

Clinicians' Lived Experience of Ethics: Values and Challenges in Helping Children

Isaac Prilleltensky and Richard Walsh-Bowers

Wilfrid Laurier University

Amy Rossiter

Atkinson College, York University

This study is based on the need to create frameworks of applied ethics that are based on the lived experience of workers. This collaborative research, which took place at a child guidance center, consists of consultations with an advisory committee, interviews with 14 front-line workers and 3 administrators, and a workshop for the entire staff of 180 members of the center. The research explores clinicians' ethical values, challenges, and recommendations for resolving ethical dilemmas. Clinicians report as important several values, including (a) respect for people's rights, dignity, integrity, and privacy; (b) compassion and responsible caring; (c) voice and choice; (d) advocating for the most vulnerable client; (e) empowering and holistic approaches based on strengths; and (f) pursuing the child's best interests. Clinicians face several challenges in their efforts to actualize their values: (a) working in interlocking systems, (b) meeting workers' needs, (c) dealing with pressure to acquiesce, (d) dealing with pressure to label, (e) facing the perils of professionalism, (f) facing gender and racial discrimination, and (g) finding time for proper reflection. The findings point to the potential positive or negative outcomes of each challenge. The implications of the study for applied ethics theory, research, and action in the helping professions are discussed.

The purpose of this article is to report on a qualitative study of professional ethics. The research, conducted with clinicians at a child guidance center (CGC), had a theoretical and an applied purpose. Its theoretical objective was to contribute to a participatory framework of applied ethics (Prilleltensky, Rossiter, & Walsh-Bowers, 1996). Its practical purpose was to investigate the ethical values and dilemmas experienced by clinicians and the resources they use in dealing with them. The study aimed to produce useful recommendations that would help administrators and clinicians maintain sound ethical practices and institute changes where necessary.

The investigation was based on the need to create frameworks of applied ethics that are constructed on the lived experience of workers. Current models of applied ethics are not very helpful to practitioners or clients because they tend to define ethics in narrow terms, and because they do not take sufficiently into account the contexts in which ethical dilemmas occur (Attig, 1995; Bowden, 1997; Brown, 1997; Bursztajn, Gutheil, & Cummins, 1987; Chambliss, 1996; Dokecki, 1996; Kitchener, 1996; Prilleltensky et al., 1996; Trevino, 1987; Wegener, 1996). To develop more useful models of applied ethics, we are investigating the lived experience of ethics with several groups of service providers in the human service and mental health fields (Rossiter, Walsh-Bowers, & Prilleltensky, 1996; Walsh-Bowers, Rossiter, & Prilleltensky, 1996). The CGC was one of the research sites.

Prilleltensky et al. (1996) distinguished between the dominant restrictive and the emerging participatory frameworks of applied ethics. They compare and contrast the two frameworks along five dimensions: (a) power and control, (b) decision-making processes, (c) scope, (d) relevance, and (e) conceptions of harm. In essence, Prilleltensky and his colleagues argued that the restrictive model fosters unequal power between professionals and clients, is rule driven and mechanistic, has a narrow definition of what constitutes an ethical issue, is minimally relevant to daily practice, and regards harm as the aberrant behavior of few professionals. In contrast, the participatory framework currently being developed promotes the equalization of power between helper and those being helped, offers a balance between attention to rules and to subjective processes, considers social as well as individual ethics, strives to be maximally relevant to daily practice, and regards harm as a latent potential in all professionals.

A central objection we level against the restrictive model is its fragmented and isolated view of the moral agent (Rossiter, Prilleltensky, & Walsh-Bowers, in press). The model assumes that, given the right developmental, psychological, and cognitive capacities, individuals should be able

to read a situation objectively and neutralize social influences that may interfere with the most ethical reading of the situation. In contrast, we maintain that individuals cannot read ethical dilemmas objectively when they are part of the very dilemma in question, and cannot remain unaffected by cultural norms that create the very notions of what we regard as ethical and unethical. Our research suggests that people's conceptions of ethics are not static but dynamic (Bowden, 1997; Chambliss, 1996). The worker coconstructs the social context in which he or she operates. Every ethical dilemma presents a unique constellation of factors that redefines the place of the professional within it. The configuration of power relations, for instance, will affect a person's ability to put other people's interests ahead of personal interests. The configuration of power affects how a person apprehends ethical possibilities. If a professional is feeling threatened, he or she may think of him- or herself prior to thinking about a client.

The application of ethical principles is not a cognitive exercise individuals can perform in isolation from the social arena where ethical dilemmas are being played. They are actors in the same play they are supposed to analyze in a detached manner, an expectation that does not seem possible to fulfil. With every new scene there is a new role to play, and what may have seemed ethical in the previous drama may not appear justified now (Chambliss, 1996).

We argue that professionals' conceptions of ethics are framed within an evolving web of social relations, and that dilemmas take place within changing intersubjective spaces. It is within this intersubjective web that the parameters for ethical discourse and action are set. Ethical knowledge is not abstract but always situated knowledge (Haraway, 1988). This is why we need to understand ethics not in the abstract but in specific social contexts (Bowden, 1997).

The participatory framework is informed by grounded, critical, and feminist theory. A grounded theory methodology suggests that theory building requires the input of lived experiences. Otherwise, theoretical postulates remain disconnected from the phenomenology of the object of study. As Strauss and Corbin (1994) pointed out, theories "may be elaborated and modified as incoming data are meticulously played against them" (p. 273). According to this approach, conceptual developments have to be grounded in social research. In our view, much of the literature on professional ethics remains less than useful because it lacks the lived experience component. Professionals do not see themselves readily reflected in the literature because it is based either on aspirational statements (e.g., Clark & Abeles, 1994; Garfat & Ricks, 1995; Walker, 1994) or simplified research vignettes (e.g., Chevalier & Lyon, 1993; Seitz & O'Neill, 1996). In ei-

ther case, accounts documenting the daily ethical struggles of professionals are missing.

The second intellectual and moral force that shapes our thinking is critical theory. Critical theory advances a concrete epistemology as well as a moral philosophy. From an explanatory point of view, it postulates that human interaction can be rendered intelligible when power differentials are taken into account. From a moral point of view, it claims that the "good life" and the "good society" are predicated on equality, fairness, and justice (Geuss, 1981; Gustavsen, 1996; Habermas, 1990; Prilleltensky, 1994; Richardson & Fowers, 1997). Thus, critical theory does not only explain social behavior in terms of power dynamics, but it also seeks to balance the decision making power among individuals (Kincheloe & McLaren, 1994; Morrow, 1994). In the applied ethics literature, professionals are largely depicted as devoid of personal interest or power motives.

In our opinion, predominant conceptions of professionalism obscure the role that social relations, status, prestige, and privilege play in the provision of professional services. However, compassionate mental health clinicians and human service workers are not beyond the negative influences of the culture of professionalism that foster power imbalances among people (Chambliss, 1996; Dawes, 1994; DeVaris, 1994; Dineen, 1996; Dokecki, 1996; Hare-Mustin, 1994; Mack, 1994; Spinelli, 1994). The implications of our critical analysis of professionalism for applied ethics are that power differentials, decision-making processes, and conceptions of harm need to be closely scrutinized for their effects on clients.

