(RE)CONSTRUCTING THE AUTONOMOUS SELF: AN EMPIRICAL FEMINIST INQUIRY INTO GENDER AND THE AUTONOMY IDEAL

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ABSTRACT

Informed consent procedures are an essential part of the ethical conduct of research, including clinical trials. The principle of autonomy justifies this process. However, it is clear that conventional assumptions about autonomy offer limited guidance in many countries where clinical research on non-Western populations is conducted by Western researchers. Beginning with a brief review of conventional approaches to autonomy, the present research explored feminist alternatives to this principle, drawn from self-in-relation and care theories.

This study aimed to determine whether there is an association between an individual's gender, autonomy, self-construal and ethical orientation. Based on the literature, it was hypothesized that men would exhibit a more conventional sense of autonomy, independent self-construal, and a stronger tendency towards an ethic of justice. Women were expected to demonstrate a more relational sense of autonomy and more relational self-construal, as well as a stronger tendency towards an ethic of care. Racial differences were investigated as a secondary hypothesis.

The Relational Being Scale, Relational Interdependent Self-Construal Scale, and the Moral Orientation Scale were administered to a sample of tertiary education students comprising 188 women (100 Black and 88 White) and 158 men (95 Black and 63 White). Women scored significantly higher than men on Relation, but there was no significant difference between men and women's scores on the Autonomy subscale. Women scored significantly higher than men on the Relational Interdependent Self-Construal Scale, indicating a more relational self-construal in women. The Justice scores of men were higher than those of women; the Care scores of women were higher than men's Care scores. These differences were not statistically significant. Analysis of racial differences yielded somewhat contradictory results.

The findings suggest that although there are gender differences in the experience of autonomy, self-construal, and ethical orientation, these differences may not be as discrete as current theories suggest. It may be that race significantly influenced the results. Further research is required to determine the exact nature of the association between gender and autonomy, self-construal, and ethical orientation, as well as the effect of race on these variables.

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DECLARATION

Unless specifically indicated to the contrary, this project is the result of my own work.

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1. INTRODUCTION

1.1 HIV/AIDS and Clinical Research in Developing Countries

Of all the people in the world who are HIV-positive, two thirds are living in sub-Saharan Africa (UNAIDS, 2004). Seventy seven percent of the global burden of HIV infection is now carried by sub-Saharan African women, while South Africa's epidemic, one of the largest in the world, shows no sign of relenting (UNAIDS/WHO, 2005). These statistics highlight the urgent need for preventive HIV research to be accelerated, and elucidate the attraction of Africa as a site for such research, where the greatest number of people at risk for becoming HIV-infected can be included as research participants. As early as 1988, HIV vaccine trials were identified as the "next major ethical challenge in South African research circles" (Barry, 1988, p. 1083). In view of the urgency to find a cure for this devastating syndrome, some have maintained that the ethical issues involved in this area of research are given too much attention, both in theory (Coovadia & Rollins, 1999) and in practice, and consideration of such issues is seen as a hindrance to urgently needed research to avert the catastrophic consequences of HIV/AIDS (Ngu & Tangwa, 2000). This line of reasoning implies that there is a point at which the importance and urgency of scientific and humanitarian goals justify certain ethical compromises. This is despite widespread awareness of the immense complexity of ethical issues involved in even the earliest stages of clinical vaccine research (Abdool-Karim, 2000; MacQueen, Shapiro, Abdool-Karim & Sugarman, 2004; Medical Research Council, 2004; Slack et al., 2000; Slack, Lindegger & Vardas, 2002; UNAIDS, 2000). Others have maintained that researchers who neglect or ignore

the ethical dimensions of their work do so at their own, as well as their research participants' peril. And nowhere is this risk greater than in developing nations (Benatar, 2002).

Parallel to the growing number of clinical research trials occurring in developing countries, there is a growing body of research on the ethics of research involving human subjects in developing countries, (see, for example, Abrams, 2004; Costello & Zumla, 2005; Farmer & Gastineau Campos, 2004; Hyder et al., 2004; Killen, Grady, Folkers & Fauci, 2002; Koski & Nightingale, 2001; Pace & Emanuel, 2005; Pitler, 2002; Schüklenk, 2000; Slack et al., 2005; Strode, Slack & Mushariwa, 2005; Upvall & Hashwani, 2001) that is highlighting the complexity of ethical issues that need to be considered. Among the motivations to keep ethics at the forefront of HIV-AIDS research – particularly when that research is being conducted in developing nations by researchers from developed nations – is that bioethical concepts developed and interpreted in the developed world cannot be directly imported into the developing world. Context may affect the meaning or application of Western bioethical principles such as autonomy, beneficence, and justice. Standard applications of the concept of autonomy and the requirements of informed consent, for instance, present ethical difficulties in cultures where personal autonomy is already extremely limited (Barry, 1988).

The dominant ethical framework and principles that are universally applied in research contexts have historically been upheld as gender-neutral and influenced neither by context (Campbell, 2003; McGrath, 1998; Meslin, Sutherland, Lavery & Till, 1995) nor by individual particularities (Carse, 1998). This routine and unconscious application of Western bioethical principles is,

however, increasingly being called into question. Some probing questions have been asked about developed-world researchers conducting research in developing countries:

> To what extent have researchers tried to understand the mind-set of potential research-subjects? Does the way in which their subjects see researchers and the privileged world matter to them…or do researchers merely want to get on with the study as quickly and economically as possible? How does this square with respect for the autonomy of research subjects? (Benatar, 2002, p. 1133).

This highlights the importance of attending to the circumstances into which developed-world researchers enter when conducting research in developing world contexts. In South Africa, not only is the rate of HIV infection particularly high, it parallels the broader infection rate in Africa by falling disproportionately on the shoulders of some of the most vulnerable citizens: poor, illiterate, unhealthy Black women and children. Within this context, as (Western) researchers design their studies, formulate their informed consent procedures, and relate to their research participants, they must continually consider the local meanings of principles such as autonomy, beneficence, and justice, in cultures whose social and moral languages and priorities differ from their own.

Furthermore, in South Africa, as in many countries around the world, the rate of HIV infection in women is rising faster than in any other group, a vulnerability that is linked to biological factors and deeply rooted in social and behavioural issues (D'Adesky, 2001; Mills et al., 2006; Wassenaar, Barsdorf & Richter, 2005) as well as in a cycle of poverty and economic disenfranchisement (Kahn, 2001). The gender-based physical, emotional, and psychological violence, as well as the social and economic deprivation that women are frequently subjected to, are symptomatic of the wider gender inequity that further increases women's lack of personal autonomy, as is the case in many of the African communities in sub-Saharan Africa (Jackson,

2002). Women living in these circumstances are thus extremely disempowered on a number of levels. One of the goals of feminism in general and feminist (bio)ethics in particular, is to make the voices of these women heard. The epidemics of HIV/AIDS and of sexual domination of men over women are paralleled and exacerbated by another pandemic: the lack of freedom, justice and basic human rights within male-female relationships and within larger society. The high incidence of HIV/AIDS among vulnerable women is not an accident; rather, it can be viewed as influenced by misshapen male-female relationships that violate women's fundamental human rights and that weaken moral notions typically identified as female. When *ubuntu* (the notion that one is a person in relation to other people) and care for one another are overshadowed by power and domination (Mkhize, 2004; Rakoczy, 2001), the disempowerment that women experience in both the public and private spheres is exacerbated. It is for these reasons and within this context that the current study attempts to present a re-conceptualization of women's autonomy within the real-life experiences of the women who are most affected by HIV, and who are likely to be the target of much of the clinical research carried out in developing countries like South Africa.

1.2 Gender and the Limits of Conventional Approaches to Autonomy in Ethics and Bioethics

The complexity of the ethical issues associated with clinical HIV/AIDS research, coupled with women's vulnerability, warrants special concern and challenges the adequacy of conventional informed consent procedures in the contexts described above (Wassenaar & Richter, 2000). Just as no facet of the HIV/AIDS pandemic is gender-neutral, no research conducted in this arena can be presumed to be so. However, this aspect of ethics is frequently neglected. Amid claims of

scientific neutrality, attempts are made to factor out the role of gender in the practice of ethics and research (Rosser, 1992; Wolf, 1996). As a result, the special dilemmas or requirements involved in research with women in developing countries are not paid the attention they deserve. This continues to be the case despite the unavoidable fact that women, as the pivotal axis around which HIV/AIDS turns, are vulnerable as a research population, and the fact that gender is hardly ever a neutral factor – neither in the multitude of factors that propel the spread of HIV/AIDS, nor in the ethics of research that is conducted in this field, the first principles of which remain inherently masculine (Crosthwaite, 1998; Lindemann Nelson, 2000; Sherwin, 1996), as argued below.

Adhering to the traditional ideal of "principled" autonomy in informed consent practices is neither sufficient nor appropriate in developing countries, for at least two reasons. Firstly, the majority of women in these countries are prevented from making fully autonomous decisions because of political, economic, social, and cultural constraints on their freedom. Even the most careful adherence to conventional informed consent requirements may not take into account the fact that, in most developing countries, women's choices are historically, culturally and structurally limited (Nyika & Wassenaar, 2006). Secondly, many non-Western cultures tend more towards relational concepts of self (Fagan, 2004; Guisinger & Blatt, 1994; Mkhize, 2004) than the isolated, independent ideal embodied within the mainstream principle of autonomy (Adshead, 2001; Fishbane, 2001; Tangwa, 2000). Similarly, the traditional ideal of "principled" autonomy is fundamentally gender- (and culture-) biased, and fails to accommodate women's conceptions of their own relational agency. Although neither the research nor the ethics of

research are gender-neutral, for the most part they are still developed and applied as though they are (Hoosain, Jewkes & Maphumulo, 1998; Mahowald, 1994; Rothenberg, 1996).

The neglect of women in biomedical research has been widespread (Kass, 1998; Macklin, 1993). Men continue to dominate at all levels of biomedical research practice: at decision-making levels of international research; in the design and prioritizing of research studies; in the presentation of results; and as providers and recipients of research funds (Campbell & Wasco, 2000; Hoosain et al., 1998). Furthermore, implicit in much of the clinical research that is carried out on both men and women is the assumption that the application of research procedures and ethical guidelines during research, as well as the research findings following research, apply equally to men and women. Consequently, gender differences in the experience of, for example, health, illness, selfhood, and personal autonomy, are usually ignored (Kass, 1998). In sub-Saharan Africa,

> …it is not only HIV prevention which is failing women; access to treatment and initiatives to mitigate the impact of the epidemic are also failing because the HIV/AIDS epidemic is fuelled by existing inequalities…There is a need to highlight the importance of taking gender inequality seriously at *all* levels and addressing the resulting inequities…(and yet) it is apparent that 'gender' analysis and subsequent interventions in Africa…have changed little over the years (Seeley, Grellier & Barnett, 2004, p. 88).

In South Africa, too, much of the work published on HIV/AIDS research has been described as being predominantly "gender blind" (IJsselmuiden & Jewkes, 2002, p. 11; Kahn, 2001). In these settings, ethical principles founded on Western concepts of abstract rationality, de-personalized obligation, procedural autonomy, and universality may fail to protect already disempowered women (Richter, Wassenaar & Abdool-Karim, 2000). It is clear, then, that in research undertaken to address the HIV/AIDS devastation in developing countries, a gender-sensitive ethics must be developed and actively applied.

From the above discussion it is starkly evident that approaches to ethical research practice in developing countries cannot simply be transported from those formulated and applied in the developed, Western world. This would not merely be an ethical oversight but may amount to gender and cultural injustice and ethical malpractice and harm. Mechanical application of Western ethical principles in the context of clinical research in developing nations is not simply insensitive - it is potentially harmful and unjust. It is unjust when it fails to *respect* participants, many of whom are extremely vulnerable women living in circumstances that severely limit their personal autonomy as this concept is understood in the dominant Western ethical framework. Thus, Western researchers should consider the impact that the combined effect of an individual's gender, culture, and daily circumstances has on her or his autonomy and on her or his ability to make truly voluntary decisions about whether or not to participate in a clinical research study. In the interface between the goals of science and the unique vulnerability of poor women in developing countries, researchers embarking on clinical research that is fraught with ethical dilemmas owe potential research participants their fullest engagement with the broader struggles of women's lives and contexts (Wassenaar et al., 2005).

Consequently, approaches to ethical practice applied in these contexts may need to be adapted, with particular emphasis on feminist, cultural and community issues. It can be argued that this entails meeting the ethical obligation of truly respecting individuals while actively ensuring that their decisions are fully autonomous within the context of their lived realities. This would require blurring many of the existing boundaries that are in place: boundaries between atomistic selves and society, between individuals and those to whom they are voluntarily or involuntarily

connected, between researchers and research participants, between research institutions and participant communities (the necessity of which is widely recognised in many non-Western, and especially many African cultures). Ultimately, this would involve blurring the divide between science and society, as well as between scientific and ethical practice. In particular, it requires researchers grounded primarily in principlism, the dominant approach that has governed Western bioethics, to considerably expand their moral horizons. Although this poses a greater challenge to researchers in these contexts, it should not be sacrificed for any goal of science.

It has been argued thus far that conventional definitions of and approaches to informed consent and autonomy need to be supplemented with equivalents from feminist approaches to bioethics, where care and the inter-connectedness of individuals are primary concerns. The fundamental ethical question is not which brand of autonomy, if any, we should endorse, nor is the aim to replace one "type" of (male-oriented) autonomy with another. Rather, as is argued here, the principle of autonomy – the central tenet of ethical consent - should be subjected to both ontological and epistemological revision to be rendered less individualistic and more gender- and culture-sensitive. Thus, the aim of this study is to combine these alternative approaches with traditional approaches to "principled" autonomy in order to present a re-conceptualization of autonomy, and its implementation in informed consent procedures, that maximizes consent capacity, and ensures that potential participants in developing countries are assisted in making fully voluntary decisions that are in their own best interests.

This work adds to feminist challenges to mainstream, male-dominated bioethics and its concepts. It aims to outline fundamental flaws in the mainstream approach, particularly when it is applied

uncritically to women and, more specifically, in countries different from those in which mainstream bioethics has been developed. This study presents alternative approaches to some key concepts in bioethical theory that are crucial components of the informed consent process in human subjects research, in an attempt to overcome some of the neglect of women in contemporary philosophy and the bias in underlying conceptualizations of the self. Because "autonomy is a key issue for the theoretical project of affirming women's subjectivity and agency" (Meyers, 2000a, p. 8) – a project that is essential in the context of much of the research that is currently conducted in the developing world – the current investigation focuses on the reconceptualization of principles of autonomy to make them more applicable to the experience of women. Concepts closely related to autonomy have also come under scrutiny because they reinforce – like self orientation - or are reinforced by – like moral orientation - notions of isolated and detached autonomous individuals. In other words, we should not only be asking what it means to respect a person (autonomy), but what it means to be a person and if they relate, how they relate. These are the questions that this study attempts to address: how individuals might approach ethical dilemmas, coming from a position of an independent, autonomous self, which would imply a justice approach, or from a position of a relational, connectedness self, implying a care approach.

Essentially, a critique of these concepts entails a critique of the individualism that underscores the current notions of autonomy that are employed in mainstream bioethics. This individualism inherent in Western society has also to a large extent dictated the dominance of independent, individualistic concepts of the self, as opposed to the relational, interdependent self that is more typical of non-Western cultures and, more significantly for this study, more typical of women.

"The individualism defined by the idea of the autonomous self reflects the value that has been placed on detachment in moral thinking and in self development" (Gilligan, 1990, p. 483). As such, the focus on individual rights and responsibilities is central to the justice moral orientation that has to a large extent governed ethical decision making. Using more relational concepts of autonomy and relational notions of the self, feminists and others have recently pitted an ethic of care against the dominant justice ethics – an ethic that, they claim, has more value for women and individuals from non-Western groups. Essentially, "the patriarchal social structures that relentlessly undermine women's autonomy must be changed, and women's selfhood and agency must be legally and culturally affirmed" (Meyers, 2000a, p. 9).

By linking the concepts of autonomy, self and moral orientation together as variables, this study hopes to demonstrate that these concepts are so closely inter-related that transformation of one inevitably requires or leads to the reformation of another. Ultimately, the individualism that dominates these concepts in mainstream bioethics is challenged and analyzed so as to demonstrate the value of introducing different, more relational ways of examining the same types of ethical situations, by more connected, relationally autonomous selves. This will be done by examining the association between concepts of autonomy and relation, independent and interdependent selves, and the justice and the care moral orientations in a mixed race sample of women and men. In particular, the study will examine whether there is a distinction along the lines of gender between individualistic concepts of autonomy (men) and more relational forms of autonomy (women). This study aims, in this way, to contribute to efforts to fill the gendered gap between the rejection of a metaphysical individualism and the embrace of a metaphysically

relational conception of the self (Christman, 2004), and, in turn, more relational conceptions of autonomy within bioethical theory and practice.

2. LITERATURE REVIEW

2.1 Conventional Approaches to Autonomy in Philosophy, Ethics and Bioethics

"Perhaps nothing has so exasperated me over the years as the deference given in bioethics to the principle of autonomy"

(Veatch, 1996, p. 41).

2.1.1 The "Four-Principles" Approach and the Principle of Autonomy

The field of bioethics, which evolved from conventional philosophy, is currently one of the powerful forces shaping the practice of health research. Over the last three decades, bioethics has attracted great public and scholarly interest and has yielded considerable social influence as an applied discipline primarily because its efforts to ground moral theory in the real world have been congruent with the liberalist ideology prevailing in Western society (Chambers, 1999; Jennings, 1998). The dominant approach that has governed Western bioethics itself, and continues to be applied largely in clinical research throughout developed and developing countries, is known as the four-principles approach or, pejoratively, as principlism. Principlism is based on the idea that common morality contains sets of moral norms which include particular principles that are connected to models of moral responsibility and have *prima facie* status as moral principles (Beauchamp & Childress, 2001). These normative moral principles are included in most classical ethical theories in some form, and serve as abstract starting points for reflecting on and resolving moral and ethical dilemmas (Beauchamp, 1999). Prominent proponents of this approach include Ross (1930) and Frankena (1973), while the most influential principlists in contemporary bioethics are Beauchamp and Childress (2001).

The four principles which serve as the most common ethical guides are autonomy, beneficence (doing good), nonmaleficence (not doing harm) and justice (fairness in distribution). The appeal of principlism is that it is grounded in a longstanding tradition of philosophical and ethical theory and makes use of the aspects of these theories that have attracted the most support (Danner-Clouser & Gert, 1999). Because of these foundations in philosophical thought, the normative ethics that has evolved into contemporary bioethics reflects the philosophical traditions initiated by, respectively, Immanuel Kant (1785) and John Stuart Mill (1867): Kantianism, or deontology, and utilitarianism (Crisp & Slote, 1997). In proposing the principle of beneficence, for instance, bioethical theorists acknowledge the value of Mill's concern with the consequences of an individual's actions for society and its members. In proposing the principle of autonomy, bioethical theory incorporates Kant's emphasis on the categorical importance of the individual person. The basic tenets of these two schools of thought are outlined later in this section.

Despite the insistence of advocates of principlism that the four basic principles presented in their approach – autonomy, beneficence, nonmaleficence and justice - are equally weighted (Beauchamp & Childress, 2001), within standard applications of principlism, "autonomy has become the default principle…the principle to be appealed to when principles conflict" (Wolpe, 1998, p. 43). Amongst standard texts, for example, Beauchamp and Childress (2001) give emphasis to autonomy, nonmaleficence, beneficence and justice; Gillon (1994) offers a similar list; Downie and Calman (1987) also emphasize autonomy and add utility; while Engelhardt (1996) presents respect for individual autonomy as the fundamental condition of ethics itself (Shildrick, 1997). The principle of autonomy owes its esteemed position at least in part to the

growing concern with the protection of individual human rights following the atrocities perpetrated by Nazi doctors during the Second World War, and the subsequent formulation of the Nuremberg Code (1946). The first principle of the Nuremberg Code is particularly important for introducing the concept of voluntary, informed consent, and has been described as absolutely essential in research with human subjects (Kimmel, 1996).

The word autonomy is derived from the Greek: *autos* (self) and *nomos* (rule or law). Autonomy is thus self-government or self-determination, and "personal autonomy" may be defined as "self-determination in the quite general sense of choosing how to act and to live one's own life" (Friedman, 2000b, p. 206). An individual is thus considered to have diminished autonomy if she or he is controlled, manipulated or coerced by others, or if she or he is in some way incapable of deliberating or acting on the basis of her or his desires. By appealing to the spirit of liberalism embodied in conventional philosophical and ethical perspectives, autonomy has thus been constructed and widely accepted as one of the essential – indeed, ideal - principles for recourse in (bio)ethical quandaries. Wolpe (1998) and Tauber (2003) provide some explanation for the prioritization of autonomy over other bioethical principles. As the censure of beneficence made way for autonomy, organic trust between patient and physician in the paternalistic era converted into rituals of trust (Wolpe, 1998), which were more easily expressed, applied and codified in the contractual procedures of informed consent. Wolpe also suggests that because autonomy is more frequently framed and presented as a negative right, i.e., a choice to refuse rather than a positive right of demanding alternatives, autonomy may actually reinforce, not corrode, the authority of health care professionals – they still hold the power of being the experts who filter and translate information to their patients.

Tauber (2003) argues further that as health care has evolved into a market commodity, so autonomous, informed patients have been turned into consumers – resulting in a somewhat different interpretation of patient rights and responsibility which removes the focus of critique or reform from the assumptions underlying health care. As in many other developed liberal nations, South Africa's democratic constitution has a marked human rights focus, emphasizing the primacy of individual rights, despite differing views of personhood amongst many of the diverse cultures in the country (Mkhize, 2004, 2005; Motsemme, 2003). Thus, it is not surprising that current ethical reflection and review in South Africa also place high value on autonomy, and upholds patients' and research participants' rights to self-determination (Henley, Benatar, Robertson & Ensink, 1995). Human rights discourse, while morally lauded in developing and developed nations, assumes individual autonomy as a prerequisite, whereas such autonomy is likely to be compromised or not desired in certain non-Western contexts.

2.1.2 Informed Consent and the Principle of Autonomy

Autonomy is also the most frequently mentioned moral principle in the literature on informed consent (Faden, Beauchamp & King, 1986). Informed consent is one of the critical issues in the ongoing debates around the ethical conduct of medical practice and biomedical research. Like the bioethical field in which it is applied, it has its foundations in multiple disciplines and social contexts, including law, moral philosophy, the health professions, and the social and behavioural sciences. The history of informed consent is well-documented (Katz, 1972). From the time of its formulation in the Nuremberg Code (1946), informed consent has remained the foundation of

ethical research and practice, as articulated in the Declaration of Helsinki (World Medical Association, 1964), the Belmont Report (1979), the Guidelines of the Council for International Organizations of Medical Sciences (1993), the UNAIDS Guidelines for HIV Vaccine Research (2000) and the Medical Research Council (MRC) of South Africa's Guidelines on Ethics for Medical Research: HIV Preventive Vaccine Research (2004). Inherent in both the early and more recent ethical guidance documents is the assumption that respect for individual autonomy is universally applicable and of utmost importance. This is evident in the way in which informed consent has been defined: an informed consent is a particular kind of autonomous choice or action - an autonomous authorization or an autonomous refusal by patients or research participants (Faden et al., 1986).

Autonomy has thus achieved pride of place in applied principlism in part because it can be "formalized, administered and ritualized as informed consent" (Wolpe, 1998, p. 50). Respecting autonomy, in this conventional sense, amounts to ensuring that participants are capable of meeting some measure of informed consent. Thus the standard conception of autonomy tends to be focused quite narrowly on various criteria of the capacity for making particular decisions or choices, such as adequate information and understanding, sufficient competence, and freedom from undue inducement and explicit coercion. Beauchamp and Childress (2001), for example, propose that the two essential conditions for autonomy on which most theories of autonomy agree are liberty (freedom from controlling forces), and agency (capacity for intentional action). They equate voluntariness with autonomy if the former holds under the conditions of autonomous action, namely, the presence of adequate knowledge, the absence of psychological compulsion and the absence of external constraints.

2.1.2.1 Components of informed consent

Definitions of informed consent (Locke, Spirduso & Silverman, 1993; Meisel & Kuczewski, 1996; Shore, 1996) have tended to focus on the different components of informed consent: the conditions or criteria that must be met if consent is to be considered real, valid or informed. Informed consent requirements in biomedical research and practice generally include the following five components: 1) disclosure of all the information relevant to the treatment or research procedure; 2) comprehension of this information by the patient or prospective research participant; 3) voluntariness, or freedom from all undue pressure or coercion, of the patient or prospective participant; 4) competence or capacity of the patient or prospective participant to understand, and make decisions based on, the information provided; 5) the explicit or formal expression of consent, usually in written form (Benatar, 2002; Kent, 1996; Lindegger & Richter, 2000; Meisel & Roth, 1983). However, while many recognize the importance of obtaining consent from patients and research participants (Lidz et al., 1983), there is considerable debate about whether these conditions are met in practice, whether consent can ever really be truly informed (Smith, 1999), and how clinicians and researchers should go about obtaining and guaranteeing such consent (Ubel & Lowenstein, 1999).

2.1.2.2 Barriers to obtaining informed consent

Even when there is agreement on what constitutes informed consent, the possibility of meeting each of the criteria identified above has been disputed by research identifying barriers to obtaining truly informed and truly autonomous consent. Illiteracy, language barriers, different explanatory models of disease, differing cultural perceptions of personhood, and limited

resources are among those factors identified as obstacles to obtaining informed consent (Henley et al., 1995). While some researchers have provided more generic overviews of the barriers to informed consent (Lidz et al., 1983), as well as of empirical literature on informed consent (Verheggen & van Wijmen, 1996), others have focused on identifying the specific factors that affect informed consent conditions. Some have identified the factors affecting comprehension in informed consent procedures (Bergler, Pennington, Metcalfe & Freis, 1980; Fitzgerald, Marotte, Verdier, Johnson & Pape, 2002; Sreenivasan, 2003), while others have focused more specifically on the disclosure of information and the impediments to comprehension and interpretation of this information (Ferguson, 2003; Helgesson, Ludvigsson & Gustafsson Stolt, 2005; Kent, 1996; Meisel & Kuczewski, 1996; Raich, Plomer & Coyne, 2005; Simon & Kodish, 2005; Stead, Eadie, Gordon & Angus, 2005). Studies of the information component of informed consent have found that, in many cases, consent falls short of being truly informed (Cassileth, Zupkis, Sutton-Smith and March, 1980), while Faden and Beauchamp (1980) discovered that information is not necessarily the primary basis of "informed" consent decisions, but rather that such decisions are often made based on factors outside of the informed consent process. Other research has identified impediments to the voluntariness requirement of informed consent (Agrawal, 2003; Abdool-Karim, Abdool-Karim, Coovadia & Susser, 1998; Barsdorf & Wassenaar, 2005; Grisso, 1996; Kass, Maman & Atkinson, 2005; Meisel & Roth, 1983; Sears, 2005), and to the formal, written consent component, where it was found that even this "signature" requirement can have unintended negative consequences (English, 2002; Wendler & Rackoff, 2001). These and other studies highlighting the flaws contaminating the informed consent process are behind the contention that informed consent is a complex, somewhat idealized process, with formalistic requirements which are almost impossible to meet (Lindegger & Richter, 2000).

2.1.2.3 Challenges to autonomy in informed consent: paternalism versus "mandatory autonomy"

The limits of the informed consent process in meeting its ethical goal of preserving and protecting the rights of individuals illustrates that research ethics can no longer be conceived of as a set of abstract rules to be applied in the detached and "value-neutral" manner of scientific practice. Rather, conducting ethical research essentially amounts to conducting relationships with research participants – relationships that should embody respect for the dignity and welfare of others (Stark, 1998). The doctrine of informed consent was developed as a legal mechanism to guide the conduct of physicians with respect to their patients (Kaufman, 1983). Indeed, one of the central concerns within the ethical spotlight on medical practice and research is the informed consent procedure as it is played out within doctor-patient and researcher-participant relationships. Here, the ethical focus falls on the tension between paternalism and autonomy. This classic power struggle between the patient's right to autonomy and the physician's benevolent responsibility has been characterized in the bioethics literature as the moral conflict between the basic principles of autonomy and beneficence (Sherwin, 1992b). The paternalism-autonomy tension is paralleled in biomedical research trials, where key ethical questions concerning how to obtain informed consent, how much information researchers are ethically required to provide, and the moral obligation of researchers to protect their research participants (reflected in the principles of beneficence, nonmaleficence, justice, and autonomy) are embodied in the researcher-participant relationship.

Opponents of the paternalistic authority of practitioners and researchers advocate autonomy as the alternative, arguing that patients' and participants' rights to make choices that are self-determined, independent and free from external influence is primary (Engelhardt, 1996; Katz, 1972; Veatch, 1995). Veatch (1995) locates the problem in the language of "consent" which, he argues, is too loaded with paternalistic baggage and does not adequately reflect the shift in biomedical research and practice towards a greater respect for the patient's needs and values. Recently, however, ethicists have begun to realize that this "mandatory autonomy" is not necessarily in the best interests of the patient, nor necessarily what patients themselves want. One study of patient participation in medical decision making found that nearly half of the patients interviewed preferred that the clinician make the therapeutic decision, rather than having to play any role in the actual treatment decisions or choices themselves (Strull, 1984). More recently, Schneider (1998), Tauber (1999), and Hanssen (2004) considered the question of whether patients really *want* autonomy to be fundamental in guiding the direction that bioethical practice should take. Regardless of how noble the ideal of patient autonomy may be, enforcing in practice the principle of autonomy at all costs is sometimes experienced by patients as abandonment (Corrigan, 2003).

These arguments are supported by recent research on informed consent in clinical contexts which points to the limited capacity of humans for making independent, autonomous choices, and the relatively contextual (O'Neill, 2000) and non-rational (Ashcroft, 2000) nature of all human choices. Empirical research in health care contexts indicates that patients "desire both more and less than autonomy" (Schneider, 1998, p. xiii). Less, because many patients indicate that they do not want to be responsible for their own treatment decisions; more in that they want more of

what Schneider calls “personal concern” (Ibid, p. xiii). Others have argued that the ideal of individualized autonomous decision-making should not be imposed on members of certain ethnic and religious sub-populations, who have been found to place greater value in shared communal and familial decision-making (Andersson, Mendes & Trevizan, 2002; Blackhall, Murphy, Frank, Michel & Azen, 1995; Blustein, 1993; Fagan, 2004; Kuczewski & McCruden, 2001).

2.1.3 The Principle of Autonomy: Conceptual Challenges

As the most frequently mentioned moral principle in the literature on informed consent (Faden et al., 1986), the importance of autonomy in modern moral and political philosophy cannot be disputed. When it comes to the conception of autonomy, however, agreement runs out. Autonomy has been criticized for being a catch-all term that lacks clear definition and that is mainly deployed for purposes of gaining approval or authorization (Mendus, 2001). The concept of autonomy is founded primarily on philosophical conceptions of the person. It follows from this that the proper application of the principle of autonomy in health care and health research ethics to some extent depends on an adequate understanding of its philosophical foundations. The application of autonomy is impeded, however, by extensive disagreement about the very conception of autonomy and by debates about whether it makes sense to attempt to explicate a single meaning of personal autonomy at all (Takala, 2001).

As mentioned above, the principal philosophers associated with the concept of autonomy are John Stuart Mill and Immanuel Kant. Within these two opposing conceptions there is convergence in the acknowledgement of autonomy as an ideal feature of persons who are in

some meaningful sense independent, rational and capable of self-control (Launis, 2001). The point at which these two philosophers diverge is in the assumptions that each makes about the essential conditions that enable the realization of autonomy. While Kant understood autonomy as freedom of will, Mill conceived of autonomy as freedom of action (McNeill, 1993). Kant (1785) located autonomy or free will within individuals as independent beings of unconditional value in and of themselves. Mill (1867), on the other hand, developed a conception of respect for the autonomy of others, following from his primary concern with the liberty of the individual in action and in thought, and with the potential restriction of this liberty by the majority in society which has the power to impose its values and beliefs on others. Thus, Kant equated self-determination with reason, deeming that "to be fully autonomous is to be a fully rational agent" (Launis, 2001, p. 280). In contrast, Mill's conception of respect for autonomy is based primarily on consequentialist reasoning: both human reasoning and happiness within society depend on each person being allowed to act on his or her own opinion of what is right (Gauthier, 2001). This is where the conflict between, for instance, the principles of autonomy and justice arises in contemporary bioethical debates. Because of this conceptual uncertainty, it is evident that the concept of autonomy should be subjected to critical, sustained analysis and review.

Although the principle of autonomy has perhaps been the most important concept within bioethics, it is no longer commonly accepted that personal autonomy should be considered an absolute value (Brody, 1998; Frank, 2000; Levine, 1991). Autonomy is also no longer considered to be a sufficient criterion of care and protection, either in ethical practice or as an ethical ideal (Schneider, 1998) and many have argued that the autonomy model is currently in crisis (Elliott, 1999; Shildrick, 1997).

> …autonomy is inadequate, by itself, to account for medicine's moral calling because of two failings. First, from the patient's perspective, the notion of autonomy is frequently distorted in the clinical setting…Second, autonomy as a construct cannot account for the ethical responsibilities of the care giver (Tauber, 2003, p. 486).

Even those who put forward a "principled" approach to autonomy now acknowledge a tendency to overemphasize, overextend and overweight respect for autonomy (Childress, 2001). Indeed, the most influential proponents of principlism contend that they have always aimed "to construct a conception of respect for autonomy that is not excessively individualistic, not excessively focused on reason, and not unduly legalistic" (Beauchamp & Childress, 2001, p. 57). They have thus contested criticisms of the principlist approach by arguing that their critics, among them many feminist scholars, have misinterpreted their theory – a response that many believe to be dismissive in neither addressing the issues raised nor assuaging critics' concerns (Ells, 2001). Although they argue that autonomy does and should not take precedence over the other three principles in the ethical framework, there are nonetheless fundamental problems with the mechanism that they, and many others, invoke to denote autonomy in health care and research settings – the informed consent paradigm.

