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# Ethical and Legal Considerations in Marital and Family Therapy

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**ABSTRACT:** *Insufficiencies of the APA ethical standards for marriage and family therapy have not been fully appreciated. Guidelines regarding therapist responsibility, confidentiality, and informed consent sometimes become ambiguous with individual clients, but they are even more complicated when multiple family members are seen together in therapy. Who is the client? How is confidential information handled? Does each family member have an equal right to refuse treatment? What is the role of the therapist's values vis-à-vis conflicting values of family members? Consideration of these questions in terms of their ethical implications is complex and controversial. Yet answers to these questions must also take into account clinical and legal considerations, which sometimes run a collision course with what is desirable from a strictly ethical standpoint. Examples and preliminary recommendations with respect to these issues are examined; further clarification of professional conduct in marital and family therapy is urged.*

In view of the increasing numbers of psychotherapists engaging in marital and family therapy, there is a need for ethical guidelines that take into account issues that arise when therapy is conducted with more than one family member. The ethical standards for psychologists (APA, 1981a) and the specialty guidelines for clinicians (APA, 1981b) are primarily formulated in terms of a therapeutic relationship that consists of one therapist and one client. Yet difficult ethical questions confronted in individual therapy become even more complicated when a number of family members are seen together in therapy. APA guidelines for group therapy (APA, 1973) supplement the more general ethical guidelines by considering situations in which there are multiple clients. These guidelines still do not directly pertain, however, to the concerns of family therapists, due to the different levels of intimacy and intensity experienced in relationships among group members compared to relationships among family members.

Marital and family therapies differ from individual therapies on both practical and conceptual levels. Practically speaking, having family members agree to convene for at least one hour per

week to focus solely on family issues is itself an intervention into the family system. Initial work with a family typically involves having family members hear each other and perhaps even imagine what it is like from the other person's perspective. In the midst of this process, the family therapist actively directs how family members express themselves, typically altering the distribution of talk time and disrupting patterns of who speaks to whom and who speaks for whom. This process is intended to increase what family members know about each other and to demonstrate how they might communicate about difficult issues.

Although the conceptual roots of marital and family therapy are as varied as individual therapy, there are some general themes that cut across theoretical lines. As contrasted with individual therapy, which deals with conflicts within the individual, family therapy deals with issues between people. Regardless of their theoretical persuasions, family therapists tend to subscribe to the general goal of helping the family obtain a better stage of accommodation. With this objective in mind, family therapists initially work to help family members shift their intentions to collaborative (Jacobson & Margolin, 1979) or rejunctive (Boszormenyi-Nagy & Ulrich, 1981) efforts. This change, which is observable in communications among family members and in communications to the therapist, occasionally may be sufficient. In most instances, however, this attitudinal reorientation helps to launch the equally difficult task of substituting functional for dysfunctional family patterns.

This article has been written to draw attention to the ethical exigencies that confront therapists who have regular or occasional contact with multiple family members. Specific ethical issues that

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require special attention on the part of marital and family therapists and that will be discussed include: responsibility, confidentiality, patient privilege, informed consent and the right to refuse treatment, and therapist values.

In the discussion that follows, it must be recognized that family therapy is characterized by diverse formats and procedures. Some therapists move from individual to family therapy and vice versa, whereas others conduct all therapy sessions with the entire family or a consistent family subunit. During the course of this discussion, it will become evident that the ethical issues vary in importance depending on which therapeutic format is used.

### *Responsibility*

The therapist's primary responsibilities are to protect the rights and to promote the welfare of his or her clients. The dilemma with multiple clients is that in some situations an intervention that serves one person's best interests may be countertherapeutic to another. Indeed, the very reason that families tend to seek therapy is because they have conflicting goals and interests. For instance, a mother's request for her child to become better behaved might ease the mother's tension, and perhaps even provide secondary benefits for the marriage, but not be advantageous to the overall development of the child. In marital therapy, a wife's goal may be to surmount her fears of terminating the relationship whereas the husband's goal may be to maintain the status quo in the relationship. Even if family members' overall goals are not in direct conflict, there may be disagreement over how to obtain those goals. Though both spouses desire improved communication, one may advocate complete openness and honesty while the other advocates tempered disclosure.

The family therapist must insure that improvement in the status of one family member does not occur at the expense of another family member. This objective is not entirely unique to family therapy. Since a person in individual therapy also makes changes that may cause unhappiness in those around him or her (Halleck, 1971; Hare-Mustin, Marecek, Kaplan, & Liss-Levinson, 1979; Hurvitz, 1967), it is prudent for the individual therapist to encourage the client to explore potential ramifications of his or her actions. Yet what sets the family therapist apart from the individual therapist is the family therapist's clear commitment to promoting the welfare of each family

member. Moreover, through direct involvement with all family members, the family therapist can directly assess how each person's behavior affects other family members. Thus, the family therapist has more responsibility for exercising judgment that takes those other individuals into account.

To work constructively in the face of conflicting family needs, some therapists identify the family system, rather than one or another individual, as "the patient." The family therapist then becomes an advocate of the family system and avoids becoming an agent of any one family member. Assuming that change by one person affects and is affected by other family members, the system advocate ensures that all problem definitions and plans for change are considered in the context of the entire family. The therapist, for example, may encourage the expression of strong feelings but structure a mode of expressing them that takes other family members into consideration (Grosser & Paul, 1964). If informed of the therapist's role as an advocate of the system, family members generally understand and accept this position, although at certain moments they still solicit the therapist as a personal ally.