Traditional renditions of the helping situation do not scrutinize sufficiently the issue of power and the socially constructed nature of ethics (Brown, 1997; Dokecki, 1996; Larsen & Rave, 1995; Prilleltensky, 1997). We propose to study these problems so that we may understand their dynamics and offer effective remedial action.

The third school of thought informing our research is feminist theory (Lather, 1991; Maynard & Purvis, 1994). Although continuous with critical theory in many ways, current feminist theory adds a critique of patriarchal domination and an emphasis on local knowledge and context (Bowden, 1997). General notions of inequality have to be understood in specific contexts. Contexts vary, and so do the constellations of factors affecting power dynamics and their subjective interpretations. In their quest to understand and eradicate the domination and exploitation of women, feminist theorists strive to illuminate the local and unique conditions that perpetuate oppression. This work entails acute awareness of the "dynamic complexity and diversity of specific situations, and the particular needs, desires, intellectual and emotional habits of the persons participating in them"

(Bowden, 1997, p. 3). The feminist orientation espoused by Bowden integrates the insights of grounded methodology and critical theory. Like us, she tried to learn about particular contexts of caring to nurture interpersonal and social relations based on mutual recognition and emancipation.

There is a dialectic between the moral principles of feminism and critical theory and grounded knowledge. This dialectic is best understood in the complementarity of situated knowledge and moral principles. What good is it to have an internally consistent set of principles and codes of ethics that do not reflect the living realities of most people? What good is it to know the ethical problems of workers if that knowledge is not processed into principles and guidelines for action? The main corollary of the first question is that moral philosophy is not enough. The main corollary of the second question is that grounded knowledge of ethics is not enough. Moral philosophy and grounded experience are complementary. Applied ethics theories have to be validated with lived experience, although lived experience has to be analyzed in light of guiding principles. Otherwise, we can end up with notions that are theoretically impeccable but practically useless, or with practices that are very convenient but morally unjustifiable.

RESEARCH OBJECTIVES

The research had a theoretical as well as an applied purpose. As part of the larger study, the research at the CGC was intended to contribute to the development of theory and to the creation of relevant and useful ethical frameworks. As an applied research project, the research at CGC inquired about clinicians' (a) general and applied values, (b) ethical challenges, (c) ethical resources and impediments, and (d) recommendations for maintaining or improving ethical decision-making processes.

RESEARCH SETTING AND PROCESS

The research took place at a CGC in a midsize city in Canada. The CGC employs about 200 clinicians in the disciplines of audiology, clinical reading, communication disorders, psychology, psychiatry, and social work. Clinicians work in interdisciplinary teams serving schools in different geographical areas of the city. The teams vary in size and composition, but most of them include clinicians from the disciplines mentioned above. The number of workers in each team ranges from about 7 to 25. Clinicians spend

most of their time seeing children in schools and consulting with teachers and parents.

We established contact with the research committee of the center in 1993 to inquire about their interest in participating in the study. The answer was favorable. The working relationship with the agency was facilitated by the fact that one of us had previously worked there for a number of years and was the investigator onsite. The research committee of the CGC served as an advisory group to the research team. The committee and the investigator discussed the terms of reference for the research and developed an interview protocol to address the research objectives stated previously. The advisory group recommended that the research include people from all disciplines and from a variety of geographical units. After the research team and the advisory committee were satisfied that research ethics for the study were properly addressed, the investigator arranged the interviews with CGC staff's assistance. Most interviews took place in the spring of 1995.

We presented a draft of the findings to the advisory committee early in 1997. The advisory group was satisfied that the content and format were appropriate for delivery to the center at a workshop to take place a month later. About 180 clinicians were present at the feedback workshop conducted by one of the investigators. Following the presentation of the findings the audience divided into groups of ten to discuss the findings and offer recommendations. Each group tackled a different ethical challenge, formulated initial recommendations, and presented the suggestions to the plenary session. Later, the investigator compiled all the recommendations and distributed them to all the units for discussion and follow-up.

METHODOLOGY AND ANALYSIS

We employed a qualitative methodology to elicit from participants their perspectives on applied ethics. We organized semistructured interviews to parallel the research objectives. We asked questions about values, dilemmas, resources, barriers, and recommendations. Some of the questions we asked were as follows: What does ethics mean to you in your work? What values guide your practice? What type of ethical dilemmas do you encounter in your job? What barriers do you encounter in attempts to resolve ethical dilemmas? What resources help you resolve ethical dilemmas? What recommendations can you make at the personal, professional, and organizational levels for improving ethical thinking and action? Workers were encouraged to provide concrete examples of their struggles and not to re-

main at a conceptual level. This facilitated a phenomenological understanding of their dilemmas.

With participants' permission, each interview was tape-recorded and later transcribed. Participants had a chance to edit their transcripts. Seventeen participants took part in the research. We interviewed 14 clinicians and three administrators from the disciplines of psychology (8), social work (4), communications disorders (4), and clinical reading (1). Ten women and seven men from nine different geographical units took part in the study. Invitations to participate in the study went out to all the staff of the CGC. Participants who volunteered made contact with the research team and an interview time was scheduled. These participants represented most areas of the city served by the CGC, and came from the four largest disciplines in the center. The discipline of psychiatry was not represented in the study. Most participants had 10 or more years of experience; some had over 20 years of experience and a few less than 10 years. Coming from different disciplines, participants adhered to different codes of ethics. Although the number of participants (17) was relatively small for the number of clinicians (about 200), the participatory workshop in which the results were presented validated the representativeness of the findings. The workshop served both to confirm the findings and generate recommendations. In it, workers affirmed what the researchers and the steering committee thought were the key issues facing clinicians.

Researchers created summaries of the transcripts and later developed categories of the various themes emerging from the data. Standard qualitative analyses procedures were employed. Initial categories were suggested and later compared and collapsed to capture the essence of what participants told us. The researchers met several times to compose the final list of categories, which was changed a few times in order to arrive at the best possible description of the data. On analysis of the first 15 interviews it became apparent that some information was missing, primarily with regards to issues of cultural diversity. This gap prompted two more interviews with key informants who could illuminate some of the issues related to practicing with minority groups.

Based on the transcripts we read and categorized it made sense to capture the essence of what clinicians said in terms of challenges. The challenges are framed in such a way as to reflect the contextual nature and lived experience of ethical struggles. Challenges are phrased in the form of actions (e.g., working in interlocking systems, dealing with pressure, etc.) because they reflect the lived experience of clinicians. This is a dynamic way of illustrating what participants told us (see Table 1).

TABLE 1
Outcomes Associated With Primary and Ancillary Challenges to Ethical Action

<i>Sources of Negative Outcomes</i>	<i>Negative Outcomes</i>	<i>Challenges to Ethical Action</i>	<i>Positive Outcomes</i>	<i>Sources of Positive Outcomes</i>
<i>Primary challenges</i> Competing definitions of: Who is the client? What is good for the client? Who controls clinicians' jobs?	Systemic entanglements among worker, team, center, school, and family.	Working in interlocking systems.	Effective collaboration among systems.	Dialogue regarding: clear expectations, mutual respect, role clarification, preferential consultation.
No team building; no support for showing weaknesses; job insecurity; poor physical conditions.	Climate of isolation and insecurity.	Meeting workers' needs.	Climate of safety and support.	Team building; peer support; support from supervisors; proper space.
<i>Ancillary challenges</i> Mind fix verses system fix mentality; threat to the status quo.	Pressure to comply.	Dealing with pressure to acquiesce.	Ability to challenge system.	Support from colleagues and superiors; good relations with schools.
Need for labels for placements; need for labels to psychologize problems.	Pressure to label.	Dealing with pressure to label.	Ability to assess without stigmatizing.	Less emphasis on labels; understanding negative effects of labeling.
Belief in expert model; restrictive orientation; need for power and control.	Professional arrogance.	Facing the perils of professionalism.	Professional humility.	Inclusive orientation; collaborative approach.
Lack of sensitivity to diversity; racial and patriarchal biases.	Discrimination.	Facing racial and gender discrimination.	Equality.	Awareness of discrimination; commitment to equality.
Giving in to pressure to be in schools.	No time for proper service and reflection.	Finding time.	Time for proper service and reflection.	Commitment to team meetings and peer consultation.

