the therapist working with a client have to inform the client about the AAMFT organization?

22) What responsibility, if any, does the therapist working with a client have to inform the client about the AAMFT Code of Ethics?

23) What responsibility, if any, does the therapist working with a client have to inform the client about the AAMFT Grievance Procedure?

24) In 1995, there were approximately 70 cases against clinical AAMFT members being deliberated by the AAMFT Ethics committee. If all clients knew about AAMFT, the Code of Ethics, and the grievance procedure; what, in your opinion, would happen to the number of cases of complaints against therapists?

- 1) Increase Dramatically
- 2) Increase a Little
- 3) No Change
- 4) Decrease a Little
- 5) Decrease Dramatically

25) How do you inform clients of your membership in AAMFT? (Mark all that apply)

- 1) Advertisement
- 2) Written in informed consent
- 3) Written in brochure/business card
- 4) Certificate on wall so clients can read it if they want
- 5) Verbally
- 6) Other (please specify) _____
- 7) I do not inform clients of my membership to AAMFT

26) If you inform clients of the AAMFT organization, what specific information do you give?

27) How do you inform your clients of the AAMFT Code of Ethics? (Mark all that apply)

- 1) Included in information packet given to client
- 2) Written in informed consent
- 3) Written in brochure
- 4) Available in office so clients can read it if they want
- 5) Verbally
- 6) Give a copy
- 7) Other (please specify) _____
- 8) I do not inform clients of the Code of Ethics

28) If you inform your clients about any or all of the AAMFT Code of Ethics, what specific information do you give?

29) How do you inform you clients of the AAMFT Grievance Procedure? (Mark all that apply)

- 1) Included in information packet given to client
- 2) Written in informed consent
- 3) Written in brochure
- 4) Available in office so clients can read it if they want
- 5) Verbally
- 6) Give a copy
- 7) Other (please specify) _____
- 8) I do not inform clients of the AAMFT Grievance Procedure

30) If you inform your clients about the AAMFT Grievance Procedure, what specific information do you give?

31) In your opinion, what percentage of your current caseload is aware of the AAMFT organization?

- 1) Less than 10%
- 2) 10% to 25%
- 3) 26% to 50%
- 4) 51% to 75%
- 5) 76% to 99%
- 6) 100%
- 7) Not in practice

32) In your opinion, what percentage of your current caseload is aware of the AAMFT Code of Ethics?

- 1) Less than 10%
- 2) 10% to 25%
- 3) 26% to 50%
- 4) 51% to 75%
- 5) 76% to 99%
- 6) 100%
- 7) Not in practice

33) In your opinion, what percentage of your current caseload is aware that there is a grievance procedure in the AAMFT organization in regards to violations of the Code of Ethics?

- 1) Less than 10%
- 2) 10% to 25%
- 3) 26% to 50%
- 4) 51% to 75%
- 5) 76% to 99%
- 6) 100%
- 7) Not in practice

Thank you.

Appendix C
Survey for National Ethics Committee Board Members

Demographics

1. Gender

- 1) Male
- 2) Female

2. Age:

- 1) 20 - 29
- 2) 30 - 39
- 3) 40 - 49
- 4) 50 - 59
- 5) 60 - 69
- 6) 70 or older

3) Ethnic Background

- 1) Caucasian
- 2) African American
- 3) Native American
- 4) Hispanic
- 5) Asian
- 6) Other (please specify) _____

4) Education (highest level)

- 1) Master's
- 2) Doctorate

5) Academic Background (mark primary)

- 1) Marriage and Family Therapist
- 2) Psychologist
- 3) Social Worker
- 4) Professional Counselor
- 9) Clergy
- 10) Clinical Nurse Specialist
- 7) Other (please specify) _____

6) What professional field do you most identify with? (mark primary)

- 1) Marriage and Family Therapist
- 2) Psychologist
- 3) Social Worker
- 4) Professional Counselor
- 11) Clergy
- 12) Clinical Nurse Specialist
- 7) Other (please specify) _____

AAMFT Information

- 7) AAMFT Status (circle all that apply)
- 9) AAMFT Clinical Member
 - 10) AAMFT State Division Past-President
 - 11) AAMFT State Division President
 - 12) AAMFT State Division President-Elect
 - 13) AAMFT National Ethics Committee Member – Present
 - 14) AAMFT National Ethics Committee Member – Past
 - 15) AAMFT State Division Ethics Chair
 - 16) Other (please specify) _____
- 8) Number of Years as an AAMFT Clinical Member
- 7) 0 - 5
 - 8) 6 - 10
 - 9) 11 - 15
 - 10) 16 - 20
 - 11) more than 20
 - 12) not a clinical member
- 9) Type of Practice (choose one that best describes your primary position)
- 10) Individual - private practice
 - 11) Group - private practice
 - 12) State or Community agency
 - 13) Employee Assistant Program
 - 14) Private non - profit agency
 - 15) University training program
 - 16) School/Education
 - 17) Other (please specify) _____
 - 18) Not in practice