Functioning as a relationship advocate sometimes has the paradoxical effect of actually creating variance between the aims of family members and those of the therapist. To be a relationship advocate requires knowledge of what is best for the relationship system that goes beyond the specific and sometimes self-centered goals of individuals. As such, the relationship advocate is likely to overhaul the family system in a way that one or more family members did not foresee. Most family members enter therapy wanting to change another person's behavior or attitudes, for example, "if only my husband would stop withdrawing." The relationship advocate first redefines such complaints into larger relationship patterns that incorporate the behavior of both partners, for example, attack-withdrawal cycles, and then endeavors to change the larger patterns. Furthermore, much of the focus of therapy concerns implicit assumptions about how a couple comes to ultimatum points. Thus, when a spouse threatens, "This relationship is finished if she doesn't stop flirting with every guy she sees!" that statement, as well as unspoken rules about interacting with members of the opposite sex, may take precedence over the act of flirting as the focus of therapy.

This stance as relationship advocate works well in many instances, but it still does not entirely eliminate the problems of conflicting interests.

Since it is impossible to provide equal benefit to all family members, how is it determined which family members are to be better served? Since intensification of emotional discomfort often is necessary for long-term improvement, how does the family therapist predict both long- and short-range outcomes of a therapeutic intervention for multiple family members as well as for the family as a total system?

There are certain instances in which working as an advocate of the relationship system and changing patterns of interaction is not advised. Weiss and Birchler (1978) point out that a therapeutic alliance based on the ostensible goal of changing the relationship is countertherapeutic if one spouse seeks therapy as a way to exit from the relationship or to ease the burden of announcing a decision to separate. In this case, an emphasis on the relationship is likely to heighten the hope and emotional investment of the rejected individual, with further disappointment and sense of failure as the ultimate result for that person. Similarly, it is misleading to maintain a guise of working on the relationship when the actual objective is to change the behavior of one family member (e.g., to reduce a father's drinking or to increase a child's compliance). If the target individual in those cases is under the mistaken impression that there will be mutual change, she or he may end up feeling deceived by both the therapist and the other family members.

Finally, in addition to clinical considerations, there are legal prescriptions defining when the welfare of an individual takes precedence over relationship issues. The clearest obligation in this regard occurs in the instance of physical abuse among family members. Child abuse reporting laws (e.g., Cal. Penal Code, §11161.5, 1976, in *Deering's California Codes, Penal Code Annotated*) require therapists to inform authorities if they suspect that a child has been abused, despite the possible consequences for the therapeutic alliance with other family members. Though the legal prescription for action is not quite as obvious for abuse between marital partners, the primary goal still is to reduce the danger of physical harm. If this objective cannot be realized within the context of conjoint therapy, it is the therapist's ethical responsibility to abdicate the role of relationship advocate and help the threatened person find protection (Margolin, 1979). More generally, it can be concluded that a family therapist's responsibility includes being an advocate of individual family members who cannot accurately represent their own rights and needs or recognize when these are

infringed on by another family member. Toward this end, there are certain situations in which an intervention to help an individual extricate from the family takes precedence over the goals of the family as a system.

#### SUMMARY

Attempting to balance one's therapeutic responsibilities toward individual family members and toward the family as a whole involves intricate judgments. Since neither of these responsibilities cancels out the importance of the other, the family therapist cannot afford blind pursuit of either extreme, that is, always doing what is in each individual's best interest or always maintaining the stance as family advocate. Framo (1981) offers the apt but perhaps understated conclusion that, "perhaps part of the skill of a therapist resides in finding the appropriate balance between the conflict of goals and expectations of all family members as well as those of the therapist" (p. 143). Adding to this already complex picture is the recognition that openly stated goals may differ from secret agendas and that goals that emerge during the course of therapy may differ from goals stated at the outset of therapy (Gurman & Kniskern, 1981).

#### Confidentiality

Relatively little in the practice of psychotherapy commands as much agreement as the tenet that it is the therapist's responsibility to safeguard information obtained in the therapy session. Deviations from this general principle of confidentiality only occur in unusual circumstances, when they are necessary to avoid clear and imminent danger to the client or others or when a specific requisite of the law takes precedence (e.g., *Tarasoff v. Regents*).<sup>1</sup> Responsibility for the decision that confidentiality must be violated rests solely on the therapist's judgment that the potential consequences of maintaining confidentiality are more onerous than if confidentiality were to be breached.

How do standard practices of confidentiality translate from the traditional dyadic client-therapist relationship to a therapeutic relationship that includes several family members? There are two divergent positions in this regard. One preference

<sup>1</sup> *Tarasoff v. Regents of University of California*, 529 P.2d 553, 118 Cal. Rptr. 129 (1974); 17 Cal. 3d 425, 551 P.2d 334 131 Cal. Rptr. 14 (1976).

is for the therapist to treat each family member's confidences as though that person were an individual client. That is, information obtained during a private session, during a telephone call, or from written material is not divulged to other family members. Some therapists, in fact, arrange for sessions with individual family members to actively encourage the sharing of "secrets" to better understand what is occurring in the family. The therapist then may work with the individual client in the hope of enabling that person to disclose the same information in the family session. Should that fail to occur, however, the therapist upholds the individual client's confidentiality and remains silent on that issue vis-à-vis other family members.

Other therapists adopt the policy of not keeping secrets from other family members. They explicitly discourage the sharing of any information that might lead to a special alliance with one individual and that excludes the remaining uninformed family members. Contrary to more traditional views of psychotherapy that hold the client-therapist confidence as a crucial factor in the overall effectiveness of therapy, this stance essentially blocks the occurrence of confidences between one family member and the therapist. Therapists who subscribe to this approach generally avoid receiving individual confidences by conducting joint, as opposed to individual, sessions. However, this one safeguard often proves insufficient against the sharing of individual confidences. Unless the client is directly informed of the therapist's policies, the client who seeks to divulge personal information will find a way to do so.

Between these two extreme positions are intermediary steps. Rather than treat all information shared in individual sessions as confidential, the therapist may indicate that (1) in general, confidentiality conditions do not apply, but (2) the client has the right to request that any specific information be kept confidential and the therapist will comply with any such requests. Likewise, it should be recognized that the therapist who does not promise to maintain confidences may, indeed, wish to exercise the option not to divulge certain information. For instance, faced with information that one spouse has had an affair, particularly one that has terminated long since, many therapists find it unnecessary and inadvisable to share such information. In conveying that she or he does not preserve the confidences of individual family members, the therapist should avoid implying that she or he will not conceal anything. Except for legal considerations mentioned previously, it is the ther-

apist's discretion, not his or her responsibility, to divulge confidential information.