Feminists challenge this conceptualization of autonomy as it is invoked in most bioethics discussions. Autonomy, they argue, is too often equated with agency (the making of a choice) (Sherwin, 1998b), and,

> when autonomy is the answer, the question is largely limited to asking whether the person has decided freely. Autonomy counsels us not to ask if the decision was wise, or even good in the short run for the person making it (Murray, 1994, p. 32).

Furthermore, both the theoretical conception of autonomy and the application of this principle in the informed consent process are founded on Western ideals of liberty and individual rights, with

little cognizance of the ontological implications and omissions inherent in this approach.[1] "Traditional views of autonomy involve a vision of personhood which is both separate from others and hierarchical" (Adshead, 2001, p. 141). Bioethics has thus played a significant part in the social construction of the autonomous person. Notions of personhood cannot be separated from their significance in (bio)ethical conceptions and applications. This, in turn, points to the largely unacknowledged influence of relationships in the lives and experiences of all individuals – relationships that, if acknowledged at all, are usually treated as confounding variables in the research process (Blustein, 1993; Goldberg, 2003; Jennings, 1993; Kegley, 1999), and as a negative influence on the ethical conduct of such research (Callahan, 1984; Gorovitz, 1986).

Notably, even proponents of the principlist approach have observed that

> there is an historical and cultural oddity about giving a standing to overriding importance to the autonomous individual (because) moral communities – indeed, morality itself – was founded at least as much on (the) other principles, and usually in a context of strong commitment to the public welfare (Faden et al., 1986, p. 18).

This signals the need for a paradigm shift from individualistic notions of the person and personal autonomy to conceptions that recognize that the autonomy of individuals is fostered or hindered by the social contexts in which they are embedded (Kegley, 1999). While the importance of autonomy and informed consent should not be discounted, these concepts are in need of a reconceptualization that acknowledges both the individual and the social nature of persons. The implication is that no appropriate conceptualization of autonomy in any form can or should be fashioned independently of a comprehensive theory of the self.

[1] An in-depth critique of the Western liberal and individualistic values upon which the principle of autonomy is based is beyond the scope of this chapter. See, for example, Daly (1994), Fox (1990), Fox-Genovese (1991), Kekes (1997), Heller, Sosna and Wellbery (1986), Light and McGee (1998), Mullhall and Swift (1995), and Rasmussen (1990) for extensive discussions of this topic. More detailed discussions and critiques of the Western liberal and individualistic values upon which the principle of autonomy is based are also explored in sections two and three of this literature review.

Benatar (2002) asserts that those who undertake research in developing world countries have an ethical obligation to actively understand their participants, including the impact of poverty and of deep-rooted power and gender inequalities; cultural understandings and experiences of selfhood; and the social, cultural, and familial contexts in which participants are embedded. These considerations, Benatar maintains, can help researchers to understand the complexities involved in obtaining informed consent in these contexts. He emphasizes, moreover, that debates to understand and resolve these issues should not be undertaken solely within industrialized countries, but that "the inclusion of scholars and others from diverse societies will enable all to see themselves and what they value in a clearer light" (Benatar, 2002, p. 1138). By emphasizing dialogical morality and an ethic of care within a matrix of relatedness (Tangwa, 1996), both African and feminist ethicists make their primary focus the respect and preservation of interpersonal relationships - both in the daily, lived experiences of participants and in the research process itself. In contrast to conventional applications of ethics, what is needed to address the ethical complexities of research in developing countries is an approach to bioethics where the primacy of care, justice, and relatedness in women's experiences of their own autonomy is recognized and respected. Feminist bioethics is such an approach.

2.1.4 The Principle of Autonomy: Challenges Posed by Contemporary Ethical Issues

It has been argued that the conceptual analytic method that distinguishes bioethics does not provide workable solutions in real-world ethical decision-making: there is such a gap between

conventional bioethics and what is actually taking place in clinical settings[2] that one cannot simply accept applied moral philosophy as medical ethics (Hedgecoe, 2004). Ethical decision making is a complex process. Advances in medical research are presenting bioethics with situations where applying the right principle from among those available is grossly insufficient. The individualistic paradigm of respect for autonomy is problematic in research and clinical reality – not only are patients and research participants encumbered with family and other social responsibilities; clinicians and researchers are also linked in complex institutional networks (O'Neill, 2002).

An extension of this is "the difficulty physicians have in moving beyond individual clinical decisions to an understanding of the collective consequences of those decisions, and…the complex and powerful set of social relations that shape decisions when they are made" (Zussman, 1997, p. 183). Moreover, relying on respect for autonomy that has essentially been reduced to respect for informed consent requirements, limits personal autonomy in clinical settings to freedom to refuse what others offer (O'Neill, 2002). In bioethical theory, the principle of autonomy may be an ideal central value; in practice, adherence to this principle at the expense of others may fail to give sufficient guidance in ethically complex situations, where there are many potential resolutions and potentially no solutions. While respect for persons, doing good, protecting justice and avoiding harm may not be far from our minds when approaching ethical problems, these principles are not necessarily the best or most appropriate means of resolving all bioethical dilemmas (Harris, 2003).

[2] It is acknowledged that clinical settings and research settings are not equivalent, nor are ethical practices within each of these contexts necessarily interchangeable. However, for the purposes of this study, examples of applied ethics in both of these settings were included in the discussion to demonstrate the problems associated with applying traditional notions of principled autonomy in clinical as well as in research contexts.

In clinical practice, there are many examples of where informed consent and rigid attempts to uphold individual autonomy fail. Ethically complex problems posed by termination of treatment dilemmas (Bedell & Delbanco, 1984; Hanson, Danis, Mutan & Keenan, 1984; Jayes, Zimmerman, Wagner, Draper & Knaus, 1993; Wren & Brody, 1992), issues arising in adult intensive care units (Zussman, 1992), and in both general medicine and general surgery (Lidz et al., 1983) are just some of the situations in which adherence to principles of autonomy offer limited options for adequate ethical resolution. Many informed consent applications are extraordinarily complex – how, for example, one speaks for an unborn child, or a comatose patient – and yet, the principles of informed consent remain remarkably straightforward and simple (Zussman, 1997). Similar failures of applications of autonomy in informed consent have been reported in research settings, examples of which are explored in the following discussion.

The current crisis of the autonomy model is intensified by new initiatives in research that are challenging the dominance of standard notions of autonomy in biomedical ethics. Ethical considerations around the technological advances in genetic medicine, for example, are according greater value to the principles of beneficence, nonmaleficence and justice, and necessitating a re-evaluation of autonomy in relation to these competing ethical principles (Green, 1999). The main reason for this is that genes transcend individuals and genetic medicine and research are likely to have an impact on persons other than the patient or research participant. "By definition, human genetics pertains to relatedness rather than separateness" (Mullen, 1995 in Green, 1999, p. 64). For example, the right to autonomy and autonomous choices for all individuals is contested by arguments justifying legal authorization of compulsory

participation in genetic screening and counselling programmes. Such arguments are based on the premise that it is the duty of society to minimize the risk of unambiguous harm to individuals who may be unable to protect themselves (Jonsen, Veatch & Walters, 1998) – a premise that espouses and upholds the principles of nonmaleficence and beneficence over the principle of respect for autonomy. The conflict between ethical principles is further highlighted in cases where individuals refuse to give (voluntary) consent for the disclosure of genetic screening results to relatives who may be at risk for developing the disease.

Another area where the primacy of autonomy is currently attenuated is in the unique ethical issues generated by the HIV/AIDS pandemic. An unprecedented, ethically-justified compromise of individual autonomy and confidentiality, for example, is demonstrated by the obligation of health professionals to inform identifiable partners of an HIV-positive person's test results if the latter is unwilling to disclose his or her status autonomously (Barrett, 2000; HPCSA, 2002; Shalowitz & Miller, 2005). HIV/AIDS research has also highlighted the inadequacies and insensitivity of conventional approaches to informed consent – and its procedural respect for autonomy – in developing countries (Lindegger & Richter, 2000).

The limitations of principlism are further exposed by issues relating to organ trade and genetic manipulation. Callahan (2003) proposes that, in these situations, principlism cannot offer clear solutions that weigh up harms to individuals, to society, to the greater good, to future generations, against benefits to the individual in the immediate present, and argues that these are examples of where a communitarian perspective might offer more effective recourse. Similarly, deference to autonomy at the expense of alternative approaches has faced serious moral

objections which prove the insufficiency of the principle of autonomy in ethical challenges presented by resource allocation (Veatch, 1996) and by egg donation (O'Neill, 2002). Gaylin (1996), too, presents a powerful argument against a rigid defense of autonomy, which

> is dangerous not just because it preempts other values such as justice and virtue, but also because it interferes with more sophisticated concepts of freedom. It is hard to imagine a paranoid schizophrenic living in the streets of New York, any more than a drug addict as being a 'free agent' (Gaylin, 1996, p. 45).

The ethical issues accompanying the development of new reproductive technologies are another critical arena highlighting the limitations of conventional applications of autonomy principles. Not only are genetic counselling, in-vitro fertilization and abortion redefining the meaning of motherhood and the moral value of mother-and-child, they are also necessitating the reexamination and reformation of biomedical ethics and its principles. Strict adherence to principles of individual autonomy frames ethical issues in the contested domain of abortion as conflict between maternal and foetal rights, a conceptualization which offers little guidance in reality. When maternal rights are pitted against the rights of the foetus, the problem becomes one of competition in which either the mother or the child wins. And, most often, the foetus takes precedence, rendering the pregnant woman virtually invisible (Sherwin, 1992b). If the frame of guidance is expanded from principles of autonomy to moral conceptions of personhood, to the relational space that mother and foetus share, the lens of ethical guidance shifts from two independent beings whose moral claims are in opposition to one another, to the relationship between the foetus and the woman (Gibson, 2004).

Harris (2000) explores the limitations of conflict- and principle-based perinatal ethics and proposes an alternative model of pregnancy. Here, too, the focus is shifted from the mutually exclusive needs of the pregnant woman and her foetus, to their mutual needs. This model also

> avoids many of the pitfalls of traditional ethical formulations - their tendency to neglect gender-specific models of moral reasoning, their implicit assumptions that application of universal principles of autonomy and beneficence results in objective ethical solutions, and their failure to account for the ways that projecting foetal needs perpetuates social inequalities (Harris, 2000, p. 786).

This view is shared by other theorists who argue that traditional enactments of autonomy neglect the vital importance of relationships, as well as the woman's own embodied experience and knowledge of her pregnancy (Goldberg, 2003).

Examination of the principle of autonomy in psychiatric settings has also called into question the skewed focus of conventional conceptions on personal liberty. Research with psychiatric patients has attended to such ethical issues as the competence of these patients to consent to research, and focused on ways of guaranteeing that individuals give such consent as autonomously as possible. Narrowing the focus to questions of autonomy has the potential to ignore the broader circumstances of these potential participants and, at worst, denies their suffering or places responsibility for the suffering solely on the 'autonomous' sufferers (Martin, 2001). Fisher (2003) also points out the inadequacy of the autonomy model in research involving adults with mental retardation and developmental disabilities. After reviewing the current theory and research on informed consent policies in such research settings, she argues that "adults with mental retardation, like all persons, are linked to others in relationships of reciprocity and dependency" (Fisher, 2003, p. 29). She goes on to explore how a relational ethics approach can counter the inadequacies of consent procedures with this vulnerable population by shifting the

focus away from individual autonomy to the goodness of fit between the decisional capacity of participants and the specific consent context (Fisher, 2003).

Such challenges to the pride of place held by the principle of autonomy are paralleled in contemporary bioethical debates about suicide and euthanasia. One ethical view on this issue holds that autonomy entails individual judgements about what constitutes unbearable life, and should have priority over competing values; others argue that "suicide (in any form) can never be a rational response to the conditions of life, (and) that society's interest in life overrides even an autonomous desire to die" (Teays & Purdy, 2001, p. 373). Daniel (2001) contends that the ethical and legal authorization of euthanasia would sanction a view of autonomy that permits individuals to entreat others, including such institutions as medicine, to aid them in their pursuit of the good life, regardless of the potentially harmful risk that this poses to the common good. Here, again, the principles of beneficence and nonmaleficence pose a significant challenge to the apparent dominance of the principle of autonomy. What each of the issues discussed above seem to highlight is that the ideology of autonomy as the freedom to make choices and to follow one's own preferences is potentially, with respect to the relations between individuals, inadequate (Ter Meulen, 2001). In the remainder of this literature review, this narrow conception of the autonomy ideal will be critically reviewed and a broader understanding of autonomy will be presented - one that recognizes how specific decisions are embedded within a complex set of relations, contexts and policies that constrain (or promote) an individual's ability to exercise autonomy with respect to any particular choice. As such, notions of the self and the ethical orientations of justice and care will be discussed. Ultimately, the question is:

> How does (bioethics) reconcile the clearly immense differences in the social and personal realities of moral life with the need to apply a universal standard to those fragments of experience that can foster not only comparison and evaluation but also action? (Kleinman, 1999, p. 70 in Hedgecoe, 2004, p. 126).

2.1.5 An Alternative Approach: Challenges from Virtue Ethics

> The morality of interdependence and mutual responsibility has been clashing with respect for autonomy with increasing frequency and harshness for the past thirty years, and autonomy has won in these clashes too often. Reason does not require that autonomy be abandoned, only that its balance with other individual and communal values be restored (Gaylin & Jennings, 2003, p. 4).

The findings discussed in section four above appear to give more weight to honouring the beneficent conduct - or paternalism - of physicians over the autonomy of patients, and are more consistent with the virtue-based ethics that owes its initial revival to Anscombe (1958) and has more recently been revived by the (ethical) theories of MacIntyre (1981) and Pellegrino (1993; 1995). It is comprehensively reviewed by, for example, Meara, Schmidt and Day (1996) and Oakley (2001).

Pellegrino (1995) has worked to promote and strengthen the sacred relationship between individuals who are ill and thus vulnerable, and their physicians, who have the power to do enormous good and enormous harm. In his call for the restoration of virtue-based ethics, Pellegrino extols the importance of physicians' virtues such as intellectual honesty and fidelity to the patient as the ethical basis of the clinical encounter. According to this approach, persons with virtue exhibit generous, caring, compassionate, sympathetic, and fair actions with integrity and, while virtuous persons may not always make good ethical decisions, decision-making is more complete – and arguably more ethical - if virtues and moral motives are included in bioethical

practice. Pellegrino acknowledges and addresses one of the main criticisms of virtue ethics – its circular logic. To break the cycle of defining virtue as "that which the virtuous person does and the virtuous person as one who acts virtuously…the concept of virtue must be defined in terms of some good, some *telos*, which the agent intends and acts to attain" (Pellegrino, 1995, p. 274).

Although virtue ethics also has its roots in early philosophical traditions – primarily in the works of Aristotle (384-322BC/1953) – its virtual absence in contemporary bioethical theory is partly a consequence of the culmination of the theories of Kant and Mill in moral philosophy (Schneewind, 1997). One of the primary aims of virtue theorists, therefore, is to restore virtues to their rightful place in ethical theory and practice – a goal clearly articulated by virtue theorist Foot, who maintains that "a sound moral philosophy should start from a theory of virtues and vices" (Foot, 1978, p. xi). Others suggest that principlist ethics and virtue ethics are complementary approaches that, if integrated, could provide a coherent framework for enhancing the ethical competence of health professionals, and for augmenting public trust in the character and actions of these professionals and their profession (Meara et al., 1996). However, one of weaknesses of the new virtue ethics is that it is under-developed in the contemporary literature as a result of its focus on criticizing the traditions to which it is opposed, rather than stating positively and precisely what its own alternative is (Louden, 1997). This deficit notwithstanding, one of the most significant virtues of virtue ethics is that it shifts the focus from autonomy-based, contractual relationships to trust-based, covenantal ones (Pellegrino, 1995).

While principled ethics could be described as "obligatory," virtue ethics encompass the "ideal" – one approach complements the other (Meara et al., 1996). Advocates of the virtue approach thus

acknowledge that it cannot operate as a stand alone normative ethic, but should be conceptually integrated with other ethical theories to offer comprehensive ethical guidance in the health professions. The value that virtue ethics brings to conventional theories like principlism is its foundation in community narratives – a contribution which, coupled with its focus on covenantal relationships, is particularly helpful in offering ethical guidance in multicultural settings (Meara et al., 1996).

> The virtues of principlism are clarity, simplicity, and (to some extent), universality…But the vices of this approach are the converse of its virtues: neglect of emotional and personal factors, oversimplification of the issues, and excessive claims to universality. Virtue ethics offers a complementary approach, providing insights into moral character, offering a blend of reason and emotion, and paying attention to the context of decisions (Campbell, 2003, p. 292).

There is recourse, perhaps, in taking what is of value in the emphasis of virtue ethics – which, notably, is also essentially individualistic - on the virtuous clinician or researcher, and extending this to an emphasis instead on virtuous relationships. Intrinsic to health care ethics is Kant's philosophy that individuals are rational beings whose autonomous decisions should be treated as sovereign. However, Ter Meulen (2001) contends that less emphasis should be placed on autonomy and more on moral virtues within relationships. As they are treated in ethical practice, says Ter Meulen, the relationships between patients and healthcare professionals, and between researchers and research participants, are predominantly contractual - defined in terms of rights and allowing no room for such virtues as solidarity and personal involvement. If, however, one shifts one's notions of personhood in bioethics from atomistic conceptions of persons to more relational constructs, then principles like autonomy become part of a wider morality of relationship and care, where ethics of relationship and ethics of responsibility are better balanced and bioethical practice is better served by an integration of the two (Tauber, 2003).

In their discussions of the failure of autonomy as both a reality and an ideal, therefore, many theorists – virtue ethicists among them - appear to be moving in the direction of the feminist ethic of care, while not explicitly offering any of the clear alternatives to autonomy that many of the feminist approaches to ethics and bioethics seem equipped to offer. (See section three for a detailed discussion of ethic of care versus ethics of justice). From the above discussion, it is evident that the four principles approach is coming under increasingly critical scrutiny - from inside and out - and that this dominant theoretical framework could benefit from exploring alternative approaches such as feminist ethics, especially as it moves out beyond its Western borders and is applied in clinical research in developing countries, and to vulnerable populations within these contexts, where both the numbers and the marginalization of vulnerable persons increase proportionately. This requires more than simply presenting the alternatives, but also integrating them into the framework of bioethics (Crosthwaite, 1998) to produce viable theoretical positions for exporting into the field, applying them in the contexts where they matter most.

> The task for those who believe that autonomy is an important but not all-important response to the moral conundrums we face, is to show what we leave out when we frame our moral and social world in such constrained terms (Murray, 1994, p. 32).

This task has been taken up by feminist theorists who, in their efforts to reconceptualize the traditional concept of autonomy, are generating some of what is needed to fill in the gaps highlighted above.

2.1.6 Contextual Implications for Researchers

In South Africa, many persons, particularly women, may be prevented from making autonomous choices (in the traditional sense of autonomy) because of political, economic, social, emotional, and cultural constraints on their freedom (Jobson, 2005; Mills et al., 2006; Sideris, 2005; Wassenaar et al., 2005). Women are more at risk for contracting HIV for several reasons – physiological factors, as well as other gendered, social norms and cultural practices. These include the accepted dominant role of the male in African cultures and the power of husbands over their wives in the marital relationship; attitudes that condone male promiscuity before and after marriage; and the belief that men should control the sexual encounter (Rakoczy, 2001; Wingwood & Diclemente, 2000). These circumstances leave women with very little personal autonomy over their sexual relationships, where they cannot negotiate safe sex or fidelity (Leclerc-Madlala, 2000; Martin & Curtis, 2004; Memela, 2005), and over decisions concerning their own bodies. The explicit and implicit expectation within many cultures (in South Africa) is that women must be socially and economically dependent on men, establishing the ownership of women by men and further decreasing their freedom. The burden of impact of the HIV/AIDS epidemic also extends to those women who are not infected. Women are responsible for caring for the sick and dying, for orphans left behind – a burden often accompanied with the financial burden of these consequences. Indeed, it is the cycle of poverty that entrenches these norms and practices deeply within these communities.

Women's lower status, the poverty that they live in and with, and their economic disenfranchisement, all have a major impact on their vulnerability to HIV/AIDS (Dunkle et al.,

2004; Kahn, 2001; Mills et al., 2006). Women living in these circumstances are thus disempowered on a number of levels. One of the goals of feminism in general and feminist (bio)ethics in particular, is to make the voices of these women heard. It is for these reasons and within this context that the present study contextualizes the re-conceptualization of women's autonomy within these daily lived experiences of the women who are most affected by the virus, and who are likely to be the target of much of the clinical research that is carried out in developing countries such as South Africa. It is clear, then, that gender is a primary issue, and not one that should only be considered as an afterthought to the scientific concerns of such research.

Thus, while autonomy should not be abandoned, it is only part of the story, and needs to be modified to include (women's) "stories about how we are to live together, and how we are to make families and communities that support the growth of love, enduring loyalties and compassion" (Murray, 1994, p. 33). The same argument applies to culture, and to the tendency to perceive one culture's worldview as superior to another. This is reflected in the domination of Western "independent" notions of self versus the interdependent views of personhood that are adopted in many non-Western cultures. In many developing countries, and in South Africa in particular, there are cultures with differing worldviews from those of the First World values of independence from which individualistic conceptions of autonomy arise. Thus, while feminist voices can help us to focus on women's unique experiences of agency, feminist (bio)ethics can also facilitate the adoption of a critical perspective when attempting to mould principles of autonomy in informed consent practices into more gender- *and* culture-sensitive conceptions.

The ethical issues associated with clinical research and especially with HIV/AIDS research, are as vast as they are complex. This, coupled with women's vulnerability, warrants special concern and challenges the adequacy of conventional informed consent procedures to the ethics of clinical vaccine trials (Mills et al., 2006; Wassenaar & Richter, 2000; Wassenaar et al., 2005). In these settings, ethical principles that are founded on (Western) concepts of abstract rationality, de-personalized obligation, procedural autonomy, and universality, may act to exploit, rather than exploit already disempowered women (Richter et al., 2000). "Trials, and in this instance, HIV vaccine trials, need to recognize that women's autonomy is historically compromised, requiring that a gender-sensitive ethics must be developed and actively applied" (Wassenaar & Richter, 2000, p. 7). In contrast to conventional applications the principles and procedures of informed consent in clinical research, what may be needed to address the ethical complexities of such research in developing countries - and in South Africa in particular - is a feminist approach to bioethics, where the primacy of care, justice, and relatedness in women's experiences of their own agency is recognized and respected. Towards this end, this study attempts to supplement and integrate conventional approaches to the principle of autonomy in informed consent with conceptual equivalents from feminist ethics. Both feminist and African ethics emphasize dialogical morality and an ethic of care within a matrix of relatedness (Tangwa, 1996), making their primary focus the respect and preservation of interpersonal relationships (both in daily lived experiences of participants and of the research process itself), rather than abstracted notions of individual autonomy (Bowden, 1997).

This first section in this literature review has attempted to demonstrate the dominance of the principle of autonomy in conventional ethical approaches and, more particularly, in principlist

approaches to bioethics. It has highlighted some of the problems – conceptual and practical – with extensive, unconscious applications of autonomy as it is typically conceived. Virtue ethics has been presented as the beginnings of an alternative approach to autonomy that might rectify some of the shortcomings in conventional principles of autonomy, particularly as applied in informed consent contexts. In the next section, it will be shown how feminist ethics takes up some of the challenges posed by the virtue ethics approach. Building on the flaws of principled approaches to autonomy outlined in the section above, the feminist critique presented in the next section will highlight the gender bias in traditional bioethical principles. Following a brief outline of feminist theory, the feminist critique of conventional autonomy will be discussed, with particular attention to the dangers of applying a principle of autonomy that is de-contextualized, de-gendered and detached in health care and health research contexts. In the sections that follow this feminist critique, reformulations of concepts that are inextricable from the theoretical project of reconceptualizing autonomy will be presented. The reconceptualization of autonomy to include notions of relation and care will be explored further in the empirical chapters of this work, where the gendered association between the variables of autonomy and relation, independent and interdependent selves, and justice and care moral orientations will be examined.

2.2 Feminist Critiques of Traditional Bioethics and the Principlist Approach to Autonomy

"And if I am for myself alone, what then am I?"

(Hillel, n.d., I:14).

Feminist bioethicists argue that the patriarchal character of the philosophical tradition on which bioethics is founded has produced a gender bias in ethical and bioethical theorizing that remains largely unacknowledged. Despite the fact that the philosophical, medical and (bio)ethical disciplines have been predominantly male-focused and sometimes misogynist (Crosthwaite, 1998; Holmes, 1999; Kourany, 1998; Little, 1999; Mendus, 1996; Rawlinson, 2001; Sherwin, 1996; Shildrick, 1997; Warren, 1992), bioethical principles and debate are usually assumed to be "uncontaminated by such contingencies as gender" (Crosthwaite, 1998, p. 32). This selective focus has narrowed the understanding of human nature and the scope of what constitutes a moral or ethical problem (Calhoun, 1988). The reliance of the principlist conception of autonomy on these ideologies may have resulted in the widely held and practiced belief that resolving ethical problems involves respecting autonomy, usually at the expense of other equally valuable considerations such as relatedness and interdependency (Ells, 2001). It is not hard to see how women have been ill served by the mainstream philosophical and ethical traditions. Of particular significance is that Western ethics has added, to the exclusion of women as moral agents, conditions for achieving agency – such as rationality and disembodied abstraction (Shildrick, 1997) - that are characteristically masculine. This neglect has attracted much criticism from feminist schools of thought, which are united by their aim to reveal how women have been excluded, neglected and maltreated by the theories and practices of the dominant, and frequently androcentric, Western tradition.

2.2.1 Feminist Theory

"…it is simply too unwieldy to try on every pair of feminist lenses available in an effort to try and get yet a better focus on a particular bioethical issue" (Tong, 1996, p. 74). The feminist approach adopted in this thesis, therefore, is an eclectic one, drawing on values, assumptions and methodologies that are associated with a wide variety of feminist theories rather than adhering exclusively to one particular position. What all of these approaches share is a concern with reassessing, reinterpreting and transforming many of the traditional Western principles in order to critically reflect women's as well as men's perspectives and experiences. This concern stems from one of the most significant aspects of feminist theory: the assertion that the social structures according to which we live are essentially male-centered, male-dominated and male-oriented, to the exclusion of female viewpoints and participation.

In contrast, feminism asserts that the perspective of women is valuable and in many ways distinct from the dominant male perspective. Feminist approaches to ethics thus seek to articulate moral critiques of actions and practices that perpetuate the subordination of women and other disempowered groups (Jagger, 1992; Tong, 1997). While traditional ethics takes abstract first principles as its starting point in ethical reflection, feminist ethics begin with women's experiences and move inductively from there to drawing conclusions and formulating guidance for ethical practice (Jakobsen, 1999). Feminist scholars thus present not only clarification of feminist goals and principles, but also work towards influencing predominantly androcentric research practices in the humanities and social sciences (Campbell & Wasco, 2000).

Feminist theory does not constitute one single perspective. Rather, the particularities and 'difference' with which the theory is concerned characterizes the theory itself: it embraces a variety of different disciplines, different political agendas, and different racial, cultural and gendered interpretations of experience.[3] Ontological and epistemological revision are central themes in all forms of feminist thought and action (Code, Mullett & Overall, 1988). Feminist bioethics also seeks to identify the implicit effects of gender inequalities and power imbalances in bioethical discourse and bioethical practices, bringing principles of autonomy and justice, and notions of obligation and responsibility, for example, under critical review (Little, 1999; Martin, 2001; Wolf, 1996). This includes advocating the formulation of more relational reconceptions of major ethical and bioethical ideals, concepts and principles that are cognizant and respectful of the experiences of women and others who have traditionally been excluded.[4] The value of this epistemological position is that it allows the conventional adherence to and practice of principled autonomy to be critically reviewed and contextualized from a distinctive perspective.

2.2.2 Feminist Critiques of Conventional Autonomy

Broadly speaking, feminist critiques of autonomy have been articulated in two different phases. Early feminist theorists, like their contemporary philosophers and ethicists, took up the concept of autonomy as a fundamental right to which all humans are entitled. Autonomy, these feminists argued, is an ideal that both men and women should have equal opportunity to realize. However,

[3] For a comprehensive overview of the varied feminist theories, ideologies, and epistemologies, see, for example, Brabeck and Ting (2000), Campbell and Wasco (2000), Code, Mullett and Overall (1988), Harrison (1985), Jagger (1988, 1992), Kourany (1998), and Tong (1989) for more thorough treatments of feminist theory, particularly as they pertain to philosophy.

[4] Reviews and summaries of distinctive feminist approaches to ethics and bioethics can be found in, for example, Cole and Coultrap-McQuin (1992), Donchin and Purdy (1999), Fricker and Hornsby (2000), Rawlinson (2001), Sherwin (1992a, 1996), Shildrick (1997), Tong (1997), and Wolf (1996).

feminists recognized that women were not in a position in society where they could claim their right to autonomy. These early critiques of autonomy thus argued for the total emancipation of women from economic, social, political and psychological subordination (see, for example, Hill, 1975). In a second phase of feminism during the 1980s and 1990s, however, feminists began to be concerned with the very ideal of autonomy as it was conceptualized in the philosophical mainstream (Friedman, 2000b), many arguing that it was fundamentally masculine. In challenging this gender bias, some feminists have explored how the ethical principles of mainstream ethics might attend to gender (Cook, 1994; Macklin, 1993). Others have gone further, investigating how these principles could be revised or reconceptualized to remove this gender bias and include the experiences of women (Held, 1998; Nedelsky, 1989; Okin, 1989; Young, 1990). Feminist bioethics thus poses a challenge to mainstream (Western) bioethics by exposing the masculine character of the generic subject it presupposes and of its supposedly gender-neutral subjects.

In the following sections, the feminist argument against conventional bioethics and principled autonomy will be discussed, highlighting in particular the shortcomings of the principlist approach with respect to gender, relationships and context. Using examples from biomedical ethics, feminist bioethicists attempt to show how principlism fails women by paying insufficient critical attention to the influence of patriarchal structures and power dynamics on its ontological and epistemological underpinnings.

2.2.2.1 Principled autonomy and (the neglect of) gender

There is considerable variation in how autonomy has been defined from study to study (Steinberg & Silverberg, 1986), which may account for the discrepancies in investigations into gender differences in autonomy. While some studies have suggested that men and women do not differ significantly in their experience of autonomy (Anderson, Worthington, Anderson & Jennings, 1994; McChrystal, 1994), others have found evidence in support of the theories that women value relatedness over autonomy (Jordan, 1984 in McChrystal, 1994; Surrey, 1991) and, as such, exhibit significant differences compared to men in terms of their experience of autonomy (Bekker, 1993; Miller, 1986, 1990). It has been argued that the duality in Western thought perpetuates the perceived differences between men and women, thereby downplaying differences within groups (beta bias) and overestimating differences between them (alpha bias) (Hare-Mustin & Marecek, 1986, 1987, 1988; Stewart & McDermott, 2004), which has led in turn to a number of studies which have focused on the diversity within groups (Ewing, 1990; Killen, 1997; Mines, 1988; Sinha & Tripathi, 1994; Turiel & Wainryb, 1994).

However, in response to findings that have found a greater desire for autonomy in women than in men (Fleming, 2005; Lamborn & Steinberg, 1993), feminists are among those who point to the role of context in determining these results. While some have suggested that the women's movement and changing gender roles in society have contributed to the greater value that women appear to place on autonomy (Anderson et al., 1994; Eagly & Mladinic, 1989; Eagly, Mladinic & Otto, 1991; Gerson, 2002; Labott, Martin, Eason & Berkey, 1991), others have argued that societal pressure places women in a conflicted position, forcing them to deny their gendered tendency toward relatedness by exhibiting greater levels of autonomy (Catina, Boyadjieva &

Bergner, 1996; Layton, 2004). This has generally been defined as a negative experience for women (Lamborn & Steinberg, 1993) and may account for other instances of psychological effects on women, such as the development of eating disorders (Mensinger, 2005; Steiner-Adair, 1990). It also draws attention to the importance of sociocultural context in shaping autonomy, which has been the focus of a number of studies (Catina et al., 1996; Collins, 1990; Henderson, 1997; Joseph, 1991; Ma & Schoeneman, 1997).

While bioethics has concentrated its focus on issues of patient and participant autonomy, and power imbalances between health professionals and their clients, researchers and their research participants, it has paid scant attention to the impact of gender on these issues (Crosthwaite, 1998). In addition, there is still a widely held belief that bioethics is cognizant of the gendered particularities of its subject matter and of its own theoretical underpinnings. Feminist charges against the concept of autonomy include arguments that

> it is inherently masculinist, that it is inextricably bound up with masculine character ideals, with assumptions about selfhood and agency that are metaphysically, epistemologically, and ethically problematic from a feminist perspective, and with political traditions that historically have been hostile to women's interests and freedom (Mackenzie & Stoljar, 2000, p. 3).

Donchin (2001) points out that the very valorization of autonomy as a norm in bioethics is problematic. Standard conceptions of autonomy in ethical approaches pit interpersonal connection against autonomy as mutually exclusive ways of relating which, combined with the contractarian model and focus on individual decision-making, presents images of "bleak dystopian scenarios" that block out alternative ways of reconciling theory and practice (Donchin, 2001, p. 375).

Shildrick (1997) has challenged the dominance of autonomy in bioethical theory and practice on the grounds that autonomy has been constructed as the exclusive privilege of a male subject. Friedman (1997) points to the role that popular culture and gender stereotyping have played in reinforcing the association of autonomy with men, rather than women. This, combined with the establishment of autonomy as an ethical ideal, implies that, compared to men, women are somehow deficient human beings. Others have also drawn attention to this pathologizing of women and minorities who do not match or aspire to the separation and independence of the idealized autonomous self (Fishbane, 2001). This "attenuation of the human in 'man' is a source of sickness, both cultural and individual" (Rawlinson, 2001, p. 405), such that the silence on gender in contemporary bioethics renders the 'other' gender – that is, women – invisible.