SOCIAL AND HISTORICAL CONTEXT OF DATA COLLECTION

The research took place during an era of budget cuts to educational, health, and social services across North America. Workers at CGC experienced uncertainty with respect to their jobs. The anxiety that pervades working environments in social services and mental health settings had an impact on the workers' discourse on ethics. The pervasive lack of time for proper service and reflection becomes even more acute in an era of diminished resources. The precious little time available to discuss ethical dilemmas shrinks even more when there are more children to see and fewer clinicians to see them. Decision-making processes related to ethics can be lengthy, and clinicians may feel they cannot afford the time to think proactively about these issues. There is evidence in the data that more time used to be allotted in the past to workshops and educational activities related to the ethical dimensions of the job.

Clinicians find themselves in the difficult position of wanting more time for ethical consultation, but having less time to see children and parents that need help. There is a paradox in this situation. At a time when ethical thinking should be applied to examine the repercussions of diminished resources for children, time for ethical thinking is regarded as a luxury precisely because there are many children waiting to be seen. We mention this dilemma at the outset of the findings, because this climate of retrenchment affects the disposition of workers and administrators to scrutinize the moral implications of their work.

FINDINGS AND INTERPRETATIONS

This section is divided into two main parts: values and challenges. In each part we present (a) main themes emerging from the interviews, (b) selected quotes to illustrate the main issues, and (c) our interpretation of the findings.

Values

Values may be defined as principles that guide workers in their desire to achieve an ideal state of affairs for their clients (Prilleltensky, 1997). Workers at the CGC talked about general and applied values. The main three general values were:

- Respect for people's rights, dignity, integrity, and privacy.
- Compassion and responsible caring.
- Community responsibility.

When asked about ethical principles guiding her work, a clinician responded by saying that: "When I think of ethics some of the ideas that come to mind include the rights of all individuals ... respect for all individuals involved ... responsible caring ... and also responsibility to society."

An administrator said that: "Ethics has to be an encompassing attitude toward the way in which you relate to other people. The integrity that is presented in every situation, whether it's working with staff or schools or parents, or whatever the service."

Other comments were as follows: "Respect for the dignity of people that I interact with. I think about the importance of privacy and nonintrusiveness."

Compassion and responsible caring came across in the following statements by two different participants: "It's important to maintain compassion. I think of ethics as safeguarding the rights of people and responsible caring."

Community responsibility was expressed by two clinicians as follows: "I think of ethics as responsibility to society in general. Duty to warn in cases of violent threats."

Clinicians identified five key principles that guide their specific applied work at the CGC. These applied values are:

- Voice and choice.
- Advocating for the most vulnerable client.
- Informed consent and confidentiality.
- Empowering and holistic approaches based on strengths.
- Pursuing the child's best interest.

Voice and choice refer to affording clients an opportunity to have meaningful input into decisions affecting their lives. Clinicians expressed their wish for family input in statements like these: "You don't have to make arbitrary decisions without their involvement. I'll always give families the choice of (intervention)."

Advocating on behalf of the most vulnerable person was a value identified by several participants. One person said that a key consideration is knowing "who is most vulnerable in this situation," whereas another affirmed the need to know "who is the most vulnerable person."

Informed consent and confidentiality featured prominently in participants' answers. Clinicians were aware of the need to protect clients' privacy. An administrator spoke about it in the following terms: "I think of people's need to have their individuality and confidentiality respected." Workers emphasized the need to adopt empowering approaches to look at clients' strengths and resources. In an environment where labels and the search for deficits are part of the job, it is particularly important to be aware of the need to balance those practices with the search for positive assets. This is how different clinicians expressed this view:

People have internal strengths and can help themselves. I look at the ability of the people to help themselves and try to empower [them] in ways that I can.

Looking at people's strengths and really digging for whatever strengths and not using sort of a basic medical model of saying what's the problem, let's treat the problem and that's that. But to look at what are the strengths that we can use that are going to help us to get beyond the problem.

Without a doubt, the primary value that these clinicians reported using to guide their ethical conduct is to do whatever is best for the child. Given that children's needs vary from context to context, it is counterproductive to have a rigid set of principles that should always be applied regardless of the specifics of the situation. Given the uniqueness of each child and family, defining the primary value in terms of doing what is best for the child under the specific circumstances makes sense. This is how three clinicians talked about this:

I go back to look [at] who the client is and what may be of benefit to the client....What does the child most need from me? So it's constantly what's in the best interest of the child. It boils down to an issue of what's best for the student.

From Values to Outcomes

Figure 1 depicts the connections between values and outcomes. Values are principles of action that should improve the situation of clients. Values are supposed to lead to positive outcomes for clients in general, and for the child in particular. Ideally, values lead to ethical action, which in turn lead to beneficial outcomes. As guidelines for moral and ethical conduct, values inform ethical action. This is the action deemed most ethically appropriate to advance the welfare of the child. However, we do not live in an ideal

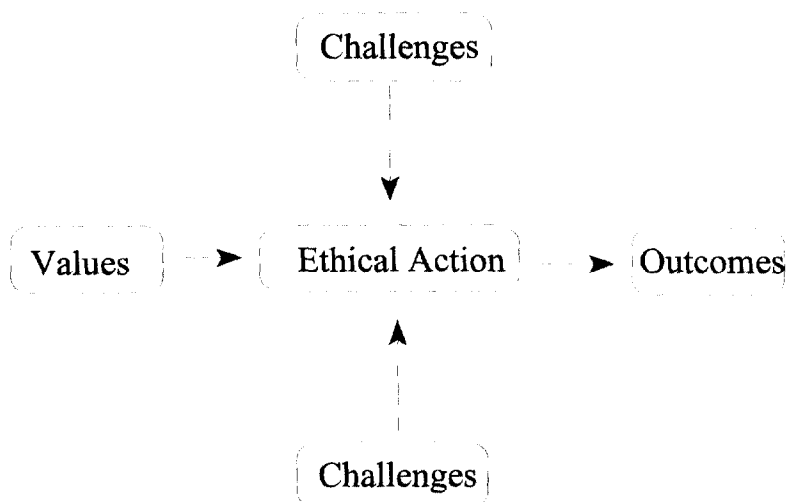


FIGURE 1 Moving from values to outcomes in applied ethics.

world and many challenges interfere with the action regarded as most ethical under the circumstances. These challenges derive from various sources and create barriers for the pursuit of the child's best interest. The extent to which clinicians are able to enact their values, engage in ethical action, and obtain favorable outcomes for children depend on the magnitude of the challenges. We present next the main seven challenges emerging from the research at CGC.