One instance that complicates issues of confidentiality is a change in the format of therapy, for example, individual therapy being replaced by marital therapy. How does the therapist handle the information that she or he has obtained during the course of individual therapy? One possibility is to obtain the individual client's permission to use such information, when necessary, in the conjoint sessions. If permission is not granted, however, that information must be kept confidential, a resolution far from desirable for the therapist who prefers not maintaining individual confidences in conjoint therapy. Even if the client permits the information to be shared, this permission has been granted *after* the information was obtained. Does the client remember all that she or he has confided under the previously assumed condition of confidentiality? Would that person have responded differently in individual therapy if it were known from the outset that such information would be available to the spouse?

As in individual therapy, clients must be informed of the limits of their confidentiality. This is particularly important in family therapy, since the limits of confidentiality, vis-à-vis other family members, essentially are left to the therapist's discretion. Therapists who will not keep confidences must inform clients of this policy before any such information has been received. Otherwise, the client, particularly one who has had previous experience in individual therapy, is likely to presume that the therapist will maintain the confidentiality of his or her statements from other family members. The therapist who does keep individual confidences likewise should inform clients of this policy so that family members do not persist in trying to obtain information about one another through the therapist.

Although both sides of the decision about whether or not to maintain confidentiality are ethically defensible, they carry different clinical implications. In certain situations, maintaining one partner's confidences severely limits the therapist's options with another family member. Consider, for example, the situation in which marital therapy has been initiated by the wife on discovering that her husband had been having an affair. While willing to give the relationship one last try, she is adamant about terminating the marriage if the husband does not end his affair and then remain sexually faithful. Although the husband initially agrees to this condition, several months later he reveals to

the therapist that he has resumed the extramarital relationship. Desperate to avoid the possibility of his wife's leaving him, the husband refuses to divulge this information in a conjoint session.

What is the therapist's course of action? If confidentiality has been promised, the therapist may find himself or herself in a position of concealing information that is crucial to the wife's decision about remaining both in therapy and in the marriage. When the wife learns about the affair, she may believe that the therapist has neglected her welfare in favor of the husband and may even accuse the therapist of keeping her in therapy for personal gain. Even if the therapist were to terminate the case, an explanation is owed to the wife, which is likely to compromise the husband's confidentiality. Even though the therapist might believe that dealing openly with the husband's behavior would have long-range therapeutic benefit, this course of action is not possible without violating the husband's confidentiality.

The therapist who has not promised confidentiality has more options open and thus must carefully consider the therapeutic ramifications of his or her actions. Deciding not to divulge this information about the husband's affair might be justifiable if (1) the wife had made it clear that she did not want to know about the husband's indiscretions, (2) the affair would not interfere with the ongoing therapy, and (3) the affair had ended, so the therapist's action could not be construed as encouraging the husband's behavior. In view of the specifics of this case, however, in which the wife has clearly stated her preference not to be duped into believing her husband is sexually faithful, open discussion of the husband's affair and the wife's ultimatum is indicated. Such discussion is likely to precipitate a relationship crisis, the long-range effects of which cannot be predicted. One or both spouses may receive the information they need, finally, to pronounce the marriage over. Alternatively, the couple may make certain accommodations despite their divergent values regarding fidelity; for example, the husband could terminate his long-term liaison while not committing himself to sexual fidelity, and the wife could abandon her ultimatum regarding sexual faithfulness as long as there are no long-standing affairs.

The most difficult predicament for the therapist would be if she or he failed to convey a policy on confidentiality. In that case, it is possible that the husband and wife would be functioning under different assumptions, for example, the husband assuming confidentiality would be maintained and

the wife assuming that there would be no individual secrets in marital therapy. Neither spouse knows the limits of confidentiality nor has made a conscious decision to accept those limits. As with the clinical options available to the other two therapists, any action taken by this therapist is potentially unsatisfactory to at least one spouse. However, this therapist faces the additional risk of misleading one or another partner about the conditions of the therapeutic relationship.

As seen in this example, how a therapist handles confidentiality comes down to basic issues of trust, between patient and therapist and between husband and wife. Situations in which the therapist is unclear regarding confidentiality (and hence not to be trusted) echo and even exacerbate the couple's trust issues with one another.

This example further illustrates that the therapist's position in terms of confidentiality can have important ramifications for how marital therapy is conducted. By maintaining the confidentiality of individual partners, the therapist is likely to have information that otherwise might not be available. The therapist's options with that information are severely limited, however, and she or he may not find it possible to put the information to therapeutic advantage from a family-system perspective. On the other hand, obtaining permission to discuss conjointly information that either partner chooses to reveal individually poses risks to the spouses (i.e., that there is no safe environment for personal disclosures) and risks to the therapist (i.e., that she or he will not gain access to important information). When this stance is clearly understood, however, individual disclosures to the therapist may simply signal the desire for guidance on how to broach a particularly difficult topic with one's partner.

Confidentiality in the family system is a somewhat different matter, due to the differences in status and maturity between parents and children. First, it is the family therapist's clinical responsibility to insure the couple's confidentiality with respect to the children (Hines & Hare-Mustin, 1978; Minuchin, 1974). Couples who have difficulty setting boundaries around their relationship, as separate from the children, need to be guided (1) to establish privacy in the marriage and (2) to avoid burdening the children with information that is frightening, provocative, or simply beyond their comprehension.