Wolf (1996) points out that many of the quandaries that bioethics confronts – from genetic screening and reproductive technologies to the HIV epidemic and allocation of health resources – have profound implications for women. And yet, bioethics has paid little attention to gender in its ethical considerations. Gender has also played a large but unexamined role in research settings, too, according to Wolf. In the selection of research subjects, for example, there has been little analysis of gender equity which, in turn, underplays the systematic exclusion of women – particularly women of childbearing age – from AIDS research protocols that may be the only means of access to a promising drug – not to mention the release of these drugs without adequate testing of safety and efficacy in women. Wolf also argued that bioethics tends to be a conversation among experts about patients' and research subjects' rights – conversations in which patients and research participants tend to be the objects of concern rather than full members of the ethical conversation.

Feminist ethics pay careful attention to context, to the social, to the unique particularities of individuals and of every moral problem, and to the power imbalances that are played out in bioethical theory and practice.

> It follows that one of its tasks is to challenge medicine's androcentrism – its standing assumption that men are the norm for human beings – and to call attention to the ways in which this assumption marks women as either unimportant or pathological (Lindemann Nelson, 2000, p. 493).

Little (1999) emphasizes the androcentrism inherent in society, and in theories and practices that grow out of this society, not least of which is bioethical theory – the effect is that what is presented as normal for all humans is actually the norm for a small, privileged group of men, when these are in fact gendered concepts. Rawlinson (2001, p. 45), too, contests the "masculine marking of its supposedly generic human subject" and shows how this has been harmful to women, rendering them invisible and silent. As a result of feminism's attention to gender, key concepts such as respect for autonomy are afforded richer understanding as their meaning is extended beyond models of values that are exclusive to a privileged group of men (Lindemann Nelson, 2000).

2.2.2.2 Principled autonomy and (the neglect of) context and relationships

Furthermore, in its attempt to find principles that can be universally applied so as to speak of and for everyone, bioethics has traditionally underplayed the significance of relationships and the importance of context. Some have argued that, as a result of this, bioethics ultimately speaks of no one, for a person sans gender, sans culture, sans context, does not exist (Wolf, 1999). This narrow, individualistic, abstract view of people is so entrenched in bioethics that how people are in reality – interconnected, interdependent and often unequal – may become obscured or

invisible in bioethical theory and practice. The frequent neglect of the contextual aspects of people's lives in principlist ethics has been attributed to the preconception that Western society is typically constituted by autonomous, self-interested individuals of equal standing (Ells, 2001). In so doing, bioethics tends to deny the relationships upon which we, as children and as adults, are profoundly dependent. This narrows the problem-solving focus to that which is rational, impartial, abstract and individualistic so that other moral and ethical problems – those to do with interconnectedness, intimacy, dependence – are peripheral or invisible to the scope of issues that bioethics seeks to resolve (Ells, 2001). This includes being blind to women's experiences. Feminist ethics, in contrast, recognizes that even such seemingly impregnable ideals as objectivity and autonomy are merely products of certain ways of seeing the world; in feminist thought, then, *re*-vision is a central theme (Code et al., 1988).

Donchin (1995) questions the assumption in principlist ethics that people are free to choose, and are thereby solely responsible for, their relationships and their actions. She argues that the central focus of principlist theory on voluntariness fails to recognize areas where responsibilities are shared, as well as the many factors that impede this voluntariness, to say nothing of situations where personal freedom to choose which relationships to belong to and which decisions to make is severely limited. Sherwin (1996) has also noted how the principled concept of autonomy has, in practice, often achieved effects contrary to its intended goal of guaranteeing freedom from oppression and exploitation, securing instead the powerful position of the privileged minority. Others have criticized the way in which conventional ethical principles are defined and interpreted, as well as the meaning and significance that is assigned to them, arguing that these are largely determined by a person's social and cultural context and may be influenced by effects

of power and oppression within these contexts (Hill, Glaser & Harden, 1995). Furthermore, the distance between researcher and research participant in current clinical research seems to reflect the androcentric philosophical tradition – a distance which may be more comfortable for men, who, it is claimed, value autonomy and independence, than for women, who value relationship and connection (Rosser, 1992).

Not only do currently applied bioethical guidelines in research tend to assign the ontological and epistemological status of relationships to the corner, they also try to factor out any of the interpersonal processes that might "interfere" with the ethical conduct of the research and with the decisions of individual research participants. The reality is somewhat different: people are in relationships in reality – they make their decisions not as isolated individuals existing in a vacuum. Personhood is most often defined and experienced relationally (Bakhurst & Sypnowich, 1995; Guisinger & Blatt, 1994; Mkhize, 2004; Tangwa, 2000) – gender, culture, context, are but a few of the factors that come into the decision making process. People involved in the research context are in relationship; research is enacted through relationships. Ethics exist because of relational contexts, and autonomy is developed and enacted within these contexts.

There is irony in a health care or biomedical ethic that is concerned with, among other things, "bodily matters," but that is curiously disembodied itself, "almost literally out of touch with lived experience" (Shildrick, 1997, p. 62). The disembodiment of Western bioethics is demonstrated, for example, in how pregnant women and their unborn children have typically been viewed as separate beings, with " a conception of the fetus as an isolated, separate individual …who just happens to be occupying space within the body of the childbearing woman" (Donchin, 2001, p.

371), revealing in this one instance, the tenacious effect of bioethical norms and practices that largely disregard individual particularities and the contexts in which these are situated. Therefore, it is argued that applications of these principles in obtaining informed consent from research participants in developing countries, whose freedom is frequently limited, is potentially disempowering and harmful. If we are indeed to return to "first principles," we should be asking not only what it means to *respect* a person, but what it means to *be* a person. This extends the principle of respect for persons to one that, in practice, truly respects research participants' real, lived experiences. In order to fully meet the ethical requirement of respect for all persons, researchers should be cognizant of the relationships and contexts of participants' lives and of the research process itself. This would entail recognizing the interpersonal nature of this process, acknowledging the relationships involved, and structuring it into consent and research procedures, rather than trying to deny or expunge its existence, or factor out its influence.

When confronted with dilemmas in dealing with pregnant women who use illicit drugs, reject medical recommendations or cause fetal harm, the approach that is frequently employed in principled ethics is a conflict-based model. In conflict-based models, maternal rights are pitted against fetal rights in such a way that moral or ethical obligations owed to the pregnant woman are considered to conflict with those owed to their fetus. Chervenak and McCullough (1985 in Harris, 2000) framed these moral obligations within Beauchamp and Childress's (2001) principle-based bioethical model, showing how principles of autonomy and beneficence are seen to conflict in the consideration of ethical dilemmas in pregnancy. Harris (2000) highlights the pitfalls of conflict-based models that view autonomy and beneficence as the primary factors. She argues that traditional ethical approaches to these dilemmas tend to neglect gender-specific

modes of moral reasoning, and are based on the implicit assumption that application of universal principles of autonomy and beneficence results in objective ethical solutions. The limitation of principle-based bioethics in this instance is that its impartialist, universal approach makes it a clumsy tool for illuminating the moral counters of intimate relationships (Harris, 2000).

Furthermore, principle-based ethics tends to neglect the broader social and political context in which ethical dilemmas are negotiated. By focusing on the mutually exclusive needs of pregnant women and their fetuses, rather than on their mutual needs, traditional conflict-based models fail to account for the ways that protecting fetal needs perpetuates social inequalities (Harris, 2000). In contrast, Harris proposes an alternative, relational model of pregnancy ethics that is cognizant of gender and the rights of both mother and fetus, thereby broadening the set of issues considered morally relevant to prenatal fetal harm.

> All things being equal, appealing to universal principles like autonomy and beneficence to sort out ethical dilemmas might result in objective solutions. However, as things are not always equal, other substantive issues must be considered (Harris, 2000, p. 790).

This is particularly relevant when applying Western bioethical principles in the developing world, where implementation of the principle of autonomy – in this case, treating the fetus as a separate entity to its mother - is likely to be in conflict with a communitarian perception of the individual (Van Bogaert, 2006).

Similarly, in ethical dilemmas faced posed by the abortion debate, traditional ethical approaches tend to focus almost all of their attention on the moral status of the fetus, neglecting the fact that the most significant moral feature of pregnancy is that it takes place in a woman's body, having a profound effect on a woman's life (Gibson, 2004). The Kantian focus on the moral significance

of the individual that is typical of principlist ethics obscures the significance of personal and social relationships and, as such, frames the ethics of the abortion decision in abstract, generalized terms. In contrast, Gibson (2004) argues that a fetus exists only in relationship with a particular other on whom it is entirely dependent for support; thus, the fetus is morally significant precisely because of that relationship, since it is out of relationships that our moral obligations arise. Based on this, Gibson (2004) reframes the abortion decision within a feminist model which shifts the focus onto the woman on whom the decision rests, while still recognizing the ontological and moral significance of the fetus by virtue of the relational ties between mother and unborn child.

Another instance where respect for autonomy overlooks women is provided by Goldberg's (2003) discussion of this principle as it is applied in the perinatal relationship with birthing women. While acknowledging that autonomy plays a crucial role in the protection of the agency of birthing women in hospital settings, Goldberg argues that conventional understandings of autonomy, divorced as they are from relationships, do little to support the birthing woman's intuitive knowledge of her own body. By removing considerations of autonomy and informed consent from considerations of context, traditional ethical approaches do not acknowledge how a woman's choices are often constrained within an oppressive patriarchal framework. Such a framework, according to Goldberg (2003), disregards essential differences, and positions women – and birthing women in particular – as epistemologically absent insofar as she is capable of enacting her own agency. Because standard concepts of autonomy seem to suggest that decision making occurs in isolation of the relationships in which women are embedded, Goldberg

contends that they offer an impoverished view of the unique experience of women with respect to their physical and emotional realities.

Current feminist accounts of autonomy are relational or contextually embedded. These show how subordination constrains autonomy (Babbitt, 1993; Benhabib, 1995; Meyers, 1989); highlight the role of emotions in autonomous lives (Meyers, 1989; Nedelsky, 1989; Weir, 1995); view autonomy as an ongoing and improvisational process (Meyers, 1989, 2000b) and note how autonomy may be exercised in certain contexts yet deactivated in others (Friedman 1993; Meyers 1989). From a feminist perspective, women's selfhood and agency can only be legally and socially affirmed if social policies are put in place that change those patriarchal structures that relentlessly undermine women's autonomy (Meyers, 2000a).

2.2.2.3 Principled autonomy, patriarchy and power

There is much support for refocusing thinking about autonomy: it shifts the emphasis "from independent self-determination towards ideals of integrity within relatedness" (Crosthwaite, 1998, p. 37); it changes the goal from removing coercive influences to enabling positive empowerment (Crosthwaite, 1998); it channels the individualistic emphasis in bioethics into an enlightened and compassionate consciousness of people's sense of interdependence and community (Heard, 1990). Parker (2001) goes further than simply re-focusing, by rejecting both the liberal individual moral subject, *and* the communitarian embedded moral subject, in favour of a deliberative moral subject and arguing that it is the combination of the individual and the social that makes a coherent approach to the ethical possible. The integration of relatedness into current theories of autonomy has potential value for both men and women, as shown by studies

that have found that men, as well as women, seek and value interpersonal connectedness, but men's interdependence is oriented towards larger social groups while women focus on one-one relationships (Baumeister & Sommer, 1997; Gabriel & Gardner, 1999). Baumeister and Sommer (1997) suggest that men's desire for power is not simply a way of gaining independence, but that men seek out power because power ties them to the person over whom power is held, thereby enabling a certain form of interdependence in relationship. Conversely, while women generally possess limited power, they do have access to the forms of power that are embedded in and sustained by their engagement in relationships (Carli, 1999).

Feminists have also drawn attention to the potentially oppressive nature of intimate relationships, by considering identifying how these relationships may both facilitate and threaten the development and experience of autonomy. Based on the influence that power and relational inequalities can have on individual autonomy, Warren (2001) recommends an alternative conceptualization of autonomy that is based on politically charged notions of empowerment. She argues that autonomy is a metaphor of power and expands on this metaphor to show how the personal and the political intertwine in applications of autonomy in clinical and research contexts, and how this can *em*power or *dis*empower individuals within these contexts. "Empowerment asks bigger questions of the whole health delivery system than does standard autonomy. The empowerment model makes it easier to consider the broader social, historical, and political context, and to search out underlying values and interests" (Warren, 2001, p. 52). Revisions of the principle of autonomy that emphasize empowerment in this way are particularly valuable in extending ethical applications of clinical research by Western institutions to developing countries, where the operation of power inequalities, both in the researcher-research

participant relationship and in the relationships in which many women in these contexts are subordinated, cannot and should not be ignored. Including a discourse of empowerment in applications of relational notions of autonomy in research ethics would also involve being mindful of the broader political, social, and cultural contexts where the research is to take place and identifying the values and interests of all concerned.

For example, in the case of abortion, conventional ethics attempts to formulate a general abstract rule about the relative importance of preserving life or protecting autonomy (Sherwin, 1992a). Whereas conventional approaches to medical ethics tend to view abortion as a moral problem, feminist ethics addresses the contextual influence of a society afflicted with patriarchal dominance relations, and views abortion as a choice embedded within women's lives. The feminist analysis thus links women's freedom from coercion over pregnancy to other aspects of women's relative power in society, positioning abortion within a socio-historical context that is sensitive to the face that male-dominated institutions have historically sought to manipulate women's sexual and reproductive lives (Sherwin, 1992a). Others have shown how, in end-of-life dilemmas, too, employing a principlist ethic could serve to reinforce the status quo of patriarchal power. Focusing particularly on the principle of autonomy, McGrath (1998) highlights the limits and superficiality of the abstract, rationalistic mode of reflection in principlist bioethics, arguing that this abstraction avoids or suppresses the evidence of how power and control are an important characteristic of biomedical discourse.

Nedelsky (1989) also acknowledges the inexorable influence of relationships of power on individual autonomy and shows how this tension between autonomy and collectivity can be

reconciled in a relational and more context-embedded conception of autonomy. Similarly, Sherwin (1998b) distinguishes between the making of informed choices – agency – and being truly free from coercion in both the choices that are made and in the circumstances that structure that choice – autonomy. She proposes a relational reconceptualization of conventional notions of autonomy that can sufficiently absorb the complexity of making apparently un-coerced choices within a broader context of oppression. Towards this end, Macklin (1999 in Noring, 1999) proposes a relationships paradigm in ethics which is context-based, taking into account culture and gender, time and place, and emphasizing power, responsibilities, and historical considerations. These alternatives offer particularly significant issues for consideration with respect to this study's contextual focus on research settings in developing countries.

2.2.2.4 Autonomy in context

Given the role of context discussed above, it is likely that the experience of autonomy in developing country contexts may be fundamentally different from autonomy as it has been traditionally conceived in Westernized countries. Studies that support this have found that cultural discrepancies exist between systems of meaning in Western and non-Western contexts (Neff, 2001; Wainryb & Turiel, 1994). Others have shown that men and women in a range of societal contexts exhibit variable degrees of both autonomy and relatedness and, frequently, experience these in combination (Pearson et al., 1998; Turiel, 1998a, 1998b; Turiel & Wainryb, 1994). Such studies highlight the important role that autonomy plays when conducting research in developed and developing world contexts, while simultaneously highlighting the necessity for a similar focus on relatedness.

In recent debates on the ethical requirements for conducting research in developing countries, the relationship between researchers and research participants is attracting greater attention. Benatar (2002) calls on researchers to recognize that they are, in most instances, from relatively privileged backgrounds, while many research participants are among the poorest, most exploited, and oppressed populations. Following this, Benatar highlights the need to be sensitive to the fact that those who are disadvantaged or vulnerable are unlikely to view the world through the same lenses as researchers from first world, developed countries or to have had experiences that are even remotely synonymous with Westernized notions or ideals. Autonomy-based theories tend to ignore the fact that people are essentially products of their social history and current environments. Such ontological neglect has the effect of protecting the privileges of powerful groups, and *dis*empowering those who are exploited and oppressed (Sherwin, 1996).

Women may place higher value than men on the centrality of relationships in their lives. It is likely, too, that they also participate differently in those relationships. While men develop power-over and distance-between qualities of relationships, women work on promoting the values of care and mutual responsiveness within relationships (Friedman, 1998). The contrast between conventional notions of autonomy and feminist alternatives is clearly portrayed in the debate that was sparked by the announcement by a transplant team at the University of Chicago of its plans to transplant a hepatic lobe from a mother to her severely ill infant daughter. One opponent of the "unethical" procedure expressed his reservations by arguing that, "simply put, how can a parent be expected to make an informed, rational, free choice when asked to consider donating an organ to his or her dying child?" (Colen, 1989 in Elliott 1999, p. 106). The reasoning behind this and other reservations was that the mother's emotional ties and moral commitment to her daughter

essentially made her decision "involuntary" and not truly autonomous. Feminist critics of principled autonomy would argue, along with Elliott, that

> it is an odd notion of autonomy which would count emotional ties and moral commitments as constraints on autonomy. The idea that a parent is *coerced* by her love for and moral obligations toward her child says something about the central place the ethic of autonomy (and the individualism that underscores that) holds in our culture (Elliott, 1999, p. 106).

In health care contexts, Dodds (2000) also shows how autonomy is frequently equated with informed consent and a person's exercise of "autonomy" is limited to choosing between the options with which she or he is presented. Similarly, Donchin (2000a) illustrates how, when the dominant, individualistic conception of autonomy is applied to ambiguous ethical cases such as physician-assisted suicide, it fails to reveal workable perspectives; perspectives that may only become clear when viewed through the lens of more relational conceptions of autonomy. Adshead (2001) provides further grounds for revising traditional views of autonomy to account for the dependency that is part of the lives of men and women alike. Conceiving of autonomy as embedded in the gaps and connections between people in their relationships, Adshead argues, is consistent with "notions of best psychological health, where mutual interdependence is seen as being a goal of mature development, and detached isolation in terms of self, is seen as being potentially pathological" (Adshead, 2001, p. 143). The individualism inherent in conventional conceptions of autonomy has also been criticized for the increasing alienation in contemporary society, where individualism and egoism is replacing the sense of community and solidarity (Ter Meulen, 2001).

Many have argued that the social is essential for the realization of autonomy. Dworkin (1988) developed an account of autonomy with explicit attention to the values of human connection; Feinberg's (1989) emphasis was on autonomy as self-legislation, self-reliance, self-possession, and yet still recognized that to be human is to be part of a community, where self-awareness comes from participating in existing social processes. However, these and other mainstream accounts of autonomy, while not entirely individualistic, are not considered sufficiently relational because they tend to regard social relationships as pre-requisites for, rather than an inherent part of, autonomy (Friedman, 1997). Accounts of autonomy should be cognizant of people's dependency, of their embeddedness in relationships, and of the relevance of both to ethical decision-making (Adshead, 2001).

Thus, feminism is not alone in its rejection of liberal individualism and of the prevailing conception of autonomy that stands at the core of this theory (Fox & Swazey, 1984; Wolf, 1996). The contribution that a feminist approach to (bio)ethics can make is a revision of theory and practice that will effectively reflect the social and the individual nature of human beings (Donchin & Purdy, 1999; Fishbane, 2001; Fricker & Hornsby 2000). One of the main charges that the feminist critique has directed at traditional interpretations of autonomy is that the notion of the self on which these interpretations are based is unacceptably individualistic. (See, for example, Code, 1991; Benhabib, 1992; Friedman, 2000b; Keller, 1985; Nedelsky, 1989; Sherwin, 1992b). In formulating relational accounts of autonomy, therefore, feminists need to begin by building new models of selfhood in order to avoid the shortcomings of traditional approaches (Code et al., 1988; Cooke, 1999). To be an autonomous self, indeed, to "*determine* itself, a being must, at the very least, *be* a self" (Friedman, 2000b, p. 219). Herein lies the

apparent contradiction in feminist theory: the demand for respect for women's individual selfhood, and the rejection of assumptions about individual rights that suppress women's experiences and negate this respect (Nedelsky, 1989).

Based on the critique above, it is evident that some of the criticisms leveled against mainstream autonomy have to do with the masculine and individualistic bias in ethics in general and in the self conceptualizations that underlie autonomy in particular. Feminists have argued above that women value the connectedness to others that is neglected in the principle of autonomy as it is conceived and applied in bioethical practice. In the next section, the androcentric and individualistic bias in contemporary ethics will be highlighted. The ethic of justice will be presented as a model of this individualistic ethics, and then contrasted with an ethic that emphasizes relatedness. Care ethics is an alternative that has been developed in conjunction with feminist calls for a more relational autonomy that is closer, they argue, to women's experiences. Care ethics has been put forward to counter the dominance of principles of rights, rationality and duty in the justice ethic that governs much of the guidance on resolving ethical dilemmas in, for example, human subjects research. The ethics of care will be described in more detail in the next section, and contrasted with the ethics of justice that has tended to dominate mainstream, male-oriented bioethics. More specifically, the development of the moral orientations – justice and care - that form the foundations of these ethical approaches will be explored.

2.3 Justice versus Care: An Ethic of Individualism versus an Ethic of Connectedness, Men versus Women?

> *(If bioethics) is an indicator of the general state of American ideas, values, and beliefs, of our collective self-knowledge, and of our understanding of other societies and cultures, then there is every reason to be worried about who we are, what we have become, what we know, and where we are going in a greatly changed society and world..*
>
> (Fox & Swazey, 1984, p. 360).

2.3.1 The Problem with Conventional Ethics: Individualism and Androcentrism

The critique in the preceding section drew attention to the masculine nature of philosophical theories and ethical principles – the androcentric nature of contemporary bioethics. The dominance of the male in bioethics led to a focus on all that is individual – the individual, detached, rational male subject. Bioethics has a distinctly masculine nature and, as a result, its theories and practices have come to be largely dominated by individualism. The unconscious individualism of Western, American bioethics is further critiqued in the first part of this section. The culmination of this individualistic, androcentric focus can be clearly seen in the ethic of justice – a typically masculine type of ethic in its focus on individual rights, duties and responsibilities. Gilligan and many following her have found fault with this one-sided view and proposed alternative theories of morality and ethical decision making – an ethic of care. In the second part of this section, the ethic of justice will be contrasted with the ethic of care as further demonstration of the potential pitfalls of an ethic that centres solely on conventional principles of (individualistic) autonomy.

Bioethics is more than the sum of its collective medical and scientific parts; it uses biology and medicine as its metaphorical language and symbolic medium to deal with the beliefs, values, and norms that are basic to our society, its cultural tradition, and its collective conscience (Fox & Swazey, 1984). Bioethics is a microcosm of ideological cross-currents within contemporary Western liberalist society (Jennings, 1998). As such, the values of individualism that Western society has consistently revered – individual rights, autonomy, self-determination and contractual relations - have also been accorded paramount status in the theories and practices of bioethics. The importance that bioethics has placed on individualism has drawn it away from involvement in social problems, as the more socially-oriented values and ethical questions have generally been relegated to the perimeter of the bioethical framework (Fox, 1990). Rather than recognizing how social and cultural forces shape individuals from the inside and outside, bioethics tends to view these factors as external constraints that limit individuals and interfere with ethical deliberation. It was from this culture of liberal individualism that the principle of autonomy emerged, built on the atomistic conception of the self that Western individualism underscores. Many have criticized the excessive focus in bioethics on individualism (Callahan, 1980, 1984; Sullivan, 1982), while others have shown how the dominance of individualism has led to a preoccupation with autonomy in contemporary bioethics (Hoffmaster, 1992) – the "triumph of autonomy" (Wolpe, 1998, p. 48). Because the principle of autonomy is tied to its foundations in liberal philosophy, challenges to the current conception of autonomy constitute a challenge to the assumptions of individualism that define Western society (Graham, 2002).

Many have challenged the universal application of bioethical principles that are based as they are in a liberal individualist framework (Gordon & Paci, 1997; Jennings, 1998; Kuczewski & McCruden, 2001). "The centrality of autonomy in bioethics is a reflection of the importance modern (Western) civilization has placed on the individual" (Dyer, 1997, p.172). As a result of its liberalist, individualistic underpinnings, Western philosophy has evolved into a culture preoccupied with the self – a self that is disembodied and disembedded and essentially reflects only aspects of the male experience (Benhabib, 1992; Cook, 1999; Schoeneman, 1994). Dyer (1997) argues that the bioethical principles of autonomy, beneficence, nonmaleficence and justice are grounded in assumptions about the relationship of members of society to one another. Not only is the concept of autonomy inherently masculine it is also, by its association with individualism, inherently Western and a minority paradigm in relation to other societies and cultures throughout the world (Elliott, 2001). Similar concerns have been raised about informed consent, where respect for autonomy dominates, leading many to question the applicability of informed consent in societies that tend to emphasize relatedness rather than individualism (Alora & Lumitao, 2001; Benatar, 2002; Christakis, 1992; Dooley, 2001; Gasa, 1999; Tauber, 2003). Even in the West, there is no consensus on ethical principles (Snell, 2000), with arguments that the liberalism on which bioethics is based attempts to extend itself beyond reasonable limits and yet cannot accommodate conflicting interests (Schneider, 1998). And yet, "while there is some evidence emerging in the literature that a preoccupation with individualism, premised on the notion of a unique selfhood, is problematic, it remains, regrettably, at a superficial level" (Cook, 1999, p. 1295).

The almost exclusive focus on individualistic principles in contemporary Western bioethics has neglected what many believe to be central to ethical conduct – relationships between individuals. The space that relationships are given in bioethics is primarily contractual. In reconceiving the principle of autonomy, the emphasis in autonomy should be shifted away from individuality and towards the social and relational nature of individuals, where the role of context is given sufficient attention (Ter Meulen, 2001). Support for this view has arisen from concerns about the deficiency of applications of autonomy in the contexts of, for example, advance care planning (Ikonomidis & Singer, 1999) and clinical rehabilitation (Jennings, 1993). Operating in an era of scarce resources, rehabilitation's social and professional goals are ill-served by unrealistic and inappropriate notions of autonomy and independence, which produce conflict and frustration rather than the empowerment and respect that are necessary for transformative healing (Jennings, 1993). In many of these cases, bioethics has been criticized for failing to address the gap between theory and practice. In reality, morality and ethics exist in the intersubjective relations between people, where community meets individual and where it is possible to capture "both the value of communal life and the moral significance of the individual ethical voice" (Parker, 2001, p. 308). Furthermore, despite the predominantly communal values held by traditional African and South African communities, Western, individualistic principles seem to be permeating these societies, as is especially evident in the way that research is being conducted in these communities. Applying universal ethical guidelines and failing to recognize the importance of community may represent serious problems for the type of research increasingly being conducted in these contexts (cf., Crawley & Himmich, 2004; Diallo et al., 2005; IJsselmuiden & Faden, 1992; Itzhaky & York, 2000; McCullough, 2002; Molyneux, Peshu & Marsh, 2005; Molyneux, Wassenaar, Peshu & Marsh, 2005; Mosavel, Simon, van Stade & Buchbinder, 2005; Quinn,

2004; Torres, 2000; Weijer & Emanuel, 2000; Weijer, 2002) – particularly regarding ethical concerns central to HIV vaccine trials in the African context, where *ubuntu* may represent the only appropriate response to the pandemic and the only hope of conducting ethical clinical trials.

Among the arguments against traditionally individualistic bioethics have been those that question the abstract, detached notion of the autonomous self – an ideal that privileges and universalizes that which is male, and removes the relational feminine self and qualities from the public ethical domain. As a result, bioethics has been criticized for its lack of attention to the role of situated context, of culture, of human emotions, of relationship, and of suffering, vulnerability, weakness, and compassion (Benhabib, 1992; Fry & Johnstone, 1994; Gaylin & Jennings, 2003; Thomasma, 1997). This tendency in bioethics to presume gender- and cultural-neutrality may be the basis of the rigid and arbitrary dichotomizing of the public and the private, reason and emotion, self and other, mind and body, culture and nature, the abstract and the concrete (Harding, 1987c). Most of what Western philosophy teaches and practices is "significantly flawed…and overwhelmingly male-dominated" and is especially harmful to women (Kourany, 1998, p. 3). The pervasiveness of this ethical androcentrism in practice is evident in, for example, societal notions that doctors - men - cure and nurses – women – care, which has historically perpetuated the perception that males practice medicine while females are assigned to the more feminine healing roles (Jecker & Self, 1991), although this is no longer necessarily universally the case.

Masculinist approaches in ethics are widely applied, despite arguments indicating how this ethic is harmful in many situations where appropriate ethical recourse is already a contested area. Parks (1999) shows how ethical androcentrism is manifest in traditional bioethics by considering

the case of maternal substance addiction to show how this ethic negatively affects the treatment of pregnant addicts. Situations such as this, when framed in a principlist framework, are treated as maternal-fetal conflicts. The mother and the unborn child are viewed as separate entities with conflicting rights and, in the case of maternal substance abuse, the rights of the fetus are given precedence over moral obligations owed to the pregnant woman. Feminist ethicists argue that a perinatal ethic based in general principles like autonomy and beneficence does not take gender into account, nor does it address the unique position of pregnant women (Harris, 2000), let alone pregnant addicts. Mahowald (1994) argues that unconscious application of allegedly gender-neutral ethics amounts, in many circumstances, to gender injustice. Because justice or equality is often construed as an ethical demand to treat all individuals in the same way, women are traditionally treated no differently from men in areas where it is clearly neither possible nor ethical to do so. In reproductive genetics, infertility treatment, prenatal testing, and pregnancy termination, both male and female partners are considered essential to the reproductive process and, thus, modalities of testing, consenting, and counselling are discussed in the context of couples, despite the fact that none of these procedures requires participation or risk by the male partner (Mahowald, 1994). Women's reasons for making these decisions

> tend to be based on the complex set of caring relationships that each women bears to others…Gender justice, implemented through support for the autonomy of those most affected by reproductive decisions, is a means, perhaps even an indispensable means, through which to realize an ethic based on caring (Mahowald, 1994, p. 74).

2.3.2 Justice versus Care Perspectives: Men (Kohlberg) versus Women (Gilligan)

2.3.2.1 An ethic of justice: Critique

The ethical androcentrism that dominates the bioethical field is mirrored by the universal application of predominantly masculine models of ethics. The ethic of justice that is conventionally and universally applied in bioethics is based on a primarily masculine model of human moral development, which has justice as its ultimate goal. Traditionally, theories of human development have focused on male development, with the result that theories of female development are constructed as deviations from the norm (Yacker & Weinberg, 1990). Kohlberg (1969, 1976, 1981, 1984) used data from the analysis of responses given by men to hypothetical moral dilemmas to develop a six-stage model of moral development, based on Piaget's (1932, 1965) theories of cognitive and moral development. According to Kohlberg's theory, individuals proceed through three progressive levels of moral development – pre-conventional, conventional, and post-conventional - with each level consisting of two stages. The highest level of moral functioning requires individuals to have developed the capacity for principle-based, utilitarian reasoning, with decisions at the final stage based on universal principles of justice, individual liberty and equality (Gump, Baker & Roll, 2000). Thus, Kohlberg's morality emphasizes autonomy, rules, and the equal distribution of rights and justice (Dierckx de Casterle, Roelens & Gastmans, 1998), and it assumes that this model is applicable universally, across gender and culture. And yet, Kohlberg developed his theory from research conducted exclusively on men and, in one of his subsequent studies, reported that most males reach a higher level of moral reasoning, while females tend to function at the lower stages at the conventional level (Kohlberg & Kramer, 1969 in Bukatko & Daehler, 1995).

Following Kohlberg's studies, many have pointed to his theory's neglect of "an entire domain of human activity, namely nurture, reproduction, love" (Benhabib, 1987, p. 160) and other human emotions, thereby excluding the perspective of care and failing to "give moral credit to or even to address many of the concerns that have historically been associated with women's experience" (Sharpe, 1992, p. 296). The only type of person that Kohlberg's model makes space for is one that has been detached from its context, rationalized, impartialized, abstracted, publicized, and reduced to its moral essence of autonomous justice. Based on this model, the criteria for autonomy in traditional ethical theories is the use of reason in an impersonal and impartial process to discern which principles should be followed. This ethic of strangers appears to give little or no weight to the importance of relationships or to the unique particularities involved in the current deliberative situation – the goal for ethical decision makers is, essentially, self-governance, and the goal of ethical decisions is justice (Fry & Johnstone, 1994). Consideration of the interpersonal consequences of ethical decisions, according to this approach, indicates a lower level of moral reasoning and thus penalizes those who focus on these interpersonal ramifications (Gump et al., 2000).

There are other crucial aspects that an ethic based on Kohlberg's theory neglects: its focus on cognition and rationality largely ignores the influence of both social and emotional experiences; its focus on justice implies that those qualities associated with caring, responsibility and empathy are antithetical to this ethic (Beauchamp & Childress, 2001; Dierckx de Casterle et al., 1998). And yet, justice is itself a "gendered concept (and) to imagine that (ethics) requires us to devise principles of justice is already to accept a male perspective (because)…men, much more than

women, value abstraction and separation" (Wolff, 1996, p. 212), as well as justice. Contemporary ethical theory may identify the basic general principles of ethical conduct, but it is only through human relationship that the individual particulars can become known (Woodward, 1998) and it is arguably only by responding to these particularities that conduct becomes truly ethical.

Feminists are among those levelling attacks against not only the prevailing ethic of justice, but against the individualism that lies at the heart of Western liberal society. The Western view that individuals are essentially autonomous and separate, existing ontologically, epistemologically, and morally prior to the collectivity may be true for men but it is not necessarily true for women (Baynes, 1990; Doppelt, 1990; Fox-Genovese, 1991). Incidentally, there is evidence to suggest that Kohlberg's justice perspective may not be relevant across all cultures, and in South Africa in particular. Ferns and Thom (2001) found that significant cultural differences exist in the stages of moral development of Black and White South African adolescents: like the women in Kohlberg's (1976) study, the majority of Black South African adolescents in Fern and Thom's study only reached stage four of moral development, which may be the result of the emphasis in their cultures' on interdependence and communality rather than the individualistic of independence and self-actualization valued in the West. Notably, too, Kohlberg's model on which justice ethics is founded has been criticized as inappropriate for application in non-Western societies.

