THE EFFECT OF DILEMMA DISCUSSION ON MORAL JUDGMENT COMPETENCE IN HELPING-PROFESSIONS STUDENTS

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Abstract

The aim of the study was to discover the effect of dilemma discussion (the Konstanz Method of Dilemma Discussion – KMDD) on the moral judgment competence of students in helping professions. The sample consisted of 36 Theology students and 45 Psychology students. The subjects were joined together and randomized to the control (n = 40) or experimental group (n = 41). Using Lind's Moral Competence Test (MCT) the author compared the experimental group, in which KMDD was applied and the control group without KMDD. Comparative analysis of the C-score was found that the experimental group scored significantly higher – there was identified a significant effect on the moral judgment competence of students ($p < 0.001$), even five months after the end of KMDD intervention ($p = 0.001$). The moral judgment competence of helping-professions students can be effectively strengthened using KMDD, which seems to represent an effective alternative to traditional forms of discussion.

Keywords: KMDD, moral judgment, competence, helping-professions, students

1. Introduction

In recent years both popular press and professional literature have shown an increasing concern over the quality of the helping professions.

Personality is helping for optimal performance in helping professions, one of the primary means and key instruments in the context of the fact that all the helping professions are focused on the problems and difficulties of other people and their efforts to provide the most effective assistance. All helping professions find in helping their sense of meaning and vocation, which satisfies the search for suitable ways to promote health, benefit, welfare and quality of life for another person.

Being a morally competence person is an essential prerequisite for work in the helping professions, which are much more about service and mission than routine jobs. The definition of competence is notoriously problematic. Already

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in the 1970's, Spady complained the 'conceptual house' of competence based education was "not in order" [1]. Since then, the discussion about 'competence(s)' and its meanings has continued. The concept of moral judgment competence is based on Kohlberg who introduced the term moral judgment competence as "the capacity to make decisions and judgments, which are moral (i.e., based on internal principles) and to act in accordance with such judgments" [2].

However, by defining moral judgment competence more precisely, Lind's approach clearly goes beyond what we may ordinarily call 'moral competence' as well as the Kohlberg's approach, which focused merely on moral orientations and the level of reasoning [3].

The moral aspects also form an integral part of helping practice. Quality helping care consists of more than the performance of helping interventions. Through morally competent behaviour, medical and nursing staff may significantly affect the quality of care. The positive relationship between moral competence and professional conduct for helping professions students is confirmed for doctors [4, 5], physiotherapists [6] and pharmacologists by [7]. Despite the fact that moral judgment competence is an important part of a professional kit, it has received too little attention [8-10]. The large reserves in this area are also highlighted by empirical studies that deliver results of the moral values of nursing students [11-15].

Developing moral judgment competence plays a key role in the professional training of helping workers. Lind identifies the right quality and quantity of education as important factors for the development of moral judgment competence [16]. The impact of education on the moral reasoning of nursing students has been researched by several studies [11, 17-19].

The importance of promoting higher-level moral reasoning in nursing practice has been demonstrated by Stavros and Lee [20, 21]. Their works have shown an urgent need to find ways to promote nurse's moral judgment competence development. Therefore, this study was conducted with an aim of investigating the effect of the Konstanz method of dilemma discussion (KMDD) on moral judgment competence among helping-professions students. Lerkiatbundit with his research team studied the effect of KMDD on moral judgment in allied health students. In conclusion, the results confirmed the significant impact of the KMDD on moral judgment. Certainly, the KMDD is an effective and practical method for developing moral judgment in allied health students. The effect on moral judgment remains at least 6 months after the intervention [22].

2. Aim of the study

The study aimed to verify the effectiveness of the dilemma discussion determining the effect of KMDD on moral judgment competence in helping-professions students. The hypothesis was that the KMDD would improve students' moral judgment competence.

3. Method

3.1. Sample and randomization

The sample consisted of 36 Theology students and 45 Psychology students in the second year of bachelor's degree study programs at a Slovak university. Participation in the survey was voluntary. At the beginning they were informed about the objectives of the research study, whose aim was to investigate the impact of the new teaching method to foster moral competence. The subjects were joined together and randomized into control (n = 40) or experimental (n = 41) groups on the basis of random numbers allocated by a computer.

3.1.1. Experimental group

In the experimental group, KMDD was used according to established instructions and didactic principles of the author, Lind [23]. The intervention procedure and dilemmas were pre-tested in the second-year Nursing students in the university in another city.