AAMFT, Code of Ethics, & Grievance Procedure

- 10) Please rate yourself on how knowledgeable you are about the AAMFT Code of Ethics.
- 6) Not knowledgeable at all
 - 7) Somewhat knowledgeable
 - 8) Knowledgeable
 - 9) Very knowledgeable
 - 10) Extremely knowledgeable

11) Please rate yourself on how knowledgeable you are about the AAMFT Grievance Procedure.

- 6) Not knowledgeable at all
- 7) Somewhat knowledgeable
- 8) Knowledgeable
- 9) Very knowledgeable
- 10) Extremely knowledgeable

12) The last time I read the AAMFT Code of Ethics thoroughly was

- 8) Within the past 3 months
- 9) Within the past 1 year
- 10) Within the past 2 years
- 11) Within the past 5 years
- 12) Within the past 10 years
- 13) Over 10 years ago
- 14) I have not read the AAMFT Code of Ethics

13) The last time I read the AAMFT Grievance Procedure thoroughly was

- 8) Within the past 3 months
- 9) Within the past 1 year
- 10) Within the past 2 years
- 11) Within the past 5 years
- 12) Within the past 10 years
- 13) Over 10 years ago
- 14) I have not read the AAMFT Grievance Procedure

14) Where do your ideas regarding ethics mainly come from?

- 11) Training program/Graduate coursework
- 12) AAMFT National Organization
- 13) AAMFT State Division
- 14) Supervisor/Supervision
- 15) Other colleagues
- 16) State licensing board
- 17) Scholarly articles/workshops
- 18) Theoretical background
- 19) Core personal values
- 20) Other (please specify) _____

15) Should clients be informed of the AAMFT organization?

- 3) Yes
- 4) No

16) Should clients be informed of the AAMFT Code of Ethics?

- 3) Yes
- 4) No

- 17) Should clients be informed of the AAMFT Grievance Procedure?
- 3) Yes
 - 4) No
- 18) Who, in your opinion, has the primary responsibility to inform clients about the AAMFT organization? (Mark only one).
- 9) Therapist working with client
 - 10) AAMFT National organization
 - 11) State AAMFT division
 - 12) Client should investigate for self
 - 13) Insurance company
 - 14) AAMFT National Ethics Committee
 - 15) Other (please specify) _____
 - 16) There is no responsibility
- 19) Who, in your opinion, has the primary responsibility to inform clients about the AAMFT Code of Ethics? (Mark only one).
- 9) Therapist working with client
 - 10) AAMFT National organization
 - 11) State AAMFT division
 - 12) Client should investigate for self
 - 13) Insurance company
 - 14) AAMFT National Ethics Committee
 - 15) Other (please specify) _____
 - 16) There is no responsibility
- 20) Who, in your opinion, has the primary responsibility to inform clients about the AAMFT Grievance Procedure? (Mark only one).
- 9) Therapist working with client
 - 10) AAMFT National organization
 - 11) State AAMFT division
 - 12) Client should investigate for self
 - 13) Insurance company
 - 14) AAMFT National Ethics Committee
 - 15) Other (please specify) _____
 - 16) There is no responsibility
- 21) What responsibility, if any, does the therapist working with a client have to inform the client about the AAMFT organization?

22) What responsibility, if any, does the therapist working with a client have to inform the client about the AAMFT Code of Ethics?

23) What responsibility, if any, does the therapist working with a client have to inform the client about the AAMFT Grievance Procedure?

24) In 1995, there were approximately 70 cases against clinical AAMFT members being deliberated by the AAMFT Ethics committee. If all clients knew about AAMFT, the Code of Ethics, and the grievance procedure; what, in your opinion, would happen to the number of cases of complaints against therapists?

- 6) Increase Dramatically
- 7) Increase a Little
- 8) No Change
- 9) Decrease a Little
- 10) Decrease Dramatically

25) Of the entire client population seeking treatment from AAMFT clinical members, what is your overall estimation of the percentage of these clients who are aware of what the AAMFT organization is?