As opposed to the maintenance of justice and individual rights that is emphasized in Western morality, moral processes from the African viewpoint are primarily concerned with the

maintenance of social unity and harmonious relationships (Mkhize, 2004; Verhoef & Michel, 1997). This implies that not only are the gender differences in moral orientation consistent across cultures (Stimpson, Jensen & Neff, 2001), but that these differences may be paralleled by similar differences between Western and non-Western cultures. However, studies in some South African cultures have found that these gender differences may not extend across all cultures due to different socialization practices (Maqsud, 1998) or to the social injustices experienced by minority groups – such as women and Black people - that have resulted in a greater concern with justice and rights (Gilligan & Attanucci, 1988; Knox, Fagley & Miller, 2004).

> If persons are regarded as atomistic, certain defensive notions of individualistic, rights-based autonomy prevail; if a relational construction of personal identity is employed instead, then respect for autonomy becomes part of a wider morality of relationship and care. By reconfiguring trust within this latter understanding of personhood, bioethics better balances its concerns over choices and actions with those of relationship and responsibility (Tauber, 2003, p. 484).

Tauber goes on to offer a trust-focused philosophical approach to harmonize the conflict between patient autonomy and physician beneficence. He argues that emphasizing the relational nature of autonomy offers a corrective to excessive individualism's neglect of the social conditions necessary for self-determination. The ethic of care, by focusing on moral knowledge as the product of the mutual interdependence between individuals, may present what is needed to correct this severely atomistic orientation.

Furthermore, the emphasis on moral obligations and contracts in the justice approach has also been criticized for assuming that the participants in contractual relationships as they are depicted in health care ethics are relatively equal in power and capacity (Peter & Morgan, 2001) – based, once again, on a limited view of personhood, and of the relationships and contexts that

individuals occupy. The values of justice and autonomy that are presupposed in current theories of moral development, of the self, and of ethical deliberation continue to imply that individuals are separate and relationships hierarchical and contractual. In contrast, the values of care and connection, salient in women's experience, present a view of the self as interdependent with others, and of relationships as networks of affiliation (Gilligan, 1986). It is this ethic of care that is described in the following section.

2.3.2.2 An ethic of care

In 1982, Gilligan – a student of Kohlberg's – contested his theory of moral development, arguing that it was a model based on and applicable to men, at the expense of women and their experiences. Using women as her subjects, Gilligan used qualitative interview schedules to conduct her own research on moral orientation and decision-making strategies, and found that women proceed through different stages of moral development than those proposed by Kohlberg. Beginning with the level of individual survival, Gilligan's stages advance through selfishness to responsibility to self-sacrifice and, finally, to a morality of non-violence, where the conflict between selfishness and responsibility to self is resolved (Brabeck, 1993). In contrast to Kohlberg's ethic of justice, then, Gilligan's model is based on an ethic of care, where the emphasis on rights and personal autonomy that is emphasized in contemporary ethical theory is superceded by the contextual nature of relationships and the maintenance of care and connection within those relationships (Yacker & Weinberg, 1990). Tronto's (2005) four ethical elements of care – attentiveness, responsibility, competence, and responsiveness – highlight the universal and the particular nature of responsible caring.

> On the one hand, it requires a determination of what caring responsibilities are in general. On the other hand, it requires a focus upon the particular kinds of responsibilities and

> burdens that we might assume because of who, and where, we are situated (Tronto, 2005, p. 256).

See Table 2.1 on page 73 for a comparison of the justice and care theories.

An ethic of care thus views individuals as part of a matrix of interdependent relationships that affects how decisions are made, thereby introducing important dimensions into ethical discourse and into conceptions of principled autonomy. The rehabilitation of the feminist ethic of care is an important step towards constructing a conception of autonomy that is compatible with a relational, care-based ethical theory, and realistically acknowledging the full extent of the mutual interdependence of human beings (Carse & Lindemann Nelson, 1996; Kasprisin, 1996). Because the ethic of care regards relationships as primary, this perspective allows for unequal and unchosen relationships to be accorded moral significance and given due consideration which, in turn, re-defines moral failure as disengagement, indifference, and detachment from self and others (Sharpe, 1992).

However, the idea of self-governance has not been deserted in the ethic of care and its emphasis on relational accounts of autonomy. Rather, it is the excessively individualistic account of human nature that lies at the heart of care ethicists' critiques. The emphasis on the relational nature of the moral agent in care ethics acknowledges the importance of relationships in the development of autonomy. Verkerk (1999) defines care as an ongoing process involving four interconnected phases – caring about, taking care of, care-giving, and care-receiving – which require such ethical elements as responsiveness, attentiveness, responsibility, and competence. Verkerk's account of care highlights both the relational nature of moral autonomy, and the necessity of relationship in achieving autonomy. It also suggests that, in practice, an ethic of care requires

Table 2.1

Comparison of Gilligan's Morality of Care and Responsibility and Kohlberg's Morality of Justice

	Morality of Care & Responsibility – Gilligan	Morality of Justice - Kohlberg
Primary Moral Imperative	Nonviolence/ Care	Justice
Components of Morality	Relationships Responsibility for self & others Care Harmony Compassion	Sanctity of Individual Rights of self & others Reciprocity Respect Rules / Legalities
Nature of Moral Dilemmas	Threats to harmony & relationships	Conflicting rights
Determinants of Moral Orientations	Relationships	Principles
Cognitive Processes for Resolving Dilemmas	Inductive thinking	Formal / Logical-deductive thinking
View of Self as Moral Agent	Connected, attached	Separate, individual
Role of Affect	Motivates care, compassion	Not a component
Philosophical Orientation	Phenomenological (contextual relativism)	Rational (universal principle of justice)
Stages	I. Individual Survival II. From Selfishness to Responsibility III. Self Sacrifice and Social Conformity IV. From Goodness to Truth V. Morality of Nonviolence (goal: care)	I. Punishment & Obedience II. Instrumental Exchange III. Interpersonal Conformity IV. Social System & Conscience V. Prior Rights & Social Contract VI. Universal Ethical Principles (goal: justice)

(Brabeck, 1993, p. 37).

more than simply not interfering – the fundamental particularity and interdependence of individuals is central to the care approach, while respecting autonomy involves compassionate interference, and trying to see the world from others' points of views. Respect for autonomy, in this sense, requires "not so much refraining from interference as recognizing our power to make and unmake each other as persons and exercising this power wisely and carefully" (Dillon, 1992, p. 116).

Gilligan's psychological account, paralleled by Baier's (1985, 2005) philosophical account, saw the beginning of powerful critiques of the nearly exclusive focus on justice, abstract rationality, rights, and individual autonomy in traditional ethical theories. Recognizing the masculine bias of contemporary approaches, feminists have articulated an alternative focus on an ethic of care (Cole & Coultrap-McQuin, 1992; Held, 1995a). Mullett (1988), for example, presents the care approach and counters some of the criticisms against this approach, offering positive solutions, as well as examples of positive caring in oppressive contexts. Women's ethical decision making processes involve focusing their attention on what the current situation requires of them, what the nature of the relationship is with those about and with whom the decisions are to be made, and how to maintain the integrity themselves and of the network of relationships in which they are involved (Hepburn, 1994). This is clearly somewhat different from the abstract, impartial and rational subject presented by the ethic of justice, in which the traits historically valued by women were - inevitably - considered inferior.

Whereas from the justice perspective the self stands as the figure of moral agency against a ground of social relationships, in the care perspective, relationships become the figure which

defines self and others – a shift in moral perspective that is reflected in the change in moral questioning from "What is just?" to "How to respond?" (Gilligan, 1987, p. 23). Gilligan's work thus gave empirical weight to the growing conviction that women are more relational than men and men more individualistic than women, and that women's identities are inextricably tied to the interdependencies between people (Friedman, 2000a). A central argument in this study is that relationships constitute the arena in which research, and specifically informed consent procedures, are carried out. Thus, the questions investigated here - of how men and women experience themselves and how they experience relationships as a result of these identities - cannot be separated from the question of how research should be conducted to ensure that the dignity of each research participant is truly respected.

The justice perspective is characterized by equality versus inequality, where morality involves the fair and dutiful mediation of conflicting claims between people and adherence to standards and principles. The care perspective, on the other hand, is characterized by attachment versus detachment. In contrast to the justice orientation, vulnerability is associated not with oppression and inequality but with abandonment. From this perspective, morality consists of nurturing connections, promoting individual welfare, and refraining from all forms of violence and exploitation (Self & Olivarez, 1993). Based on these distinctions, Self and Olivarez (1993) hypothesized that there would be significant differences in the moral orientations of men and women. Their findings supported this hypothesis, with a higher percentage of women exhibiting the care orientation and a greater percentage of men exhibiting the justice orientation. Their study follows on from other studies which yielded similar results (Gibbs, Arnold & Burkhart, 1984; Gilligan & Attanucci, 1988; Lyons, 1983; Pratt, Golding, Hunter & Sampson, 1988;

Rothbart, Hanley & Albert, 1986) and was followed by further research in which significant gender differences were found (Wolff, 1996).

Subsequent to her earlier work, Gilligan stressed that neither orientation is superior – care and justice are complementary perspectives (Gilligan & Attanucci, 1988). This was in response to increasing evidence against her finding that men and women differed significantly in their use of the two distinct moral orientations (Aldrich & Kage, 2003; Baumrind, 1986; Beal, Garrod, Ruben & Stewart, 1997; Forsyth, Nye & Kelley, 2001; Friedman, Robinson & Friedman, 1987; Galotti, 1989; Krebs, Vermulen, Lenton & Carpendale, 1994; Lifton, 1985; Pratt et al., 1988; Thoma, 1986; Walker, 1984, 1986, 1989; Walker, de Vries & Trevethan, 1987). Against those who set out to show that there are no sex differences or biases in Kohlberg's theory, Baumrind (1993) argues that these findings do not warrant the conclusion that there are no sex differences in moral orientation but instead suggest that the source and specific nature of the differences have yet to be established.

The controversy over Kohlberg's morality of justice versus Gilligan's morality of care generated numerous empirical and non-empirical studies to further investigate the issue (e.g., Brabeck, 1993; Woods, 1996). Some studies that did find a gender difference put forward a number of variables other than moral orientation that could account for the difference, including personality (Glover, 2001), age (Aldrich & Kage, 2003; Gump et al., 2000; Pratt et al., 1988; Walker et al., 1987, social status (Puka 1989; Tronto, 1987), and type of dilemma presented (Wark & Krebs, 1996). After reviewing the literature on both types of moral orientation, Woods (1996) concluded that what is most evident in all the studies reviewed is not that there are or are not

significant gender differences, but that the moral orientations posited by these two theories are far from universal, and are probably relevant only in Western cultures and, even then, only applicable to specific socioeconomic and educational groups. Similarly, Schminke, Ambrose and Miles (2003) present findings both for and against gender differences in moral orientation and suggest that context is a particularly important factor in determining difference, which is supported by other research (Jaffee & Hyde, 2000; Weinberg, Yacker, Orenstein & DeSarbo, 1993). It has been suggested, for instance, that women from minority or low socioeconomic status groups may have higher scores on measures of justice because emphasizing rights, justice and fairness is more likely to rectify the inequalities that they experience (Beal et al., 1997; Ward, 1995).

The importance of context in the development of moral orientation is further highlighted by studies that have found that individuals exposed to significant degrees of conflict appear to demonstrate bimodal patterns of moral reasoning as a means of reconciling conflicting messages from their internal and external worlds (Tudin, Straker & Mendolsohn, 1994). Orbach (1986) has contended that women's 'internal' feminine values are in conflict with the new femininity that they are striving for outside of the home, which involves embracing masculine values such as independence and rejecting their femininity. Across cultures, the ideal self appears to be inherently masculine (Williams & Best, 1982 in Williams & Best, 1990). The process of coping in stressful environments – such as growing up in the context of apartheid South Africa – is complicated by the conflicting values and attitudes that an individual caught in the juxtaposition of two cultures has available as resources (Lazarus, 1984 in Anderson, 1991). Black adolescents in South Africa may have been particularly vulnerable to such conflict due to the breakdown of

traditional families and loss of appropriate role models (Myburgh & Anders, 1989), denial of opportunity (Stevens & Lockhat, 1997), racial identity confusion (Bloom, 1994) and acculturative stress (Le Grange, Telch & Tibbs, 1998) resulting from the racial discrimination and subordination enforced by apartheid. This conflict and psychological and acculturative distress has been linked to suicidal behaviours (Wassenaar, Pillay, Descoins, Goltman & Naidoo, 2000; Wassenaar, van der Veen & Pillay, 1998) and eating disorders (Garner & Olmsted, 1984; Garner, Olmsted & Polivy, 1983; Hooper & Garner, 1986; Marais, Wassenaar & Kramers, 2003; Szabo & Le Grange, 2001; Wassenaar, Le Grange, Winship & Lachenicht, 2000) within these groups.

Others have approached the issue from a different angle. The justice and care orientations described above not "only reflect different ways of thinking about dilemmas but also define the kinds of situations that are seen as dilemmas" (Yacker & Weinberg, 1990, p. 19). Yacker and Weinberg (1990) developed a short objective test to measure the two different perspectives as defined by Kohlberg and Gilligan, hypothesizing that men would exhibit greater preference for the justice orientation and women would show greater preference for the care mode of reasoning. Their results supported this hypothesis – although they caution against dichotomizing moral judgement and artificially assigning men and women to categories of care and justice, proposing instead that men and women exhibit propensities for each orientation, rather than one or the other type of thinking, as shown by other studies (Cook, Larson & Boivin, 2003; Smetana, Killen & Turiel, 1991). Similar findings were presented by Jaffee and Hyde (2000), who conducted a meta-analysis to determine whether there were significant gender differences in the two moral orientations – justice and care. Their findings showed that females consistently used more care

reasoning and men more justice reasoning. Their results also suggested that the differences in effect sizes may be attributable to other specific moderator variables – such as age, socioeconomic status, type of dilemma, and gender of the protagonist in the dilemma. Nonetheless, their findings demonstrated clear evidence in support of a distinct care orientation, and the influence of other moderator variables on the results do not diminish Gilligan's larger point.

2.3.2.3 Value of care ethics

Despite the lack of agreement on the existence or significance of gender differences in the care versus justice moral orientations, the value of Gilligan's work lies in its acknowledgement of a distinctive alternative orientation to Kohlberg's theory which emphasized the importance of interdependency to women's identities, in contrast to the individualistic outlook typical of men (Friedman, 2000b). Thus, the care based approach has made visible those values that have historically held value for women but have not been regarded as fully moral or relevant in the ethical domain (Peter & Morgan, 2001). In response to arguments that the care perspective has no place in the existing impartialist ethical paradigm, Carse (1998) argues that there are aspects of the care perspective that are consonant with the mainstream bioethics' commitment to impartiality. She then goes on to locate some of the more important contributions and challenges that the care orientation offers to moral and ethical theory. Indeed, there are many contexts in bioethics in which care offers a more relevant and meaningful approach: in children's rights contexts (Cockburn, 2005), for example, in the context of advance care planning (Ikonomidis & Singer, 1999), and in the roles of parent, friend, physician, nurse, where "contextual response,

attentiveness to subtle clues, and deepening relationships are likely to be more important morally than impartial treatment" (Beauchamp & Childress, 2001, p. 372).

In the interface between professional commitments and the ethics of health care, the care perspective can provide much-needed flexibility and liberation from health professionals' narrow conceptions of their roles and responsibilities (Beauchamp & Childress, 2001). In contrast to the impartial and abstract principles of the justice approach, care theory allows for openness to discussion, disclosures, and mutual decision-making in health care that, in turn, shifts the focus of ethical decisions to relationships and to the family, with support from health care professionals. Others, too, have suggested that contemporary bioethics needs to be supplemented with theoretical accounts, like care-based relational theory, that pay particular attention to the value of relationships in ethical practice and, especially, ethical decision making (Ikonomidis & Singer, 1999). Olsen (2003) argues that the dominant rights-based approach guides decisions about whether autonomy is respected, but offers no further guidance across the full range and types of ethical influence involved in clinical research and practice. This is where the assumptions of a relational approach like care ethics can be of value – assumptions that acknowledge that influence is inherent in clinical relationships and that all decisions are subjective and continuous (Olsen, 2003). Furthermore, there are many similarities between Gilligan and other feminists' care theories and those of African ethicists. Characterized by similar ontologies, epistemologies, and moralities, these theories share a rejection of the individual autonomy emphasized in Western, male-dominated approaches, replacing this with individuals' relations to others and to nature (Cameron & Lalonde, 2001; Harding, 1987c; Mkhize, 2004).

2.3.2.4 Problems with care ethics

Despite the value that the alternative approaches offered by care ethics have brought to contemporary bioethics, some feminists have questioned substituting an ethic of justice for an ethic of care, not least because autonomy and justice are rights which women strive for and have been – and continue to be – denied – in both the public and private spheres (Held, 1995b). While some feminist critics have acknowledged the importance of an ethic of care for women, they also point out the negative impact on women's welfare of accepting this orientation without critical examination of its origins. This may exacerbate women's unrecognized and exploited self-sacrificial position and lead to further oppression and powerlessness (Bowden, 1997; Chang, 1996; Mullett, 1988; Tong, 1996). Card (1988) goes further to argue that an ethic of care emerged out of necessity, developed by women as a way to survive in oppressive relationships with men. Those who caution against theories which may exaggerate differences between men and women by focusing on stable gender characteristics, draw attention to the importance of context in determining moral orientation (Hare-Mustin & Marecek, 1988; Mednick, 1989). Men may tend towards an ethic of justice because this approach of rights and rational control support their superior position in society, while women and minority groups appeal to the sympathy and mercy of a care approach because of their subordinate position (Clopton & Sorell, 1993). Such theories are consistent with research finding that the development of moral orientation is largely determined by social, cultural, and historical factors (Ferns & Thom, 2001; Gielen & Markoulis, 1994; Huebner & Garrod, 1991; Tappan, 1997), including education (Colby, Kohlberg, Gibbs & Lieberman, 1983) and racial and political conflict (Burman, 1986; Dawes, 1994; Smith & Parekh, 1996; Tudin et al., 1994; Wilson & Ramphele, 1989).

Similarly, the ethic of care has been criticized for being an underdeveloped theory, too confined to the private sphere and thereby reinforcing "uncritical adherence to traditional social patters of assigning caretaker roles to women" (Beauchamp & Childress, 2001, p. 375). Underdeveloped, however, does not imply incomplete. Peter and Morgan (2001) have suggested that it is perhaps in combination with an ethic of justice that an ethic of care could address injustice while still maintaining a more connected sense of social relationships. Doing so would require recognition of the distortions of caring that result from the oppressive structures of society: the economic dependence of the care-giving person on his/her partner; relegating the responsibility of caring to one partner; and the restriction of women to caring roles at the expense of their sense of self outside of these roles (Mullett, 1988).

Cautions against an unconscious application of care ethics have continued. Cockburn (2005) drew attention to the contested nature of care, and to the potentially harmful effects of valorizing the perspectives of careers over those being cared for – thus replacing conceptions of justice and equality with a needs-based discourse. Cockburn recommended instead that the limitations of current justice-based approaches should be acknowledged and then used strategically and partially, complemented by elements of care theories. The absolute value of care in the relational ontology of many care approaches, at the expense of other values, has also been criticized. Problems with the central notion that we do not *have* connections, we *are* connections, include the valuing of the relationship over the individual, and the jump from the idea that human survival depends on maintaining caring relationships to the idea that all relationships are good (Davion, 1993). Care approaches offer an impoverished ethical account if the moral integrity of

the self is lost within the ontological importance of the relationship; ultimately, care ethics must embrace the relational while still incorporating a sense of autonomy so that the positive aspects of both self-and other-care are maintained (Davion, 1993; Hoagland, 1988; Meyers, 1989).

Carse and Lindemann Nelson (1996) outline these major criticisms and then go on to address them, arguing that much can be done to assuage the complaints that have been leveled against care ethics in order for further progress to be made toward rehabilitating care. While justice ethics calls for blindness to particulars of gender, race, and religion, the ethic of care challenges ethicists to develop an awareness of these particularities – not simply applying care to those connections that are closest and most visible to us, but extending care beyond dyadic relationships and proximate spheres of social interactions. The rehabilitation of care and the integration of justice and care, will require the de-gendering of ethics such that the norms and prescriptions of both orientations are extended to women as well as to men, and to their respective social domains. "It is only after we bring the moral work of caring to the table that we can begin to articulate unromanticized, realistic, and just conceptions of what this ethic should entail" (Carse & Lindemann Nelson, 1996, p. 32).

2.3.2.5 Integration of justice and care

In more recent years, discussions have centered on how to best combine justice and care approaches (Held, 1995b). Feminist approaches to moral agency which seek to synthesize principle-based justice ethics with relationship-based care ethics offer researchers a means of reconciling their professional obligation to produce valid scientific knowledge with their humanitarian commitment to the welfare of their research participants (Fisher, 2000). This stems

from a growing recognition in recent years that justice ethics can and does co-exist with care ethics (Baier, 2005; Brabeck, 1989; Carse, 2001; Crittenden, 2001; Dierckx le Casterle et al., 1998; Dillon, 1992; Higgins, 1989; Smetana et al., 1991; Waithe, 1989; Walker, 1992). Gilligan (1982) compared the synthesis of justice and care to a gestalt figure of moral landscape, showing how moral maturity entails an ability to speak in at least two languages and to see in at least two ways – suggesting that "wisdom comes, not in seeking closure, but in alternating between the two gestalts" (Little, 1998, p. 202). This view also emphasizes the tension between the universal autonomy of justice and the context-specific interdependence of care, where assigning half to males and half to females lacks empirical support and reduces the complexity of morality – and, more importantly, overlooks an opportunity to revise both theories (Brabeck, 1993). Botes (2000) argues that if only one of these two perspectives was consistently used in ethical decision making, certain ethical dilemmas would almost certainly remain unresolved. When the two perspectives are combined, however, moral choices become reasoned and deliberate ethical judgements that ensure justice while maintaining impassioned concern for the welfare and care of each individual (Brabeck, 1993).

Care ethics developed as a feminist alternative to the principlist ethics derived from Kant's philosophy. But some have argued that, upon re-examination, Kant's writings appear to offer everything that care ethics requires and, beyond that, elements that repair the deficits in theories of care (Paley, 2002). This lends greater support for the possibility of integration of justice and care. Similarly, the ethics of love and obligation that Baier (1985) presents have parallels with Gilligan's care and Kohlberg's justice. Baier (1985) integrates care and justice into a trust approach, arguing that relationships of trust involve both love (trusting others not to harm us)

and obligation (trusting others to recognize and fulfill obligations). The concept of trust has the potential to facilitate the integration of justice and care, helping to overcome the problems of both approaches (Baier, 1985; Tauber, 2003). "Neither atomistic autonomy nor the ethics of responsibility can claim hegemony, for they are mutually interdependent, and a complete account of medicine's moral axis requires that they be integrated" (Tauber, 2003, p. 484).

Ultimately, knowledge of both justice and care is necessary to resolve complex ethical dilemmas because actual moral life presupposes moral integration, including the integration of care and justice – a contention that is supported by empirical evidence (Peter & Morgan, 2001). What remains to be established is how justice and care can be successfully integrated. Held (1995b) proposes that care is the wider moral perspective into which justice should be incorporated, arguing that care is the most basic moral value and causally primary to justice. While the value of autonomy, individual rights and justice should not be undermined, these should be developed and sustained within a relational framework of trust. By re-examining the current conception of care, Verkerk (1999) combines respect for autonomy with attentiveness and responsive commitment, and introduces the notion of compassionate interference which is not so much a threat to autonomy but a means of attaining autonomy.

Until recently, the ethical values of individualism and caring have been presented as incommensurable values, occupying different realms of meaning (Gadow, 1995). The conflict between these values is ultimately based on opposing views of the self – respect for individuals in the justice perspective is based on the universal rationality that all autonomous beings possess; the relational ethic of the care perspective views individuals as embodied and unique. Many of

the criticisms that advocates of care invoke against the justice ethic centre on the individualistic bias of this ethic and, ipso facto, disembodied and disengaged notions of the self that confer autonomy with the high status that it holds in traditional ethical models (Benhabib, 1992; Friedman, 2000b; Keller, 1997). It is the existential re-conceptualization of the self underlying these approaches that provides the means for resolving the conflict between individualistic justice and engaged caring. If women are to escape the moral limitations of the current philosophical tradition, "they require nothing less than new models of the self, in terms of which moral imagination, empathy, and feelings are taken at least as seriously as autonomy, rationality, and detachedness have long been taken" (Code et al., 1988, p. 9). By re-meaning the values and interpreting them so that they belong to the same realm of meaning, integration becomes possible; similarly, re-interpreting the self in existential terms allows for reconciliation of the two realms (Gadow, 1995).

The above discussion suggests that if autonomy can be severed from its individualistic assumptions, the values of autonomy do merit a central place in bioethical theory and practice. A justice-care perspective is likely to be more appropriate in informed consent and research settings with vulnerable populations, for example, where moral arguments for the consideration of participant perspectives in ethical decision-making stem from a synthesis of principle-based justice ethics and relational-based care ethics (Fisher, 1999). What most arguments for the integration of these two approaches seem to share is the call for a shift away from an excessively individualistic ethic to accommodate more relational values. Critiques of traditional interpretations of ethics as principle-based and justice-oriented have directed at least some of their criticisms against the notion of the self underlying these interpretations (Cooke, 1999). The

starting point, therefore, for reconstructing current conceptions of autonomy is a reconsideration of the accounts of self-identity that form the basis of these conceptions.

> Crucial to the reformulation of autonomy is a positive conception of human agency that recognizes relational experiences as an integral dimension of individuality…(which, along with) recognition of the specificity and complexity of social relations, has significant implications for the reconceptualization of other principles comprising the canonical inventory of bioethical principles, particularly beneficence, justice, and equality (Donchin, 2001, p. 367).

What is hopefully evident from the discussion above is that women are more inclined to feel connected to others and, therefore, to employ a care approach, whereas men seem to prefer detachment from others and thus adopt a justice approach to ethical dilemmas. Based on evidence that the gender differences in moral orientation described above are due to differences in women's and men's self concepts (Ryan, David & Reynolds, 2004), some theorists have suggested a causal relationship between conceptions of the self and conceptions of morality (Gilligan & Attanucci, 1988; Lyons, 1983). Because a justice and a care moral orientation involve different ways of relating to others, it is evident that discussions around integrating justice and care require an examination of the way in which the self is defined in relation to others. Furthermore, as with the distinction between care and justice, the connected and separate self concepts are also closely related to gender (Ryan et al., 2004). In the following section, conceptualizations of the self that underscore the moral orientations described above – the independent, autonomous self typical in the justice approach versus the interdependent relational self of the care approach – will be discussed in the next step towards the development of a relational autonomy.

2.4 Feminist (Re)-Conceptions of the (Gendered) Self

"I think, therefore I am"

(Descartes, 1641 in Anscombe & Geach, 1954, p. 299).

"I am because we are, and since we are, therefore I am"

(Mbiti, 1969 in Kigongo, 2002, p. 3).

"The question of the self has always been central to feminism since in society we are never simply selves, but gendered selves" (Coole, 1995, p. 121). The basic premise of individualistic notions of the self that are implicit in most Western mainstream ideologies and philosophies is that society is outside of individuals, individuals exist independently of society, and that society is merely a collection of individuals. But feminists argue that to speak of individuals existing prior to and separately from society is an anomaly – society is inside and outside of individuals, it both constitutes and is constituted by them. In attempting to move away from Western understandings of autonomy, predicated on an individualistic view of persons, some feminists have proposed a relational conception of personhood in order to capture the complexity of the relations that exist between persons and their communities. This, in turn, acknowledges the inextricability of existential and metaphysical issues about the self from moral and ethical theory, since

> philosophical accounts of the self have implications for conceptions of what it is to lead a good life (and) feminist reconstructions of the nature of the self are interwoven with arguments that draw out the emancipatory benefits of conceiving the self one way rather than another (Meyers, 2000a, p. 11).

2.4.1 Gender and Self

Separately, theories of the self (see, for example, Chen & Welland, 2002; Leary & Tangney, 2003; Pederson, 1999; Sedikides & Brewer, 2001; Singelis, 1994; Snodgrass & Thompson, 1997; Van der Meulen, 2001) and explorations of gender differences in psychological functioning (see, for example, Else-Quest, Hyde, Goldsmith & Van Hulle, 2006; Hyde, 1990, 1994; Jaffee & Hyde, 2000; Roothman, Kirsten & Wissing, 2003; Umberson, Chen, House, Hopkins & Slaten, 1996) have been widely researched for many years. The association between gender and notions of the self have, however, only recently started receiving attention. While some studies have found no significant differences between men and women's self-construals (Grace & Cramer, 2002; McChrystal, 1994), much of this research has suggested that men and women do differ in their self-representations, women having a more relational, interdependent self-construal and men a more independent one (Cross, Bacon & Morris, 2000; Cross & Madson, 1997; Gilligan, 1982; Jordan & Surrey, 1986; Maccoby, 1990; Madson & Trafimow, 2001; Markus & Oyserman, 1989; Mather, 1997; Miller, 1990; Norris, 1998; Pearson et al., 1998; Sampson, 1988; Stewart & Lykes, 1985). Alternative conceptualizations of the relational self were propelled into the center of feminist thought largely by Gilligan's (1982) theoretical and empirical exploration of the differences between men's and women's moral identity development. Her research highlights how principlist ethics, by conceiving of individuals as separate and of relationships as contractual, neglects the values of care, connection, and interpersonal responsibility that are central to how women make ethical decisions in their lives. In contrast to the rights- or justice-focused reasoning typical of men, the kinds of ethical problems identified by women in Gilligan's study were concerned with maintaining self-integrity

in relational contexts while responding to perceived obligations to others within these relationships (Fry & Johnstone, 1994).

Gilligan's (1982, 1986) work gave empirical weight to the growing recognition that women are more relationally inclined than men, while men are more individualistically-orientated and place less value on relationships. Some have attributed this to differing socialization experiences (Chodorow, 1978, 1989; Maccoby, 1990; Madson & Trafimow, 2001; Maltz & Borker, 1982; Triandis, Leung, Villareal & Clack, 1985; Triandis, Chan, Bhawuk, Iwao & Sinha, 1995), while others go further to argue that the self is fluid and determined to a large extent by context, including the nature of the relationships that individuals hold with others (David, Grace & Ryan, 2004; Friedman, 1998; Kashima et al., 1995; Onorato & Turner, 2001; Ryan et al., 2004; Turner, 1985; Turner, Hogg, Oakes, Reicher & Wetherall, 1987). And yet, relationships constitute the arena in which research, and, specifically, informed consent procedures, are played out. Thus, questions of how men and women experience themselves, and how they experience relationships as a result of these identities, cannot be separated from issues about how research and informed consent should be conducted to ensure that the dignity of each individual research participant is respected. Gilligan's work is also particularly important in advancing the application of feminist theory to, for example, clinical research and practice in that it highlights the need to reconceptualize all relationships – between, for example, parent and child, researcher and research participant – to include not only the negative significance of inequality and power dynamics, but also the positive significance of relatedness and interdependency.

Following Gilligan's watershed work, a number of feminist analyses (see, for example, Bekker, 1993; Mather, 1997; Norris, 1998) began to suggest that women's sense of self is a self-in-relation (Miller, 1990), characterized by an emphasis on caring (Noddings, 1984), empathy, and interpersonal responsiveness that blurs the boundaries between selves and others (Chodorow, 1978). In her empirical investigation of selected experiences of men and women, Lykes (1985) found evidence of two notions of the self: autonomous individualism and social individuality. In contrast to values associated with the autonomous individualism typical of the Western tradition, social individuality involves a "dialectical understanding of individuality and sociality grounded in an experience of social relations characterized by inequalities of power" (Lykes, 1985, p. 356). Lykes's work highlights again the inseparability of notions of gender and power from notions of the self, and the neglect of women's experiences in traditional self-theories. However, this does not only apply to women's experiences, as demonstrated by Lyons (1983), who found that equal numbers of the men and women in her study tended to value some form of interpersonal relatedness by including a relational component in their self-definitions. These findings add weight to the need to develop more relational notions of the self that will be applicable to both men and women.

2.4.2 Models of Self Development

In "an eerie suspension of biological reality" individual selves are traditionally conceived in Western thought as entirely self-sufficient, denying any form of interdependency at the beginning, end, or during the course of life (Meyers, 2000a, p. 4). Essentially, each of the two opposing self orientations – the atomistic self and the relational self – give autonomy a different

meaning which, in turn, determines the contested understanding of patient autonomy, and the task is to find their reconciliation (Tauber, 2003). Recognizing that the capacities of a self that is socially constituted are also constitutively social and relational, many feminists began to incorporate models of the relational self into alternative notions of relational autonomy. Several relational models of autonomy built on social conceptions of the self have been developed (Donchin, 1995; Ells, 2001; Friedman, 1998; Hoagland, 1988; Meyers, 2000a; Nedelsky, 1989; Sherwin, 1998a, 1998b; Shildrick, 1997). Alternative conceptions of autonomy are grounded on the view that people are embedded in relationships and, feminists argue, are able to accommodate the reality of interdependency that is lacking in conventional notions of autonomy. "A person, perhaps, is best seen as one who was long enough dependent upon other persons to acquire the essential arts of personhood. Persons essentially are *second* persons" (Baier, 1985, p. 84). The developmental significance of human interdependence is reiterated in the relational model of autonomy developed by Code (1987). She notes that because human life begins in interdependence, "theorists who take communality and interdependence as their starting point seem better able to accommodate the requirements of autonomy than theorists who take autonomous existence as the 'original position' are able to accommodate community" (Code, 1987, p. 360).