Below, it is described how the group process of solving moral dilemmas operated. Students read the text of the moral dilemma. The researcher, during the discussion in the position of facilitator, checks that each person present understands the dilemma and that each participant understands the key conflict of the dilemma. In some cases it was necessary to summarize the plot and clarify the basic facts of the story – the people, their relationships and basic moral contradiction of the main character. Following, each student alone at its sole discretion decides whether the actions of the actor of the dilemma story were correct or not. Then the students were asked to write down on what grounds they decided. After this, students publicly voted by lifting their hands for their choice (yes-no) and on the basis of the vote they were divided into two groups (group for and group against), according to their opinion, whether they had expressed approval or disapproval of the actions of the main actor. Any large group was then divided into several small groups of 5-6 students. In the small groups, interviewees informed each other of the reasons for their decision and presented their individual solutions. Then, the students in a small group tried to reach a compromise regarding the relevant reasons for appraising the actor in the dilemma story, to agree on common solutions.

The work in a small group creates an intimate setting and provides conditions for statements of opinion under less social pressure, more immediate response, less shyness to voice one's own opinions.

The researcher asked one group to present their collective views in front of all others in attendance. After the speech, the presenter invited another student from another group (e.g., a student from a 'for' group called a student from an 'against' group) to express their views on the questions: to what extent were the presented opinions acceptable? Which argument was a principled? What should

be the best reasoning to solve the dilemma? Then another student was selected and the discussion was similarly repeated several times. That part lasted about 25 minutes. During the discussion, the researcher acted as a listener or a facilitator to lead the discussion. At the same time he recorded on the board all the major arguments for and against which the individual presentations presented.

In the next section all participants returned to their original groups and continued to debate about how far are acceptable the reasons of the other side. The also considered whether their opinions changed when they heard opposite views. They were given the opportunity to confront the problem from the view at the beginning (individual treatment) and at the end (after the joint group discussion). Again it was necessary to find relevant arguments in favour of the solution to the dilemma.

Both groups chose spokesman, summarizing the results of past discussions and commenting on the views of other groups. At the end, the final vote took place, whether the protagonist of the dilemma was right or wrong. The researcher thanked the students for participation in the discussions and encouraged them to further solve moral dilemmas.

The meeting lasted about 90 minutes and was held once a week for a period of a month and a half. Topics for discussions on six moral dilemmas were taken from the literature (death penalty, euthanasia if no chance of cure of the patient, saving lives on a sinking ship, false statement with the intent to save the father of the family who is the sole breadwinner, falsification of one mark to get scholarship, to turn in a good neighbour – a prisoner who escaped from prison and police looking for him).

Students in the control group met in small groups once a week for 6 weeks. They were invited to discuss topics that were not related directly to moral problems (such as violence in society, academic problems, ideal helping professionals and others). The task of each group was to summarize all comments and write a report at the end of each discussion. The discussion lasted 90 minutes usually. Students experienced how important it is to remain sentiment of how they speak in order to foster the feeling of moral ambiguity in their listeners.

3.2. Data collection

The role of all respondents was to complete the Moral Competence Test (MCT) [24] three times: firstly a week before applying KMDD, then, after completion of the overall discussion meetings, and finally five months later.

3.2.1. Moral competence test

MCT is derived from Lind's dual-aspect theory of moral behaviour and moral development [24]. For over 30 years, MCT has been translated into 39 languages and used throughout mote than 40 countries.

The test was developed to simultaneously measure moral judgment competence and moral attitudes [25]. The standard version of MCT consists of two short stories: the dilemma of workers who deal with the violation of the law – illegal bugging of conversations; and the dilemma of a doctor who has to face a decision about whether to facilitate the death of a woman who is terminally ill and wants to die. When the participant decides whether the actions of the main actor/actors of the dilemma story were right or wrong, the participant is confronted with six arguments pro and six arguments contra his/her opinion on how to solve the dilemma. The arguments have been carefully designed to represent each of the six stages of Kohlberg's moral orientation [26]. The participant evaluates arguments based on their acceptability on a scale from -4 (totally unacceptable) to +4 (completely acceptable).

The main index, C-score, is based on the analysis of the overall structure of the responses, not the individual responses, which in themselves are not significant. The total score of an individual, the value of the capacity to make moral decisions based on 24 sub-decisions that are structurally analyzed. It then examines the extent to which participants' preferences were based on the moral qualities of the arguments (i.e. ranking strong arguments with respect to weak arguments) or whether the arguments are, or not in accordance with their opinions.

The test result, the C-score (for competence) is constructed such that a zero score belongs to the individual, who does not distinguish between the various arguments, but instead accepts all arguments that are in line with his own opinion or rejects all opposing arguments that are in contradiction. The highest C-score corresponds to the individual whose order of arguments solely reflects the quality of the arguments offered. The C-score is classified according to its value – low or pre-conventional (1-9); medium or conventional (10-29); high or post-conventional (30-49) and very high (above 50) [27].