- 1) Less than 10%
- 2) 10% to 25%
- 3) 26% to 50%
- 4) 51% to 75%
- 5) 76% to 99%
- 6) 100%

26) Of the entire client population seeking treatment from AAMFT clinical members, what is your overall estimation of the percentage of these clients who are aware of the AAMFT Code of Ethics?

- 1) Less than 10%
- 2) 10% to 25%
- 3) 26% to 50%
- 4) 51% to 75%
- 5) 76% to 99%
- 6) 100%

27) Of the entire client population seeking treatment from AAMFT clinical members, what is your overall estimation of the percentage of these clients who are aware of the AAMFT Grievance Procedure?

- 1) Less than 10%
- 2) 10% to 25%
- 3) 26% to 50%
- 4) 51% to 75%
- 5) 76% to 99%
- 6) 100%

Thank you.

Appendix D
Participant Informed Consent Form

Title of Study: AAMFT Code of Ethics and Grievance Procedure: Should Clients Be Informed?

Investigator: This study is being conducted by Ms. Lisa Locke, candidate for the master's degree in Marriage and Family Therapy at Virginia Polytechnic Institute and State University. Her advisor is Dr. Eric McCollum. Ms. Locke or Dr. McCollum can be reached at 703-538-8470.

I. Study Purpose

The purpose of this study is to survey a sample of AAMFT members to determine their beliefs and actions regarding the AAMFT code of ethics and grievance procedure. It will ascertain the professional community's opinion regarding if clients should be informed about the code of ethics and grievance procedure; whose responsibility it is to inform the client; and do therapists have a specific responsibility to inform their clients. It will seek to understand the participants' perception of client knowledge of the code of ethics and grievance procedure, along with determining if differences exist within the professional community regarding the above topics.

II. Procedures

To participate in the study, you are asked to sign this informed consent form, fill out the enclosed anonymous survey and return both in the self-addressed, stamped envelope provided. A reminder postcard will be mailed to everyone selected to participate asking you to return the survey if you have not done so already. This survey is anonymous and the researcher will not link your name to the returned survey.

III. Risks

Because of the nature of this project, we do not anticipate any risks

IV. Benefits of Project

Participation in this project may help the field to understand this difficult issue. It may help to clarify the ambiguity in the field regarding informing clients of the AAMFT code of ethics and grievance procedure and help each participant clarify his/her own personal beliefs and actions.

V. Confidentiality

Your responses to this survey will remain completely anonymous. The survey and the signed informed consent will be returned in the envelope provided. The return envelope is addressed to the researcher, with the researcher's address as the return address. The researcher is the only person who will open the returned surveys. Immediately upon opening them, the consent form will be separated from the survey and kept in a secure location separate from the surveys. There will be no identifying information on the survey or the return envelope. The surveys will be color-coded to determine which category (clinical members, state division members, and national ethics committee members) the subject is in, and if applicable, which state division the clinical

member belongs to. The data will be entered into a database and coded by the above categories. Each individual response will be grouped into these categories and will only be identifiable by the assigned category. The researcher will be the only person to code the responses and enter them into the database. Surveys will be kept in a secure location. No participant's name will be associated with any published report of this study.

VI. Compensation

Other than our sincere appreciation, no guarantee of benefits is being made to encourage you to participate in this study.

VII. Freedom to Withdraw

If at any time you change your mind about participating in the study, you are encouraged to withdraw your consent and to cancel your participation. You are free not to participate in this study and are free to answer only those questions you wish to answer. There will be no negative repercussions to you if you choose to withdraw.

VIII. Approval of Research

This research project has been approved, as required, by the Institutional Review Board for projects involving human subjects at Virginia Polytechnic Institute and State University and by the Department of Family and Child Development.

IX. Participant's Responsibilities

I voluntarily agree to participate in this study and to record my opinions on the survey as accurately and truthfully as I can. I have read and agree to the conditions described above.

Participant's Signature

Date

Should I have any questions about this research, I will contact:

Lisa Locke
Researcher
703-538-8470

Eric McCollum
Faculty Advisor
703-538-8463

Jerry Cline
Departmental IRB Reviewer
703-538-8492

LISA DANIELLE LOCKE

6903 Winners Circle
Fairfax Station, VA 22039
(703) 978-2130

EDUCATION:

Virginia Polytechnic Institute and State University, Falls Church, VA 1994-1998

- M.S. in Marriage and Family Therapy, December, 1998
- Received over 500 counseling hours from an AAMFT accredited program
- Thesis: AAMFT Code of Ethics and Grievance Procedure: Should Clients Be Informed?
- Student member of AAMFT, VAMFT, NCFR