Previous theories of self development suggested that the sense of self is attained through stages of varying degrees of separation (Erikson, 1963 in Stevens & Lockhat, 1997; Kohlberg, 1976; Kroger, 2002; Streitmatter, 1993). The goal of human development, according to these theories, was one of separation or individuation – a prerequisite for mental health. And yet, theorists have increasingly come to recognize that these models of self development do not fit the experiences

of women, or people from minority groups and non-Western cultures (Kemmelmeier & Oyserman, 2001). New theories have since incorporated values of relation and interdependence along with independence and separation in integrated models of mature self development (Lawler, 1990). This view is supported by Guisinger and Blatt (1994), who traced the individualistic bias in Western traditional self theories and present challenges which show this view to be incomplete. More importantly, they argued that "although biological theory has long been cited to account for the development of individuality and aggressive self-interest, there are now evolutionary models that can account for the development of an altruistic, cooperative, interpersonally related self" (Guisinger & Blatt, 1994, p. 106) and they go on to present evidence of the evolutionary basis of intrinsic relatedness in humans.

Feminists have proposed alternatives to the traditional models of healthy self development. Miller (1990), for example, proposed a theory of self-in-relation, outlining an alternative process of self development in which the primary goal is not separation-individuation but relationship-differentiation. Alternative models like Miller's self-in-relation do not work through self development as a series of separation, where dependency or connection is perceived as unhealthy. Instead, they propose that unhealthy development is a matter of extremes, excess and degree: excessive separation or extreme dependency is not desired – "what is important is the harmony of the two notions produced by the rich counterpoint of separation, yet connection, of independence, yet relationship" (Lawler, 1990, p. 653).

2.4.3 The Self in Ethical Context

Several studies have highlighted the influence of cultural context on self development, focusing on the fluidity and diversity of the self identities of individuals who occupy different cultural, socioeconomic, historical, racial and power hierarchical positions in society (Collins, 1990; Dongxiao, 2004; Franchi & Swart, 2003; Immamoglu & Karakitapoglu-Aygun, 2004; Li, 2002; Stevens & Lockhat, 1997; Uskul, Hynie & Lalonde, 2004; Watkins et al., 1998; Watkins et al., 2003; Yeh & Hwang, 2000). Along similar lines, Meyers (2000a) draws attention to other flaws in prevailing conceptions of the self, which include the tendency to view the self as a homogenous, stable entity, when the reality is of multiple, sometimes fractious sources of self identity. She also argues that traditional theories valorize masculine qualities such as dominance and rationality, while stigmatizing those qualities associated with femininity – emotionality and concern for others. Similarly, since independence is the goal of self development in these theories, no morally significant relations, whether consensual or non-consensual, are acknowledged – all affiliations are considered to be contractual and freely negotiated. In most clinical research contexts, as in real life, this is not the case. In contrast, human connectedness and intersubjectivity are prominent themes in feminist thought. The goal of feminist reconceptualization of notions such as self-identity is to "reclaim the venues traditionally associated with women as morally significant sites, and to reclaim the moral agency of the individuals whose lives are centered in these sites" (Meyers, 2000a, p. 8).

Western ethics has typically viewed problems in ethics as conflicts between self-interest and the greater good, with little guidance for reconciling the two. In this limited view, conventional

ethical approaches have tended to neglect the "moral aspects of the concern and sympathy that people actually feel for particular others, and what moral experience this intermediate realm suggests for an adequate morality" (Held, 1998, pp. 104-105). Feminists have recognized and incorporated these previously neglected values into alternative theories of self which emphasize care and connectedness, suggesting that the constitution of individuals is more about the relations than about the distance between them. Kasprisin's (1996) integration of concepts of autonomy with the relational ethic of care makes an important contribution to advancing a model of autonomy that realistically acknowledges the mutual interdependence of human beings. The implications for individuals of these more relational autonomy narratives, including "the lived practical and ethical consequences for individuals when their own self-story becomes more relational" have been further explored by Fishbane (2001, p. 273). When autonomy is understood relationally, respecting others' autonomy requires a reconfiguration of the participant's relationships and their personal perspectives, and is "a far more complex issue than is apparent within the standard conception (of autonomy)" (Donchin, 2000a, p. 187). Social relations are not only causally necessary for the development of autonomy, but are seen as constitutive of autonomy (Friedman, 1997). Incidentally, the idea that the self and relationships are inextricably interwoven is consistent with African conceptions of personhood. From an African perspective, selfhood cannot be defined individualistically because human beings are always in dialogue with the surrounding environment and are thus never alone (Mkhize, 2004).

The importance of paying attention to how selves are experienced is nowhere more evident than in the context of HIV/AIDS, at the heart of the cultural politics surrounding the pandemic. The politics of AIDS appear to be about identity and difference, about the boundaries of personhood,

about how individuals shape their identities and draw their boundaries, and about how conflicts experienced within the self are resolved (Crawford, 1994). "The AIDS epidemic is clearly both a social crisis and a crisis of identity" (Crawford, 1994, p. 1347), and this makes crucial the revision of conventional definitions of identity which underscore the ethical principles that are to form the boundaries of the research that is conducted in this context. In South Africa, this would also entail changing perceptions of self-identity that are entrenched within a culture of power and superiority over women, where notions of masculine identity are typified by aggressiveness and dominance (Abrahams, Jewkes, Hoffman & Laubsher, 2004; Jobson, 2005; Memela, 2005; Sayagues, 2004; Sideris, 2004, 2005). The power inequalities created by the legacy of apartheid in South Africa, and the conflicting messages about entitlement and denial, may also have resulted in a degree of ambiguity in young individuals' self-concepts, which could account for inconsistencies in findings of independent versus interdependent self-construals within different racial groups (Carli, 1999; Kemmelmeier & Oyserman, 2001; Majoribanks & Mboya, 2001).

There have been other criticisms leveled against the dominant conceptions of the individualistic self. From their postmodernist position, social constructionists propose that identity and meaning are socially constructed, and are not formed in the mind of the individual. There are those who locate the development of self identity within the discourses about the self that exist between people (Gergen, 1991, 1994); others emphasize the consequences of an individual's actions on those to whom s/he is related, and propose that a healthy sense of self is inextricably linked to the capacity for relational accountability (Boszormenyi-Nagy & Krasner, 1986). Common to both these views is a shift from the formulation of self identity as an individual activity to a focus on the relational nature of self development. Fishbane (2001) extended this theoretical shift from

individualistic to more relational notions of the self by integrating relational theory from disparate fields. She goes on to explore the implications for individuals and the relationships between individuals "when they move from traditional autonomy-based narrative of their own sense of self to a more relational narrative" (Fishbane, 2001, p. 273).

2.4.4 Feminist (Re)Conceptions of the Self

As is evident from the discussion above, feminists are among those who have challenged the dominant conceptions of autonomy which are based on atomistic views of the self, and begun to put forward alternatives of autonomy that are grounded on more relational notions of the self (Donchin, 1995; Friedman, 1997; Hoagland, 1988; Meyers, 2000a; Nedelsky, 1989; Sherwin, 1998a; Shildrick, 1997). Wallace (2003), for example, formulated a relational theory of autonomy based on a conception of the self that is both socially relational and independently reflexive. Building on Mead's (1934 in Wallace, 2003) hypothesis that the self is constituted by a "me" and an "I," Wallace shows how autonomy arises from a self that is reflective of the whole community while simultaneously aware of it*self*. The me is the self as generalized other within the community; the I is the response of self to attitudes of others. This notion of autonomy allows for a self to be socially constituted but not reduced to the constitutively social. Such alternatives recognize that people develop and exist within relationship, thereby filling the gaps in conventional theories with a more realistic conception of autonomy as interdependent (Ells, 2001). The growing support for theories of relational autonomy prompted Keller (1997, p. 152) to assert that

> whatever shape feminist ethics ends up taking, it will incorporate a relational model of moral agency. That is, the insight that the moral agent is an encumbered self, who is

> always already embedded in relations with flesh-and-blood others and is partly constituted by these relations, is here to stay.

Following these alternative notions of the relational self, many feminists began to recognize that the capacities for autonomy of a socially constituted agent are necessarily also constitutively social and relational (Barclay, 2000; Friedman, 2000a; Mackenzie & Stoljar, 2000). Notably, these feminist critiques do not call for the abandonment of notions of autonomy. The alternatives presented in this thesis call for a transformed approach to autonomy that can account for the multiple and fractious identities of the autonomous agents who are both emotional *and* rational, and the complex social and historical contexts in which these agents are embedded. Relational approaches also extend the focus from the individual to the effects of socialization, and of oppressive social contexts on autonomous agents.

> (Indeed), the difficulties generated by providing an adequate explanation of impairment of autonomy in contexts of oppressive socialization, together with feminist critiques of traditional notions of autonomy, have provided the main impetus toward the development of a relational approach…Analyzing the way in which socialization and social relationships impede or enhance an agent's capacities for autonomy has drawn attention to the connections among an agent's self-conception, her social context, and her capacities for autonomy (Mackenzie & Stoljar, 2000, pp. 21-22).

Others have focused on the inter-relational spaces between cultures, using the notion of bicultural competence (LaFromboise, Coleman & Gerton, 1993) to explain how individuals from minority cultures negotiate their self-identities within cultural contexts where the dominant self identity differs from their own (Yeh & Hwang, 2000).

In this section, an attempt has been made to demonstrate how the self-in-relation can be an important extension of the notions of autonomy and independence underlying most conceptualizations of the self. Drawing on feminist theories of the gendered self, this section has

presented alternatives to the individualistic notions of the self that have tended to dominate in Western philosophical and bioethical thought. The following section will attempt to show how incorporating these relational accounts of personhood into conceptualizations of autonomy can make a contribution to conventional bioethical approaches to ethical paradigms such as informed consent, and to the welfare of individuals that bioethics professes to serve. It is this relational view of the self that underlies many of the feminist alternatives to traditional notions of (individualistic) autonomy that have been developed. As such, feminist ethics is in an ideal position to present alternatives that locate autonomy both within a person's sense of identity, of self, and within the context of their particular daily, lived realities. These relational autonomy models, developed primarily by feminist ethicists, will be discussed in detail in the next section, followed by an attempt to locate these models within ethics as applied in clinical research in developing countries.

2.5 Feminist Alternatives to Principled Autonomy: Relational Models

"*We know ourselves as separate only insofar as we live in connection with others; we experience relationship only insofar as we differentiate other from self"*

(Gilligan, 1982, p. 63).

2.5.1 Relational Autonomy: Feminist Models

As has been shown in the preceding sections, several feminist theorists have developed models of autonomy that require a social or relational context. Relational alternatives to conventional notions of autonomy have been presented, for example, by Baier (1985), Benhabib (1992), Code (1991), Fox-Keller (1985), Hoagland (1988), Kasprisin (1996), and Nedelsky (1989). In contrast to what has been discussed as the traditionally male-oriented principle of autonomy, feminists have advocated relational concepts of autonomy that support the agency of participants without abandoning them to their rights (Sherwin, 1992b), thereby shifting the ethical perspective from self to self-in-relation-to-other (Murdoch, 1970; Noddings, 1984). The feminist approaches that seek to integrate justice-centered principlist ethics with relationship-based care ethics provide a means by which researchers might resolve the dilemma they are confronted with in human subjects' research in trying to reconcile their professional commitment to the generation of technical knowledge with their humanitarian commitment to the protection of their research participants (Fisher, 2000).

This also extends to re-conceptualizations of autonomy that seek to render it more relational, contextualized and relevant to women and other marginalized groups. It must be emphasized

here that developing and applying notions of relational autonomy in ethics does not amount to replacing traditional notions of autonomy with alternative conceptions drawn from this feminist ethic of care, among other feminist propositions. In the afterglow of Gilligan's (1982) work on the differences between men and women's moral identities, many feminists warned against the potential ramifications of reifying these differences, arguing that this might serve to reinforce the oppression of women, entrenching them in the very same emotional, irrational, marginalized roles to which they had been assigned by Western patriarchal society. Sherwin (1992b), for example, cautions that articulating a feminine ethic which assigns to women values of care and emotional responsiveness risks reinforcing those characterizations of women that patriarchal society has traditionally used to justify women's relegation to the private sphere and their subordination to men. "Renouncing autonomy (altogether) would defeat feminist efforts to achieve justice and foster social change" (Donchin, 2000a, p. 189). This reflects yet another recurring feminist theme: a resistance to the dichotomous, dualistic, divisive modes of thinking that are typical of the philosophical tradition – dichotomies such as abstract/concrete, reason/emotion, universal/particular, subjective/objective, knowledge/experience, public/private, theory/practice, and mind/body (Code et al., 1988). Thus in this study, as in many other feminist works, the care and justice approaches which offer differing perspectives on autonomy are viewed not as antagonistic but as symbiotic approaches that, together, can generate a richer understanding of the principle of autonomy.

Wary of unwittingly advocating any absolute alternatives to autonomy, the alternatives presented here follow the call for a poststructuralist feminist ethic that *dis*places, rather than *re*places autonomy (Shildrick, 1997). It is hoped that the ideas explored here will initiate further

investigation into and debate around richly gender- and culture-conscious perceptions of autonomy that will complement, indeed supplement, conventional, male-oriented approaches. This can be achieved, as we have seen, by looking to feminist ethics to provide a critical voice from women's perspectives. Like the perceptual shift invoked by ambiguous gestalt figures, the ethical reasoning of men and women demonstrates a similarly ambiguous shift, so that their perspectives are cast as different but complementary frames or visions of the same situation, depending on the dimensions of relationship in which they are grounded (Gilligan, 1987). By focusing on relational autonomy in this way, this study takes up one of the fundamental principles of feminist thought by explicitly steering clear of splitting the principle of autonomy into a masculine autonomy and a feminine autonomy. Instead, the two poles of yet another dichotomy implicit in Western thought are presented, not as alternatives in opposition to one another, but as complementary perspectives in symbiosis.

There is further danger in the dichotomous thinking inherent in the Western tradition. Once individuals have been assigned to one side of the autonomy/connection duality, for instance, other assumptions are automatically made. Implicit in the idea that women are relational by nature and men autonomous, is the assumption that women are *not* autonomous and men are *not* relational (Berlin & Johnson, 1989). As a result, those masculine values traditionally associated with autonomy – isolation, independence, competition, and self-sufficiency – are removed from what is perceived as women's reality. Such associations are transformed when autonomy and relatedness are no longer conceived as bipolar characteristics but as integral parts of healthy maturity. Berlin and Johnson (1989) outline a new form of autonomy that allows for a commitment to oneself and one's relationships, to being a whole self within relationships. This

two-stranded commitment highlights the ability of a new, tuned-in autonomy to be realized within relationship while simultaneously "underscoring the absence of both freedom and warmth when caregiving takes place from a submissive position" (Berlin & Johnson, 1989, p. 94). Their argument is strongly for not abandoning autonomy, but for using the valuable contributions from Gilligan and other care theorists to re-focus notions of autonomy on the importance of relationships and caring, connectedness and empathy. The primary goal is to reclaim and revise the concept of autonomy so that both autonomy and relatedness can co-exist in mature selves.

Elaborating further on the concept of relational autonomy, feminists have drawn attention to the ways in which the development and preservation of autonomy is inherently social. Selves-in-relation are both pre- and co-requisites of autonomy. Friedman (1998) highlights the social nature of autonomy as follows: To acquire the very capacity for autonomy requires the self-reflection borne from socialization; maintaining autonomy involves interacting in the social world, relating to others in particular ways; and sustaining autonomy requires socially created meanings whereby an individual recognizes and evaluates herself and her goals and values in relation to those around her. Social identities, social selves, and social contexts intersect to shape relational autonomy, thereby focusing conceptions of individual autonomy, and of moral, political, and bioethical agency, through the lens of the intersubjective and social dimensions of selfhood and identity (Mackenzie & Stoljar, 2000). Developing this situated notion of relational autonomy, Holler (2001) puts forward as an alternative a "whole-system ethic" that is "necessarily ontological," maintaining that the illusions of separation and of self-interest apart from other-interest in conventional notions of autonomy "threaten the very existence of the

living community" (Holler, 2001, p. 220). Holler points out that there is evidence for the ontological primacy of relationship prior to isolation in our existence.

"Unlike the autonomous man, who thinks that his self is entirely separable from others, the autokoenomous woman realizes that she is a self inextricably related to other selves" (Tong, 1997, p. 94). Another alternative to the traditionally individualistic conceptions of autonomy in the ethical mainstream has been proposed by Hoagland (1988). Her alternative, *autokoenomy* represents the self-in-community and captures the sense of being free from dominance without necessitating self-domination (Sherwin, 1992b). One advantage of these alternative conceptions of autonomy is that they support richer and more acceptable notions of persons and, as a result, they support more comprehensive understandings of what counts as ethical problems. By recognizing that individuals are "situated within a web of relationships and contexts from which their decisions cannot be separated," responsibility for choices and actions extends to the contribution that society makes – allowing for conceptions of autonomy that do not reinforce unacceptable ideology (Ells, 2001, p. 423). This is particularly significant when considering that principles of autonomy are applied in contexts where consent is required from disadvantaged or vulnerable populations by privileged groups of researchers. The task becomes one of balancing autonomy with community solidarity, both in ontological thought and epistemological action (Code, 1987) to ensure that principles applied in research ethics are as ethical in practice as they are in theory.

Keller (1997) outlines the alternative model of autonomy proposed by Meyers (1987, 1989), which takes the relational self, situated in an ethic of care, as its starting point. Meyers' account

also severs traditional notions of autonomy from individualistic assumptions by building into autonomy the idea that the self is socially constituted and, therefore, the way that individuals experience and think about the world is a function of the relationships in which they are involved. However, this alternative does not eliminate the importance of autonomy in the caring individual's self concept. Self-respect is a central component of Meyers' theory, whereby autonomy and self-respect are each necessary for the realization of the other – they are reciprocal and mutually reinforcing. Meyers' relational autonomy is built on models of friendship. She looks at how women relate to one another, how they maintain and reinforce their sense of self-respect through seeking out other's care and support and engaging in discussions with others when making major decisions. Autonomy is also enhanced through this dialogical process, Meyers argues, as it not only helps to solidify the relationships in which individuals develop their self-respect, but also can help the individual to make decisions which are more autonomous.

> Conceiving of autonomy as a dialogical process helps to distinguish which aspects of autonomy can be shared and which must be exercised by the autonomous person alone;…it explains how a person can be very much connected to others and still be autonomous; it illustrates how friendship (and mutually respectful researcher-participant relationships) can enhance the autonomy competency, and thereby the self-respect, of someone who can be minimally autonomous to begin with; and it issues one last challenge to the individualistic conception of autonomy by conceiving autonomy as an intersubjective activity (Keller, 1997, p. 161).

Towards this end, many feminists acknowledge the central place that autonomy has in bioethical theory, while emphasizing that it must be scourged of its individualistic presumptions and reformulated as a concept which recognizes the centrality of relational experiences in human agency. This, they argue, will offer a conception of patient autonomy that is better suited to the practical work of bioethics than the dominant principlist model (Donchin, 2001). Common to

these alternative models is the emphasis on relationship. Much of the work in this area has been advanced by Donchin (2001), who has explored the alternative metaphors of mothering and of friendship put forward by earlier feminist theorists as more appropriate for application in health care contexts, and presented the sisterhood model which, she argues, overcomes some of the potential flaws of the previous two approaches. Donchin (2000a) presents a more inclusive understanding of autonomy that offers solutions to controversial ethical dilemmas like physician-assisted suicide that the limited perspective of the dominant individualistic conception misses.

Donchin (2000b) has also shown how prevailing accounts of autonomy which do not take the complex interplay between individual autonomy and biological and social relationships into account are ill-equipped to offer guidance in, for example, genetic decision making. She proposes the development of a strong relational model of autonomy which recognizes that "autonomy is not solely an individual enterprise, and that respect for the autonomy of others requires collaboration, long-term reciprocity, and equitable balancing of power relationships" (Mackenzie & Stoljar, 2000, p. 26). Dodds (2000) has also developed a more relational approach to autonomy. Like Donchin, Dodds argues that autonomy is narrowly conceptualized as informed consent in the bioethical literature, which, in turn, limits the options available in health care contexts and restricts ethical decision-making. Dodds presents relational autonomy as a more appropriate option for ethical recourse in clinical contexts.

2.5.2 Relational Autonomy in Context: Power and Relationship

There has been much support in health care contexts for the expansion of traditional conceptions of autonomy. One such context is in the caring for dependent elderly persons. Here the individualistic bias of the conventional notion of autonomy fails to capture how individuals experience their changing identities, abilities and realities as they age and become more dependent on others. Ter Meulen (2001) argues for inclusion of three aspects of autonomy which are typically not acknowledged in contemporary healthcare ethics: identification, identity, and sense of meaning. Autonomy as the development of identity is necessarily a relational process, one which requires continuous identification with changing circumstances. In the context of aging, being autonomous also requires a sense of meaning of what it is to be old and, particularly, dependent, which, in turn, requires the solidarity and commitment of the care giver (Ter Meulen, 2001). The importance of shifting notions of autonomy from abstract concepts to shared interpretations of lived experiences is of particular significance in these contexts.

Contextualizing the debate around the principle of autonomy in end-of-life ethical dilemmas with cancer patients, McGrath (1998) also discusses reformulating the principled approach to autonomy to one that is a way of approaching patients which views them as people in contexts and empowers them in more ways than simply providing them with information and asking them to sign the consent form. The idea of autonomy as empowerment changes the principle from one that should be applied in difficult situations to a way of continuously responding to the patient and their family. This shifts the focus from a concern with the information and signature requirements of the consent form to a more holistic approach that emphasizes patient

empowerment and is more respectful and inclusive of the particularities of patients' lives and experiences (McGrath, 1998).

Moving beyond the narrow focus of informed consent in research contexts on conditions of adequate comprehension and competency to make voluntary choices is a central goal of Fisher's (2003) relational ethics. Fisher broadens the scope of informed consent in research to the relationship between the researcher, the research participant and the consent context. This involves not only recognizing how the broader social context affects individuals' decisions in the research setting, but also how researchers' own competencies and obligations are grounded within a particular context. From a relational perspective, informed consent becomes a product of mutual understanding and requires a shift from fulfilling conditions of autonomous choices to being responsive to the research participant's concerns, values and abilities. Obtaining consent then becomes an expression of connection and goodness-of-fit between researchers and their research participants (Fisher, 2003).

Accompanying the awareness that social relationships are necessary for the realization of autonomy, however, is acknowledgement that relationships can also impede or obstruct autonomy, or, as is the case for many women in non-Western cultures, eradicate autonomy altogether. The connection between autonomy and the social is a complex one, which can be positive and negative. Autonomy can be both enhanced and impeded by relationships. In developing relational conceptions of autonomy, therefore, it is necessary to be cognizant of how social relationships can both promote and hinder the realization of autonomy (Friedman, 1997).

Nedelsky (1989) acknowledges the inexorable influence of relationships of power, of the collective, on individual autonomy and shows how this too often dichotomous tension between autonomy and collectivity can be reconciled in an alternative, more relational and more context-embedded conception of autonomy. Instead of viewing autonomy as a process of erecting walls between the individual and the threat of the collective, Nedelsky argues that relationships, not isolation, are necessary for the development and maintenance of autonomy – they constitute both the source of and danger to autonomy. "To be autonomous, a person must feel a sense of her own power (which does not mean power over others), and that feeling is only possible within a structure of relationships conducive to autonomy" (Nedelsky, 1989, p. 25). Autonomy is an individual value which comes into being in the context of the social.

Others, too, have traced the theme of empowerment in relational conceptions of autonomy. Fishbane (2001) considers how power imbalances do exist in society but shows how reconceptualizing the nature of persons alters these narratives of power. Competitive values of power-over have traditionally been associated with notions of autonomy; changing the underlying perspective to one of a relational view of persons challenges Western notions about power and the self.

> While acknowledging and working to change these power differences and abuses of power, relational and feminist theorists are also challenging the power-over model with a power-to (Goodrich, 1991) or power-with or mutual empowerment (Surrey, 1991) model, especially in interpersonal relationships (Fishbane, 2001, p. 277).

This applies to men as well as women, argues Fishbane, in that the power-over model is socialized into our thinking about men's development – a dominant perception which can be altered by rethinking development in relational terms and reconsidering gender assumptions implicit in our culture.

Building on the recognition of the influence of power and relational inequalities on individuals' autonomy, Warren (2001) recommends an alternative conceptualization of autonomy that is based on notions of empowerment. While traditional autonomy is essentially individualistic, concepts of empowerment capture both the social and political context and reveal how power affects relationships and individual autonomy. An ethic of empowerment is, in many respects, better suited to realizing individual autonomy in research settings than are conventional applications of informed consent. This is especially significant when research is conducted with vulnerable populations in developing countries like South Africa, where the operation and influence of power relationships is clearly evident and unavoidable: both in the informed consent process, between researchers and research participants, and in the relationships between men and women in this society, where male power and control over females extends into many areas of their lives (Jobson, 2005; Memela, 2005; Sideris, 2004, 2005). Translating the discourse of empowerment into the ethical practice identifies and challenges these sources of power and inequality and finds ways of enhancing autonomy within these contexts (Warren, 2001).

Thus, while autonomy should not be abandoned, it is only part of the story, and needs to be modified to include (women's) "stories about how we are to live together, and how we are to make families and communities that support the growth of love, enduring loyalties and compassion" (Murray, 1994, p. 33). The same argument applies to culture, and to the tendency to perceive one culture's worldview as superior to another. This is reflected in the domination of Western "independent" notions of self versus the interdependent views of personhood that are adopted in many non-Western cultures. In many developing countries, and in South Africa in

particular, there are cultures with differing worldviews from those of the First World values of independence from which individualistic conceptions of autonomy arise. Thus, while feminist voices can help us to focus on women's unique experiences of agency, feminist (bio)ethics can also facilitate the adoption of a critical perspective when attempting to mould principles of autonomy in informed consent practices into more gender- *and* culture-sensitive conceptions. "The provisional goal here must be to acknowledge always the textuality of morality, and to encourage the self-determining individual to root herself in the moral community rather than abstract herself from it" (Shildrick, 1997, p. 123).

This section has provided a review of feminist models of relational autonomy. It has attempted to show how these models are a synthesis of the concepts explored in the preceding sections – integrating relational concepts of the self into traditionally individualistic principles of autonomy, and building on the integration of the predominant ethic of justice with an ethic of care that is based on these more connected notions of the self in relationship. What has become evident in these relational autonomy models is how the conventional principle of autonomy that was critiqued in previous sections can benefit from attending to the individualism inherent in Western bioethics and incorporating concepts from self-in-relation theories and care ethics that have previously been neglected in mainstream ethical approaches. The discussion above has demonstrated how these relational autonomy models can work in context by balancing out the power dynamics in the relationships that are inextricable from the research process, and empowering those involved in the informed consent process by meeting them where they are in their lives. In the final section of this literature review, the models of relational autonomy that have been developed in this chapter will be further contextualized, showing how such relational

alternatives are more appropriate, more respectful, and, ipso facto, more ethical, for conducting research with women within their situated, real, lived circumstances and experiences.

2.6 Situating Relational Autonomy in Research Ethics in HIV Vaccine Trials in Developing World Contexts: The Contribution of Social Science Research to Ethics in Research

An ethic of interrelationship and interdependence would be able to accommodate the co-existence of selves in community, showing not only how individuals relate to and depend on each other, but how they depend on and are depended on by their communities, as well as the way various collectivities are interdependent (Loewy, 1993). It follows from this that a genuinely universal and genuinely *ethical* ethics will be concerned with "*embodied* persons: racially, culturally, and historically specific, gendered individuals" (Kourany, 1998, p. 12). Rather than trying to deny the existence of the concrete particularities of potential participants' lives, applications of feminist ethics in research settings recognize the impact that these relational contexts have on individual participants' autonomy. These alternative, relational perspectives could enrich existing principles of autonomy and its application in informed consent practices, especially, but not exclusively, in the case of women, and of women in developing countries in particular. Moreover, the research process itself, as well as the procedures for ensuring that research involving human subjects is ethical, occur within relationship. Therefore, building relationally conceived principles into the informed consent process would involve transforming this from a detached, contractual process into a mutually respectful interaction that fully acknowledges participants as individuals with their own particular and unique life histories. These relational conceptions of autonomy, therefore, would not reinforce unacceptable ideology and practice, and are more truly synonymous with the ideal of respect for persons that lies at the heart of the principle of autonomy.

In acknowledging the existence and impact of relationships and contexts on individuals, the alternative, richer models of autonomy presented by feminists also turn the spotlight onto the inequalities that exist within these relational contexts for many of the participants from developing countries. Extending this relational model of ethics to the research process, Fisher (2000) argues that ensuring that research will be both valid and socially valuable, and formulating fair and ethical procedures, cannot simply be achieved through the scientist's moral reflections and ethical deliberations. She argues that a truly relational ethic can only be derived through scientist-participant dialogue, based on respect and mutual cooperation. This focus on mutual respect is also emphasized in other recent works on research ethics (Emanuel, Wendler, Killen & Grady, 2004; Lysaught, 2004). In addition, feminist models of relational autonomy in ethics also allow scientists and researchers to "integrate their rational and relational caring selves in ways that enhance their ability to engage research participants as partners in creating experimental procedures reflecting both scientific and interpersonal integrity" (Grossman et al., 1997 in Fisher, 2000, p. 137). Fisher thus builds on the conceptual foundations of feminist ethics to develop a more a relational ethic for science and research that incorporates and enhances the interpersonal nature of and obligations inherent in the scientist-participant relationship. Such a process could arguably have improved the understanding of the research process in some complex microbicide HIV prevention studies, which reported that less than 30% of the women enrolled in the South African arm of the trial understood essential components of trial participation (Ramjee et al., 2000). Ironically, the scientific aim of the study was to empower women's agency in the fight to reduce sex workers' vulnerability to HIV.

In acknowledging the existence and impact of relationships and contexts on individuals, the alternative, richer model of autonomy presented by feminists discussed above turns the spotlight onto the inequalities that exist within these relational contexts for many of the participants from developing countries. A relational interpretation of autonomy is conscious of both interpersonal and political relationships of power and powerlessness, acknowledging that autonomy is not simply about being offered a choice or consenting to some predetermined research project, but about having the opportunity to resist oppression and to adequately shape the world (Sherwin, 1998a). While autonomy ultimately resides in the individual, under relational autonomy, society, and not just the individual, is the subject of examination, so that responsibility for autonomy extends, but it not limited to, the social. Sherwin (1998a) emphasizes that, when relational interpretations of autonomy are applied in research contexts, informed consent is understood as an ongoing, interactive process in which both parties can be transformed.

> A relational view helps us to understand how the specific social location of (patients) can affect their autonomy status. It explains why requiring health care providers to disclose relevant information and seek the permission of (patients) is a necessary, but not a sufficient, criterion for protecting (patient) autonomy (Sherwin, 1998a, p. 42).

Feminist theory moves traditional ethical approaches out of their neutral standpoint, turning the spotlight on relationships and contexts in which people – men and women - are embedded. Not only do the above arguments address the current lack of attention to the relationships in which research participants are embedded, and their impact on individual autonomy, but they also allow for the acknowledgment in ethical theory and practice of the relationship between researchers and research participants. Central to these relational theories is the idea that informed consent is a collaborative project in which researcher and research participant are moral agents who work

together to ensure that research is socially valuable and valid while being conscious that participant perspectives should inform but not replace ethical deliberation by researchers (Fisher, 2000). Key themes in this approach are those aspects of the researcher-participant relationship which enhance ethical research – trust, mutual understanding, and collaborative decision making which is cognizant of each individual's value orientations. While it may not be possible to completely eliminate power differences from the research relationship, Fisher (2000) argues that the relationship between researcher and participant can be rendered complementary and non-exploitative. Feminist relational ethics challenge traditionally universalistic and principled ethical positions to acknowledge the importance of intersubjectivity, particularity and context; they aim to equip researchers with ethical tools that reflect the interpersonal nature and obligations inherent in the researcher-participant relationship (Fisher, 2000).

Research in the social sciences traditionally reflects the values and concerns of dominant social groups and, as such, has neglected issues of concern to women and other minority groups (Cameron, 2001; Kass, 1998; Macklin, 1993; Sherwin, 1996; Sinha, 2003; Wolf, 1996). Feminist bioethicists, on the other hand, argue that research is both personal and political and challenge social scientists to reconceptualize research as a setting for consciousness raising and social change (Campbell & Wasco, 2000). The dominant ethical discourses and practices can be transformed through engaging in dialogue with women who occupy both the centre and the margins of power (Donchin & Purdy, 1999; Nicholas, 1999). Such collaboration between researchers and research participants, and between Western and non-Western bioethicists "reflects a process of mutual influencing to discover shared and unshared values through which truly fair and ethical procedures can be derived" (Fisher, 2000, p. 130). Developing and applying

guidelines that espouse more relational forms of autonomy in and outside of the informed consent process is one such step in the (right) ethical direction.

This brings the discussion to a pivotal question underlying the current study: What contribution can social science studies such as the one here make to the ethical conduct of biomedical and health research? It has been argued that, until recently at least, the field of bioethics has not fully acknowledged the role and implications of social science research for the practical implementation of ethical principles and theories. As a result, there has been a significant gap between ethics as it is theoretically presented in bioethics and the way in which ethical deliberation actually takes place in real world situations. Hedgecoe (2004) contends that this gap can isolate bioethics from practice and undermine the validity of its claims. "While it is possible for social science research to support the principlist approach, for example, it is also quite likely that in some, if not many cases, the evidence will not fit into this particular way of structuring the social world" (Hedgecoe, 2004, p. 137). The relationship between bioethics and the empirical social sciences is now receiving greater attention. Many have begun to acknowledge that social science research can contribute in a meaningful way to philosophical and medical bioethics (Emanuel, 2002; Haimes, 2002; Hedgecoe, 2004; Hoffmaster, 1992; Yeager, 1996; Zussman, 1997). Social science studies on bioethical topics can yield useful information that, while not morally determinative, is morally relevant (D.R. Wassenaar personal communication with H. Richardson, December 2004). For example, empirical evidence is the basis of decisions about whether children of a particular age are competent to give informed consent, but this has serious implications for ethical medical treatment and clinical research. Thus, such empirical research can be regarded as basic moral work (Hedgecoe, 2004). Furthermore, ethics is no longer a purely

abstract discipline, as can be seen from the growing interest in empirical investigations and applied work within the fields of both philosophy and bioethics (Haimes, 2002).