Challenges to Ethical Action

Challenges to ethical action derive from multiple sources. Clinicians interface with people in various contexts. Figure 2 shows the clinician-child dyad at the center of the picture, surrounded by four possible direct sources of influence on their relationship. Although the clinician tries to pursue the child's best interest, his or her actions are heavily influenced by what people in those other systems think and do. The figure shows only four contexts that impact on the clinicians' work, although others could be added to the picture.

Players in any of these contexts have a stake in the welfare of the child, and in their own welfare as well. Although we assume that most people involved desire what is best for the child, their actions may not always promote what the clinician considers to be the best course of action. Conflicting opinions present a serious challenge to the clinician who is forever mediating among systems. The various challenges we later describe

should be seen against the background of the interactions among various systems. There are seven challenges emerging from the data. We divide them into primary and ancillary challenges. Primary challenges are:

- Working in interlocking systems.
- Meeting workers' needs.

Ancillary challenges are:

- Dealing with pressure to acquiesce.
- Dealing with pressure to label.
- Facing the perils of professionalism.
- Facing gender and racial discrimination.
- Finding time for proper service and reflection.

Table 1 summarizes the main challenges, their positive or negative repercussions, and their respective sources. Each challenge, presented in the

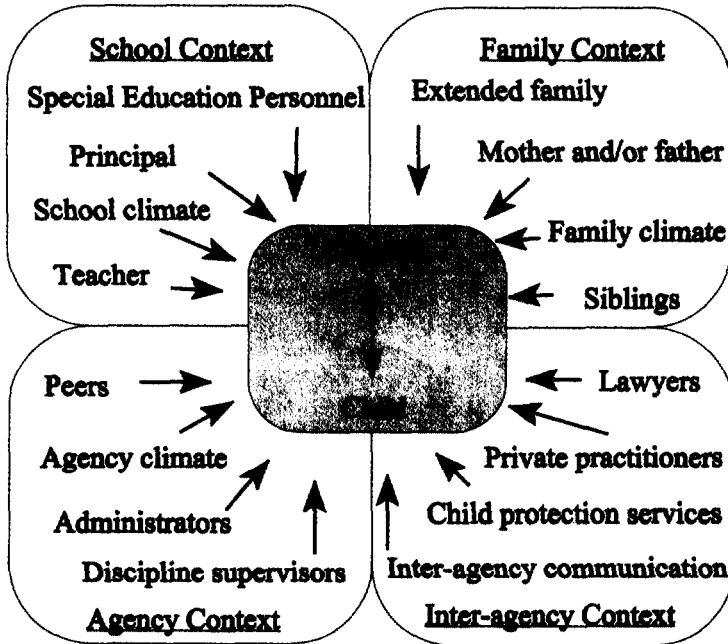


FIGURE 2 The systemic context of ethical challenges.

middle column, can lead to a positive or negative resolution, depending on the availability of resources and people's willingness to deal with them. Although we describe the challenges separately, they interact to either facilitate or inhibit ethical dialogue. The top two challenges are deemed primary because they permeate all the rest. The ubiquitous nature of these two primary challenges influences the way the other dilemmas are resolved. From our previous research on the subject (Rossiter et al., 1996; Walsh-Bowers et al., 1996), we know that workers who enjoy a safe working climate have a good start on resolving ethical dilemmas. When collaborative practices characterize interactions among professionals, it is possible to address moral concerns, such as discrimination, without feeling too vulnerable. In other words, we regard the resolution of the two primary challenges as a prerequisite for tackling the ancillary dilemmas. This does not mean that ancillary challenges cannot be addressed until the primary ones have been completely resolved. What it does mean is that it will be very difficult to address the ancillary issues without attending to the primary ones at the same time. We believe that a positive chain reaction may take place once the primary issues are addressed with the relevant constituencies. The interactive effects of the various challenges should be kept in mind when reading each of them individually.

Challenge 1: Working in interlocking systems. This challenge permeates all the activities of clinicians. It is part of the process of pursuing the child's best interests. We view it as the central process affecting ethical decision making. The process of mediating among systems affects the remaining challenges. The ability to navigate successfully through various contexts will facilitate greatly the resolution of all other conflicts. Thus, for instance, engaging administrators in dialogue could address workers' needs, whereas facing school personnel honestly about pressures to label could begin a resolving dialogue.

The challenge of working in interlocking systems involves facing influences from various corners and from various players. When a clinician asks him- or herself how should the best interest of the child should be pursued, the answer must take into account how others are going to react to the suggestions. When we asked a clinician about ethical dilemmas typical of her work she said:

Most commonly, it seems to be dilemmas related to system issues. Political kinds of situations where a client is referred to me maybe for a certain set of problems and someone in the school system may want the service provided

in a certain way and the parent of that child may want it delivered in a different way, and so there are different players involved wanting different things.

We termed these conflictive situations *systemic entanglements*. The clinician is faced with the task of enlisting everyone in the common cause of pursuing the child's best interests, but his or her success depends not only on his or her personal abilities and blind spots, but also on other people's capacities for collaboration. Issues of power and control over clinicians' jobs are central. Clinicians want to listen to others but still exercise control over their own time and priorities. Conflict is sometimes occasioned by competing definitions of who is the client (child, parent, teacher, or school as a system?), what is good for the client (special education, family therapy, group therapy, remedial learning, another school, or all of the above?), and who controls clinicians' jobs (school principals, discipline supervisors, or clinicians themselves?). Competing definitions of issues derive from multiple players involved in decision-making processes (parents, teachers, colleagues, other agencies, etc.). The main issue, an administrator said, is one of control.

To overcome this challenge, good communication practices among systems must be reinforced. Agencies have to build on existing models of effective communication. Establishing priorities together with schools, clinicians told us, is an effective practice that takes place in many schools. Effective school team meetings are a good model for the establishment of clear communication processes.

Challenge 2: Meeting workers' needs. The personal needs of workers should be taken into account. Supported and satisfied workers are able to perform their duties better than isolated and threatened clinicians. Clinicians' well being is paramount because of its intrinsic value, but also because their welfare is instrumental in helping children.

Clinicians work by themselves a lot of the time. They go from school to school and interact with many people but rarely is there sufficient time to develop intimate connections or to foster a sense of community with colleagues at school and at the CGC. Feeling supported by peers, administrators, and supervisors is a crucial element in the morale of clinicians. The concept of professionalism bears on this issue, for there is an unwritten expectation that professionals can handle pressure. A participant talked about the risks involved in showing weaknesses, as if clinicians are not allowed to share personal difficulties or even mild dilemmas, lest they will be regarded as inadequate. Another clinician reported at length on the

need for self-protection: to have your recording done properly in case of a subpoena, to inform managers about “politically sensitive cases,” and the like. The worker made an insightful distinction between politics and ethics at the center. He said that politics is about protecting yourself, whereas ethics is about protecting the client. This clinician spoke about the need for personal safety as a prerequisite for the delivery of ethical service for children and families.

Challenge 3: Dealing with pressure to acquiesce. It is common for clinicians to identify systemic issues in schools, families, or other agencies, affecting the life of the child. However, efforts by clinicians to change family or school dynamics are often not welcome because of a perceived threat that the clinician will “rock the boat.” In other words, the clinician may deal with issues that other people would rather avoid. This dynamic may result in pressures to acquiesce to educational and family structures. The unwritten message is “deal with the child, leave us alone.” This dictum is very difficult to follow because a child’s welfare largely depends on the environment in which he or she develops.