Virginia Polytechnic Institute and State University, Blacksburg, VA 1988-1992

- B.S. in Psychology, Minor in Family and Child Development, May 1992; GPA: 3.346
- Dean's List
- Research Assistant for Psychology Department
- Member of three national honor societies

COUNSELING EXPERIENCE:

Family Counselor

Family Systems Counseling Unit, Fairfax County Juvenile and Domestic Relations Court, Fairfax, VA

September 1998 – Present

Intern

August 1996 – August 1997

- Provide systemic family therapy to voluntary and court-ordered families
- Serve on Inter-Disciplinary and Diagnostic Teams – conduct family assessments
- Co-facilitate Conflict Resolution Group for couples involved in court system
- Responsible for writing Court required progress reports, family histories, and family assessments

Family Counselor

Northern Virginia Family Services, Falls Church, VA

April 1998 – Present

- Provide systemic therapy to individuals, couples, and families
- Coordinator and facilitator for Anger Management Groups
- Co-facilitate Impact of Separation and Divorce on Children (COPE) seminars
- Responsible for financial management and client records

Family Therapist

Department of Family and Child Development, Virginia Polytechnic Institute and State University, Falls Church, VA *May 1997 – Present*

- Provide couples therapy to domestic violence batterers and their partners in intact relationships using co-therapy format
- Co-therapist for individual couples
- Co-therapist for multi-couple groups
- Co-therapist for multi-couple alumni groups
- Grant funded program from NIMH
- Responsible for client records

CO-FACILITATOR, MEN'S ANGERMANAGEMENT GROUP

Office on Women, City of Alexandria, Alexandria, VA *July 1998 – September 1998*

- Co-facilitator of a men's anger management program for treatment of domestic violence batterers

FAMILY THERAPIST INTERN

Center for Family Services, Virginia Polytechnic Institute and State University, Falls Church, VA *August 1995 – December 1997*

- Provided systemic therapy to individuals, couples, and families
- Responsible for financial management and client records
- Received over 500 of direct client contact hours

RAPE CRISIS HOTLINE VOLUNTEER

Sexual Assault Response and Awareness Program, Office on Women, Alexandria, VA *August 1992- Present*

- Perform crisis intervention and support counseling for hotline
- Accompany victims to hospital and/or police station
- Provide follow-up counseling and support

RESEARCH AND ACADEMIC EXPERIENCE:**RESEARCH ASSISTANT**

Department of Family and Child Development, Virginia Polytechnic Institute and State University, Falls Church, VA *August 1998 – Present*

- Co-manage three year grant from NIMH to develop a manual for couples treatment for domestic violence
- Responsible for managing client records and paperwork, client qualitative interviews, follow-up testing, and alumni therapy groups

ADMINISTRATIVE ASSISTANT

Center for Family Services, Virginia Polytechnic Institute and State University, Falls Church, VA *May 1997 – Present*
Graduate Assistant *August 1995 – May 1997*

- Conduct and develop research, outreach, and grant opportunities
- Develop internship opportunities for students
- Develop and manage public relations
- Maintain client and office records
- Conduct intakes with potential clients
- Maintain accounting records

INTAKE COORDINATOR

Northern Virginia Family Services, Falls Church, VA August 1998 – Present

- Conduct and coordinate all intakes for Falls Church office for large non-profit community agency
- Conduct and coordinate intakes for anger management program within agency
- Verify insurance information and benefits
- Schedule initial clinical sessions

MENTORING TRAINING COORDINATOR

Department of Family and Child Development, Virginia Polytechnic Institute and State University, Falls Church, VA September 1997 – May 1998

- Coordinated and developed training program for high school mentors for middle school students
- Supervised trainers and presentations

GRADUATE ASSISTANT

Department of Engineering, Virginia Polytechnic Institute and State University, Falls Church, VA January 1996 – August 1996

- Provide information about education to potential students and professionals
- Edited published book
- Assisted in the development of training program for American Red Cross

PUBLICATIONS AND PRESENTATIONS:

- Co-authored article entitled “Inter-rater reliability and validity of the Global Assessment of Relational Functioning (GARF) Scale in a clinical setting: A preliminary study” in The American Journal of Family Therapy, 25 (4), Winter 1997
- Presenter for workshop conducted at 56th Annual AAMFT Conference entitled “Treating violent men with their partners: A developing model” October, 1998
- Presenter for poster presentation at 56th Annual AAMFT Conference entitled “Client’s satisfaction with live observation and therapy” October, 1998