Collaboration between ethicists and social scientists can thus enhance the way that ethical work is conducted and, through social science's concern with connecting the particular with the general, and empirical data with theoretical explanations, the scope of issues open to ethical scrutiny could be expanded (Haimes, 2002; Hedgecoe, 2004). For instance, social science research into the interactions between the prevailing values in society and those of its individual members can provide empirical evidence against which ethical intuitions can be checked (Yeager, 1996). In addition, the contribution that social science research could make to understanding not only ethics but ethicists themselves, and how their social identity can affect their influence on the conduct of ethics, could be a matter of practical as well as theoretical interest for bioethicists (Haimes, 2002). In other words, social science theories are useful for illuminating how ethics is historically and culturally located and can shape and be shaped by social forces (Haimes, 2002). It is clear, therefore, that traditional bioethics should engage with the social sciences, acknowledging that the way things are can tell us something about the way things ought to be. The current social science study has attempted to contribute in this way to how ethical principles such as autonomy are practically applied and experienced in real world contexts.

This section has attempted to show links between the theoretical concepts that were discussed in the preceding sections, and the research context, showing how relational autonomy models are practically applicable in the ethical conduct of research. It is only through locating relational

principles of autonomy within real-world contexts that the value of these concepts can be demonstrated. In the summary section that follows, the theoretical concepts explored in the literature review above will be linked to the empirical aims of this study.

2.7 Summary

The preceding sections have attempted to show that, when applying alternative models of autonomy to research contexts in developing countries, respecting autonomy in this relational sense involves a number of complex ethical issues that pose a significant challenge to bioethicists and all those involved in the research process. Nonetheless, Macklin (1999 in Noring, 1999) argues that it is both possible and desirable to posit universal ethical principles for health research with human beings. Recognizing that there are many circumstances in which conventional principlist ethics offer insufficient guidance for ethical decision making, she proposes that this approach should be complemented with a new context-based paradigm that brings relationships and individual particularities to the ethical arena. This ethical paradigm can account for the impact that gender, race, culture, and community factors have on ethical decision making, and recognizes that relationships change over time, emphasizing the importance in this process of interactions, power, responsibilities, and historical considerations (Macklin, 1999 in Noring, 1999).

In these contexts, focusing on and engaging actively with the complex network of relationships involved in human subjects research is, arguably, more appropriate than the current focus on those individualistic, abstract, contractual applications of principlist ethics. In research settings in developing countries especially, Sherwin (1998a) points to the importance of conceiving of the informed consent process as interactive and continuous, where relational interpretations of autonomy can reveal both how social influences may enhance or constrain women participants' decision making, and how an interactive informed consent process may be transformative for

participant and researcher alike. The process of research, in other words, is as important as the outcome (Emanuel et al., 2004; Ramcharan & Cutcliffe, 2004; Wassenaar, 2006).

Many advocate collaborative partnerships between researchers, policy makers, and communities in developing countries (see, for example, Benatar, 2002; Emanuel et al., 2004; Heath, 2005; Mosavel et al., 2005; Mugisha, 2003). This could be extended beyond the macro-contextual level to the fostering of collaborative partnerships and interactions between individual researchers and their research participants. The ethical conduct of clinical research is an ongoing process and should not be deemed ultimately ethical after informed consent has been obtained (English, 2002; Holzer, 1991; Ramcharan & Cutcliffe, 2004). It is only when clinical research truly recognizes and respects the contexts in which individual participants are embedded, as well as those relationships and circumstances within which participants make fully informed choices, does it begin to fulfill its ethical and moral obligations.

> This does not mean that (ethical) principles are relativistic…moral arguments take place in context, and they therefore depend at least implicitly on…beliefs about human nature and social process…the arguments begin from where we are, and appeal to where we live now. This is why moral relativism is seldom as important an issue in practical as it is in theoretical ethics (Gutmann & Thompson, 1996, pp. 14-15).

Jones (1999) and Nicholas (1999), for example, have developed strategies to that will enable participants to bring about change from within their own countries where, in many cases, power imbalances and gender inequalities are the norm and where women continue to be the victims of harmful practices and abuse in all forms. They argue that women should be empowered to determine the most ethical and effective ways of resolving the problems they face in their daily lives, with non-directive support from Western feminists, bioethicists and researchers that is

conscious and respectful of the complex realities of these women's lives. Clinical research in developed and developing world contexts can be transformed by opening up avenues of dialogue across this gulf between the developed and developing worlds. Such collaboration between researchers and research participants, and between Western and non-Western bioethicists, to discover shared and unshared values and experiences allows for truly fair and ethical procedures to be derived and subsequently applied. Explorations of how ethical principles, such as autonomy, can be reconceptualized to ensure a more acceptable fit between the typically abstract principles and goals of science and research with the lived realities and experiences of research participants in developing countries, is but one of the dialogues that need to be entered into. It is hoped that this thesis will make a step in this direction in attempting to situate feminist models of relational autonomy in developing world contexts, where much biomedical research is being, and will continue to be, conducted.

Having reviewed the theoretical literature, some key issues have emerged. The dominance and the shortcomings of principled autonomy as it is employed in conventional bioethics have been highlighted. A review of feminist approaches to bioethics has shown how feminist ethics has been fundamental in providing a critique of autonomy, particularly with respect to its gender bias and neglect of values important to women. From these discussions, it has emerged that a central target in these critiques is the individualism inherent in Western bioethics and bioethical principles. Subsequent sections have demonstrated how this individualist approach has given rise to the individualistic notions of the self that underlie dominant conceptions of autonomy, and to the justice ethic that has tended to dominate bioethical thinking.

In the course of the above discussion it has become evident that the alternative approaches developed by feminists in response to these shortcomings have incorporated relational theories of the self into an ethic which pays specific attention to the particularities of gender and the importance of context – the ethics of care. More significantly, the emphasis on relation and connection in these models allows for the application of more relational principles of autonomy in research settings. The questions that remain are whether the combination, in theory, of concepts of a relational self and a moral orientation of care in relational autonomy models, would be evident in practice, and whether the way in which these combinations are experienced are associated with an individual's gender, as has been suggested in the literature. This study aims to address these questions. By combining the concepts of autonomy, self, and moral orientation as variables, it will investigate to what extent they are interlinked, and the role that gender plays in determining how these variables may be combined with respect to autonomy versus relatedness, independent versus interdependent self construals, and justice versus care. A description of an empirical study to explore these relationships follows this chapter.

3. METHODOLOGY

3.1 Aims and Hypotheses

The main aims of the present study are:

1. To determine whether there is an association between an individual's gender and their identification with a particular "type" of autonomy – relational versus independent
2. To determine whether there is an association between gender and independent versus relational self-construal
3. To determine whether there is an association between gender and an ethic of justice versus an ethic of care
4. To determine whether there is an association between an individual's gender, autonomy, self-construal and ethical orientation, in the direction as demonstrated in Table 3.1 below:

Table 3.1
Predicted Associations between Variables

GENDER		AUTONOMY		SELF		ETHIC
Women	→	Relational Autonomy	→	Relational Self	→	Care
Men	→	Independent Autonomy	→	Independent Self	→	Justice

→: associated with

To meet these objectives, the following hypotheses will be investigated:

1. Autonomy: Women will exhibit higher levels of relational autonomy than men; men will exhibit higher levels of conventional autonomy (as defined in the literature review) than women.
2. Self: Men will exhibit a more independent self-construal than women and women will demonstrate a more relational self-construal than men.
3. Moral Orientation: Men will show a greater tendency towards a justice orientation than women, while women will show a greater tendency towards a care orientation than men.
4. There will be a consistent directional association (positive correlation) between relational autonomy, relational self, and care orientation for women, and a consistent directional association (positive correlation) between independent autonomy, independent self, and justice orientation for men.

Secondary hypotheses: Although culture was not an explicit focus of this study, further investigation was done to see what the results would be when culture was taken into consideration, as hypothesized below.

1. Autonomy: Black women are expected to have a higher level of relational autonomy than White women who, in turn, are expected to have higher levels of relational autonomy than Black men, who, in turn, will have higher levels of relational autonomy than White men. Conversely, it is hypothesized that White men will show greater levels of conventional autonomy than Black men, who, in turn, will exhibit a greater degree of

conventional autonomy than White women, who, in turn, will have a higher level of conventional autonomy than Black women.

2. Self: White men will exhibit a more independent self-construal than Black men, who will show a more independent self-construal than White women, who are expected to have a more independent self-construal than Black women. Conversely, Black women will demonstrate a more relational self-construal than White women, who will have higher levels of relational self-construal than Black men, who will have a more relational self-construal than White men.

3. Moral Orientation: White men will show a greater tendency towards a justice orientation than Black men. Black men are expected to exhibit a greater tendency towards a justice orientation than White women, while White women will show a greater tendency towards a justice orientation than Black women. Conversely, Black women will exhibit a greater tendency towards a care orientation than White women. White women will have a greater tendency towards a care orientation than Black men, who will have a greater tendency towards a care orientation than White men.

4. There will be a consistent directional association (positive correlation) between relational autonomy, relational self, and care orientation for Black women and for White women, and a consistent directional association (positive correlation) between independent autonomy, independent self, and justice orientation for White men and for Black men.

3.2 Research Design & Methodology

It is not within the scope of this current research to review, evaluate, or reconcile all the feminist epistemologies that challenge traditional ideologies, nor to attempt to employ the diverse range of feminist methodologies available. The common link between these epistemologies lies in feminists' answer to the question, who can be the knower? Women can indeed be knowers and their experiences legitimate sources of knowledge that are worthy of the critical reflection that informs our understanding of the social world (Campbell & Schram, 1995; Campbell & Wasco, 2000). Adopting a woman's perspective involves shifting the focus of research design and methodology, re-viewing and reinterpreting existing data from this new perspective. As a result, things that were previously unseen may be revealed by feminist inquiry, and anomalies – observations or data that do not fit the current theory – may be generated (Nielson, 1990).

3.2.1 Feminist Critiques of Quantitative Methodology

In reaction to the dominance of the male perspective in social science, many feminists have taken a stand against the over-reliance on empiricist, reductionist, quantitative research methods in social science research. As a result, "…a symbiosis has occurred between 'feminist' and 'qualitative' in the minds of many people, (where) qualitative methods are thought to be the methods that protest against the status quo, just as feminism does more generally" (Reinharz, 1993, p. 69). Similarly, the feminist critique of positivism assumes that the subject/object separation (and, indeed, many of the dualisms that are problematized in feminist theory) is a problem exclusive to quantitative methodologies (Sprague & Zimmerman, 1989).

Qualitative methods, presumed untarnished by quantitative shortcomings, have been presented as the appropriately ameliorative alternative in feminist research. In doing so, feminists have – ironically – adopted the dualistic stance, or false dichotomizing, they set out to do away with (Sprague & Zimmerman, 1989; Thorne & Varcoe, 1998). "If one actually examines a large amount of feminist research, however, one quickly learns that the fusion of 'qualitative' and 'feminist' is more myth than reality" (Reinharz, 1993, p. 69) and,

> while significant attention has been paid…to the ways in which quantitative methods are identified with masculinist versions of scientific rigor, there has been little discussion of the idea that this coupling is *historically produced* and is not *necessary or inevitable* (Lawson, 1995, p. 451).

When one studies quantitative methods more closely, it becomes clear that there is nothing inherent in these methods that promotes patriarchal analyses simply because the two have been linked historically (Risman, 1993).

3.2.2 Value of Quantitative Methodology in Feminist Research

"It is important to note…that qualitative methods are no more essentially feminist than quantitative techniques are essentially masculinist" (Lawson, 1995, p. 450). Both methods have their own strengths and weaknesses. A number of writers have recently begun to defend and advocate the use of quantitative techniques in feminist research, arguing that, if critically employed, these methods can actually be more appropriate – indeed, essential – in certain instances (Dunn & Waller, 2000; Griffin & Phoenix, 1994; Reinharz, 1993; Risman, 1993; Sprague & Zimmerman, 1989). Others have gone on to identify specific methodological features that typify feminist methods, rather than particular data collection techniques – a focus on

women's experiences; the stipulation of explanations for women; and the researcher's position on the same critical plane as the explicit subject matter (Harding, 1987b). Quantitative research has been shown to be equally valuable in highlighting the unequal treatment of women and men by utilizing the techniques of quantification while avoiding the methodological pitfalls evident in traditionally 'masculine' research (Sprague & Zimmerman, 1989). "Thus health professionals working from a standpoint consistent with feminist theorizing will not disregard the potential for quantitative research or empirical science within the larger project of developing knowledge for the reduction of gendered social inequalities" (Thorne & Varcoe, 1998, p. 490).

Feminist methods, like feminist theories, do not employ a monolithic approach; feminist scholarship embodies a multiplicity of research methods (Dunn & Waller, 2000; Harding, 1987a) that are conscious of personhood and of the involvement of the researcher (Reinharz, 1992). Because all of our perspectives are partial and situated, the use of one or the other method alone does not resolve this subjective tension. Given this, Lawson (1995) contends that feminist scholars can and should take advantage of quantitative techniques within the context of relational ontologies to answer particular kinds of questions and to demonstrate how processes of oppression operate. As part of their methodological work towards transforming gender relations and exposing the diversity of individual experience, the goal of feminist researchers is to erode polarized distinctions by producing work that is both theoretical and practical, basic and applied, abstract and compellingly concrete (Crawford & Kimmel, 1999).

This study employs quantitative methodology to investigate the relationship between gender and autonomy. It is a between-subjects, correlational design which compares the scores of two

groups – men and women - from the student population to test the difference between population means on measures of autonomy, self-construal, and moral orientation. The main research hypothesis is that men will exhibit higher levels of independence in their experience of both autonomy and self-construal, and, correspondingly, will show a greater tendency towards an ethic of justice; women will exhibit higher degrees of interdependence in their experience of their autonomy and their self-construals, and greater tendencies towards an ethic of care in their moral orientations.

3.3 Sample

The primary comparison in this study focused on gender differences. Thus the main sample was comprised of 188 women and 158 men for gender comparison. However, a mixed race (Black and White) sample of men and women was chosen so that a secondary analysis could determine whether there would be similar differences along racial lines. For this purpose, the sample was drawn specifically from student populations of Black men, Black women, White men, and White women. A group of Black student men and women was included as a comparison group to assess the relative degree of independent autonomy versus relational autonomy in Black students compared to White students, and to evaluate whether Black men and Black women experience a more relational form of autonomy than White men and White women respectively. Indian students were not included in this sample because this would have generated too many variable cells for comparison and analysis would have been diluted. It was initially intended that the sample for this study would be comprised of 400 participants: 200 women (100 Black women and 100 White women) and 200 men (100 Black men and 100 White men). However, due to

poor response rate (n=675; 45%) and a large number of spoiled questionnaires (n=329; 48.74%), the final sample was made up as follows: 188 women (100 Black and 88 White) and 158 men (95 Black and 63 White). The demographic details of this sample are shown in Table 3.2.

Table 3.2

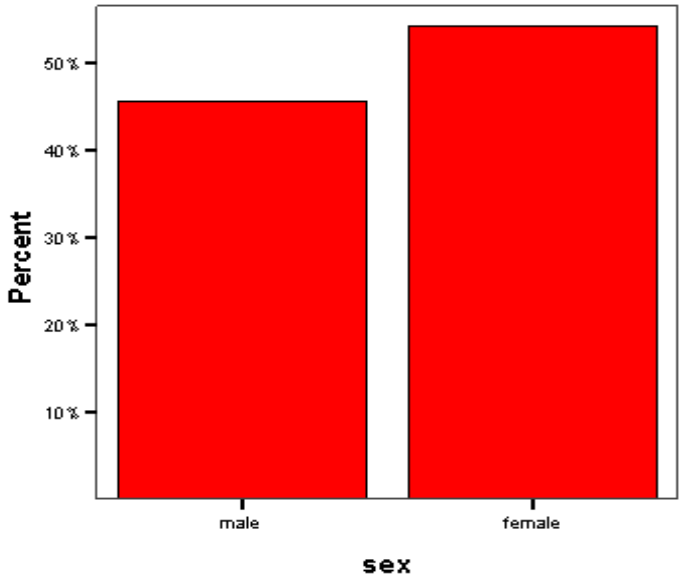
Demographic Data

			RACE		
			BLACK	**WHITE**	**TOTAL SEX**
SEX	**WOMEN**	n	100	88	188
		% of TOTAL	53.19%	46.82%	54.34%
	MEN	n	95	63	158
		% of TOTAL	60.13%	39.87%	45.66%
	TOTAL RACE	n	195	151	346
		% of TOTAL	56.36%	43.64%	100%

3.3.1 Gender

Of the total sample group, 45.66% (n=158) were men and 54.34% (n=188) were women, as depicted in Figure 3.1.

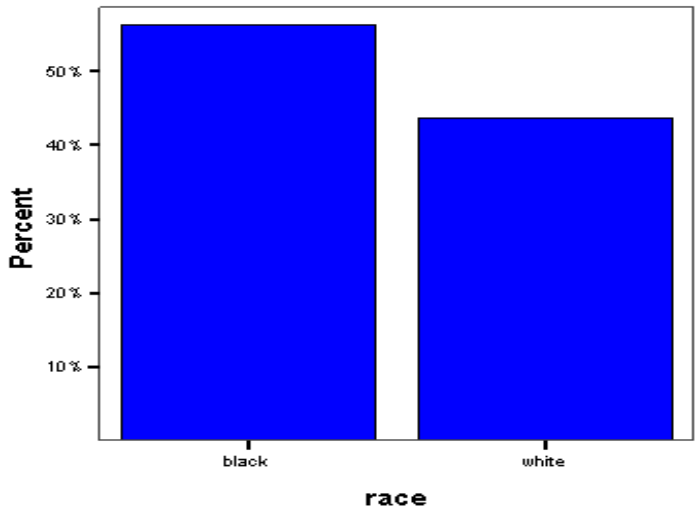
Figure 3.1 Gender



3.3.2 Race

The student sample was made up of 195 Black students (56.36%) and 151 White students (43.64%). (See Figure 3.2).

Figure 3.2 Race



3.3.3 Other Demographics

Age of the sample participants was between 17 and 50 years of age. The majority (n =261; 75.4%) of the sample fell into the 17–21-year age category.

Home language: First-language English speakers comprised the largest language group (n=147; 42.5%), followed by first-language Zulu-speakers (n=143; 41.3%). Other languages reported included Xhosa, Afrikaans, and other African and European languages.

Occupation: Students made up the majority of the sample (n=335; 96.8%). Other occupations were reported mostly as temporary or part-time jobs over and above being students, including waiter, teacher, coach, sales clerk, librarian, and research assistant.

Course: The largest proportion (n=80; 23.1%) of the sample were BSocSci degree students, followed by students in the SFP (Science Foundation Programme) courses (n=79; 22.8%), and thereafter variously distributed between BA, BCom, Psychology, Law, BSc and BAgric students. The majority of the participants were in first year (n=165; 47.7%) and unmarried (n=335; 96.8%).

3.4 Instruments

While many of the standard questions about conditions of informed consent – competence, language, understanding, voluntariness – have been widely explored in the current literature

(Benatar, 2002; Kent, 1996; Lindegger & Richter, 2000; Meisel & Roth, 1983), to date, very little work has been done on the principle of autonomy as it is applied in informed consent procedures in South Africa. As outlined in the literature review above, autonomy does not equate with voluntariness, that is, with competence, understanding, and freedom from coercion. Perceptions and experiences of autonomy extend beyond these checklist criteria, and develop from a web of inter-related factors, among them, selfhood, culture, gender, social and historical influences. The measurement of autonomy, therefore, is not straightforward, and requires instrumentation that will assess as many of the aspects that constitute personal autonomy as possible.

An extensive search of the empirical literature on autonomy was conducted and a number of autonomy scales were found, using gender, self, agency, culture, morality, and ethics/informed consent as the major parameters. It was interesting to note that many of the more relational discussions and assessments of autonomy came from the nursing literature, while review of the literature revealed more frequent treatment of autonomy as voluntariness according to standard criteria of principled autonomy in informed consent. This could be because nurses work more in the divide between the principles of medical ethics and the practice of patient care, creating a need for a more relational form of ethical principles and practices.

The assessment of autonomy in the South African context is problematic, because no appropriate measures of autonomy were found for application to the South African population with adequate validity. In choosing instruments, the primary aim was to measure autonomy as it is understood and practiced in mainstream bioethics vs. relational autonomy as proposed by, among others,

feminist scholars. The main factors being measured were the selfhood dimension of autonomy – independent vs. relational self identity – and the care and justice orientations of autonomy, using gender as the independent variable. Autonomy- and self-related constructs from a number of empirically validated scales were reviewed in order to identify the most appropriate measures for the purposes of this study. An extensive review of the literature yielded several possible scales that could potentially be used in combination to measure the relevant aspects of autonomy, self, and moral orientation. From the 65 measures that were examined, the following 8 instruments were subsequently considered more closely for inclusion in this study: the Autonomy Scale (Bekker, 1993); Autonomy, the Caring Perspective (Boughn, 1995); the Relational-Interdependent Self-Construal Scale (Cross et al., 2000); the Moral Justification Scale (Gump et al., 2000); the Relational Being Scale (McChrystal, 1994); the Relationship Self Inventory (Pearson et al., 1998); the Self-Construal Scale (Singelis, 1994); and the Moral Orientation Scale (Yacker & Weinberg, 1990).

3.4.1 Pilot Instruments

Ultimately, the final instrument had to include a measure of independent versus relational autonomy; a measure of independent versus relational self; and a measure of justice versus care orientations. Of these, the following were chosen to measure autonomy – Bekker (1993), Boughn (1995) – the following to measure relational / independent aspects of the self – Cross et al. (2000), McChrystal (1994), Pearson et al. (1998), and Singelis (1994) – and the following to measure the justice and care moral orientations – Gump et al. (2000) and Yacker and Weinberg (1990). (See Appendix A for a comparison of these scales). The authors of each scale were

contacted to explain the purpose and goals of the research and to request permission to use their scales in this study. Every author responded positively and granted permission for their scales to be used in this research. Further correspondence was entered into with some of the authors concerning subsequent studies that they had conducted using their scales, and providing valuable insights or comments on the proposed research. After further examination the measures that were included in a preliminary pilot study were Bekker's (1993) Autonomy Scale; Cross et al.'s (2000) Relational-Interdependent Self-Construal Scale; and Pearson et al.'s (1998) Relationship Self Inventory.

During the pilot study (N=52), it became clear that the Autonomy Scale (Bekker, 1993) and the Relationship Self Inventory (Pearson et al., 1998) were not the most suitable measures for inclusion in a final questionnaire. Participants in the pilot reported that the statements of the Autonomy Scale were vague and confusing, possibly as a result of the translation of this scale from Dutch to English. The results generated by this scale were also unsatisfactory as they were inconsistent and their reliability and validity questionable. It was also found that the Relationship Self Inventory was too long (60 items) and reportedly tedious to answer; it was thus not included in the final questionnaire given the time constraints in asking participant students to complete the instrument in an allocated amount of time.

Based on the feedback and results from the pilot study, available instruments were reconsidered. Length of the scale was an important consideration, as was simplicity of language. In the final elimination, three self-report questionnaires were included to assess autonomy, self-other orientation, and moral orientation: McChrystal's (1994) Relational Being Scale; Cross et al.'s

(2000) Relational-Interdependent Self-Construal Scale; and Yacker and Weinburg's (1990) Moral Orientation Scale. These instruments are discussed in further detail below.

3.4.2 Relational Being Scale

3.4.2.1 Description

The Relational Being Scale (McChrystal, 1994) is based on the Stone Center's self-in-relation theories – that relational beings develop in and through a matrix of relationships with, rather than through separation from, other people (McChrystal, 1994). The Relational Being Scale (RBS) (see Appendix C) is a self-report, visual analogue scale that was developed to quantitatively measure the qualities of relatedness and autonomy as defined by Gilligan (1982), Miller (1986, 1990), Surrey (1991) and their colleagues at the Stone Center. Comprising 28 items in total, the RBS has two subscales: the Autonomy subscale (A) with 13 items, and the Relational subscale (R) with 15 items. R subscale items were devised using key concepts from Relational Being theory – "the maintenance of relationships over adherence to abstract concepts of justice; definition of self; the theory of human development; the concept of the ideal person; the capacity for empathy; psychopathology and psychotherapy practice" (McChrystal, 1994, p. 5). These concepts were formulated into statements which required participants to consider their opinions of themselves in their responses. Items for the A subscale were inferred from the concepts generated from the work on relatedness.

3.4.2.2 Reliability and validity coefficients

In the original study, total scale alphas and item total correlations were 0.68 for the A subscale and 0.77 for the R subscale. The interscale correlation (-0.18) indicated no correlation between the two scales (McChrystal, 1994). No reliability data were given by the authors.

3.4.2.3 Administration and scoring

The RBS is a visual analogue scale: each statement is followed by a 9cm line, with 'very accurate' at the left end of the line and 'very inaccurate' at the right end of the line. Respondents are asked to make a cross at the point which most accurately reflects the accuracy of the statement as it applies to them. A ruler is used to score each item – it is placed along the line and the centimeter measurement (of 1-10) where the participant has marked his /her cross is given as the score. The lines are measured from right to left.

3.4.3 Relational-Interdependent Self-Construal Scale

3.4.3.1 Description

The Relational-Interdependent Self-Construal (RISC) Scale (Cross et al., 2000) developed out of the growing concern that Western, individualistic assumptions of personhood dominate much of the research on the self, while the connection of the self to others has largely been ignored (Cross & Madson, 1997). More recently researchers have begun to recognize the importance of others in the self-identities of many people, particularly women, while individual differences in the self-construal have been shown to explain some of the differences women and men's behaviours (Markus & Oyserman, 1989; Surrey, 1991). The RISC Scale (see Appendix C) was developed by

Cross et al. (2000) to measure the tendency to define self in relation to others, identified as the relational-interdependent self-construal. Items were generated from concepts related to relational forms of the interdependent self-construal as defined in the literature, as well as from modifications of conceptually related measures. It was found that individuals with high RISC Scale scores were more committed to and placed greater importance on their close relationships, and were more likely to take the needs and opinions of others into account when making decisions (Cross et al., 2000). The RISC Scale was subsequently examined in three separate studies: a validation study; a study of the role of relationship considerations in decision-making; and an investigation into the association between the relational-interdependent self-construal and relationship development strategies (Cross et al., 2000). In the original studies, women consistently scored higher on the RISC scale than men did.

3.4.3.2 Reliability and validity coefficients

The original validation study found the RISC to be a relatively stable self-report measure of individual differences in the relational-interdependent self-construal construct (Cross et al., 2000). Factor analysis revealed that the scale is underscored by a single factor, while reliability tests showed the scale to have high internal consistency, convergent, discriminant, and criterion validity, and good test-retest reliability. Coefficient alpha for the original study (averaged across the sub-samples) was 0.88.

3.4.3.3 Administration and scoring

The RISC Scale consists of 11 questions which require subjects to rate self-other attitudes according to a ‘strongly agree’ (score = 7) to a ‘strongly disagree’ (score = 1) forced choice

format (Likert-type scale). Total scores range from 11 to 77. Two of the eleven items are negatively phrased and their scoring is reversed in the data analysis.

3.4.4 Moral Orientation Scale

3.4.4.1 Description

The Moral Orientation Scale Using Childhood Dilemmas (hereafter referred to as the MOS) is an objective test developed by Yacker and Weinberg (1990) to measure two distinct moral orientations as outlined in the work of Kohlberg and Gilligan. Concepts underlying the MOS were based on the hypothesis that individuals showing a stronger care orientation or ethic place greater emphasis on responsibility towards others and the preservation of relationships; those showing a greater tendency towards a justice orientation emphasize individual rights over relationships (Yacker & Weinberg, 1990). The MOS consists of 12 moral dilemmas that children (aged 8-10) typically face in their daily lives (see Appendix C). Although the scale was designed to measure adult moral orientation, childhood dilemmas were used in the assessment as they are relatively simple and universal, as opposed to the moral dilemmas that adults might face (Yacker & Weinberg, 1990). The childhood moral dilemmas were formulated in consultation with child development specialists, and were based on published and unpublished materials including curricula, moral judgement interviews, popular child-rearing texts, and interviews with parents (Yacker & Weinberg, 1990).

The MOS consists of two subscales: a Justice subscale (J) and a Care subscale (C). As hypothesized in the original validation study, there was a significant gender difference on the

scores of the MOS, with men showing a stronger tendency towards a justice orientation and women showing a stronger tendency towards a care orientation.

3.4.4.2 Reliability and validity coefficients

The MOS was found to provide a valid assessment of preferred mode of moral thinking (Yacker & Weinberg, 1990). Initial validation showed the scale to have stable discriminant validity and good test-retest reliability (0.71). No other reliability data was provided in the validation study.

3.4.4.3 Administration and scoring

As mentioned above, the MOS consists of 12 childhood dilemmas that require respondents to imagine that they are helping an 8-to 10-year-old child decide what to do in each situation. Each dilemma is followed by four choice alternatives that respondents must rank from 1 to 4, according to their preferences for choosing each consideration in helping a child decide what to do. Without being identified as such, two of the four choices presented with each dilemma are defined within the justice mode of moral reasoning, and two are framed within the care mode (Yacker & Weinberg, 1990). Only the first choice given for each dilemma is scored in the final analysis: a respondent's total score on the Care subscale is calculated by adding the number of care responses selected as first choices; the number of justice responses selected as first choices are added to obtain the total score on the Justice subscale. Scores may therefore vary from 0 to 12, with higher scores on the Justice and Care subscales indicating a stronger orientation towards justice and care respectively. In order to avoid falsely dichotomizing moral thinking, the authors of the MOS did not designate cut-off scores for the scale, in line with Gilligan's own findings

that individuals do not exhibit one or the other type of moral orientation, but rather stronger tendencies towards a care or justice orientation (Yacker & Weinberg, 1990).

3.4.5 Demographic Questionnaire

A demographic questionnaire (see Appendix C) was included in order to obtain information about participants' age, gender, race, familial, and demographic details. This data provides another source of information against which significant findings can be compared.

3.5 Procedure

3.5.1 Pilot Study

As discussed in section 3.4 above, the first measures chosen for this study were Bekker's (1993) Autonomy Scale; Cross et al.'s (2000) Relational-Interdependent Self-Construal Scale; and Pearson et al.'s (1998) Relationship Self Inventory. From August 2004 to September 2004, the author obtained demographic data from, and administered the Autonomy Scale (AS), the Relational-Interdependent Self-Construal (RISC) Scale, and the Relationship Self Inventory (RSI) to a convenience sample of Black and White South African students after obtaining permission from lecturing staff. A research assistant was employed to go to lecture theatres at the end of Psychology lectures to explain the research to students and ask them to complete the pilot questionnaires. Confidentiality and anonymity were ensured.

There was a very poor response rate (10%) using this method. Students either did not take questionnaires to complete or they would take them and not return them, or fill them out incorrectly. One of the main problems identified was the length of the questionnaires. As a result, the original questionnaires selected were reviewed and the instrument was modified to exclude the longer questionnaire and include different, shorter measures: McChrystal's (1994) Relational Being Scale (RBS), the Relational-Interdependent Self-Construal (RISC) Scale (Cross et al., 2000), and Yacker and Weinberg's (1990) Moral Orientation Scale (MOS). A small, second pilot study was conducted to test whether these questionnaires yielded suitable results for the purposes of this research. Feedback from both this and the initial pilot was valuable in that it indicated ambiguous questions and problematic areas including comprehension of concepts for second language speakers and overlap of measures. Based on these findings, it was decided that the final study would comprise the RBS, the RISC Scale, and the MOS.

3.5.2 Main Study

From January to March 2005, the author approached lecturers to request permission to come into their lectures and use the last 10 minutes to explain the research to students and ask them to complete the questionnaire in class. Permission was obtained from lecturers of psychology, philosophy, law, and English undergraduate classes to hand out questionnaires at their lectures. The author and four research assistants went to different lectures with prior approval from lecturers to explain the research and hand out questionnaires at the end of lectures to those students willing to complete them. The researcher requested that time be allowed for a brief explanation of the nature and aims of the study (Appendix B), as well as confirmation of

confidentiality and the right to refuse to participate or to withdraw. Students were not required to put their names on the questionnaires and this anonymity ensured confidentiality. It was also emphasized that completion of the questionnaires was not related to course requirements or assessment, and some students chose not to take questionnaires to complete. Those who took questionnaires to fill out were asked to hand them in on completion or, if they did not finish before their next lecture, were told to hand in to their lecturer or at the School of Psychology. Of the 1500 sets of questionnaires that were distributed, 675 were returned, a response rate of 45%. Of the returned questionnaires, 346 (51.26%) were usable.

The questionnaires were scored, and the results were entered onto a spreadsheet. The data was subsequently analyzed using the Statistical Package for the Social Sciences (SPSS, 2004). Demographic information was analyzed quantitatively using descriptive statistics on SPSS (2004). The results obtained from analysis of questionnaire scores was correlated with the demographic data, and specifically with the categories of gender and culture to determine if results were systematically associated with gender and demographic variables.

3.6 Analysis of Data

The data comprised self-report questionnaire responses and the results were generated by the scoring of these responses. Descriptive statistics were used to analyze the information obtained from the demographic questionnaire. The scores for each subject on the Relational Being Scale (RBS) subscales, the Relational-Interdependent Self-Construal (RISC) Scale, and the Moral

Orientation Scale (MOS) subscales were calculated and analyzed using inferential statistical procedures on SPSS (2004). The significance level was set at $p<0.05$ throughout the analysis.

3.6.1 Assumption Testing

Levene's test for homogeneity of data was used to establish that the data were normally distributed. Parametric tests (Multivariate Analysis of Variance) could thus be used to test for significant differences because the data were normally distributed and had equal variances.