Confidentiality issues also arise when a therapist has individual sessions with a child. Ethical standards of confidentiality apply to the child as a

client just as they do for adult clients. In some states parents have the right to inspect the therapist's records, but they have no legal right to demand that the therapist reveal information to them. The therapist's foremost objective in child therapy is to protect the rights of the child, particularly since the child is less able to understand or guard his or her rights. Yet secondarily the therapist must show sensitivity to the concerns of interested parents, since their help and support is often quite influential in the overall effectiveness of child therapy. Before beginning child therapy sessions, it is important to set up an agreement with both the child and the parents about what, if any, information from the child's sessions will be discussed with the parents. The limits of confidentiality should be determined; for example, can the child specifically request that the parents not be told certain information? The structure of this feedback also should be determined: for example, How often will the therapist meet with the parents? Will the child be present at those meetings? In setting up these conditions, the therapist may wish to indicate that other family members are not to pressure the child to reveal what has transpired in his or her individual sessions.

#### SUMMARY

The handling of confidentiality in family therapy requires that the therapist: (1) determine a policy that is compatible with his or her method of conducting therapy and (2) convey that policy to the family. Boszormenyi-Nagy and Ulrich (1981) outline a policy compatible with viewing the family as a system while not losing sight of the integrity of the individual: "The privacy of what was discussed (in individual sessions) was preserved; it is not our intention as family therapists to dissolve all privacies, and we no longer push for the unconditional disclosure of all 'secrets'. Automatic 'confidentiality' of everything covered in separate sessions, however, is seen as 'inconsistent' with the relationship approach to the therapy" (p. 175). This policy, although appealing in its flexibility, places tremendous responsibility on the therapist for predicting the clinical consequences of introducing or not introducing certain information into conjoint sessions.

In terms of conveying the policy to the family, there can be no assumptions that conditions of confidentiality in family therapy are understood until they are discussed directly in the therapy session. The therapist must inform clients how she or he

intends to handle confidences and discuss openly the responsibilities of all who are present. It behooves the therapist to inform family members that they, too, are to treat the content of sessions as confidential. All persons present should be aware that information from therapy sessions is not to be disclosed to any party outside the family or to be used in any way that could be detrimental or hurtful to an individual. These precautions lessen the threat that confidential material from a family session would be used in an untoward manner and increase the likelihood that family sessions will be a time to reveal important thoughts and feelings.

#### *Patient Privilege*

Ethical issues related to confidentiality are closely intertwined with legal constraints dictated by state, and occasionally federal, laws regarding privileged communication. The granting of privileged communication permits a psychotherapist to refuse to testify in legal proceedings on matters deemed to be confidential in order to protect the privacy of a client who has not waived the right to privilege (Bersoff & Jain, 1980). The client, as holder of the privilege, is the one who bears responsibility for determining when privilege is to be waived.

Who holds the right to waive privilege in family therapy? This is not merely an academic question but has direct bearing for any couple seen in conjoint therapy who later want the psychotherapist to testify in a divorce proceeding or a child custody case. A case seen by a New Jersey psychologist (Sugarman, 1974) vividly illustrates this point. When the couple, who were seen in marital therapy, decided to divorce, the psychotherapist was subpoenaed by the husband's lawyer to testify in court about statements made during conjoint therapy sessions. Since the wife refused to waive privilege, the therapist refused to testify. On the basis of psychologist-patient privilege in New Jersey, the wife's confidentiality would not have been protected. The judge decided to rule to protect the wife's confidentiality, however, on the basis of laws in that state for marriage counselors. In similar cases faced by psychiatrists, courts in New York and Tennessee maintained privilege, but a Virginia court denied the psychiatrist that protection. As reported by Herrington (1979), the Virginia judge ruled that "when a husband and wife are in a counseling session with a psychiatrist . . . there is no confidentiality because statements were made not in private to a doctor, but in the presence of the spouse" (p. 1).

For the most part, privilege tends to be ill-defined for the situation in which two or more clients are seen simultaneously in therapy. Since privilege only covers communications that are uttered in confidence, the question arises of whether statements made in the presence of another family member indeed are confidential. The question also arises of whether privilege covers client-to-client communications. Since some states extend privilege to persons who aid in the delivery of personal services and are present during the uttering of confidential information (e.g., nurses, technicians), a liberal interpretation of privilege statutes might show that family members (or group members) are agents of the therapist (Bersoff & Jain, 1980). Lacking definitive legislation on these issues, however, family therapists cannot comfortably assume that existing privilege statutes protect the communications that occur during family therapy. In view of the inconsistencies of current laws, the therapist might wish to have a clear understanding with family members on these issues, for example, obtaining a written agreement that none of the members will call on the therapist to testify in litigation.

### *Informed Consent and the Right to Refuse Treatment*

The trend for clinicians to include some type of informed consent procedures as standard clinical practice reflects both an orientation toward clients as consumers and a recognition of increasing legal regulation of psychotherapeutic practices. The primary consideration in family therapy is that procedures for informed consent be conducted with all persons who participate in therapy, including those family members who join therapy at a later time. In addition to ethical reasons for taking the time to obtain informed consent from the entire family, this procedure communicates important therapeutic messages: No one family member is the "sick" or "crazy" person. No one person will be "treated" while others simply observe. No one will be excluded from knowledge about what is to transpire.

Recent reviews of informed consent (Everstine et al., 1980; Hare-Mustin et al., 1979) recommend that the following types of information be provided to clients before therapy is formally initiated: (a) an explanation of the procedures and their purpose, (b) the role of the person who is providing therapy and his or her professional qualifications, (c) discomforts or risks reasonably to be expected,

(d) benefits reasonably to be expected, (e) alternatives to treatment that might be of similar benefit, (f) a statement that any questions about the procedures will be answered at any time, and (g) a statement that the person can withdraw his or her consent and discontinue participation in therapy or testing at any time.

Each of these guidelines also applies to marriage and family therapy. Guidelines c and d, for example, deserve special attention inasmuch as risks and benefits are different in family than in individual therapy. Since each family member has less control over the eventual outcome of family than of individual therapy, clients should be warned that marital and family therapy may lead to an outcome viewed as undesirable by one or another of the participants, for example, the decision to divorce or compromises in one's power over other family members.