MCT was conceived as a multivariate experiment, with a $6 \times 2 \times 2$ dependent orthogonal design in which the three design factors are orthogonal or uncorrelated. The C-score is calculated analogously to the multivariate analysis of variance (MANOVA) [24].

3.3. Data analyses

Descriptive statistics were used to describe the basic characteristics of the participants. The effect of the KMDD on moral judgment competence was assessed with analysis of variance. All statistical analyses were performed using SPSS 18.0.1. for Windows.

4. Ethical issues

The questionnaire was filled out anonymously and contained no identification data. The students were informed about the participation in the survey and its aims, and ethical approval was obtained from the university ethics

committee. The results were calculated not for individual students but for groups of students. Participation in the study was voluntary.

5. KMDD impact on moral judgment competence – results

The composition of the experimental and control groups with respect to age, gender and program of study participants was approximately the same (Table 1). It was dominated by women and the age range was between 17 to 24 years. The number of students in the experimental group (n = 41) who regularly attended discussion meetings was in the range of 37 to 41. In the control group students participated in approximately the same number as in the experimental group.

Table 1. Characteristics of the students in the experimental and control group.

	Experimental Group	**Control Group**
Number	41	40
Male	10	5
Female	31	35
Psychology students	22	23
Theology students	19	17
Age (years)	18.82 ± 1.15	18.80 ± 1.19

In resolving moral dilemmas during individual discussion sessions, students were divided into two groups – one group defended its opinions and the other group presented contradictory arguments.

Table 2 shows the C-score values: before applying KMDD, immediately after and 5 months after applying. ANOVA revealed a significant relationship between the time periods of collection of data and groups, with $F(1.08, 87.36) = 15.64$, $p < 0.001$).

Table 2. C-scores of the students in the experimental and control group.

	Before KMDD	**After KMDD**	**5 Months After KMDD**
Experimental (n = 41)	21.58 ± 14.46	36.19 ± 11.97	34.01 ± 12.03
Control (n = 40)	25.99 ± 17.13	25.30 ± 15.80	24.68 ± 15.36
P-Value	0.178	< 0.001	0.001

There was subsequently transferred between the two groups a comparative analysis of the achieved C-score obtained after administration of MCT at different times. In the beginning, the C-score of the experimental and control groups were very similar ($p = 0.178$). At the end after application KMDD the experimental group scored significantly higher – there was identified a significant influence on moral judgment competence ($p < 0.001$). The C-score

also maintained its level five months after the end of the KMDD intervention ($p = 0.001$).

The C-score in the control group maintained a reasonably even value during the whole course of the study. It remained nearly unchanged, which may be due to several factors. One factor is the minimum intervention in the control group compared to the experimental group. There are also other relevant factors – unexpected experience during the course, during which students did not meet with that form of teaching. Based on previous findings, we can say that the increase in C-score is due to KMDD. Indeed, results indicate that the significant influence KMDD was evident during the six 90-minute discussions. This shows that KMDD may represent an effective alternative to traditional forms of discussions, and that significant effect on moral judgment competence was confirmed in the range of 25-29 hours [28]. The effect size of the KMDD (Cohen's d) was 0.83, which represents a higher value compared to the effect of traditional methods [29]. From the beginning, the dilemma discussion has shown to have a substantial effect size ($r = 0.40$) [16].

Of course, from a comparative point of view, the results should be interpreted with extreme caution, as previous studies, and this study used different research tools, research sample and duration of the regular discussions. A higher degree of validity of comparison would be aided by the application of the two methods in the same study. In this study, the C-index after intervention increased by almost 15 points. The result is in line with what Lind states in his study of applying KMDD to 42 German students, where the C-index increased from 12 to 20 points, during a period of one semester [28].

6. Discussion

The interventions produced positive results. At the end after application KMDD the experimental group scored significantly higher. In addition, the participants were interested in it very much; they very well received the KMDD. The group atmosphere was relaxing and vivid. It was good for students to discuss with each other. They could share their opinions with others in the group – favourable learning environment. Results of the study show that the dilemma discussion is not only seen to raise the moral judgment competence of the students, but also to make them more interested in learning and improve the educating climate. It can be stated that KMDD is suitable not only to improve the participant's moral judgment but also the quality of student groups.

Education, in terms of quality and quantity, has been described as the primary driver of the development of moral judgment competence [26, 30-32] and moral competences may be considered as clusters of integrated knowledge, skills and attitudes that all professionals need in their daily practice in order to flourish as morally good professionals [33].

Thus, it is not enough to aware of a moral situation (moral sensitivity), to be able to reason and make judgments about it (moral reasoning), to be committed and motivated to give more weight to moral considerations than to

others (moral motivation), and to be persistent in trying to be moral (moral character). In order to be a morally competent professional, one should also act on these considerations [34].

