

## **Nine Ethical Values of Master Therapists**

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*This study employed the Consensual Qualitative Research method (Hill, Thompson, & Williams, 1997) to reanalyze interview data from a previous qualitative study of the personal characteristics of master therapists (Jennings & Skovholt, 1999). Previous research has demonstrated that therapists utilize a variety of resources when making ethical decisions, including professional codes of conduct and their own values. The current study's analysis of 10 master therapists' interviews resulted in the identification of nine ethical values related to their clinical practice: (a) relational connection, (b) autonomy, (c) beneficence, (d) nonmaleficence, (e) competence, (f) humility, (g) professional growth, (h) openness to complexity and ambiguity, and (i) self-awareness. Conducting oneself ethically is a critical task of the competent therapist (American Psychological Association, 2002). Making the best ethical decisions can be extremely challenging for most therapists due to the multitude of complex ethical situations that arise in practice. The goal of this study is to examine the ethical values of therapists considered to be "the best of the best" by their professional colleagues. It is hoped that such an examination will help to illuminate the ethical values that these master therapists seem to draw upon in their work.*

Ethics are beliefs about conduct and principles that inform rules for proper behavior (Corey, Corey, & Callanan, 1998; Knauss, 1997). In mental health professions, ethics codes are intended to "set out expected professional behavior and responsibility" (Eberlein, 1987, p. 354). However, studies involving ethical dilemmas have found a discrepancy among therapists between knowledge of proper actions and actual behavior (Bernard & Jara, 1986; Bernard, Murphy, & Little, 1987; Smith, McGuire, Abbott, & Blau, 1991; Wilkins, McGuire, Abbott, & Blau, 1990).

Why the inconsistencies? Researchers suggest that when therapists thought

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the ethical infraction violated a clear professional code, they were more likely to act as they felt they should, especially when the violation was bolstered by a legal precedent (Bernard et al., 1987; Smith et al., 1991). However, in situations that depended more on individual judgment, practitioners were less likely to do the right thing. It appears that when written ethical guidelines are unclear, mental health practitioners rely on their own individual value systems and their interpretation of the ethics code (Bersoff & Koepl, 1993; Eberlein, 1987). One possibility for the discrepancy between knowing and doing what is right is that some clinicians suffer from deficits in principles such as integrity and honesty (Smith et al.). Rest (1984) theorized that a therapist who is reluctant to follow through with understood ethical behavior may lack the courage to act. To date, studies on therapist values have tended to focus on their conceptualizations of what constitutes good mental health (Consoli & Williams, 1999; Haugen, Tyler, & Clark, 1991; Jensen & Bergin, 1988; Kelly, 1995; Khan & Cross, 1983; Myers & Truluck, 1998).

Kitchener (1984) believed that some parts of formal organizational ethical codes are too broad, whereas other sections are too narrow. The fundamental ethical principles identified by Kitchener are autonomy, beneficence, non-maleficence, justice, and fidelity. Meara, Schmidt, and Day (1996) expanded on Kitchener's work by defining principle ethics (i.e., formal, obligatory codes) as distinct from virtue ethics (i.e., focus on character traits and ideals). Virtue ethics are rooted within the traditions of a cultural group and, therefore, present a more complete account of moral life than actions based on prescribed rules. Meara et al. proposed that virtue ethics complement principle ethics by assisting helping professionals to achieve the ideals of being competent, serving the common good, and retaining professional autonomy. Given that the authors argue professional decision-making is "seldom either totally absolute or completely relative and thus requires virtuous, competent individuals to exercise careful professional judgment" (p. 5), the concept of ethics should encompass issues of character as well as professional obligations. The work of Kitchener and Meara et al. supports the idea that ethical decisions in psychology are complex and rarely absolute. In order to understand ethical decision-making, it seems important to know the therapist's ethical values that influence each unique situation.