Data on individual versus family therapy are central to Guideline e, particularly for the person torn between wanting to improve marital/family relationships and wanting the sanctuary of an individual therapeutic relationship. According to Gurman and Kniskern's (1978) comprehensive review, though marital therapy may be risky, individual therapy for marital problems is even riskier: Individual therapy for marital problems yields improvement in less than half of its consumers, whereas therapies that involve both partners yield improvement in approximately two thirds of the clients. Furthermore, the rate of deterioration in individual marital therapy is twice that of all *conjoint or concurrent-collaborative marital therapies*. In terms of family therapy, Gurman and Kniskern conclude that "family therapy appears to be at least as effective and possibly more effective than individual therapy for a wide variety of problems, both apparent 'individual' difficulties and more obvious family conflicts" (p. 883).

It is typical of most families that some members are more eager to participate in therapy than others, raising the issue (Guideline g) of voluntary participation. Obviously, coercion of the reluctant individual by other family members or by the therapist is unethical; however, this does not mean that the therapist cannot strongly encourage a family member to attend at least one session to discover what therapy may offer. Nor does it suggest that the therapist ignore what may be underlying reasons contributing to the person's reluctance, such as feeling threatened. In sorting out whether or not a particular family member will participate in therapy, the therapist should identify the extent

to which each person will be expected to participate, for example, whether some persons simply can attend the therapy sessions in the role of observer, learning enough about the therapeutic process so that they do nothing to impede its progress. The therapist also should explain to the reluctant member that if other family members still choose to participate, the family as a whole is likely to change regardless of that individual's lack of participation.

A potential source of coercion surrounding voluntary participation comes from the relatively common therapeutic policy of refusing to see families unless all family members are present. Do other family members go untreated just because one person is unwilling to participate? Does one person's decision to terminate mean that all family members must discontinue contact with the therapist? To avoid the conclusion that one family member denies the others access to therapeutic services, therapists with a strong preference for working with the entire family should inform the family that other therapists do not necessarily share this preference and should have available a list of competent referral sources.

Standards for informed consent are necessary, but the family therapist's conceptual model largely determines the degree of specificity in the information presented. In respect to Guideline a, for example, most therapists can give an overview of the objectives (e.g., better family adjustment) as well as the format of therapy (e.g., how often sessions will be held, approximately how long therapy will last). Full compliance with this guideline can be somewhat difficult, however, particularly for a strategic therapist who mobilizes the oppositional tendencies of family members through paradoxical interventions (Stanton, 1981; Watzlawick, Weakland, & Fisch, 1974). Or as indicated in Bodin's (1981) description of the interactional approach, homework is "likely to be of a type which is not explained in advance to the patient and thus serves to stimulate the patient's interest in discovering something new about himself or herself either alone or in interaction with others" (p. 302). There are striking differences between these approaches and behavioral family therapies (e.g., Patterson, Reid, Jones, & Conger, 1975) that explicitly teach parents the underlying principles and specific skills of social learning theory so that they eventually learn to engineer change on their own.

Moreover, most forms of marital and family therapy involve certain types of manipulation limiting "true" informed consent and free choice

about therapy. For example, while not guaranteeing changes (Guideline d), therapists often find it helpful to express optimism about the outcome of therapy in an effort to reduce the family's anxiety, to raise expectancies, and to increase the family's persistent efforts (Jacobson & Margolin, 1979). The therapist also might manipulate coalitions to fortify an intervention. Some therapists, for example, capitalize on parents' concern for their children, that is, "stressing the children's entitlements for a trustworthy climate for growth" (Boszormenyi-Nagy & Ulrich, 1981, p. 183) as therapeutic leverage to evoke collaboration in marital therapy. Successful involvement of child clients sometimes requires forming a coalition with the child that seemingly excludes the parents, for example, "Together you and I will beat the system." Another type of manipulation concerns the types of explanations and interpretations a therapist offers the clients. Within certain theoretical models, therapists reattribute and relabel behavior in a way that does not necessarily reflect reality but that allows "the family to behave in more efficient ways and engage in more effective processes to protect interpersonal functions more directly" (Barton & Alexander, 1981, p. 424).

Thus, even though clients deserve an accurate portrayal of therapy in informed consent procedures, complete objectivity and openness may not be possible. At the same time that families need factual information to make an informed decision about therapy, they also need the therapist's support, encouragement, and optimism for taking this risky step. An overly enthusiastic discussion of alternatives to therapy or overly detailed explanation of the risks of therapy may convince the client that the therapist does not want him or her in therapy (Hare-Mustin et al., 1979).

#### CHILDREN'S RIGHT TO CONSENT

Recently there has been an increasing ground swell of opinion that children should be allowed to exercise the right to consent to psychological treatment. Generally speaking it is the parent or legal guardian who takes responsibility for providing the child's consent to treatment (Morrison, Morrison, & Holdridge-Crane, 1979). Exceptions to this general policy are found in some state statutes that offer teenagers the right to obtain sexual counseling, abortions, or drug counseling. In view of the legal constraints for children, the psychological community needs to address the issue of informed consent with children. The therapist needs to be

sensitive to the fact that children constitute a consumer group who require extra protection, since even those parents who are well intentioned do not always know what is best for their children. It has been recommended that there be a child advocate to examine and protect what is in the best interest of the child client, particularly when a child is adamantly opposed to therapy (Morrison et al., 1979) or when the child does not have the capacity to give full unpressured consent (Koocher, 1976).