3.6.2 Reliability Testing

Reliability analyses were performed on the RBS, RISC Scale and the MOS to establish the internal consistency of each of these measures. The alpha (Cronbach) value of 0.82 for the RISC was sufficiently high to justify inclusion of this measure. The low alpha values for the Relational Being Scale subscales (0.64 for the A subscale and 0.52 for the R subscale) suggest that this scale was not a sufficiently reliable measure for inclusion, and that the results should be interpreted with caution.

3.6.3 Descriptive Statistics

The mean scores and standard deviations for each subscale of the RBS, the RISC and the MOS were calculated separately for men and women, and then for Black men, Black women, White men, and White women.

3.6.4 The Relational Being Subscales

A Multivariate Analysis of Variance (MANOVA) was used to test for significant differences in average values between men and women on the RBS subscales. It was possible to use this parametric test because the groups had equal variances.

3.6.5 The Relational-Interdependent Self-Construal Scale

The differences between men and women on the RISC Scale scores were assessed with MANOVA.

3.6.6 The Moral Orientation Subscales

Significant differences between men and women on the MOS subscales were tested for using the MANOVA.

3.6.7 The Relationship between Gender, Race, and the RBS, RISC and MOS Subscales

MANOVA was used to test for significant differences on the RBS subscales between Black men, White men, Black women and White women. MANOVA was also used to test for significant differences between Black women, White women, Black men and White men on the RISC Scale and on the MOS subscales. Where there were significant interactions between groups, Bonferroni's pairwise comparisons indicated where the significant differences were.

3.6.8 Correlations

Using Bivariate Correlation Analysis, the correlations between the RBS subscales, the RISC Scale, and the MOS subscales were computed separately for men and women, and for Black women, Black men, White women and White men.

3.7 Ethical Considerations

At the time that this study was planned and conducted, no mandatory ethics review procedures were in place for social sciences at the University of KwaZulu-Natal. The researcher and supervisor accepted the responsibility for ensuring ethical practice for the duration of this study. The recruitment of participants for the interviews was on a voluntary basis. The volunteers were informed of their freedom to choose not to participate and their right to withdraw. Although this study is located in the context of HIV/AIDS vaccine trials, the specific content of the discussions and envisaged questionnaire contained no reference to HIV/AIDS, and pertained instead to informed consent and autonomy-related topics, which were not considered to be of a particularly sensitive nature. No risks or potentially harmful consequences of the interview were thus anticipated or experienced, nor was debriefing considered necessary. Questions surrounding the validity of employing Western theories and measures in the South African cultural context demonstrate the importance of developing a culture- and gender-sensitive measure of autonomy, and interpreting results with caution. Every effort was made to avoid any gender or cultural bias and insensitivity while conducting the study and reporting the findings.

4. RESULTS

This chapter will present the results generated by analysis of the data collected in the investigation. The variables that were analyzed are as follows: the Autonomy and Relational subscales of the Relational Being Scale (RBS); the global scores of the Relational-Interdependent Self-Construal (RISC) Scale; and the Justice and Care subscales of the Moral Orientation Scale (MOS). The results are presented in six sections. Firstly, the demographic data of the sample, followed by the mean subscale scores for the RBS, RISC and MOS for both groups - women and men - are summarized. Thereafter, each of the four hypotheses of the study is addressed. Although the association between subscale scores, gender and *race* was not a primary hypothesis of this study, the effects of race and gender are also presented for review and discussion in each of the above sections as a secondary investigation in this research. Finally, qualitative observations are discussed.

4. 1 Demographic Data

Of the 1500 sets of questionnaires that were distributed, 675 (45%) questionnaires were returned, of which 251 (37.18%) were spoiled, 78 (11.56%) had missing data, and 346 (51.26%) were usable. Of the useable sample, 45.66% (n=158) were men and 54.34% (n=188) were women. Demographic data for each of the groups can be found in Table 3.2 on page 131.

4.2 Mean Subscale Scores

4.2.1 The Relational Being Scale

The mean RBS subscale scores for men and women are presented in Table 4.1, and the subscale scores for Black men, Black women, White men, and White women are presented in Table 4.2.

Table 4.1

Means for Relational Being Scale Subscales by Gender

		GENDER	
		Men	Women
AUTONOMY	Mean	91.12	88.64
	n	158	188
	Std Deviation	13.40	12.78
RELATION	Mean	91.50	94.53
	n	158	188
	Std Deviation	14.61	12.75
McCHRYSTAL'S AUTONOMY	Mean	58.52	61.16
	n	19	33
	Std Deviation	15.51	9.78
McCHRYSTAL'S RELATION	Mean	71.00	74.82
	n	19	34
	Std Deviation	25.49	15.36

Table 4.2

Means for Relational Being Scale Subscales by Gender and Race

		GENDER & RACE			
		Black Men	Black Women	White Men	White Women
AUTONOMY	Mean	91.2	90.46	91.04	86.81
	n	95	100	63	88
	Std Deviation	14	14.58	12.56	10.11
RELATION	Mean	95.79	93.14	87.21	95.93
	n	95	100	63	88
	Std Deviation	13.36	13.75	15	11.4

The mean scores on both of the RBS subscales (A and R) for all South African sample groups were higher than the male and female sample from McChrystal's (1994) original study. Men scored higher on average than women on the Autonomy (A) subscale, while women's mean score on the Relation (R) subscale was higher than men's.

The Black group scored higher than the White group on both the Autonomy and the Relation subscales (see Appendix E for table of RBS means by race). Black men had the highest mean scores and White women the lowest on Autonomy. Black men only scored marginally higher on average than Black women on Autonomy, a result that is particularly interesting when compared with the mean scores of these two groups on the R subscale, where Black men's mean scores were notably higher than Black women's mean scores. Of the four race by gender groups, White

women scored highest on Relation, followed by Black men. White men scored the lowest on this subscale.

4.2.2 The Relational-Interdependent Self-Construal Scale

The mean scores of the RISC Scale for men and women, and for Black men, Black women, White men, and White women, are summarized in Table 4.3.

Table 4.3

Means for Relational-Interdependent Self-Construal Scale Scores

		GENDER		GENDER & RACE			
		Men	Women	Black Men	Black Women	White Men	White Women
RISC	Mean	55.58	58.04	55.04	54.6	56.11	61.49
	n	158	188	95	100	63	88
	Std Deviation	11.07	9.92	10.28	10.08	12.22	8.39
CROSS et al.'s RISC (Sample 1)	Mean	52.89	55.11				
	n	111	152				
	Std Deviation	8.07	10.03				
CROSS et al.'s RISC (Sample 8)	Mean	54.48	57.78				
	n	111	143				
	Std Deviation	9.38	9.50				

There were marginal differences between the mean scores on the RISC of women in the present study and those in the original validation study (Cross et al., 2000), with the former group scoring higher than both Sample 1 and Sample 2 from the original study. Interestingly, the male sample in this study had higher mean scores than the men in Samples 1 and 2 of the original study. In the current study, women's mean scores were consistently higher than those of the men. The mean scores of the White group on the RISC were higher than the RISC mean scores of the Black group (see Appendix E for table of RISC means by race). Examination of the race by gender sample groups reveals similar findings to the gender analysis for the White but not the Black group. On average, White women scored higher than White men and all other groups on the RISC; however, Black men scored higher than Black women. Interestingly, the mean scores of White men were higher than the scores of both Black women and Black men.

4.2.3 The Moral Orientation Scale

The mean subscale scores of the MOS for men and women are presented in Table 4.4, and the mean scores for Black men, Black women, White men, and White women are presented in Table 4.5. Consistent with expectations, men in this study had higher mean scores than women on the Justice subscale, while women scored higher on average than men on the Care subscale. In both cases, the differences were marginal.

Comparing these subscale scores in the race and the race by gender sample groups, however, the results are somewhat different. The Justice mean scores of the White group were higher than those of the Black group, while the Black group's Care mean scores were higher than those of

the White group (see Appendix E for table of MOS means by race). White men had the highest mean scores on Justice, closely followed by White women. Interestingly, Black men scored lower on Justice but higher on Care than all other groups. Black women had the second highest mean scores on Care, followed by White women. Consistent with their highest scores on Justice, White men had the lowest mean scores on Care.

Table 4.4

Means for Moral Orientation Scale Subscales by Gender

		GENDER	
		Men	Women
JUSTICE	Mean	7.02	6.94
	n	158	188
	Std Deviation	1.85	1.70
CARE	Mean	4.98	5.06
	n	158	188
	Std Deviation	1.82	1.72
YACKER & WEINBERG's MOS* (Sample 1)	Mean	5.62	5.95
	n	29	22
	Std Deviation	2.4	2.2
YACKER & WEINBERG's MOS* (Sample 2)	Mean	5.90	6.86
	n	20	28
	Std Deviation	2.8	1.8

***** Total MOS score is equal to the number of care responses selected as first choice and may vary from 0, indicating a strong justice orientation, to 12, indicating a strong care orientation.

Table 4.5

Means for Moral Orientation Scale Subscales by Gender and Race

		GENDER & RACE			
		Black Men	Black Women	White Men	White Women
JUSTICE	Mean	6.62	6.79	7.43	7.09
	n	95	100	63	88
	Std Deviation	1.84	1.75	1.76	1.64
CARE	Mean	5.37	5.2	4.6	4.9
	n	95	100	63	88
	Std Deviation	1.83	1.80	1.73	1.62

***** Total MOS score is equal to the number of care responses selected as first choice and may vary from 0, indicating a strong justice orientation, to 12, indicating a strong care orientation.

4.3 The Association between Autonomy and Gender (and Race)

4.3.1 Autonomy and Gender

The differences between average values for men and women on the Autonomy and Relation subscales of the RBS were tested for significance using a Multivariate Analysis of Variance (MANOVA). As shown in Table 4.6 below, only one of the two expected gender differences on the Relational Being Scale subscales was significant. As predicted, women had significantly higher scores than men on Relation. While men scored higher than women on Autonomy, this difference was not significant.

Table 4.6

Comparison of Gender Means on Relational Being Scale Subscales

	Men: Mean	Women: Mean	df	Mean Square	F	Significance
AUTONOMY	91.21	88.64	1	517.089	3.041	.082
RELATION	91.50	94.53	1	770.594	4.336	.038*

*The mean difference was significant at the .05 level.

4.3.2 Autonomy and Race

There was one significant difference between race groups on the Relational Being Scale subscales. The Black group had significantly higher scores than the White group on the Relation subscale. The Black group also scored unexpectedly higher than the White group on the Autonomy subscale but this difference was not significant. These results are shown in Table 4.7 below.

Table 4.7

Comparison of Race Means on Relational Being Scale Subscales

	White: Mean	Black: Mean	df	Mean Square	F	Significance
AUTONOMY	88.93	90.83	1	301.432	1.773	.184
RELATION	91.57	94.46	1	701.299	3.946	.048*

*The mean difference was significant at the .05 level.

Differences between the RBS subscale scores of Black women, Black men, White women, and White men were assessed for significance using Multivariate Analysis of Variance (MANOVA). These results are summarized in Table 4.8. Significant differences between each group on the

Autonomy and Relation subscales were assessed using Bonferroni's pairwise comparisons, as shown in Table 4.9.

Table 4.8

Comparison of Gender by Race Interactions on Relational Being Scale Subscales

	df	Mean Square	F	Significance
AUTONOMY	3	368.775	2.175	.091
RELATION	3	1174.964	6.612	.001*

*The mean difference was significant at the .05 level.

Table 4.9

Comparison of Significant Differences on RBS Scores between Black Men, White Men, White Women and Black Women

			Black Men	White Men	White Women	Black Women
AUTONOMY	Means		91.2	91.04	86.81	90.46
	Black Men	Sig.	-	1	.142	1
	White Men	Sig.	1	-	.301	1
	White Women	Sig.	.142	.301	-	.342
	Black Women	Sig.	1	1	.342	-
RELATION	Means		95.79	87.21	95.93	93.14
	Black Men	Sig.	-	.001*	1	.993
	White Men	Sig.	.001*	-	.001*	.036*
	White Women	Sig.	1	.001*	-	.915
	Black Women	Sig.	.993	.036*	.915	-

***** The mean difference was significant at the .05 level.

Overall, women's mean scores on the Relation subscale were higher than men's scores; men's Autonomy mean scores were higher than women's Autonomy scores. The mean scores of Black men on Autonomy were ranked the highest, followed by White men, Black women and, finally, White women. Conversely, White women scored highest on the Relation subscale, followed by Black men, Black women and, finally, White men.

Analyzed for significant differences by race and gender using MANOVA, the above results show that White women's Relation scores were significantly higher than White men's scores on this subscale. However, while White men scored higher than White women on Autonomy, this difference was not significant. The higher scores of Black men compared with Black women on the Autonomy subscale were consistent with the results of the White subgroup; however, this difference was not significant. Contrary to expectation, the scores of Black men on Relation were also higher than those of Black women, although not significantly so. Results across all four groups showed that there were no significant differences between Black men, White men, Black women and White women on the Autonomy subscale. On the Relation subscale, Black men, Black women, and White women all scored significantly higher than White men.

4.4 The Association between Self-Construal and Gender (and Race)

4.4.1 Self and Gender

Women scored significantly higher than men on the Relational Interdependent Self-Construal (RISC) Scale, as shown in Table 4.10.

Table 4.10

Comparison of Gender Means on the Relational Interdependent Self-Construal Scale

	Men: Mean	Women: Mean	df	Mean Square	F	Significance
RISC	55.58	58.04	1	509.984	4.931	.027*

*The mean difference was significant at the .05 level.

4.4.2 Self and Race

The RISC mean scores of the White group were significantly higher than the RISC mean scores of the Black group. These results are presented in Table 4.11 below.

Table 4.11

Comparison of Race Means on the Relational Interdependent Self-Construal Scale

	White: Mean	Black: Mean	df	Mean Square	F	Significance
RISC	58.8	54.82	1	1325.798	12.820	.001*

*The mean difference was significant at the .05 level.

The results of the analysis by gender and race, using MANOVA and Bonferroni's pairwise comparisons on the RISC scores are summarized, respectively, in Table 4.12 and Table 4.13 below. White women scored significantly higher than White men on the RISC. In contrast, Black men's RISC scores were higher than Black women's scores but this difference was not significant. The RISC mean scores of White women were significantly higher than those of Black women, Black men and White men. There were no other significant differences. Interestingly, the RISC mean scores of White men were higher than those of Black women and Black men, although not significantly different.

Table 4.12

Gender by Race Interactions on the RISC Scale

	df	Mean Square	F	Significance
RISC	3	913.694	8.835	.001*

*The mean difference was significant at the .05 level.

Table 4.13

Comparison of Significant Differences on RISC Scores between Black Men, White Men, White Women and Black Women

			Black Men	White Men	White Women	Black Women
RISC Scores	Means		55.04	56.11	61.49	54.6
	Black Men	Sig.	-	1	.001*	1
	White Men	Sig.	1	-	.009*	1
	White Women	Sig.	.001*	.009*	-	.001*
	Black Women	Sig.	1	1	.001*	-

***** The mean difference was significant at the .05 level.

4.5 The Association between Moral Orientation and Gender (and Race)

4.5.1 Moral Orientation and Gender

No significant gender differences were found on either the Justice or the Care subscale of the Moral Orientation Scale. The Justice subscale scores of men on the MOS were greater than women's Justice scores. Women's Care scores were higher than the scores of men on the Care subscale, as shown in Table 4.14 below.

Table 4.14

Comparison of Gender Means on the Moral Orientation Scale Subscales

	Men: Mean	Women: Mean	df	Mean Square	F	Significance
JUSTICE	7.02	6.94	1	.596	.195	.659
CARE	4.98	5.06	1	.464	.151	.698

4.5.2 Moral Orientation and Race

Whites scored significantly higher than Blacks on the Justice subscale, while the Black group scored significantly higher than the White group on the Care subscale, as seen in Table 4.15 below.

Table 4.15

Comparison of Race Means on the Moral Orientation Scale Subscales

	White: Mean	Black: Mean	df	Mean Square	F	Significance
JUSTICE	7.26	6.71	1	25.723	8.397	.004*
CARE	4.76	5.28	1	22.854	7.447	.007*

*The mean difference was significant at the .05 level.

The interaction effects between the mean subscale scores on the MOS for Black women, Black men, White women, and White men were analyzed using MANOVA and are presented in Table 4.16 below. Significant differences between each group were assessed using Bonferroni's pairwise comparisons, as shown in Table 4.17. There were no significant gender differences within the White group or the Black group on the MOS subscales. White men scored higher on Justice than White women, while White women scored higher on Care than White men. These differences were not significant. Conversely, Black women's Justice scores were higher than those of Black men; Black men's Care scores were greater than Black women's Care scores. Neither of these differences was significant. The scores of White men on the Justice subscale were significantly higher than the scores of Black men but there were no other significant gender by race differences on this subscale. Black men scored significantly higher on the Care subscale than White men. The mean ranks for the Justice and Care subscales were as follows: Justice: White men > White women > Black women > Black men; Care: Black men > Black women > White women > White men.

Table 4.16

Comparison of Gender by Race Interactions on the MOS Subscales

	df	Mean Square	F	Significance
JUSTICE	3	9.651	3.150	.025*
CARE	3	8.614	2.807	.040*

*The mean difference was significant at the .05 level.

Table 4.17

Comparison of Significant Differences on MOS Subscale Scores between Black Men, White Men, White Women and Black Women

			Black Men	White Men	White Women	Black Women
JUSTICE	Means		6.62	7.43	7.09	6.8
	Black Men	Sig.	-	.029*	.423	1
	White Men	Sig.	.029*	-	1	.144
	White Women	Sig.	.423	1	-	1
	Black Women	Sig.	1	.144	1	-
CARE	Means		5.38	4.6	4.91	5.2
	Black Men	Sig.	-	.045*	.509	1
	White Men	Sig.	.045*	-	.219	.209
	White Women	Sig.	.509	.219	-	1
	Black Women	Sig.	1	.209	1	-

***** The mean difference was significant at the .05 level.

4.6 Correlations between Scores by Gender (and Race)

4.6.1 Correlations between RBS, RISC and MOS Scores by Gender

Correlations between each of the subscales of the RBS, MOS, and the RISC Scale were done separately for men and women and are shown in Table 4.18 below. Correlations between men's scores on all three scales showed significant positive correlations between Autonomy and RISC scores, and between Relation and RISC scores. As expected, there were significant negative correlations between the Justice and Care subscale scores of both men and women. There were no significant positive correlations between the subscale scores of the RBS, MOS and the RISC Scale scores of women.

4.6.2 Correlations between RBS, RISC and MOS Scores by Race

Correlations by race on each of the scales are shown in Table 4.19 in Appendix F. Correlations by race were as follows: Consistent with what was expected, there was a significant negative correlation between the Justice and Care scores of the Black group. However, the scores of the Black group on the Autonomy subscale were significantly positively correlated with their scores on the Relation subscale. This is contrary to the hypothesis, as these two subscale scores were designed to measure variables on opposite ends of the autonomy/relation continuum. This, together with the low reliability score of the RBS, suggests that there may be problems with the validity as well as the reliability of the Relational Being Scale. Similarly, in the White group scores on the Autonomy subscale were significantly positively correlated with RISC scores.

Table 4.18

Correlations between RBS, RISC and MOS Scores by Gender

GENDER			Autonomy	Relation	RISC	Justice	Care
Men	Autonomy	Pearson Correlation	1	.128	.232(**)	.011	-.014
		Sig. (2-tailed)	.	.109	.003	.893	.858
		n	158	158	158	158	158
	Relation	Pearson Correlation	.128	1	.234(**)	-.135	.135
		Sig. (2-tailed)	.109	.	.003	.090	.091
		n	158	158	158	158	158
	RISC	Pearson Correlation	.232(**)	.234(**)	1	-.058	.065
		Sig. (2-tailed)	.003	.003	.	.467	.414
		n	158	158	158	158	158
	Justice	Pearson Correlation	.011	-.135	-.058	1	-.995(**)
		Sig. (2-tailed)	.893	.090	.467	.	.000
		n	158	158	158	158	158
	Care	Pearson Correlation	-.014	.135	.065	-.995(**)	1
		Sig. (2-tailed)	.858	.091	.414	.000	.
		n	158	158	158	158	158
Women	Autonomy	Pearson Correlation	1	.012	.055	.093	-.068
		Sig. (2-tailed)	.	.872	.451	.203	.352
		n	188	188	188	188	188
	Relation	Pearson Correlation	.012	1	.074	.085	-.056
		Sig. (2-tailed)	.872	.	.314	.244	.447
		n	188	188	188	188	188
	RISC	Pearson Correlation	.055	.074	1	-.054	.021
		Sig. (2-tailed)	.451	.314	.	.460	.771
		n	188	188	188	188	188
	Justice	Pearson Correlation	.093	.085	-.054	1	-.934(**)
		Sig. (2-tailed)	.203	.244	.460	.	.000
		n	188	188	188	188	188
	Care	Pearson Correlation	-.068	-.056	.021	-.934(**)	1
		Sig. (2-tailed)	.352	.447	.771	.000	.
		n	188	188	188	188	188

** Correlation is significant at the 0.01 level (2-tailed).

Since constructs measuring components of autonomy and of the relational interdependent self would be expected to be negatively correlated, this overlap is unexpected and points to the potential validity problems with the subscales of the Relational Being Scale. Other significant correlations in the White group were found, as predicted, between Relation subscale scores and RISC scores (positively correlated) and between Justice and Care subscale scores (negatively correlated).

Correlations between the Autonomy and Relation subscales of the RBS, the Justice and Care subscales of the MOS, and the global scores of the RISC Scale were calculated separately for Black women, White women, Black men and White men. Significant correlations are shown in Table 4.20 in Appendix F.

White men had the only significant positive correlation between Relation subscale scores and RISC scores. However, significant positive correlations between Autonomy subscale scores and RISC scores were obtained for Black men, White women, and White men. This is contrary to the hypothesis that Autonomy scores would correlate negatively with Relational Interdependent Self Scores. Furthermore, the Autonomy and Relation subscale scores of Black men and White women were significantly positively correlated. Considering that these are polar subscales on the same scale, these results suggest that findings associated with this scale require further investigation and should be interpreted with caution, especially in view of the low reliability of the RBS. There were no significant positive correlations between the scores of Black women on all three scales. The Justice and Care subscale scores for all four groups (Black men, White men,

Black women and White women) were all significantly negatively correlated, consistent with the polarity of these two subscales on the Moral Orientation Scale. Contrary to expectation, there were no significant positive correlations between scores on the Justice and Care subscales and the scores on any of the other subscales for any of the groups.

4.7 Summary of Results

Three hundred and forty six usable questionnaires were returned of the 1500 that were administered. Of this sample, 158 were men and 188 were women. On the Relation subscale of the Relational Being Scale, women scored significantly higher than men. Although men scored higher on average than women on Autonomy, there were no significant differences between men and women on the Autonomy subscale of the Relational Being Scale. Reliability scores on the RBS subscales were relatively low and therefore results on this scale should be interpreted with caution. Women scored significantly higher than men on the Relational Interdependent Self-Construal Scale. No significant gender differences were found on either of the Moral Orientation Scale subscales. Men's Justice subscale scores on the MOS were higher than women's Justice scores; women's Care scores were higher than the scores of men on the Care subscale. Reliability scores for both the RISC and the MOS were considered sufficiently high to justify inclusion of these measures.

In the race-only analysis, the sample comprised 195 Black and 151 White participants. As expected, the Black group scored significantly higher than the White group on the Relation subscale. There were no significant differences between race groups on the Autonomy subscale. The RISC mean scores of the White group were unexpectedly significantly higher than the RISC

mean scores of the Black group. As hypothesized, Whites scored significantly higher than Blacks on the Justice subscale, while the Black group scored significantly higher than the White group on the Care subscale.

The sample by race and gender was divided as follows: 100 Black women, 95 Black men, 88 White women, and 63 White men. While White men scored higher on average than White women on the Autonomy subscale, and Black men scored higher than average than Black women on the Autonomy subscale, these differences were not significant. Analyzed for race and gender, results across all four groups showed that the mean scores on the Autonomy subscale of Black men, White men, and Black women were significantly higher than the mean scores of White women. Given that this was the only significant result found on the Autonomy subscale across all analyses, and given the unexpected significant positive correlations between Autonomy and Relation subscale scores, it seems likely that the reliability of the results on the Autonomy subscale, and on the Relational Being Scale in general, is low. On the Relation subscale, Black men, Black women, and White women all scored significantly higher than White men, as expected. The RISC mean scores of White women were significantly higher than those of Black women, Black men and White men. There were no other significant differences on this scale in the gender by race analysis. Black men scored unexpectedly higher than Black women on the RISC scale but this was not a significant difference.

The scores of White men on the Justice subscale were significantly higher than the scores Black men. Black men scored significantly higher on the Care subscale than White men. These were the only significant differences in the gender by race analyses on the Justice and Care subscales.

Although White men had higher Justice scores than White women and White women had higher Care scores than White men, these differences were not significant. Contrary to the hypothesis, Black women's Justice scores were higher than the Justice scores of Black men, while Black men scored higher on the Care subscale than did Black women. Neither of these differences was significant.

There were significant positive correlations between the subscale scores of men on Autonomy and RISC and between Relation and RISC. There were no significant positive correlations between any of the subscale scores for women. Analyzed by race alone, Autonomy and Relation were significantly positively correlated for the Black group, while Autonomy and RISC scores and Relation and RISC scores were significantly positively correlated for the White group. Significant positive correlations were also found between the Autonomy subscale scores and RISC scores were found for Black men, White women, and White men. Moreover, the Autonomy and Relation subscale scores of Black men and White women were significantly positively correlated. Given that these results were unexpected and unlikely, it is probable that the low reliability of the Autonomy subscale in particular significantly influenced the results. The Relation subscale scores and RISC scores of White men were significantly positively correlated. No significant positive correlations were found for Black women on any of the scales. Justice and Care subscale scores were significantly negatively correlated across all groups, consistent with their polarity on the Moral Orientation Scale.

In summary, the hypotheses of this study were only partially confirmed. In the primary analysis, hypotheses were tested by gender alone. In terms of gender differences on the Relational Being

Scale subscales, the hypothesis that women would show significantly higher results on Relation than men was supported, suggesting higher levels of relational autonomy in women. Although the direction of difference on the Autonomy subscale was as predicted (men higher than women), this difference was not statistically significant and therefore cannot confirm the hypothesis. The hypothesis that women would be significantly higher than men on the Relational Interdependent Self Construal scale was supported. However, the gender differences found on the Justice and Care subscales of the Moral Orientation Scale, although in the expected direction, were not significant.

When analyzed by race, the hypothesis that Black participants would score significantly higher on Relation than White participants was confirmed. However, this result was somewhat complicated by the finding that the Black group also scored higher than the White group on the Autonomy subscale, although this difference was not found to be significant. The significant differences between Black and White scores on the RISC were in direct contrast to what was hypothesized, as the White group actually scored significantly higher on the RISC than the Black group. The hypotheses on the Moral Orientation Scale were confirmed for race: Whites scored significantly higher than Blacks on Justice, while Blacks scored significantly higher than Whites on Care. In the third and final analysis, examining race by gender, similar contradictory results were found. Within the White group, the significant gender difference that was found on the Relation subscale of the RBS was consistent with the hypothesis, as were the significant gender differences on the RISC scale. However, no other significant gender differences were found within the White group to support any of the other hypotheses. Similarly, none of the hypotheses were supported by the results according to gender differences within the Black group.

The finding that White women scored significantly lower than the other three groups (Black women, Black men and White men) on Autonomy, and that White men scored significantly lower than all other groups on Relation, cannot confirm or disconfirm the predicted hypotheses with respect to gender by race differences. Similarly, given that the only significant difference between all four groups on RISC was that White women were higher than Black women, Black men and White men, there is little support for the predicted differences on this variable. Finally, the significantly higher scores of White men on Justice and of Black men on Care than all other groups lends only partial support to the hypothesized differences on the Moral Orientation Scale. These results will be discussed in chapter five in terms of the main hypotheses outlined in chapter three and the literature reviewed in chapter two.

5. DISCUSSION

Most of the expected results were not significant, although all results with respect to gender were in the direction expected and consistent with the hypotheses about autonomy, self-construal, and ethical orientation. However, the fact that most of the expected results were not significant needs to be explored. Examining the results according to race, and race and gender (hereafter gender by race), it seems likely that race was a variable that significantly influenced the findings for gender. In the sections that follow, significant results on each of the hypotheses will be discussed. However, most results on all hypotheses were not significant. Therefore, a number of explanations will be explored to account for why the expected differences turned out to be mostly non-significant.

5.1 The Association between Autonomy and Gender (and Race)

The scores on the Relational Being Scale (RBS) are a measure of qualities of autonomy and relatedness. The Relational subscale measures concepts of relatedness as defined by self-in-relation theories, the priority of relationships over abstract concepts of justice, theories of human development, and notions of the capacity for empathy and the concept of the ideal person (McChrystal, 1994). Items on the Autonomy subscale were inferred from the concepts generated from the work on relatedness. The RBS positions relatedness and autonomy as polar opposites, with high scores on the Relational subscale corresponding with low scores on the Autonomy subscale, and vice versa. It was hypothesized that men would have higher scores on the Autonomy subscale than women, while women would score higher than men on Relation. A

subsequent hypothesis was that the White group would be higher than the Black group on Autonomy, and the Black group would be higher than the White group on Relation.

5.1.1 Autonomy and Gender

Significant findings

Women scored significantly higher than men on the Relation subscale of the Relational Being Scale (RBS). This result lends support to the hypothesis that women have a more relational sense of autonomy than do men. This study drew on theories from the Stone Center and others (Baker-Miller, 1984 in McChrystal, 1994; Jordan, 1984 in McChrystal, 1994; Surrey, 1985 in McChrystal, 1994) that women differ from men in fundamental ways and, specifically, that they value relatedness more than autonomy. The significant gender difference on Relation is consistent with other studies that have found significant gender differences in autonomy (Bekker, 1993; Chodorow, 1978; Miller, 1986, 1990; Surrey, 1991), with women exhibiting a more relational sense of autonomy than men.

However, the lack of significant differences between men and women on the Autonomy subscale of the RBS, as discussed below, suggests that women have a greater tendency towards conventional autonomy than current feminist theory implies. It seems likely that gender differences in the experience of autonomy are less pronounced than previously thought, and that women's stronger tendency towards the relational continuum of this autonomy scale (RBS) lends more support to women's relational sense of self than to a significant difference between men and women's experience of autonomy, particularly given the similarity between women and men's scores on the measure of conventional autonomy. This significant difference in

relatedness between men and women is paralleled by the significant difference between men and women in the experience of a relational interdependent self, and is discussed in further detail in section 5.2.1 below.

Non-significant findings

No significant differences were found between men and women on the Autonomy subscale. The difference between men and women was in the direction anticipated (men higher than women) but was not statistically significant. No conclusions can thus be drawn in support of the hypothesis that men would exhibit greater levels of conventional autonomy than women. This finding adds to a body of research that has also found no evidence in support of differences between men and women in the experience of autonomy (Anderson et al., 1994; McChrystal, 1994). This may be, in part, due to the considerable variation in the way that autonomy has been defined from study to study (Steinberg & Silverberg, 1986).

However, it should be noted that the non-significant results of this study do not necessarily imply that a difference in men's and women's experiences of autonomy does not exist. It could be that men and women do differ in their experience of autonomy, but not as much as posited by some feminist theorists. These differences may have changed in the years since these theories were posited, or it could be that a tertiary education sample of men and women may be more androgynous. Differences between men and women may not be as extreme or distinct as some theories propose, with both men and women experiencing both independent and relational aspects of autonomy. Furthermore, differences between groups may have been previously

overestimated, and there may in fact be greater variation within groups (for example, women) than between groups (Ewing, 1990; Killen, 1997; Turiel & Wainryb, 1994).

While acknowledging the important contribution that relational theories have made to expanding the understanding of the self for women in particular, Berlin and Johnson (1989) argue that, by acknowledging that women have relational capabilities, it seems to be simultaneously concluded that they lack the capacity for or interest in autonomous ability. They attribute the emphasis on difference between the sexes with respect to autonomy to the masculinist connotations that the concept is encumbered with – isolation, hierarchy, self-sufficiency and isolation – making it the opposite what women reportedly value. This could lead to an assumption of homogeneity within groups that plays down the differences within genders. The exaggeration of difference has also been highlighted by Stewart and McDermott (2004). Hare-Mustin and Marecek (1986, p. 210) note that the "construction of gender emphasizes difference, polarity, and hierarchy, rather than similarity and equality of the sexes. Because autonomy and relatedness are viewed as gendered, they come to be seen as opposites, and their similarities are overlooked." This may explain why women scored high on both the Relation and Autonomy subscales of the RBS, indicating high levels of both autonomy and relatedness.

The fact that the results of the current study do not seem to be consistent with previous research that has both found and not found gender differences in autonomy and relatedness may be partially explained by the presence of alpha bias and beta bias (Hare-Mustin & Marecek, 1987) in the theories that focus on gender. Alpha bias is the tendency to exaggerate gender differences, as is apparent in psychodynamic theories, sex role theory, and feminist psychodynamic theories;

beta bias is the tendency to over-generalize psychological research done on men, to women, and is evident some systems approaches to family therapy, and in theories that view male and female roles as complementary (Hare-Mustin & Marecek, 1987). The lack of significant differences between men and women on Autonomy in this study may be in part due to greater similarities between the sexes, and greater differences within the sexes. Furthermore, while interpersonal connection has been shown to be particularly important to women, as demonstrated by women's significantly higher scores on Relation in this study than men, autonomy and its connotations of freedom and agency may actually contribute to the probability of satisfying connections (Berlin & Johnson, 1989). This could account for women's higher than expected scores on the Autonomy subscale of the RBS, whilst still scoring significantly high on Relation.