The majority of empirical studies that examine ethical decision-making in practice have focused on therapists' responses to particular ethical dilemmas (Conte, Plutchik, Picard, & Karasu, 1989; Haas, Malouf, & Mayerson, 1988; Smith et al., 1991; Wilkins et al., 1990). Another approach has been for researchers to survey practicing clinicians in an open-ended way about their critical ethical challenges. This method, as described by Pope and Vetter (1992), mirrors the original process that the American Psychological Association (APA) used to create the first ethics code for psychologists. In

1952, the APA surveyed its membership in an attempt to develop guidelines for ethical conduct that reflected the concerns of practitioners. These surveys, although providing valuable information, did not investigate the cognitive process involved in ethical decision-making.

Thus far, little research on ethical values has focused on seasoned or expert therapists. However, studies have examined clinicians' years of experience, providing some information about the growth of professional ethical judgment over the course of a career (Conte et al., 1989; Haas et al., 1988; Jensen & Bergin, 1988). Conte et al.'s survey of therapists found that beliefs about ethical standards varied widely. The authors concluded that certain behaviors were thought by some therapists to be inappropriate, but not necessarily unethical, whereas other therapists felt that similar behaviors were either clearly unethical or grounds for malpractice. In addition, therapists with more experience were (a) more likely to feel that pledging to cure a client's symptoms was unethical and (b) less likely to break confidentiality to warn a potential victim of harm.

Jensen and Bergin (1988) found that years of professional experience did not predict desirable mental health values. In addition, Haas et al. (1988) found the length of time after attaining one's professional degree to be inversely related to the mental health practitioner's willingness to take the most ethically preferred course of action. The authors hypothesized that this surprising result may be due to burnout factors or to a recent training focus for younger practitioners on specific ethical obligations. Pope and Bajt (1988) surveyed ethically knowledgeable senior psychologists (e.g., served on boards of ethics, authors of ethics textbooks, American Board of Professional Psychology status) and found that a majority admitted having willingly violated ethical codes. Further, 77% of respondents felt that formal ethical standards should be broken when necessary for client welfare "or other deeper values" (p. 828).

Thus far, research has yielded limited data on therapists' values in general and has, at times, painted an unfavorable portrayal of the ethical practices of experienced therapists. What appears lacking in the literature is an examination of actual values, perhaps deeper values that guide therapists' ethical behavior. Even more useful may be an examination of the ethical values that expert or master therapists seem to draw upon in their work. To fulfill this goal, the present study was conducted to provide an understanding of the ethical values of master therapists.

## METHOD

### Procedure and Participants

This study utilized data derived from transcripts from a Jennings and

Skovholt (1999) study in which master therapists were asked questions about their personal characteristics and therapy practices. Well-regarded psychotherapists in a major Midwestern metropolitan area were approached and then asked to nominate three colleagues they considered to be master therapists. Nomination of master therapists was based on the following criteria: (a) This person is considered to be a “master therapist,” (b) this person is most frequently thought of when referring a close family member or dear friend to a therapist because the person is considered to be the “best of the best,” and (c) one would have full confidence in seeing this therapist for one’s own personal therapy. Therefore, this therapist might be considered a “therapist’s therapist.”

After 212 nominations, the sample of 10 master therapists (7 women and 3 men) receiving the most nominations consisted of 6 doctoral level psychologists, 3 master’s level social workers, and 1 psychiatrist. All held at least one license in their respective fields. The master therapists ranged in age from 50 to 72 years ( $M = 59.0$  years,  $SD = 7.9$  years). Their number of years practicing psychotherapy ranged from 21 to 41 years ( $M = 29.5$  years,  $SD = 6.6$  years). The theoretical orientations of the master therapists were divided among psychodynamic ( $n = 4$ ), family systems ( $n = 2$ ), existential-humanistic ( $n = 2$ ), and integrative ( $n = 2$ ). All master therapists were European Americans who worked full-time in private practice. Overall, their practices included short- and long-term work, with both managed care and clients who paid out-of-pocket within the fee structure of the community. For more detailed information about the sample and sampling method, refer to Skovholt and Jennings (2004).