Perhaps children's rights to psychological treatment should become more similar to their rights to consent as research subjects. Regulations on the protection of human subjects from the biomedical and behavioral research of the Department of Health and Human Services propose that research should require the assent (not consent) of children over age seven in addition to permission from parents or guardians (Foltz, 1978). The rationale for obtaining informed consent from children who will be participating in therapy is at least as compelling as that for participating in research. Since the effectiveness of psychotherapy depends on a trusting relationship between the therapist and client, there is much to be gained by explaining what is to occur and having the child become involved in decisions that will contribute to the therapeutic endeavor (LoCicero, 1976). Describing procedures in simplified language that children can understand and questioning the children about what has been said reveals to both the therapist and parents the extent to which each child comprehends what will occur. Children who lack the experiential background or intellectual sophistication to weigh the risks and benefits of an informed decision should not be pressured to give written informed consent (Levy & Brackbill, 1979). Yet even partial understanding, without formal consent, is preferable to proceeding with therapy in the absence of any explanation.

#### SUMMARY

It is suggested that family therapy be prefaced by obtaining the informed consent of all family members. To be informed, family members must possess relevant information about the therapy to be offered, the therapist, and other therapeutic options. Consent implies a conscious decision, based on that information, about whether or not to participate. Formal regulations plus their own cognitive limitations place children in a subordinate position in this regard; however, the therapist can recognize the inherent discrepancies and make efforts to include children in decisions that affect

them. Obtaining consent has been emphasized for therapeutic as well as ethical reasons. Entering into a therapeutic agreement with each other and the therapist encourages each individual to take responsibility for the decision to participate in family sessions.

#### *Therapist Values*

The impact of the therapist's values, inescapable in any therapeutic change process, can play a particularly weighty role in marital and family therapies. Issues discussed in family therapy elicit very important personal, familial, and societal values regarding preservation of the family system, extra-marital relationships, and sex roles. Dealing therapeutically with these values is not easy, particularly when the therapist confronts a conflict in values among different family members and is inclined to reinforce the beliefs and attitudes of one family member over another.

#### PRESERVATION OF THE FAMILY

To what extent does a marital or family therapist express personal opinions about whether a couple should separate or divorce? The clearest professional standard on this issue is found in the Professional Code of the American Association for Marriage and Family Therapy (AAMFT), which states, "In all circumstances, the therapist will clearly advise a client that the decision to separate or divorce is the responsibility solely of the client" (AAMFT, 1979). Although appealing in principle, this stance is difficult, if not impossible, to exercise in practice. Certainly one function of marital therapy is to help distressed couples decide whether to stay together. Indeed, most couples who enter marital therapy have considered separation or divorce, and some seek therapy with the express purpose of making that decision. These couples "are primed to be influenced by the therapist and are quite sensitive to the cues which the therapist provides concerning his/her opinions about the relationship" (Jacobson & Margolin, 1979, p. 335).

Though few therapists would deny formulating impressions about whether a couple should remain together, there is substantial variability in how comfortable therapists feel in sharing those opinions. A debate on this issue by Yoell, Stewart, Wolpe, Goldstein, and Speierer (1971) conveys two extreme positions. Wolpe, for one, argues that "frequently the therapist needs to make the decision for the patient." He undertakes such a de-

cision "if the patient is gravely unhappy in her marriage, if every step that could be taken seems to have been taken and has failed. If the prognosis for the relationship in terms of happiness is close to zero, then I accept the responsibility not only to advise the dissolution of the marriage but to help in every practical way to bring it about" (pp. 128-129). The opposite viewpoint is expressed in Stewart's response, indicating "discomfiture about making decisions for a person. The thought constantly pops up—Is this going to be a meaningful decision for the individual if it is made by somebody else?" (p. 129).

Several other therapists endorse an explicit statement of one's opinion to the clients while claiming that the opinion is a personal one rather than a reflection of professional expertise (Gurman & Klein, 1981; Halleck, 1971). Perhaps by making this influence explicit, clients are better able to choose how much they want to be swayed by the therapist's opinions and to sort out their own reactions as distinct from those of the therapist. It is yet to be demonstrated, however, that differentiating a therapist's personal impression from his or her professional expertise is a meaningful distinction for the client.

What marital therapists must guard against is equating the dissolution of a relationship with treatment failure. When the standard for successful therapy is designated as an *improved*, or implicitly a *continuing*, marriage, there is a tendency for marital therapists to align themselves with the perpetuation of marriages. As such, it should be recognized that even subtle predilections on the part of the therapist toward the preservation of marriage can be imparted to clients (Jacobson & Margolin, 1979). Focusing on the desirability of attempting to improve a relationship or failing to explore divorce as a reasonable possibility can seriously constrain the options available to spouses.

A therapist's bias also can go in the opposite direction so that clients feel pressured toward separation or divorce. As Jacobson and Margolin (1979) caution,

It is not uncommon to work with a couple in such high distress that one wonders why they are putting themselves through this misery. If the therapist feels a particular affinity for one spouse and views his/her suffering as the fault of the other person, there may be a predilection to see the preferred partner rid of the other person. A bias towards divorce can also be the product of having gone through a successful divorce oneself and having learned that, in certain instances, divorce is the correct decision. Caution against a bias towards divorce is especially crucial with couples who talk about divorce

more than they mean to act upon the idea. Spouses may use "divorce talk" as a metacommunication to express their dissatisfaction. By responding to these comments more seriously than the spouses themselves intend them, the therapist can inadvertently promote divorce as an inevitable outcome. (p. 335)

Awareness of predilections toward either the perpetuation of marriages or the dissolution of marriages is the therapist's best mechanism for minimizing the effects of these biases on couples.

#### EXTRAMARITAL AFFAIRS

Knapp's (1975) recent survey indicates that marriage counselors hold strong values about extramarital sex. According to her results, 28% of the counselors surveyed approved of sexually open marriages and 43% would be supportive of this arrangement for their clients. Attitudes were less positive toward recreational "swinging," with only 13% approving of and 23% showing support for this practice.

Does knowledge that one partner is currently engaging in an extramarital affair alter the course of therapy? Therapists who answer "no" to this question often focus on improving the primary relationship, which if successful may cause the other relationship to dwindle in importance. A small number of therapists even encourage one spouse to initiate or continue an affair for the well-being of that individual or perhaps even for the betterment of the relationship. For example, in the Yoell et al. (1971) debate, Speierer cites the instance in which restitution of sexual potency with someone other than the spouse has been followed by a return of potency with the partner.