Assume a child with attention deficit hyperactivity disorder is placed in an open concept classroom. The clinician may want to say “please consider transferring the child to another class,” but because of political considerations the worker may be prevented from saying so. Similarly, assume a clinician realizes that certain practices in other agencies are not helpful, and perhaps even detrimental, to the child. What is the clinician to do when there is an implicit code that says “do not meddle with our agency?” Clinicians who are put in these situations face the dilemma commonly known as *whistle blowing*. Are they to reveal to others, in particular to parents, that the system is not serving the child well? It is difficult to decide when and how to discuss these issues, but what is clear is that clinicians need a place and time to dialogue with others about the best course of action.

Challenge 4: Dealing with pressure to label. This challenge is closely related to the previous one: Schools placing expectations on clinicians and clinicians not always agreeing with the request. Clinicians recognize the need for proper identification of strengths and weaknesses in a child, but they do not always agree with the need to give a battery of tests resulting in a formal label. Schools, in turn, need diagnostic labels to process applications for special education resources. Schools may not like labels either, but

they are sometimes obliged by law to identify and evaluate children with special needs. This is a case in which legislation requires schools and clinicians to operate under laws that may inadvertently lead to stigma. There is a delicate balance to be reached regarding the need to identify children to receive services and the risk of labeling.

In other instances, the request for labels derives from a culture that psychologizes problems. In other words, there is a culture that tends to view problems exclusively in internal terms—difficulties lie within the child, and psychological testing can reveal the intrapsychic sources of the problems.

The dilemma facing clinicians is that assessments can be helpful in planning proper interventions, but testing often results in labels that stigmatize the child. Not only do labels stigmatize, but they also tend to overshadow external sources of problems. When psycho-educational reports focus intensely on “what is wrong within this child,” schools and family dynamics take second place. A number of clinicians said that labels can create self-fulfilling prophecies and can be prejudicial. Other clinicians were more blunt and said that testing can be harmful and used to get rid of children.

Challenge 5: Facing the perils of professionalism. Participants talked about the danger of professionals behaving in arrogant fashion. By virtue of their extensive training and social prestige, some professionals tend to arrogate to themselves a lot of power. They dominate discussions, impose their opinions on others, and in general tend to exclude participation of other stakeholders from decision-making processes. People who engage in this type of behavior undermine team building and the collaboration that is needed to deal with ethical issues in a climate of safety and respect.

When we talk about facing the perils of professionalism, we mean facing one's own as well as others' inclinations to arrogate power. One clinician acknowledged that professionalism can become a liability if it becomes arrogance. Furthermore, this clinician said that “someone [is arrogant] whose professionalism would not be open to questioning the ethical decisions that he [or] she made.” Participants told us of colleagues whose sense of self-importance was, in their view, exaggerated. This inflated sense of personal confidence sometimes led other professionals to make recommendations clinicians thought were inappropriate.

Challenge 6: Facing gender and racial discrimination. A few clinicians talked about incidents of discrimination based on gender. Some inci-

dents were subtle, others more overt. Some took place outside the center, some within the center. Women clinicians talked about experiences of being overpowered by male professionals in the center and in the educational system. Part of the problem had to do with the dominance of male professionals in the educational and social service sector. The concept of the *old boys network* was invoked to describe women's difficult time raising gender issues. Although the instances of blatant discrimination reported were few, examples of subtle discrimination, such as stereotyping women as "weak," were more prevalent.

The issue of racial discrimination was especially present in areas of the city where there is a high concentration of aboriginal youth. Some clinicians reflected on the need to have more minority staff in these schools. In addition, mention was made of the constant need to increase cultural sensitivity in working with families from other cultures. Clinicians noted a discrepancy between the appropriate rhetoric and the inadequate action on this regard. There is talk about cultural sensitivity but little action by way of training and hiring minority workers.

Challenge 7: Finding time. The challenge of finding time has ethical repercussions at various levels of practice. With decreased budgets and increased caseloads, clinicians have less time to (a) consult with colleagues, (b) provide therapy, (c) engage in preventive activities, (d) do thorough assessments, and (e) experience professional development activities. These are not trivial matters. Clinicians shared with us that treatment plans are compromised when there is not sufficient time to train parents or volunteers, or when follow-up cannot be done. Similarly, with the increase in children to look after, each client receives less time.

DISCUSSION

In this section, we draw the implications of the study for action, theory, and research. We begin by showing how the findings can be used in the local context and how others may benefit from our conceptualization of the data. We then discuss our contributions to the professional ethics literature, concluding with some lessons for collaborative applied research.

Implications for Action

As Figure 3 shows, ethical action is multiply determined by values, resources, and impediments. The findings of our research can be organized into resources and impediments influencing ethical action. Following Kurt

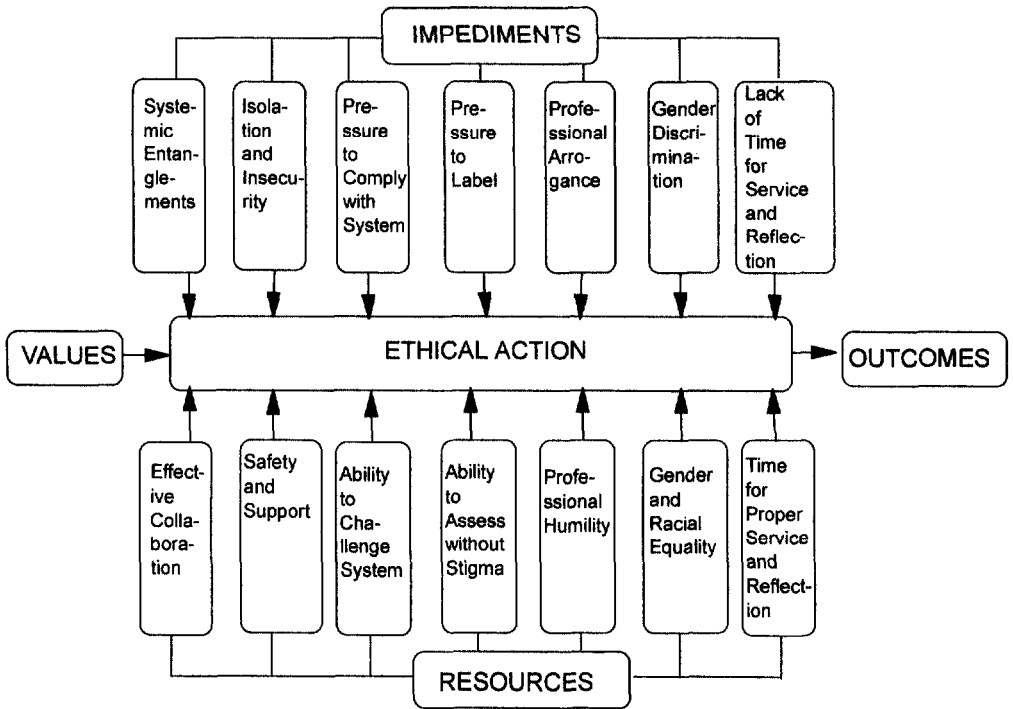


FIGURE 3 Resources and impediments influencing ethical action.