### **Data Analysis**

Using archival data enabled the current researchers to unobtrusively assess the ethical values of master therapists (Webb, Campbell, Schwartz, & Sechrest, 1966). The possibility of socially desirable responses may have increased if the master therapists had been asked directly about their ethical values. For purposes of this study, ethical values were defined as strongly held beliefs that inform moral judgment and professional conduct. We chose the Consensual Qualitative Research (CQR) method (Hill, Thompson, & Williams, 1997) to code the transcripts. CQR allows data to emerge from the interview transcripts while multiple researchers distill the meaning by consensus. One major advantage of CQR is that the use of multiple researchers, decision-making by consensus, and systematic examination of the data across cases greatly reduces the biases of a sole investigator (Hill et al.).

The primary research team consisted of a psychologist and two doctoral level graduate students. Another psychologist with an academic teaching background in ethics and qualitative research methods served as auditor, a

role recommended by Hill et al. (1997) to enhance the trustworthiness of the results. The auditor reviewed the research process and provided analysis feedback to the research team.

We began data analysis by choosing a preliminary ethical framework for analysis of the transcripts. Our research team elected to create a set of sensitizing concepts as a "start list" (Hill et al., 1997, p. 543) to identify, classify, and categorize the qualitative data. These sensitizing concepts or preliminary ideas, derived from the relevant existing research and theoretical literature, were used to structure the initial analysis. We chose as our preliminary sensitizing concepts the values embedded within the six General Principles of the Ethical Principles of Psychologists and Code of Conduct (APA, 1992): competence, integrity, professional and scientific responsibility, respect for people's rights and dignity, concern for others' welfare, and social responsibility.

We began by consensually analyzing the explanatory text of the six APA General Principles (APA, 1992), line-by-line, coding the ethical values embedded within. From the original six APA General Principles, we identified 24 ethical values. Then in a pilot analysis, each of the researchers individually coded a copy of the same master therapist interview transcript using the list of 24 ethical values. After coding the first transcript, the research team met and together examined each line of text, consensually determining which ethical value seemed to best represent each quotation or unit of meaning. Differences in coding among the researchers were resolved through the process of discussion and debate until there was consensus. After using this process with the transcripts of three master therapists, the research team met with the auditor for feedback on the pilot analysis.

Based upon the auditor's suggestion, we revisited the writings of Gilligan (1982), Kitchener (1984), Kohlberg (1984), and Meara et al. (1996) to ensure that we had not overlooked other important ethical concepts. From this search, two ethical values (i.e., the ethic of relational connection from Gilligan's work and fidelity from Kitchener's work) were added to our ethical value list. In addition, six new ethical values (i.e., faith, courage, openness, resiliency, self-actualization, and cultural competence) were added based upon ethical values we identified during our pilot analysis. As a next step, all of the transcripts were analyzed with the final list of 32 ethical values. That is, each researcher first individually analyzed a transcript by assigning an ethical value to each quotation in the transcript. Then the researchers met as a team and consensually decided on how to best code the ethical value for each quotation from that transcript. This process concluded after all 10 transcripts had been analyzed, resulting in more than 1,300 quotations coded with one of the 32 ethical values. Next, each of the quotations was cut and stapled onto note cards to facilitate the manipulation and organization of the data.

The researchers then reexamined all quotations making up 32 ethical val-

ues. It should be noted that because the original study did not focus on ethics per se, each of the 1,300 quotations had to be carefully reanalyzed to determine if each quotation was truly representative of an ethical value. At this point, quotations that were deemed by consensus to be only minimally related to ethical values were excluded from the analysis. Next, the researchers tallied the number of quotations representing each ethical value as well as the number of therapists holding that particular ethical value. Of the 32 ethical values, 9 (i.e., confidentiality, professional responsibility, equality, justice, truth, integrity, philanthropy, resilience, and fidelity) were eliminated because they were associated with a low number of quotations by a few therapists and because they logically could not be consolidated with another ethical value. The remaining 23 ethical values and corresponding supporting data were consensually reexamined for internal consistency. At this point, some data (i.e., note cards) were reassigned to a more appropriate code by the research team. During this stage of the analysis, we determined that the remaining 23 ethical values could be logically consolidated into nine themes. The nine themes then were organized within two categories: (a) Building and Maintaining Interpersonal Attachments, with four ethical values; and (b) Building and Maintaining Expertise, with five ethical values. Finally, quotations that seemed to be excellent illustrative representatives of the ethical values were identified, a subset of which will be presented in the Results section so that the reader may get a better sense of the master therapists' viewpoints that made up these ethical values.