There are, however, several potential drawbacks to advocating extramarital affairs for clients. First, even if the affair is beneficial to one person, the other is bound to suffer. Second, therapy that is directed toward the relationship is unlikely to work if one spouse is splitting his or her attention between two relationships. Third, since such behavior is technically illegal in some states, the psychotherapist who encourages such behavior could be liable for criminal conspiracy prosecution or alienation of affection civil suits (Paulsen, Wadlington, & Goebel, 1974).

The other alternative is to actively discourage extramarital relationships or even to stipulate that extramarital affairs must be ended for therapy to commence (e.g., Ables & Brandsma, 1977; Jacobson & Margolin, 1979). This stance, typically described as strategic rather than moralistic, assumes

that the affair would impede both partners' abilities to commit themselves fully to relationship improvement and would result in a halting and frustrating course of therapy. Though widely endorsed, this position represents a *professional value*, rather than an empirically derived conclusion. The therapeutic benefit of this stance is that it often prompts termination of an affair as a demonstration of that spouse's desire to work on the relationship. However, the drawback is that a spouse might carefully conceal information about an affair for fear of being excluded from therapy.

Perhaps the decision about how to handle an affair should not rest solely with the therapist's predilections about this matter but also take into account the couple's views about nonmonogamous relationships. Exploring the meaning of the affair gives the therapist an idea of how it might affect marital therapy with this particular couple. Certainly it is counterintuitive to pursue relationship enhancement with spouses who view the continuance of an affair as threatening to the very core of their relationship. Yet spouses who view extramarital sexual relationships as acceptable or even desirable for their relationship should not automatically be denied marital therapy. Furthermore, the therapist must acknowledge when his or her personal values on this issue impede his or her ability to help the couple attain their goals. A joint decision is then in order about the feasibility of continuing this course of therapy versus obtaining counseling with another therapist (Stuart, 1980).

#### SEX ROLES

To what extent does the therapist accept the family's definition of sex role identities as opposed to attempting to influence and modify their attitudes in this regard? Recent attention to this question has led to the conclusion that marital and family therapy often tends to reinforce sex role stereotyping (Gurman & Klein, 1981; Hare-Mustin, 1978). Of the sexist attitudes found to characterize psychotherapy in general (APA Task Force on Sex Bias and Sex-Role Stereotyping, 1975), family therapists are particularly vulnerable to the following biases: (1) assuming that remaining in a marriage would result in better adjustment for a woman; (2) demonstrating less interest in or sensitivity to a woman's career than to a man's career; (3) perpetuating the belief that child rearing and thus the child's problems are solely the responsibility of the mother; (4) exhibiting a double standard for a

wife's versus a husband's affair; and (5) deferring to the husband's needs over those of the wife.

How does the therapist respond when family members agree that they want to work toward goals that, in the therapist's viewpoint, represent sexist ideologies? By attempting to remain nonjudgmental about the client's objectives, the therapist may unwittingly reinforce these sexist attitudes. But by attempting to reorient them to an egalitarian viewpoint, the therapist might thwart the family from attaining their goals and alienate those individuals whose socialization is such that they are happy with traditional roles (Hare-Mustin, 1978). Consider, for example, the following disagreement over management of a household. The husband complains that the wife does not accomplish her responsibilities around the house and the wife complains that she gets no assistance from the husband. Helping this couple successfully negotiate an agreement whereby the house is better managed by the wife and the husband assumes more responsibility for certain tasks may be an expedient solution, but it does not alter the underlying assumption that the household is the wife's domain, with the husband agreeing to help her out occasionally. Prior to reaching such a solution, the therapist at least should assess whether the narrowly defined complaints actually reflect more fundamental issues about how mutual responsibilities are defined and delegated.

A more difficult dilemma arises when the woman challenges traditional sex roles while the husband seemingly is an intractable sexist. As soon as the therapist even privately identifies the husband's sexism as the problem, that therapist has violated guiding principles in marital therapy—balancing alliances with each partner and seeking to understand each spouse's perspective on an issue. What needs to be sorted out is whether the conflict regarding roles reflects vastly divergent ideological positions or whether the ideological differences are accentuated by relationship issues; that is, the wife's demands threaten the husband, who becomes more rigid in his position, which causes the wife to make more demands, and so on. In this latter situation there are a number of ways to reverse the couple's intensifying polarity so that the therapist can avoid becoming embroiled in an ideological conflict.

Several excellent reviews of sex role stereotyping and family therapy offer concrete suggestions on how to be a nonsexist family therapist and how to utilize the therapy situation to change the oppressive consequences of stereotyped roles and expect-

tations in the family (see Berger, 1979; Gurman & Klein, 1981; Hare-Mustin, 1978; Rice & Rice, 1977). Since inattention to gender role issues runs the risk of reinforcing sex role inequalities, it is recommended that family therapists examine therapeutic objectives in light of traditional versus non-traditional values. It also is recommended that therapists examine their own behavior for unwitting comments and questions that may imply that the husband and wife command differential roles and status. Subtle nonverbal behaviors, such as attending to the husband when discussing finances and to the wife when discussing child rearing, communicate the therapist's own expectations about sex role divisions. In contrast, eliciting each partner's perspective regarding both instrumental and expressive domains of the relationship models the absence of preconceptions about sex roles to the adults as well as to any children who may be present. Finally, it is recommended that the therapist be aware of his or her personal views about sex roles in order to avoid imposing these views on the family or judging the family from a predetermined perspective of how families should function.

In view of these suggestions, the therapist must steer a fine course between expanding a couple's options and not moving into areas that may be too disruptive to a relationship. At times this means overhauling a relationship in a more profound way than the couple requested, for example, using a complaint about parenting responsibilities to explore and alter roles in general, the couple's balance of resources, and so on. At other times a more limited type of change that deals strictly with the presenting problem is acceptable. The basis for such decision, although often unclear, comes primarily from exploring these issues with the couple and from observing their response to preliminary therapeutic probes.