Lewin’s (1951) idea of force field analysis, we frame the positive outcomes of the various challenges as resources and the negative outcomes as impediments (see Table 1), we obtain a clear picture of the forces shaping ethical action.

Figure 3 can serve as a guide for positive outcomes. We can promote ethical action by strengthening the resources and by trying to remove the impediments. A set of specific recommendations may be derived from the data obtained in the research. Thus, clinicians and administrators at the CGC can work to reduce systemic entanglements and increase effective collaboration. Similarly, administrators can strive to establish a climate of safety and support where ethical dialogue may thrive. Other suggestions can be formulated to address the remaining five challenges. Thus, the grounded knowledge generated in the study can be put to use in the form of concrete action plans. Indeed, in our work with the agency we offered many recommendations based on this conceptual model.

Although the data presented in Figure 3 emerged from the setting we studied, other studies indicate that they are not entirely unique to a setting like the CGC (Chambliss, 1996; Deaton, 1996; Holland & Kilpatrick, 1991; Philips & Rehnström, 1996; Rossiter et al., 1996; Walsh-Bowers et al., 1996; Wood, Rogers, McCarthy, & Lewine, 1994). Mental health and human service organizations may compare their situation to CGC and determine to what extent their dilemmas parallel the ones presented in Figure 3. These organizations may learn from the challenges faced by clinicians at the CGC. However, even if the challenges experienced by other organizations were completely different, there is still merit in applying the templates presented in Table 1 and Figure 3 to their unique circumstances. The benefit of doing so is that they can conceptually represent their challenges, values, resources, and impediments in action-oriented frameworks.

Similarly, educational and psychological consultants can use Figure 3 to anticipate and resolve ethical challenges they may face in their work. Furthermore, Figure 3 can be used by consultants as a tool to prevent ethical dilemmas. If we know that systemic entanglements can cause problems, developing effective collaboration with consultees can be a useful preventive measure. If we know that a climate of insecurity disempowers consultants and consultees, promoting a safe environment for communication can facilitate honest discussion of dilemmas. We may even recommend to consultants to bring to their consultation sessions with schools an empty template of Figure 3. By acknowledging that there are ethical dilemmas, and that there are impediments and resources to resolve them, members of a consultation team may feel more at ease to address sensitive or conflictive issues. Also, by naming some key issues, like gender discrimination, we convey a message as consultants that we know it exists and that it is acceptable to address it.

Naming sensitive issues such as discrimination or lack of safety can have a therapeutic effect and can improve communication. Consultees may be afraid to call a problem for what it is, lest he or she may be seen as a trouble maker. Acknowledging the presence of competing interests and barriers may facilitate more open discussion among consultants, school personnel, and parents.

Implications for Theory

Our research had applied as well as theoretical objectives. In addition to our wish to be helpful to applied settings, we were also challenged to advance professional ethics theory. In our view, professional ethics discourse

can be enriched by attending to the lived experience of ethics and the role of power.

There is a substantial literature on values and principles of professional ethics (Clark & Abeles, 1994; Dockecki, 1996; Prilleltensky, 1997; Prilleltensky et al., 1996; Sinclair, 1996; Sundram, 1994; Walker, 1994). There are also decision-making frameworks to help the professional arrive at the most desirable ethical action (Garfat & Ricks, 1995; Hill, Glaser, & Harden, 1995; Neukrug, Lovell, & Parker, 1996; Pettifor, 1996; Plante, 1995; Wegener, 1996; Woody, 1990). In addition, there is survey research documenting dilemmas frequently encountered by clinicians (Pope & Vetter, 1992). However meritorious, these various approaches are somewhat limited in their ability to inform theory and action. The limitations derive from two main sources: the lack of integration of these disparate methodologies and failure to document how ethics are experienced on a daily basis by specific agents in concrete settings. Each approach addresses an important but circumscribed facet of professional ethics. What we need is an integrative approach that examines how clinicians negotiate values, dilemmas, and decision-making processes in particular contexts. Without a grounded theory perspective that probes workers' lived experience of ethics, the various pieces of the ethical puzzle fail to come together. It was in light of that need that we set out to document the lived experience of ethics in a child guidance center. By comparing and contrasting findings across settings it is possible to determine to what extent findings are generalizable.

The essence of our contribution to the literature lies in showing how contextual dynamics interact with subjective processes to mediate ethical outcomes. Our research points to the need to be sensitive to the unique circumstances influencing ethical action. The contextual considerations we described are an integral part of ethical outcomes. Systemic entanglements and feelings of isolation and insecurity were crucial determinants of ethical outcomes in our research. Each setting has its unique constellation of factors affecting professional ethics. Given their powerful inhibitory or facilitative role, it is imperative that these forces be taken into account when practicing and theorizing professional ethics.

There is a tendency in the literature to undermine the role of power in the behavior of mental health professionals. The effects of personal and social power are minimized because of the pervasive and illusory belief that professionals are above power games, as if the title of *professional* protected workers from the temptations of privilege, arrogance, and abuse (Brown, 1997; Dockecki, 1996; Mack, 1994; Pilgrim, 1992; Spinelli, 1994). Critical and feminist theory reminds us of the potentially pernicious impact of power differentials in interpersonal and social relations (Bowden, 1997;

Gustavsen, 1996; Larsen & Rave, 1995; Toulmin, 1996). Power differentials are omnipresent in professional–client and professional–professional relationships (Dineen, 1996; Dokecki, 1996; Salhani, 1997). Although the authority of the professional is readily apparent when working with clients, the power dynamics among professionals are somewhat obscure. Although there are clearly established hierarchical lines dividing professionals into more or less influential, these are hidden under a veneer of pseudoequality (Salhani, 1997). Typical cases entail the dominance of physicians over nurses in health care settings, and the higher status accorded to psychologists over social workers or teachers in health, educational, and social service settings (Chambliss, 1996; Philips & Rehnström, 1996; Salhani, 1997; Walsh-Bowers et al., 1996).

In our research, the impact of power differentials was felt at many levels. Some clinicians were afraid of criticizing school principals, whereas others were worried of contradicting psychiatrists. Participants also witnessed professionals making use of their power to “get their way,” without considering other people’s opinions. In general, clinicians were afraid to challenge rules and practices because of their precarious job situation in the current economic climate. Our research documented the pervasive impact of unacknowledged power differentials in terms of gender, race, and professional status. Women clinicians felt silenced at times by males in position of authority. Several clinicians commented on the “boys network” phenomenon; an invisible web that filters women’s experiences. The issue of race came up in relation to a large aboriginal population served by the CGC. During our first round of interviews we did not find much information related to this issue. As a result, we decided to interview clinicians working specifically with aboriginal children and youth. The concerns identified by participants related primarily to cultural sensitivity in terms of assessment tools and interaction with parents, but there was not a discussion of social issues like injustice or cultural oppression. Clinicians showed sensitivity to experiences of powerlessness in themselves and in children in general, but there was not particular mention of the disempowered conditions of Aboriginal families. This phenomenon reinforces the argument that ethical sensitivity is related to subjectivity, race, and gender. Women clinicians appeared are more sensitive to gender issues, whereas White clinicians did not emphasize the social oppression of Aboriginal families.