## RESULTS

### **Building and Maintaining Interpersonal Attachments**

This category contained four ethical values: relational connection, autonomy, beneficence, and nonmaleficence.

**Relational connection.** This ethical value appeared as the most important to the master therapists. Master therapists valued their relationships with themselves, clients, colleagues, family and friends, and members of the community. The master therapists believed that, to maintain competence and build expertise, they must continually be in relationships with others in the field, whether in supervision or consultation or purely for collegial support and friendship. One therapist commented on the need to avoid professional isolation through consistent contact with other professionals:

I have made sure to practice here with colleagues that are close by, and when the leases are up and some move out, we get others in, and we meet once a week for a long lunch, to talk about cases or plans for the waiting room or whatever. That sort of collegial connect, especially on a day-in, day-out basis, is really quite important.

Pertaining to performing competently in their work, which is central to ethical practice, these master therapists believed that the client-therapist relationship is the key to effecting positive change in clients. One therapist stated,

The core of psychotherapy to me is the development of that relationship and the connection, and so it's the development of a relationship ... the purpose of which is to heal or help the other person. But to me, psychotherapy is the relationship, as opposed to, you know, a technique that I do or whatever else. It's really about forming and working in the in-between.

Many of the therapists interviewed attempted to uphold high ethical standards when interacting with others in both their professional and personal life. In most relationships, even those in the community at large, the master therapists strived for congruence between their values and the way they lived their lives. As one therapist said,

It is honoring the integrity of relationship. If I have ... whatever relationship I have, whether it's with a friend that I'm having dinner with, or I am negotiating a price on a used car with a car dealer, or I am planning a vacation with my wife, or I'm talking with a client about his or her life, I'm going to be honest.

**Autonomy.** The right of individuals to determine the course of their own lives seemed to be a central value guiding master therapists when making ethical practice decisions. Master therapists appeared to greatly respect the phenomenological worldviews of their clients and hold the belief that for change to occur, clients must be allowed to determine the timing and direction of the therapeutic process. One therapist made the point this way:

I think you always have to give people a choice. Our basic mission is to help them see their choices, and if they want to make bad choices ... if somebody wants to go into a bar and scream that everybody in the bar is a son-of-a-bitch and get the hell beaten out of them, that's their choice. My job is to help them see what the consequence will be if they do that.

The interview data suggested that master therapists were aware of the ethical dangers of thinking they know what is best for their clients and, therefore, worked to avoid imposing their own beliefs, values, and ideals on clients. Perhaps because autonomy had been such a central tenet of their own personal development, master therapists believed strongly in the ability of their clients to direct their own lives. One master therapist said,

I mean, we really know what's best for ourselves and what the truth is about ourselves and our own direction. I think that a big part of our job as therapists is to help get all the other voices out of the way for the clients, so they can hear their own and begin to have some faith in it.

The master therapists seemed to believe that facilitating autonomous decision-making in clients was a central part of ethical practice. One therapist mentioned how experience and increased competence contributed to being able to better assist clients in discovering their own answers: "The better you get, the more you know how to help the person work, instead of you trying to do the work for them."

**Beneficence.** Master therapists felt moved to reduce human suffering and to work toward improving the welfare of others. In the unique role of therapist, they have had the opportunity to demonstrate caring by helping to transform painful experiences into sources of personal strength. One master therapist viewed the role of a therapist this way:

Sometimes I think, as therapists, we are like that second fairy godmother at the christening. I can't change what was laid down earlier; but then I can help a person soften it or make it go in ways that are more interesting.

Master therapists expressed a good deal of satisfaction in helping others. However, rather than acting out of completely altruistic motives, these therapists acknowledged that they entered this field to meet their personal need to be useful or to accrue other personal benefits in their professional work. One master therapist succinctly summed up the personal satisfaction of doing therapy: "Where else would I ever have this kind of intimate contact with such interesting people? I feel like I am doing a useful job."