Studies that used the MCT show a decline of moral judgment competence score for medical students during the last two years compared to first-year students [35], a phenomenon known as 'moral regression'. Schillinger [36] confirmed moral regression the same as Lind [16] assumes that the regression of moral judgment competence in the cognitive component may be caused by a shortage of educational opportunities. Both authors have confirmed that the described phenomenon is associated with a learning environment that does not support moral development of students.

More attention needs to be devoted to the evaluation healthy humanities teaching. The Konstanz Method of Dilemma Discussion has been developed for fostering moral competencies. This study showed the significant impact of the KMDD on moral judgment competence in students, a finding that several other studies have also reported [37-39]. Many of the studies confirmed that special intervention programs enhance the ability of schools and colleges to foster moral development [34, 40-42].

Self et al. in their study evaluate film discussions, which were aimed at developing the moral reasoning of helping-professions students [43]. The students participated in an elective course on social issues in medicine, which consisted of weekly one-hour discussion of short films. There were statistically significant increases in the moral reasoning scores of both the course registrants with the fall quarter exposure to the film discussion ($p < 0.002$) and those with the fall and winter quarters ($p < 0.008$) compared with the scores of the students who did not take the course and had no exposure ($p < 0.109$).

The objective of Lerkiatbundit's study was to determine the effect of the Konstanz method of moral dilemma discussion on moral judgment in allied health students [22]. The experimental group participated in a 90-min KMDD once a week for 6 consecutive weeks. The results confirmed that the experimental group scored significantly higher than the control group did after the intervention. In these results the KMDD is practical and effective intervention for developing moral judgment in allied health students.

Results of the present study support findings of previous studies providing evidence that principled moral reasoning can be advanced by deliberate educational interventions [44]. The experience is crucial in strengthening of personal moral-democratic competencies.

There are several limitations to the current study, including sample size. The validity of the observed data is limited to a set of students in selected fields. Additionally, the principal researcher delivered all of the moral dilemmas discussions and collected the data, which may have created an unavoidable bias. The limitations identified in this study should encourage researchers to conduct empirical studies that involve both quantitative and qualitative approaches. However, studies on the effectiveness of innovative methods in education to promote students' moral judgment competence are lacking.

7. Conclusions

In general, there is an urgent need to find ways to promote helping-professions students' moral development with regard to their future practice in helping professions. Morally responsible helping consists of being able to recognize and respond to unethical practices or failure to provide quality client care. In their everyday life, helping professionals are constantly confronted with decisions of an ethical nature. Raines' study on ethical decisions points out that oncology nurses in the course of one year are subject to 32 different types of moral dilemmas. The most frequently encountered dilemmas are of addressing the patient's pain, the issues of the expenses on the dying, quality of life, or whether it was necessary to make further decisions regarding the best interests of the patient [45].

It is generally true that the technological advances in helping in postmodern environment and the increasing complexity of client care require that helping professionals constantly and critically think about how they can contribute to the welfare of their clients, which inevitably depends not only to their high level of professional competence, but also on a high degree of moral maturity [46, 47].

Helping professionals who consistently practice with moral competence base their decisions to act upon the ethical principle of beneficence (doing good for others) along with internal motivation predicated on virtues, values, and standards that they believe uphold what is right, regardless of personal risk.

The consistency in helping professionals' pattern of moral reasoning and ethical practice over time and between countries indicates that helping-professions students educators, leaders and researchers need to give high priority to the development of helping-professions students' moral competence.

The present study demonstrates that the use of KMDD is an appropriate method for teaching healthy humanities if increasing the moral-reasoning skills of helping-professions students is one of the major objectives. Moral competence as the ability to solve conflicts on the basis of shared moral principles can be very effectively fostered with the KMDD. This method is one of the few educational methods whose efficacy has been scientifically tested. It has been shown that the moral judgment competence of students can be very effectively cultivated and promoted with the KMDD method. Research findings on the positive effects of KMDD on moral judgment competence among psychology and theology students should be applied in practise to implement KMDD in pre-professionals care curricula. This is a practical method that has been developed and refined over the past two decades in the interests of fostering education for moral-democratic competence. Therefore, KMDD can be valuable, especially for building a harmonious society. The Medical School of Monterrey in Mexico [C. Hernandez and G. Medina, *Ethics and professionalism in medicine: Cross-curricular integration of ethical basis for medicine students*, Presentation at the AME meeting, Cambridge (MA), 2005] and the German

Armed Forces are about to implement this method for teaching ethical and civic competencies throughout their system [48].

Future studies should investigate whether mere gains in moral reasoning scores translate to a broader range of moral behaviours.

Supporting the moral competencies of pre-professionals is a way to prepare them to better understand the issues that will emerge in situations requiring the application of ethical values when it will be needed to take difficult decisions.

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