When clinicians are in a position of dominance, by virtue of their professional status, gender, or culture, they run the risk of glossing over the suffering endured by those in position of relative powerlessness. Clinicians’ and consultants’ ethical sensitivities are forged within power relations that

condition the definition of what is an ethical issue and what is not. Whereas cross-cultural adequacy of assessment tools may be regarded an ethical issue, the social oppression of certain groups may not. What is and what is not regarded as an ethical issue depends on professional culture and the position of power held by the person (Rossiter et al., in press).

Our conceptual framework identified issues of power as central to the construction of ethical discourse. In our view, power issues permeated all the challenges identified by clinicians. Power affected the ability of workers to negotiate in interlocking systems, to advocate for better working better conditions, and to resist pressure to label, but it also affected their ability to question their privileged professional authority.

Implications for Research

We position ourselves within the tradition of action research. This tradition represents "efforts to link research directly to processes of change and development: research is responsible, or co-responsible, for the achievement of certain results, definable as new practical arrangements" (Gustavsen, 1996, p. 5). Critical theory and action research are compatible in that both approaches accept the premise that they should "contribute to a transcendence of the world as it is and the realization of a better one" (Gustavsen, 1996, p. 6). There are some useful implications of our study for applied action research.

Throughout the research process we tried to model the values of collaboration and democratic participation by working closely with an advisory committee. The committee reviewed the research questions and design and offered valuable input to us. Following the analysis of the data, we shared the preliminary interpretations with the committee to make sure the results resonated with their perceptions. We also planned together with the advisory committee the feedback workshop where the entire center would hear the results for the first time. At the workshop itself we provided an opportunity for clinicians to participate in the formulation of recommendations to be incorporated in the final report to the agency. Our report to the center included the many suggestions raised by various small groups during the workshop. Prior to circulation of the report to the entire agency, we gave it to the advisory committee to make sure that they approved of it and that it did not harm or identify anybody. These various forms of stakeholder involvement enhanced the credibility of the project and contributed to a mutually beneficial research relationship (Gustavsen, 1996).

We recommend the use of this participatory action research framework in studying applied ethics. Stakeholder participation increases both the trustworthiness of the data and the chances that the results will be put to good use. Seldom do we see in the literature efforts to translate applied ethics research into organizational change. Although it is too early to tell whether the CGC will implement some or most of the recommendations we made, the collaborative research model we employed laid the groundwork for positive change.

CONCLUSION

Creating frameworks of applied ethics that are both emancipatory and grounded in lived experience is a humbling enterprise. This research is a building block in this arduous task. Although we derive satisfaction from knowing that the agency found the research illuminating, we are very much aware that our research contains limitations. Our project focused only on the experiences of clinicians and did not take into account the views of clients. This is a clear limitation. We have continued a tradition that focuses on the views of the powerful professionals and regards as secondary the views of the clients. This is a contradiction that we, as authors, have to deal with.

Although this particular study is based on 17 clinicians within one organization, the results are compatible with other studies we conducted (Rossiter et al., 1996; Walsh-Bowers et al., 1996). For sure some of the issues, like relationships with schools, are unique to this setting, but many other dilemmas, such as the need for time and safe space to discuss ethical dilemmas, or the role of power in silencing or enabling people, are common to all the settings we researched. Commonalities notwithstanding, caution should be exercised in generalizing findings from one setting to another, as the social context varies from setting to setting. We recommend using this study as a point of departure from which other settings can examine their own ethical issues.

We strived to facilitate change by engaging in what Putnam (1996) called "interventions to create productive dialogue" (p. 41). We can only hope that the dialogue we conducted with the agency is "useful for enhancing learning, for developing knowledge for practice, and for enabling communities of practitioners to make better choices for collective action" (p. 42).

At the level of theory building, we began meeting the need for grounded constructions of applied ethics. We have a better idea now of

what it means to experience ethical dilemmas in helping children. By asking participants about their values, dilemmas, and resources in handling real-life scenarios, we hope to have brought to the helping professions a more integrative view of ethics than has been available hitherto. "The ethical task is that of making the social world better—that is, criticizing and correcting oppressive abuses of power" (Dokecki, 1996, p. 58). Contextual knowledge of the forces aiding or hindering ethical action is a small step toward meeting Dokecki's criteria for ethical behavior. The challenge of translating this knowledge into action, however, reminds us that our contribution to applied ethics is still very modest.

ACKNOWLEDGMENTS

This research was supported by the Social Sciences and Humanities Research Council of Canada. We wish to thank the participants for their time and effort. We also thank Geoff Nelson for his comments on an earlier version of this article.

REFERENCES

- Attig, T. (1995). Can we talk? On the elusiveness of dialogue. *Death Studies, 19*, 1–19.
- Bowden, P. (1997). *Caring: Gender-sensitive ethics*. London: Routledge.
- Brown, L. (1997). Ethics in psychology: Cui bono [Who benefits by it]? In D. Fox & I. Prilleltensky (Eds.), *Critical psychology: An introduction* (pp. 51–67). London: Sage.
- Bursztajn, H. J., Gutheil, T. G., & Cummins, B. (1987). Conflict and synthesis: The comparative anatomy of ethical and clinical decision making. In S. J. Reiser, P. S. Bursztajn, P. S. Appelbaum, & T. G. Gutheil (Eds.), *Divided staffs, divided selves: A case study approach to mental health ethics* (pp. 17–40). New York: Cambridge University Press.
- Chambliss, D. (1996). *Beyond caring*. Chicago: University of Chicago Press.
- Chevalier, N. E., & Lyon, M. A. (1993). A survey of ethical decision making among practicing school psychologists. *Psychology in the Schools, 30*, 327–337.
- Clark, B. J., & Abeles, N. (1994). Ethical issues and dilemmas in the mental health organization. *Administration and Policy in Mental Health, 22*(1), 7–17.
- Dawes, R. M. (1994). *House of cards: Psychology and psychotherapy built on myth*. New York: Free Press.
- Deaton, A. V. (1996). Ethical issues in pediatric rehabilitation: Exploring an uneven terrain. *Rehabilitation Psychology, 41*(1), 33–52.
- DeVaris, J. (1994). The dynamics of power in psychotherapy. *Psychotherapy, 31*, 587–593.
- Dineen, T. (1996). *Manufacturing victims: What the psychology industry is doing to people*. Toronto, Canada: Robert Davies.
- Dokecki, P. (1996). *The tragi-comic professional: Basic considerations for ethical reflective-generative practice*. Pittsburgh, PA: Duquesne University Press.