**Nonmaleficence.** Not only did master therapists value helping others, they also were aware of the tremendous potential to do damage in the context of the therapeutic relationship. They seemed mindful of the ways they could potentially harm their clients and had developed measures to minimize this risk. For example, one master therapist said,

I think one of the ways therapy goes awry is that the therapist starts to use the client for their own emotional sustenance ... regulation of the therapist's self-esteem, all those sorts of things. I think that to be a good therapist, you must be well fed and well loved.

Master therapists strongly believed in managing the personal and professional stressors that can lead to harming clients. One master therapist said it this way:

Those therapists who have been in consultation with me before who were not willing to do [personal therapy] were so difficult to deal with. Any time they were stuck for a period of time, they'd make it about the client, instead of about themselves or instead of about both of them. And when you do that, you're going to be abusive to your client.

### **Building and Maintaining Expertise**

This category contained five ethical values: competence, humility, professional growth, openness to complexity and ambiguity, and self-awareness.

**Competence.** Master therapists clearly valued being exceptionally skilled in their clinical work. In fact, they were highly motivated to move beyond the minimum competency level required by ethical and practice standards toward expertise in their field. These therapists, even after years of experience and training, placed a high value on maintaining and building their skills set. Throughout the interview data, references to becoming competent and maintaining competency as a practitioner indicate the importance of this value. One master therapist recollected how the accumulation of experience aided in developing competence as a practitioner:

I've got a lot more experience, and as much as I used to want to believe when I was younger that age and experience didn't count, and not just experience in the terms of being a therapist, but life experience, it counts a lot, in terms of your ability to empathize and understand a wider range of things. The other part is that when I came out of school, I did not feel as though I knew much of anything. And the training and supervision and experience that I got during those years made an incredible difference.

**Humility.** A sense of humility characterized the master therapists' responses. These master therapists expressed a realization of their limits as a practitioner and human being. In fact, awareness of these limitations seemed to inspire them to keep on growing professionally and personally. In addition, some master therapists expressed concern for therapists who are not aware of their weaknesses. For example, one said, "One of the things that I tell people when they are looking for a therapist is to really ask them the question about what can't they do. And boy, if they don't have something they can't do, get out." Another said,

Bad therapists don't know what they don't know. They think they know everything, they have a "got to solve it" kind of perspective on everything, and their theory is very sound, and [yet] they don't really know how little they know.

Displaying humility, one master therapist spoke of the hazard of grandiosity in considering oneself an expert:

I think if one begins to think of oneself as a master therapist, it can lead to grandiosity. It can pave the way to all sorts of misuse of power. There is one phenomenon that has to do with the seasoned clinician who is so confident that the rules no longer apply.

**Professional growth.** Master therapists continually sought out formal and informal training to broaden their cognitive and clinical abilities. The drive for competency combined with an awareness of limitations inspired master

therapists to be lifelong learners. It is likely that keeping current on the latest developments in their profession and exposing their work to others for feedback minimizes the potential for unethical behavior. Several master therapists spoke of the importance of looking for professional growth experiences beyond didactic venues and finding other arenas for challenge and inspiration, primarily through consultation, supervision, and their own therapy. As one master therapist stated,

I meet with other people who are calling me on my stuff; so I get a chance to look at myself on the outside over and over and over again, through personal therapy, through lots of supervision, through ongoing consultation. That helps incredibly. I think that's essential.

Challenging the idea that experience alone equals expertise, the same master therapist spoke eloquently of the importance of bolstering the accumulation of clinical experience with sustaining professional relationships in order to grow professionally:

I don't think years of experience by itself does it, because I might have the same year of experience 20 times, and so I need to put that together with good consultation and a good collegial system. So that you actually are learning from what you're doing and [learning] more about how you're impacting and affecting people.

Amassing years of clinical practice is only one component of commitment to professional development. For master therapists, experience combined with clinical consultation, ongoing traditional academic training, and personal reflection yielded a deep level of professional growth.