#### SUMMARY

It is inevitable that a family therapist's values regarding the emotionally charged issues of divorce, extramarital affairs, and sex roles will influence how that person conducts therapy and, ultimately, affect the course of his or her clients' lives. Obviously there are no answers to questions surrounding these values that are correct for all families. Thus, the therapist must guard against becoming such a strident advocate of any one position that she or he cannot evaluate the needs of a particular family. Similarly, the therapist cannot ignore his or her values and beliefs in favor of blind accep-

tance of the family's values and objectives. Convergent recommendations (e.g., Berger, 1979; Gurman & Klein, 1981) to therapists include: (1) taking time to become aware of their own values; (2) investigating how those values influence clinical practice; and (3) informing clients of personal values implicit in their mode of therapy. As Stuart (1980) concludes, "While value statements such as these offer no fail-safe protection for clients, they do put both the therapist and the client on notice of the possible direction of value-governed influence attempts, and these help to limit any unwanted ill effects of clinical influence" (p. 25).

Particular attention needs to be given to situations in which the family members themselves express a conflict of values. It is advisable for the therapist to become familiar with the values of each family member. Since the therapist's own values are likely to agree more closely with one or another of the family members, the therapist must take care not to sacrifice the therapeutic relationship with the person maintaining an opposing viewpoint. In some instances, a conflict of values between the therapist and one or more family members will lead to expanded perspectives. In other instances, a conflict in values may so inhibit desirable therapeutic outcomes that alternative referrals are in order.

#### *Training and Supervision*

With formalized training in marital and family therapy the exception rather than the rule in graduate training programs, few therapists are adequately prepared by their training to work with two or more family members. As stated earlier, models of marital and family therapy evolved from theoretical and experiential bases that are distinct from individual therapy models. Some family therapists maintain that supervised training in individual therapy may be helpful, or even essential, to the marital and family therapist (e.g., Framo, 1981; Whitaker & Keith, 1981). Others feel that "considerable prior experience as an individual therapist *is not necessarily harmful*" (Stanton, 1981, p. 397, emphasis added); however, untraining may be required if the therapist's way of thinking is individually oriented rather than interactional or interpersonal in focus.

There is widespread consensus that conducting marital and family therapy requires specific *learning about* family therapy (through readings, seminars, observation, and rehearsal) and *learning to do* family therapy through direct supervised ex-

perience with couples and families (Gurman & Kniskern, 1981). Recommended substantive areas for marital and family therapists include the study of healthy families, human sexuality, contemporary theories of the family, parenthood, gender identity, marital dissolution, and remarriage (Winkle, Piercy, & Hovestadt, 1981). These content areas, plus knowledge of theories of family therapy per se, require readings and seminars that go beyond the typical graduate school curriculum.

The strong emphasis on the experiential dimensions of training stems from recognition of therapist factors that are unique to marital and family therapy, for example, knowing when to join, versus when to exclude oneself from, the family system. As Gurman and Kniskern (1981) suggest, "family therapy may produce dangers different from individual therapy that require the therapist to be much more than, e.g., empathic, warm and genuine. The family may become quite vicious in its treatment of some family members, or one member may show problems or behaviors that are very frightening to the family. In these situations, the family therapist may need to demonstrate rather forceful qualities if the treatment situation is to remain viable" (pp. 760-761). Alexander's recent work (Alexander, Barton, Schiavo, & Parsons, 1976) identifies therapist characteristics that directly affect the outcome of marital and family therapy, but there are still many unanswered questions about relationship skills in family therapy. Another type of therapist factor to consider is the use of cotherapy, a practice common to marital and family therapy (Gurman & Kniskern, 1981; Roman & Meltzer, 1977). Cotherapy is lauded, on the one hand, as a way to monitor multifaceted process considerations and to model constructive interaction. Yet cotherapy has been criticized for modeling a traditional male-female balance of power. At times cotherapy fosters a consistent set of alliances, based perhaps on common gender, that simply extend the couple's adversary stance (Hare-Mustin, 1978; Rice & Rice, 1977).

Based on these special considerations, for a person untrained and unsupervised in family therapy to invite a number of family members into a therapy session would be construed as practicing beyond that person's area of competence. Given the interest in marital and family therapy both by consumers and practitioners, it is evident that there is a need for greater emphasis on marital and family therapy in most training programs. At the very least, all clinicians should be familiar with the differences between individual and family therapy,

able to recognize what situations call for individual versus family therapy, and knowledgeable about when they have reached the limits of their own competence. Until the time that more clinicians receive specialized training in this area and marital and family therapy are better understood, consultation with colleagues is a particularly prized commodity. While necessary in all forms of therapy, conferring with colleagues is especially crucial for marital and family therapists who work with complicated family systems, using therapy procedures that for the most part are not tested and subtle therapist skills that remain largely undefined.

### Conclusion

This article has been presented with the view that ethical issues related to marital and family therapy require somewhat specialized attention. Even if the family therapist is totally familiar with the APA guidelines, that is not adequate preparation for the types of issues that she or he will encounter in working with more than one family member. Thus, it is recommended that formal training programs in family therapy provide an arena for discussing these specialized ethical concerns, as they would for discussing therapeutic procedures that are unique to family therapy. It must also be recognized, however, that the considerations discussed above apply more broadly than just to those making marriage or family cases their standard practice. In some regards, decisions surrounding confidentiality are more thorny for the therapist who schedules only occasional family sessions than for the therapist who works with the entire family in each session.

Further elucidation of the issues presented here needs to occur on two levels: First, each therapist must become cognizant of personal and professional choices that influence his or her therapy so that these preferences and decisions can be communicated to families in an overt and timely manner. Second, since many of these unresolved questions are basic to conducting effective therapy with families, they demand further considerations and clarification from the profession as a whole in future refinements of ethical guidelines.

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