- Garfat, T., & Ricks, F. (1995). Self-driven ethical decision-making: A model for child and youth care. *Child and Youth Care Forum, 24*, 393-404.
- Geuss, R. (1981). *The idea of a critical theory: Habermas and the Frankfurt school*. New York: Cambridge University Press.
- Gustavsen, B. (1996). Development and the social sciences: An uneasy relationship. In S. Toulmin & B. Gustavsen (Eds.), *Beyond theory: Changing organizations through participation* (pp. 5-30). Philadelphia: Benjamins.
- Habermas, J. (1990). *Moral consciousness and communicative action*. Cambridge, MA: MIT Press.
- Haraway, D. (1988). Situated knowledges: The science question in feminism and the privilege of partial perspectives. *Feminist Studies, 14*, 575-599.
- Hare-Mustin, R. T. (1994). Discourses in the mirrored room: A postmodern analysis of therapy. *Family Process, 33*, 19-35.
- Hill, M., Glaser, K., & Harden, J. (1995). A feminist model for ethical decision making. In E. J. Rave & C. C. Larsen (Eds.), *Ethical decision making in therapy: Feminist perspectives* (pp. 18-37). New York: Guilford.
- Holland, T. P., & Kilpatrick, A. C. (1991). Ethical issues in social work: Toward a grounded theory of professional ethics. *Social Work, 36*, 138-144.
- Kincheloe, J. L., & McLaren, P. L. (1994). Rethinking critical theory and qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 138-157). London: Sage.
- Kitchener, K. S. (1996). There is more to ethics than principles. *The Counselling Psychologist, 24*(1), 92-97.
- Larsen, C. C., & Rave, E. J. (1995). Context of feminist therapy ethics. In E. J. Rave & C. C. Larsen (Eds.), *Ethical decision making in therapy: Feminist perspectives* (pp. 1-17). New York: Guilford.
- Lather, P. (1991). *Getting smart: Feminist research and pedagogy with/in the postmodern*. New York: Routledge.
- Lewin, K. (1951). *Field theory in social science*. New York: Harper.
- Mack, J. E. (1994). Power, powerlessness, and empowerment in psychotherapy. *Psychiatry, 57*, 178-198.
- Maynard, M., & Purvis, J. (1994). Doing feminist research. In M. Maynard & J. Purvis (Eds.), *Researching women's lives from a feminist perspective* (pp. 1-8). London: Taylor & Francis.
- Morrow, R. A. (1994). *Critical theory and methodology*. London: Sage.
- Neukrug, E., Lovell, C., & Parker, R. J. (1996). Employing ethical codes and decision-making models: A developmental process. *Counselling and Values, 40*, 98-106.
- Pettifor, J. L. (1996). Maintaining professional conduct in daily practice. In L. J. Bass, S. T. DeMers, J. R. P. Oglloff, C. Peterson, J. L. Pettifor, R. P. Reaves, T. Rétfalvi, N. P. Simon, C. Sinclair, & R. M. Tipton (Eds.), *Professional conduct and discipline in psychology* (pp. 91-100). Washington, DC: American Psychological Association.
- Philips, M. E., & Rehnström, K. (1996). Workplace development, gender and communicative competence. In S. Toulmin & B. Gustavsen (Eds.), *Beyond theory: Changing organizations through participation* (pp. 53-66). Philadelphia: Benjamins.
- Pilgrim, D. (1992). Psychotherapy and political evasions. In W. Dryden & C. Feltham (Eds.), *Psychotherapy and its discontents* (pp. 225-253). Bristol, PA: Open University Press.
- Plante, T. G. (1995). Training child clinical predoctoral interns and postdoctoral fellows in ethics and professional issues: An experiential model. *Professional Psychology: Research and Practice, 26*, 616-619.
- Pope, K. S., & Vetter, V. A. (1992). Ethical dilemmas encountered by members of the American Psychological Association: A national survey. *American Psychologist, 47*, 397-411.

- Prilleltensky, I. (1994). *The morals and politics of psychology: Psychological discourse and the status quo*. Albany: State University of New York Press.
- Prilleltensky, I. (1997). Values, assumptions, and practices: Assessing the moral implications of psychological discourse and action. *American Psychologist*, 47, 517-535.
- Prilleltensky, I., Rossiter, A., & Walsh-Bowers, R. (1996). Preventing harm and promoting ethical discourse in the helping professions: Conceptual, research, analytical, and action frameworks. *Ethics and Behavior*, 6, 287-306.
- Putnam, R. W. (1996). Creating reflective dialogue. In S. Toulmin & B. Gustavsen (Eds.), *Beyond theory: Changing organizations through participation* (pp. 41-52). Philadelphia: Benjamins.
- Richardson, F. C., & Fowers, B. J. (1997). Critical theory, postmodernism, and hermeneutics: Insights for critical psychology. In D. Fox & I. Prilleltensky (Eds.), *Critical psychology: An introduction* (pp. 265-283). London: Sage.
- Rossiter, A., Prilleltensky, I., & Walsh-Bowers, R. (in press). A postmodern perspective on professional ethics. In B. Fawcett, B. Featherstone, J. Fook, & A. Rossiter (Eds.), *Researching and practicing in social work: Postmodern feminist perspectives*. New York: Routledge.
- Rossiter, A., Walsh-Bowers, R., & Prilleltensky, I. (1996). Learning from broken rules: Individualism, bureaucracy, and ethics. *Ethics & Behavior*, 6, 307-320.
- Salhani, D. (1997). *The social construction of interprofessional teams in human service organizations: Two case studies*. Unpublished doctoral dissertation, Wilfrid Laurier University, Waterloo, Ontario.
- Seitz, J., & O'Neill, P. (1996). Ethical decision-making and the code of ethics of the Canadian Psychological Association. *Canadian Psychology*, 37, 23-30.
- Sinclair, C. (1996). A comparison of codes of professional conduct and ethics. In L. J. Bass, S. T. DeMers, J. R. P. Ogloff, C. Peterson, J. L. Pettifor, R. P. Reaves, T. Rétfalvi, N. P. Simon, C. Sinclair, & R. M. Tipton (Eds.), *Professional conduct and discipline in psychology* (pp. 53-70). Washington, DC: American Psychological Association.
- Spinelli, E. (1994). *Demystifying therapy*. London: Constable.
- Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273-285). London: Sage.
- Sundram, C. J. (1994). A framework for thinking about choice and responsibility. In C. J. Sundram (Ed.), *Choice and responsibility: Legal and ethical dilemmas in services for persons with mental disabilities* (pp. 3-16). Albany: The New York State Commission on Quality of Care for the Mentally Disabled.
- Toulmin, S. (1996). Introduction. In S. Toulmin & B. Gustavsen (Eds.), *Beyond theory: Changing organizations through participation* (pp. 1-4). Philadelphia: Benjamins.
- Trevino, L. K. (1987). Ethical decision-making in organizations: A person-situation interactionist model. *Academy of Management Review*, 11, 601-617.
- Walker, K. D. (1994). Notions of "ethical" among senior educational leaders. *The Alberta Journal of Educational Research*, 40(1), 21-34.
- Walsh-Bowers, R., Rossiter, A., & Prilleltensky, I. (1996). The personal is the organizational in the ethics of hospital social workers. *Ethics and Behavior*, 6, 321-335.
- Wegener, S. T. (1996). The rehabilitation ethic and ethics. *Rehabilitation Psychology*, 41(1), 5-17.
- Wood, K. A., Rogers, J. H., McCarthy, S. M., & Lewine, R. R. J. (1994). Psychologists in public inpatient psychiatric settings: Ethical dilemmas. *Professional Psychology: Research and Practice*, 25, 234-240.
- Woody, J. D. (1990). Resolving ethical concerns in clinical practice: Toward a pragmatic model. *Journal of Marital and Family Therapy*, 16, 133-150.

Isaac Prilleltenky teaches in the community psychology graduate program at Wilfrid Laurier University. His research interests include value-based practice in the helping professions, critical psychology, and child and family wellness.

Richard Walsh-Bowers is professor of Psychology at Wilfrid Laurier University. He contributes to the literature in the history and ethics of psychology and the prevention of violence against women. His interests include the health status of psychiatric consumers and survivors.

Amy Rossiter teaches at York University in the School of Social Work. She is interested in feminist critical approaches to social work. As well, she studies the application of critical perspectives to professional ethics.