**Openness to complexity and ambiguity.** Master therapists saw no easy answers in their work with clients. They seemed to be searching for uniqueness and intricacy in every interaction. This appreciation of complexity had ethical implications because it helped prevent premature closure (Skovholt & Rønnestad, 1995), which is a tendency of the therapist to latch on to the first solution considered or to use the same techniques with virtually every situation. One master therapist said, "Every person is different. Therefore, any technique that one uses, to use it each time in the same way is in some ways denying the truth of the uniqueness of every individual and the uniqueness of every interaction." Another master therapist noted how difficult it was to train therapists who were not open: "Having taught psychologists, they [often] grab onto an interpretation and come hell or high water, they're going to prove they're right. Instead of saying, 'Here's an interpretation, but does it fit?'"

The following example illustrates a deep commitment to openness, which may lead to more competent and, therefore, ethical interventions: "I think

you have to have a certain amount of flexibility, in that you will hear things and you won't make sudden decisions and then push them through," said one master therapist. "You sort of wait and watch until the pieces fit." Similarly, another master therapist stated how important it is to avoid acting prematurely:

So, I think [it is important] to be open to not knowing and to an ambiguous situation, so that you can hear what it is that is emerging, rather than laying something on the situation. ... When you don't know, then you can listen more curiously and have more of an openness about what all might be coming here. So, I think the ambiguity is a part of that; it helps you stay more curious about sorting it out and understanding it, finding out more.

**Self-awareness.** Master therapists expressed a deep commitment to awareness of their own life issues. Their self-awareness seemed to center around two issues: (a) understanding and fulfilling their personal emotional and physical needs; and (b) awareness of their own unfinished business, personal conflicts, defenses, and vulnerabilities. More importantly, the master therapists were well aware of the potential for these issues to intrude upon the therapy session. Seeming paramount to the therapists was an awareness of personal emotional needs and fulfilling those needs through various activities including travel, exercise, spiritual practice, and contacts with colleagues, friends, and family. For example, one master therapist said,

When I think about therapists who've gotten themselves in difficulty, it's often because there hasn't been self-care, and there's been a looking either to the client to provide something for them or else not really being available for all that the client might need or want to do as part of their therapy work.

The ability to meet the clients' needs also became compromised when therapists did not obtain appropriate resources to meet their own personal needs. One therapist said, "I think that self-awareness is really the key to helping you understand if you're getting in the way or not getting in the way, of facilitating, being with and not being with."

An awareness of personal problems, biases, and conflicts was vital to master therapists in order to be therapeutically effective. The management and resolution of countertransference issues was critical to these therapists in terms of providing quality care for their clients and minimizing the risk of harm to the clients, as illustrated by the following:

If I'm sitting here and you're a client and I'm worried about you liking me, I'm worried about you thinking I'm competent, I'm worried about you not getting mad at me—any of those kinds of unfinished issues inside of me makes me powerless to help, makes me very self-centered, and isn't going to do much for you.

## DISCUSSION

The current study illuminated several noteworthy findings regarding the ethical values of master therapists. In the discussion that follows, we will explore the relationship between the nine ethical values highlighted in this study and expertise in psychotherapy. The nine ethical values will be grouped into two categories: (a) Building and Maintaining Interpersonal Attachments, and (b) Building and Maintaining Expertise.

The first category, Building and Maintaining Interpersonal Attachments, contained four ethical values. Perhaps the most striking finding of the study was the level of importance the master therapists placed on the ethical value of relational connections. The master therapists seemed to value interpersonal relationships in all areas of their lives. They seemed to be very aware of their impact on others and strove for respectful encounters. This respectful attitude toward others appeared to be true for the client as well as for the car salesperson. Gilligan's (1982) ethic of care concept seems to be the best way to describe the ethical value of relational connection. Gilligan emphasized that moral decision-making for women often focused on how the decision would impact the quality of one's relationships. Whereas some ethical guidelines (e.g., APA, 1992) seem to align more with Kohlberg's (1984) justice orientation, with its emphasis on rules and fairness, master therapists seemed to give greater weight to how their actions impacted the quality of their working relationships with clients. In addition, this caring for clients found in the interview data is related to the ethical value of beneficence. It is clear that these master therapists cared deeply about their clients' well-being and that this caring attitude most likely enhanced the therapeutic relationship. This hypothesis is supported by Lambert's (1992) estimate that nearly 30% of a client's improvement can be attributed to a positive therapeutic relationship.

Respectful attitudes toward clients also were found in the ethical value of autonomy. Master therapists seemed committed to encouraging clients' self-determination while working to avoid imposing their own beliefs and values. It is likely that clients who receive affirmation of their personal power will feel stronger in their attachment to the therapist. Respectful attitudes toward clients' self-determination also seemed to minimize the risk of harming clients. These attitudes seem related to the master therapist's ethical value of nonmaleficence. For example, therapists who are not respectful or aware of other worldviews may impose their own beliefs and values during therapy, not recognizing the individual and cultural differences and needs of their clients. This lack of awareness and respect can be harmful to clients because the therapist's solutions, not the client's, are emphasized.

The second category, Building and Maintaining Expertise, contained five

ethical values. Another important theme of the study was the ethical value of competence. This value was explicitly addressed in various ethical guidelines and was of great importance to these expert therapists. Master therapists worked hard to achieve a high level of skill as therapists and continued to hone their skills through peer consultation, continuing education, readings, self-reflection, and personal psychotherapy. The master therapists' motivation for maintaining a high level of competency was a pervasive theme in the interview data. They recognized that psychotherapy is an extremely difficult profession that requires a high level of skill and commitment to continually maintain one's competency.

The ethical value of humility seems to remind the master therapists of their limitations and may help keep them oriented toward learning and growth. The master therapists believed that holding an attitude of not knowing all of the answers kept them curious. Staying curious seemed to serve to minimize stagnation in their work and led to new opportunities for growth and development. Maintaining this level of humility may help them to avoid the professional arrogance that Prilleltensky, Walsh-Bowers, and Rossiter (1999) found to be a major challenge to therapists' ethical behavior.

The ethical value of professional growth was another ethical value that was prominent with master therapists and related to maintaining one's competence. These therapists were strongly motivated to enhance their clinical work to best serve their clients. They sought out learning opportunities well beyond the minimal requirements of licensing boards. This high level of motivation to be outstanding in their work seems to be a critical trait that enabled them to achieve and maintain expertise in their field.

The ethical value of openness to complexity and ambiguity may serve to keep the master therapists from prematurely closing down options for therapeutic interventions when working with difficult cases. Not being open to complexity and ambiguity can lead to less than competent work because a therapist might prematurely come to a conclusion that relieves his or her anxiety even though the conclusion is not an appropriate fit for the client (Skovholt & Rønnestad, 1995). Dlugos and Friedlander (2001) also found that passionately committed therapists demonstrated a high level of adaptiveness and openness in overcoming obstacles and challenges. In addition, the ethical value of self-awareness seemed to be an important factor for developing competence. If therapists did not look at how their own motives and issues might negatively impact their work, they risked arresting their professional development. Master therapists seemed dedicated to the pursuit of self-knowledge and to the recognition that therapists who are aware of their issues are less likely to unconsciously act out and possibly harm their clients.

## LIMITATIONS

The results of this study should be interpreted in light of several limitations. One limitation of the study was the lack of a culturally diverse participant pool. Although the sampling was fairly representative of a Northern, Midwestern state, exploring the ethical values of White, European American therapists may limit the usefulness of the results. For example, autonomy, with its emphasis on the individual versus the group, is a concept representative of a Western worldview. Another limitation was the use of existing interview data. Although utilizing existing data is a strength of the research because it is an unobtrusive, thus less reactive, research method (Webb et al., 1966), it could be that other salient issues might have emerged if the researchers had interviewed these master therapists specifically about ethical values. Despite this limitation, we found that ethical values were clearly embedded in the descriptions of the master therapists' therapeutic practice.

## CONCLUSION

Overall, this study reinforces the importance of several fundamental ethical principles such as doing good (i.e., beneficence), doing no harm (i.e., non-maleficence), and respecting the self-direction of clients (i.e., autonomy). In addition, master therapists appeared to go beyond ethical guidelines to exceed the requirements to be competent. An important finding of the current study was the emphasis that master therapists placed upon building and forming relationships and how this enhanced their ability to practice ethically.

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