That the men and women in the current study did not differ significantly on the Autonomy subscale could also be a reflection of the changing times, and of changing gender-role perceptions and expectations. Fleming (2005) also found only marginal gender differences with regard to desire for autonomy. Conversely, significant differences were found between men and women regarding their achievement of autonomy, suggesting that girls do not exhibit the same tendency to struggle for independence as boys, relying more on parental norms. An important implication of Fleming's (2005) study is that girls appear to value autonomy and personal agency as much as boys. Fleming (2005) suggests that studies that have found marked gender differences in autonomy may have been focusing on the achievement of, rather than the desire for, autonomy. These implications lend support to the Autonomy results of this study, and are supported by previous research (Steinberg & Silverberg, 1986).

Similarly, Lamborn and Steinberg (1993) found that girls were more likely than boys to demonstrate emotional autonomy in the context of a supportive parental relationship. Their results call into question the conventional view that the development of autonomy is more developed in males than in females. However, they also found that greater emotional autonomy tended to be associated with more negative outcomes for girls, particularly for girls from certain ethnic backgrounds, which they attribute partially to the cultural pressure on girls to remain less autonomous. This may also explain why the Autonomy scores of women in the current study were higher than expected – but not as high as the scores of men. Women who desire and/or are experiencing greater autonomy may simultaneously be experiencing negative consequences as a result of their increased autonomy, and hence may be placing a limit on the amount of autonomy they achieve or exhibit. Indeed, it has been pointed out that females in societies that value autonomy, assertiveness and individuation, learn to value autonomy and separation and thereby devalue their gender identity, which tends towards affiliation and involvement (Gilligan, 1990; Orbach, 1986). This theory could also account for why women's Relation scores in the current study were significantly higher than men's Relation scores, but, simultaneously, women and men's scores on Autonomy did not differ significantly.

The differences that appear to have existed between men and women in terms of autonomy and relatedness may have narrowed in recent years, with women becoming more autonomous and men more relational. Studies that have found differences between men and women in the opposite direction to what has previously been put forward – i.e., women being more autonomous than men - support this argument (Lamborn & Steinberg, 1993; Steinberg & Silverberg, 1986). Anderson et al. (1994) also suggest that the lack of significant differences may

be, at least in part, because the women's movement has altered past gender discrepancies in levels of autonomy. This may also have resulted in a degree of conflict for women, as they negotiate the discrepancy between their previously relational roles and desires, with their new desire for and levels of autonomy (Gerson, 2002).

Some suggest that women are experiencing a 'splitting' in terms of their gender roles, expectations, and identities (Catina et al., 1996; Layton, 2004). Layton (2004) notes that the psychological position of women is moving away from the relational psyche, towards defensive autonomy – a transition stage, characterized by splitting, between the submissive relational female and the defensively autonomous male. She suggests that since women have moved into the workplace and are doing the same work as men do, they also have the same difficulty with finding time for relationships as men do. Incongruity between women's relational values and the individualistic values of society may lead to identification with an ideal (autonomy) that contradicts gender identity, and is associated with a range of negative outcomes and maladaptive responses for women, such as the development of eating disorders (Mensinger, 2005; Steiner-Adair, 1990). This seems consistent with the conflicting findings on the RBS in this study, where women showed a significantly greater tendency towards relational autonomy than men, but, equally, a tendency towards conventional autonomy that did not differ significantly from men.

In summary, there is evidence to suggest that the differences between men and women with respect to autonomy may not be as pronounced as previously suggested. There has been both alpha – exaggerating difference - and beta – underplaying difference - bias in gender difference research., conversely, that women value autonomy as much as men. It also seems that the gap

between men and women in terms of autonomy has narrowed, although this may have resulted in some conflict for women as they negotiate contradictory gender roles and expectations within themselves and in society. This also suggests that autonomy and relation might not be binary concepts, which is particularly evident in the current study's finding that women scored high on measures of Relation as well as Autonomy.

5.1.2 Autonomy and Race

Significant findings

As hypothesized, Black participants scored significantly higher on the Relation subscale than White participants. It seems likely, then, that individuals from Black cultures have a more relational sense of autonomy than those from White (and arguably more Westernized) cultures. However, in a similar finding to that of the gender differences on this scale, the scores of the Black and White groups on Autonomy were not significantly different and, in fact, Black participants scored higher on average than White participants on this subscale. Therefore, the significant difference on the Relation subscale may reflect a more relational sense of self in Black individuals than a consistently more relational sense of autonomy. As such, the significant difference between Black and White groups on the Relation subscale only partially confirms the hypothesis that White participants would exhibit a more independent, conventional sense of autonomy and Black participants a more relational sense of autonomy.

Non-significant findings

The hypothesis that White participants would score higher than Black participants on Autonomy was not supported as there was no significant difference between the groups as a whole. In fact,

contrary to the expected direction of difference, Black participants actually scored consistently higher on Autonomy than White participants. The absence of a significant difference between Black and White groups on Autonomy will be explored further in section 5.1.2.2 below.

5.1.2.1 Gender differences within race groups

Significant findings

Analyzing the results according to gender differences within each race group yielded some interesting findings. Consistent with the hypothesis, White women's scores on the Relation subscale were significantly higher than White men's Relation scores. For this group, therefore, the hypothesis in terms of relational autonomy was supported statistically. The results on Relation are consistent with theories on the value that men and women place on independence and relatedness, respectively (for example, Friedman, 1998; Meyers, 2000a, 2000b; Nedelsky, 1989; Rosser, 1992) and with empirical research that confirms such differences between men and women (for example, Chodorow, 1978; Bekker, 1993; Miller, 1986, 1990; Surrey, 1991). One possibility for this is that Whites in South Africa can be classified as a Westernized group, and, as such, their preferences for independence and relation are congruent with differences that have been found in other Western samples (Catina et al., 1996).

The significant difference on Relation between White men and women could indicate that men have a stronger tendency towards autonomy and independence than women, whereas women tend towards relatedness and involvement in relationships, at least in this White group. However, as discussed below, there was no significant difference between White men and women on the Autonomy subscale, which suggests that women have a greater sense of

conventional (independent) autonomy than previously argued, and indicates that the hypothesis in terms of gender differences in conventional autonomy for this group can not be confirmed.

Non-significant findings

No significant difference was found between White men and women on Autonomy. Similarly, there was no significant difference between Black men and women on the Autonomy subscale, although, consistent with the findings on gender differences, the direction of difference for this group was as expected, with Black men higher than Black women. These findings are contrary to previous research that has shown consistent gender differences in the experience of conventional notions of autonomy (Chodorow, 1978; Bekker, 1993; Friedman, 1998; Meyers, 2000a, 2000b; Miller, 1986, 1990; Nedelsky, 1989; Rosser, 1992; Surrey, 1991). It is worth noting that, in every analysis conducted on the Autonomy subscale (that is, by gender, by race, and gender by race), no significant differences were found between any two groups, nor were there any significant interactions. This could imply that there were fundamental problems with the construction of this subscale in particular that may have reduced its reliability and complicated the validity of the results. As a result, no conclusive deductions can be made about the relative experience of Autonomy across both gender and racial groups.

Black men and women's scores on Relation were also not significantly different. Furthermore, the hypothesized direction of difference was not supported: the scores of Black men were unexpectedly greater than Black women. Perhaps Black women are tending towards greater autonomy – hence the marginal differences between their scores and those of Black men on Autonomy – and this is reflected in the lower-than expected scores of this group on the Relation

subscale. Since the first democratic elections in South Africa in 1994, the empowerment of women has received a great deal of attention and has been accompanied by the advancement of women, and Black women in particular, in the workplace. These factors may have contributed towards the higher Autonomy and lower Relation scores of Black women, especially if one considers that the sample tested was predominantly university students, who are likely to be more educated and more urbanized than women from rural, traditional Black cultures.

5.1.2.2 Gender differences between race groups

Significant findings

The hypothesis that White men would score significantly lower than White women, Black women and Black men on Relation was statistically supported by the results. However, given that this was the only significant difference between Black men, Black women, White men and White women on both the Autonomy and the Relation subscales, the hypotheses with respect to the experience of independent autonomy and relational autonomy by men and women from Black and White race groups cannot be confirmed.

Non-significant findings

White women had the highest scores on the Relation subscale, although they were not significantly higher than Black women or Black men. In summary, the direction and order of difference in the mean ranks of all four groups, Black men. White men, Black women, and White women, were almost all as expected, although few were significant. Exceptions to the hypothesized direction of differences were the unexpectedly lower scores of Black women than Black men on the Relation subscale, and the higher than expected scores of Black men than

White men on the Autonomy subscale. However, neither of these differences was significant.

Interestingly, although Black men and Black women's scores on Autonomy, while not significantly higher than White women's scores, were higher on average than the scores of White women, while Black men's Autonomy scores were higher on average than White men's Autonomy scores. This is contrary to another study that found Whites to score the highest on a measure of Autonomy compared with both Black and Hispanic cultural groups (Anderson et al., 1994). This, combined with the similarity of Black men and women's scores on Autonomy, and Black women's lower Relation scores than Black men, has interesting implications for the apparent experiences of Black women in terms of autonomy and relation. These will be discussed in further detail below.

Previous studies investigating the claims about culture, gender and the self-concept have found that women exhibit a more interdependent self-construal only in individualistic societies (Watkins et al., 1998; Watkins et al., 2003). This somewhat explains the low scores of Black women in the Relation subscale. Furthermore, the results appear to be partially supported by Watkins et al. (2003) who found that Indian (non-Western) women tended to define themselves in terms of more personal (individual) preferences, while Indian men made more reference to social or group identity. In addition, as mentioned above, the sample in the current study were almost all university students living in an urban environment and experiencing a degree of acculturation (not assessed), which could explain why the expected differences between Black and White participants on Autonomy were not significant. Indeed, Ma and Schoeneman (1997) found that the independent vs. relational divide existed between men and women in rural Kenyan

communities, but that Kenyan university students were similar to American university students in their responses.

Similarly, studies that examined gender differences in collectivist cultures (African, Indian and Nepalese) have found that women who achieve relative educational success (such as reaching a tertiary educational level) tend to be atypical in comparison to other women in their culture, exhibiting more male-like and individualistic self-conceptions (Watkins et al., 2003). This seems to hold true for the Black but not the White women in the current sample. Catina et al. (1996) investigated the differences in the experience of autonomy between women from economically-developed Western European countries, and less well-developed Eastern European countries. They found that women in the latter countries were socialized so as to prepare them for the dual role of mother and professional – roles which are portrayed as compatible rather than oppositional, as they are in West European countries.

> Apparently, German females define social ideals of autonomy, individuation and separation in terms of interpersonal detachment, whereas Bulgarians are more inclined to see them as individual enhancements in the context of interpersonal relationships (Catina et al., 1996, p. 105).

It could be argued that the socialization experiences of White women versus Black women in South Africa can account for the contrary findings on both the Autonomy and Relation subscales.

It has been previously suggested that Black women may not be as high as expected on measures of relation because they have different child-rearing and socialization experiences to White women. While acknowledging the value of relational theories for Black women, Black feminists have pointed out important differences between groups of women, which include differences in

mothering, and in the mother-daughter relationship, as well as the societal and historical contexts within which women's identities are formed (Henderson, 1997). Like the women in the Bulgarian sample, some argue that Black women are raised to become strong, independent women who may have to eventually become heads of households as a result of precarious circumstances growing out of poverty and racism (Joseph, 1991). This, they argue, is in contrast to White girls, who are raised to be relational and dependent. Collins (1990) argues that independence, self-reliance and resistance are central themes in Black women's psychology, while simultaneously emphasizing the importance of relationships in their lives. Because Black women's development of self tends to be within a societal context of negative images of Black women, Black mothers may be teaching their daughters resistance and self-acceptance concurrently.

The arguments above are in line with those theories that focus on the diversity and heterogeneity within groups, both male and female, and Black and White (Ewing, 1990; Killen, 1997; Mines, 1988; Sinha & Tripathi, 1994; Turiel & Wainryb, 1994). Social scientists are also becoming interested in the discrepancies that may exist between shared cultural systems of meaning and individual beliefs (Neff, 2001). One study of this nature found that non-Western, traditional females believed that they should obey male authorities, as required by cultural tradition, but they also perceived this obligation to be unfair (Wainryb & Turiel, 1994). In a similar study, Neff (2001) found that Hindu Indians, a cultural group that is perceived as prototypical of collectivism, did not display the general tendency to subordinate personal to interpersonal concerns, but instead made diverse judgments about autonomy and responsibility. Given the culturally embedded nature of gender hierarchy, these exceptions to what has widely been

accepted as the norm point to the need for future research to focus on the way that "gender, culture and power intersect to influence social and moral development, in Western as well as non-Western cultures" (Neff, 2001, p. 253).

This, in turn, highlights the role of context in the development of personal autonomy and interpersonal connectedness. It also suggests that personal autonomy and interpersonal connectedness are present in both men and women, and brought out in varying combinations of contextual influences, including social and power relationships. Like the results of gender, the race by gender results in the present study may be ambiguous or non-significant because men and women from a range of cultures develop a multifaceted social orientation that includes concerns with both individual autonomy and interpersonal relatedness (Turiel, 1998b). Previous research supports this (Pearson et al., 1998; Turiel & Wainryb, 1994). Instead of prioritizing one mode of reasoning (autonomy or relation), women and men give emphasis to each concern depending on particular aspects of the situation being considered at the time, including the relative positions of power held by men and women in society (Turiel, 1998a).

As has been argued throughout this study, the development of any form of autonomy is inextricably linked to the development of self (Code et al., 1988; Cooke, 1999; Friedman, 2000b). Because self is hypothesized to be a product of culture, the lack of significant differences between men and women, and the contrary findings in terms of Autonomy and Relation within the Black group, could also be attributed to changing gender roles as a result of the relation between self-construal and gender (Cross & Madson, 1997). The transitional and transformative nature of South African society over the past decade has brought in changes in the

circumstances of many individuals, not least of which the previously disadvantaged groups – women and Black people. This suggests that an acculturation measure should have been included which might account for some of the findings with respect to race. Conventional gender roles are gradually being eroded within the current culture of Black and female empowerment, as Black Economic Empowerment and affirmative action policies – favouring Black women in particular – are moving more women into higher positions in the workplace and, (presumably) affording them greater personal and financial freedom and autonomy. This is discussed in more detail in section 5.2.2 below.

5.2 The Association between Self-Construal and Gender (and Race)

Items on the Relational Interdependent Self-Construal (RISC, Cross et al., 2000) scale were based on concepts related to relational forms of the interdependent self-construal as defined in the literature, as well as from modifications of conceptually related measures. The relational-interdependent self-construal is defined as the tendency to think of oneself in terms of relationships with close others (Cross et al., 2000). According to Cross et al. (2000), individuals who score high on the RISC scale characterize their relationships as more committed and closer than those who scored low on this measure, and are more likely to take the needs and wishes of others into account when making decisions. The hypothesis of this study was that women would have higher scores than men on the RISC. A secondary hypothesis was that Black individuals would score higher on the RISC than White individuals.

5.2.1 Self-Construal and Gender

Significant findings

Women's scores on the Relational Interdependent Self-Construal Scale were significantly higher than men's scores on this scale, which is consistent with the hypothesis. This is a result that is consistent with the theories, largely emanating from the United States, that the independent, autonomous self-construal is more typical of men, while the qualities of interdependence and relatedness describe the self-construals of women (Gilligan, 1982; Jordan & Surrey, 1986; Maccoby, 1990; Markus & Oyserman, 1989; Mather, 1997; Miller, 1990; Norris, 1998; Sampson, 1988; Stewart & Lykes, 1985). This result is also supported by the original study in which the Relational Interdependent Self-Construal scale was developed (Cross et al., 2000) as well as other studies in which women scored consistently higher than men on measures of interdependent self-construal (Cross & Madson, 1997; Madson & Trafimow, 2001; Pearson et al., 1998).

It should be noted, however, that the original study was based on a sample of university women only, and the significant differences that have been found in the other studies listed above were marginal. Pearson et al. (1998) found that, while women did have higher scores than men on their Connected Self subscale, these differences were small, and no gender differences were found on the Primacy of Other Care and Self and Other Care subscales. They suggest that both the Connected and Separate Self constructs appear to be meaningful for both men and women. Other studies have found no difference, or found contradictory differences between men and women (Grace & Cramer, 2002; McChrystal, 1994).

One of the explanations offered for why men and women's self-construals may differ in this way concerns their differential socialization experiences. Triandis and his colleagues have argued that allocentric values are similar to collectivist values – that is, interpersonal closeness and attending to the needs of others – and that allocentrism is to individuals what collectivism is to groups (Triandis et al., 1985; Triandis et al., 1995). Extending this argument, others have proposed that men and women grow up in distinct subcultures that differ in the same way that individualist cultures differ from collectivist ones (Maccoby, 1990; Maltz & Borker, 1982). As a result, women are socialized to be interdependent and attuned to relationships (Gilligan, 1982; Jordan, Kaplan, Miller, Stivey & Surrey, 1991 in Madson & Trafimow, 2001; Markus & Oyserman, 1989; Surrey, 1991), while men are brought up to be autonomous and self-reliant (Maccoby, 1990). This is consistent with feminist psychoanalytic work that has suggested that the development of women's relational and men's independent sense of selves may largely be a result of child-rearing practices (Chodorow, 1978, 1989). This is supported by other empirical research (Madson & Trafimow, 2001). Kemmelmeier and Oyserman (2001) suggest that this similarity between men's self-construal and the values of the broader culture is partly the result of the dominant influence that men have had, and continue to have, in Western society. Women, on the other hand, may understand and participate in the values of the larger cultural framework, but must find a way of reconciling the gap between their self-construals and the social context.

This does not only apply to women, however, as demonstrated by Lyons (1983) who found that equal numbers of women and men seem to value some form of interdependence in their self-concepts. Lykes (1985) has shown how the inseparability of gender and power in notions of the

self suggest that independent versus interdependent self-construals are less a function of biologically assigned gender roles and more a product of social context and the relative distribution of power. This implies that independent and interdependent self-concepts are not necessarily the sole domain of men and women respectively. Indeed, many have suggested that men and women's notions of self are grounded in their different experiences of and access to power and resources (Chen & Welland, 2002; Lykes, 1985). Lykes (1985) sought to clarify the link between the social context and notions of self, and found that women and lower socioeconomic groups – i.e., people from less powerful groups - tend to be more likely to recognize the connectedness of the self and others, and the self-defining nature of social experiences. The findings of the current study on the RISC, with women scoring higher than men, add to these findings. However, Lykes also emphasized that differences in self-conceptions do not differ from one individual to the next but rather, that alternative notions of the self are systematically revealed by individuals from particular social groups with particular social experiences. Crucial for understanding variations in men's and women's sense of selves is recognition of the variations of men's and women's positions in society relative to the distribution of power and not to biology (Lykes, 1985).

Chen and Welland (2002) examined the effects of power as a function of self-construal and gender and showed how interdependent versus independent self-construals in women and men are influenced by power. Because men and women are likely to experience different combinations of power and self-construal, they have different goals and motivational foci. Individuals with independent self-construals will pursue self-interest goals when in power, while those with interdependent self-construals will pursue other-oriented responsibility goals (Chen &

Welland, 2002). It seems likely that such dynamics are present in South African society and differences in men's and women's self-construals are perpetuated by the existing power differentials.

This also points to the importance of context in the formation of self – a cycle that "is perpetuated in part because women's gender socialization emphasized relatedness, so that women are more likely to think in…situated terms, a way of thinking not well suited to the Western cultural paradigm of individualism" (Kemmelmeier & Oyserman, 2001, p. 130). Indeed, many have argued that the separate and connected self-concepts are not stable and invariant across time and context, but fluid and dependent on contextual factors, including the nature of the self-other relationship (David et al., 2004; Onorato & Turner, 2001; Turner, 1985; Turner et al., 1987). Perhaps the perceived nature of the particular relationship and the way in which individuals participate in these relationships led to the results for men and women in this study as they have in others (Friedman, 1998) – but it would be interesting to see what differences may have emerged both between and within groups (i.e., men and women) had there been a follow-up investigation.

The above arguments for the fluidity of self-concepts do not necessarily discount theories that women and men experience predominantly different types of selves (Chodorow, 1989).

> Rather, it is proposed that concrete differences in social context can mediate these gender differences. In situations where the nature of the self-other relationship is ambiguous, such as when the familiarity of the hypothetical other is unspecified, individuals may need to look to other sources of information to determine the appropriate behavior. It is suggested that in a situation such as this, individuals may look to their own identity (i.e., male or female), making salient the norms and stereotypes that exist for gender, with women more connected and care-oriented and men more separate and justice-oriented (Ryan & David, 2004) (Ryan et al., 2004, p. 248).

Nonetheless, Ryan et al. (2004) found that gender was not a significant predictor of the social distance between self and other, in contrast to the results of the present investigation. However, closer examination of men and women's perceptions of the nature of self-other relationships could dilute the apparent gender differences in their self-concepts that were found in this study. Indeed, the fact that these significant results do not hold across cultures (Black and White) in this study, are evidence of the influence of factors other than gender in self-development.

5.2.2 Self-Construal and Race

Significant findings

Contrary to the hypothesis that Black participants would score higher on the RISC than White participants, the scores of the White group were actually significantly higher than the Black group on this scale. This could be, in part, due to the fact that this scale was validated on a Western sample of college women, which suggests that the generalizability of the scale in non-Western contexts is questionable. Another possibility is that the majority of Black participants were second language English speakers and may have had difficulty understanding some of the terms in the questionnaires, as suggested by the low reliability scores. This could point to potential problems with the validity of the results for this group in particular.

A study by Stevens and Lockhat (1997) offers some insight into Black adolescent identity formation in South Africa. They contend that the successful negotiation of congruence between self image and the role expectations of the environment as postulated in Erikson's (1963 in Stevens & Lockhat, 1997) model of identity development has been hindered in Black South African adolescents. Exposure to images of personal success and achievement in the external

environment while simultaneously being refused access to these symbols, as well as the breakdown of traditional family structures and values are partly responsible for impeding the development of healthy self-concepts. What is emerging from the debris of apartheid, according to Stevens and Lockhat (1997, p. 253) is a "Coca-Cola culture," a culture of rampant individualism which is encouraging Black adolescents to reject collectivist identities and embrace Western ideologies, including individualism, in order to cope with the current socio-historical context – resulting in a number of difficulties in social adjustment and identity integration among Black adolescents in post-apartheid South Africa. This could explain why the scores of the White group on the RISC were significantly higher than those of the Black group in this sample.

5.2.2.1 Gender differences within race groups

Significant findings

As expected, the RISC scores of White women were significantly higher than those of White men. As such, this finding lends greater support to the hypothesis that men would be greater than women. A discussion of these significant gender differences can be found in section 5.2.1 above.

Non-significant findings

The difference between Black men and women on the RISC was not significant. In fact, contrary to the hypothesized direction of difference (Black women would be greater than Black men on RISC), Black men scored higher on average than Black women on the RISC. This result is consistent with the findings on the Relational Being Scale (RBS), where Black women scored lower than expected, and lower than Black men, on the Relation subscale. Results within the

Black group on both the Relation subscale and the RISC are in direct contrast to the hypothesis that women, and Black women in particular, would have more relational self-concepts than men. This finding is consistent with others that have found no significant gender differences in ratings of independent-interdependent self-construal in their non-Western samples (Misra & Giri, 1995 in Li, 2002). Given that the difference between Black men and women on this scale was not significant, it appears that the significance of the gender difference within the White group was powerful enough to render the gender difference for the whole sample significant.

5.2.2.2 Gender differences between race groups

Significant findings

White women's scores were significantly higher than the scores of the other three groups (White men, Black men and Black women) on the RISC. These findings only partially confirm the hypotheses, with the exception that Black women were expected to score significantly higher than White women on this Relational Interdependent Self-Construal scale. This can also be linked to the previous results for Black women on the Autonomy and Relation subscales, and implies that Black women may not be as relational in their self-concepts as previously proposed.

Non-significant findings

The mean rank differences between the four groups also showed some interesting and unexpected trends. The finding that both White and Black men scored higher on average, although not significantly higher, than Black women on the RISC is completely contrary to what was expected. Again, this can be linked to the previous results of Black women on the Autonomy and Relation subscales, and is consistent with similar findings that non-Western women appear

to have more independent self-construals than non-Western men and Western men and women (Imamoglu, 2003 in Imamoglu & Karakitapoglu-Aygun, 2004; Uskul et al., 2004). It is also surprising that White men's scores were higher (but not significantly) than Black men on this scale, given that Black individuals were expected to be more relational than White individuals. This is particularly surprising when one considers that the results of the previous section (5.1.2) showed that Black men scored higher on Relation than expected. However, it does appear to be consistent with the finding that Black men scored higher than White men on Autonomy.

The lower than expected scores of both Black women and Black men on the RISC contradict theory and empirical evidence that indicates that women, Black people, and individuals from the lower end of the economic spectrum are not faithfully represented by self-theories that emphasize individualism and autonomy (Lykes, 1985). Others, however, caution against the pigeonholing of groups into individualistic versus collectivistic frameworks, arguing that this may obscure subtle differences within groups, where there is more heterogeneity and diversity than made apparent by current widely held views (Dongxiao, 2004). Contextual influences are once again brought to the foreground, and the unique contextual experiences occurring within South African society may be particularly pertinent in explaining the ambiguity of the results between cultural groups in this study.

> In South Africa, self-identity is constructed and re-constructed against the backdrop of structurally entrenched asymmetries (on the basis of race, class and gender), created and maintained through historical processes (such as apartheid, struggle politics, and the negotiated transition to a liberal democracy) (Franchi & Swart, 2003, p. 149).

Race, class, power, ethnicity, sexuality and local context probably intersect in the formation of identities. And yet, some critical theorists argue that a systematic examination of differences in constructions of self along these lines among women who occupy different socioeconomic and racial positions in society is sorely lacking (Collins, 1990). Critical feminists argue that the self is essentially a product of power relations between groups of individuals within particular sociocultural and historical contexts – and understanding the self requires analysis of the power relationship between dominant and subordinate cultures (Dongxiao, 2004). As such, the ambiguity of the results with respect to differences between and within race groups in the present study may be a function of the unique conflict experienced as a result growing up in a particularly conflicted environment.

Yeh and Hwang (2000) investigated how individuals from minority groups construct their identities within the context of the majority culture when that culture is different from their own. They refer to the notion of bicultural competence (LaFromboise et al., 1993) to describe how individuals may negotiate the integration of two cultures without experiencing conflict through a process of behavioural adaptation to a given social or cultural context without necessitating the commitment to a specific cultural identity. While relational self theories allow for multiple ways in which the self can be expressed across multiple contexts, bicultural competence only recognizes two main cultural identities – dominant and culture of origin. This may explain why Black women and Black men scored lower than both White men and women on the Relational Interdependent Self-Construal scale: their experiences of self could be argued to center more on bicultural competence than on conventional notions of an interdependent or relational self-concept, to which they are potentially less likely to relate.

This also points to a possible explanation for the lower than expected scores of Black women on the Relation subscale, and the lower than expected scores of both Black men and women on the RISC, particularly when compared with the scores of White men. It may be that the constructs that are typically used interchangeably – that is, relational interdependence and collectivist interdependence - are actually empirically separable. Cross et al. (2000) argue that the relational interdependence that is evident in women and even men in Western cultures is not the same as the collectivist interdependence that characterizes both men and women in non-Western cultures. This is also supported by Imamoglu and Karakitapoglu-Aygun (2004) who found that women in their non-Western sample actually had more independent self-construals than did men. In a similar finding to that of the current study that White women were significantly higher on the RISC than Black women, Imamoglu and Karakitapoglu-Aygun also found that American women tended to be more relational and other-directed than Turkish women. Other studies have shown that Western and non-Western men had markedly similar levels of connectedness between themselves and close friends – contrary to the theory that Western individuals and men in particular, are more independent than collectivist cultures on all dimensions of interpersonal relations. In Li's (2002) non-Western sample, men appeared to be closer to their friends than females were. However, while Li found no gender difference at the self-family connectedness level, there was a large cultural difference at this level.

Contrary to previously drawn parallels between allocentrism and collectivism (cf., Triandis et al., 1985; Triandis et al., 1995), these findings suggest that the cultural differences in collectivist versus individualistic self-concept do not correspond to gender differences between men and

women in interdependent versus independent self-construals, which may explain why the hypotheses regarding the differences between Black and White individuals in this sample were not supported. Further evidence for this comes from a comment made by one of the Black male participants in this study. While completing the RISC scale he commented that, for Black people, it is hard to answer questions in which family and friends are grouped together because family comes first and is more important. Watkins et al. (1998) found that a cultural difference existed between individuals from collectivist versus individualist cultures in the salience that they placed on family relationships in their self-concepts. However, this cultural difference did not extend to social relationships. Their findings are consistent with other studies that have shown that the salience of social relationships does not differentiate individuals from predominantly individualist countries from those from collectivist countries (Kashima et al., 1995).

Consistent with the results of this study, there is further evidence that the gender difference between men and women in terms of independent and interdependent self-concepts appears to be supported in individualistic cultures, but not in collectivist cultures (Watkins et al., 2003). The RISC did not make any distinction between self-other relationships with friends and with family members, which could account for the unexpectedly lower scores of both Black men and women than White men and women on this scale. This seems to be consistent with the view that while both men and women define themselves in relation to others with equal frequency, their characterizations of the nature of these relationships is different (Lyons, 1983). There is some support in this, too, for the higher than expected scores of White men on the Relational Interdependent Self-Construal scale.

The lack of significant gender differences on the RISC in the Black group, as well as the finding that Whites were significantly higher than Blacks on the RISC, could be attributed, at least in part, to the fact that this was a sample of relatively well-educated, urbanized university students. As such, the distinction between men and women and Black and White in terms of independent and relational self-construals, could be argued to be more subtle in this environment, or absent altogether. Others have also noted this trend toward both individuation and relatedness among non-Western university students, particularly among women who, with higher levels of education and socioeconomic status (SES), show more autonomy and independence in their attitudes, values, and self-descriptions. Similarly, several investigators have noted that as women achieve higher levels of education and SES, they tend to show more autonomy and independence in their attitudes, values, and self-descriptions (Imamoglu & Karakitapoglu-Aygun, 1999 in Imamoglu & Karakitapoglu-Aygun, 2004; Uskul et al., 2004).

Indeed, Ma and Schoeneman (1997) found that the independent vs. relational divide that existed between men and women in rural Kenyan communities was absent in Kenyan university students, who were similar to the American university students in their predominantly non-social responses. They suggest that sociocultural factors of urbanization, education, and Westernization, appear to correlate with individualized self-conceptions. However, analyzing their data by gender revealed that women were consistently more likely than men to give social responses to the Twenty Statements Test, which continues to support the cultural feminist suggestion that women form a subculture that counters patriarchal society's gender biases through interdependent relationships (Sampson, 1988; Schoeneman, 1994). Hence the reason, perhaps, why the White women in the present study were significantly higher than White men on

the RISC. But this does not account for why Black men were higher (though not significantly) than Black women on this measure. The results of this study seem to lend support to the contention that, in many collectivist cultures, women who reach higher levels of educational achievement tend to display more idiocentrism and male-like independence in their self-concepts than is typical of other women in their cultures – whereas predicted gender differences might be found in a wider cross-section of the community, or might not (Watkins et al., 2003).

White men scored higher than expected on the RISC. While their scores were still significantly lower than those of White women, they were higher on average than the scores of both Black men and Black women. It is likely that men and women possess the capacity for both types of self-construal – independent and interdependent (e.g., Guisinger & Blatt, 1994). This may be accentuated by changing gender roles in society (Eagly & Mladinic, 1989; Eagly et al., 1991; Labott et al., 1991), which may be happening more in the White culture than the Black at this stage. Women, for example, now have more opportunities to wield power, and to be independent, competitive and aggressive – holding upper managerial positions in business world, for instance, and ministerial positions in government (Cross & Madson, 1997). Similarly, men are becoming more involved in child-care and family-based activities and, as they take on these more nurturing roles, they may internalize these roles as a part of their self-construals through self-perception processes (Cross & Madson, 1997).

In Black culture in South Africa, on the other hand, there still seems to be a predominantly male dominated culture of power and superiority over women. Some have attributed this perpetuation of male dominance to the legacy of apartheid, which transformed male identity into something

typified by aggressiveness, risk-taking, sexual prowess and dominance over women – notions of masculinity that have now become entrenched (Abrahams et al., 2004; Jobson, 2005; Memela, 2005; Sayagues, 2004; Sideris, 2004, 2005). While this, too, may be changing, the extent to which gender roles are being transformed may not be as pronounced within Black culture, as it appears to be among White men and women.

Viewing these two self-construals as two dimensions of the self system raises additional questions about when, and in which contests, each construal determines of dominates behaviour (Cross & Madson, 1997). It raises, again, the question of context and the dynamics of power between men and women of different cultural groups. Chen and Welland (2002) are among those who have shown how interdependent versus independent self construals in men and women are influenced by power. It is possible that Black men and women did not differ significantly on the RISC because being in relationship has allowed both of these groups access to a certain type of power while they have been denied other forms of power due to the immediate and residual consequences of apartheid (Carli, 1999; Kemmelmeier & Oyserman, 2001).

It could be argued that the context described above - that of conflicting messages about gender role expectations and changing power differentials - could result in a degree of ambiguity in young individuals' self-concepts. An example of this ambiguity in Black women in particular is evident in the following attitudes within a local community towards church leadership. Amongst themselves, and other women in the church, Black women appear to be strongly in favour of empowerment and greater autonomy for women, but when given the opportunity to put this into practice, they tend to vote in the opposite direction, keeping men in and women out of key

leadership positions. Thus, their desire for autonomy seems to be verbal or theoretical, but does not translate to practical action (Personal communication with Carleen Richardson, minister's wife, 18 February 2006). This apparent ideological versus pragmatic schism in the self-concepts of Black females is evident in the finding that they scored lower than Black men on Autonomy but also lower than Black men on both Relation and the RISC. It is perhaps also reflected in Majoribanks and Mboya's (2001) findings that Black male adolescents had more positive self-concepts than did Black females.

5.3 The Association between Moral Orientation and Gender (and Race)

The Moral Orientation Scale (MOS, Yacker & Weinberg, 1990) was designed to measure two distinct moral orientations as defined in the literature and, as such, consists of a Justice subscale and a Care subscale based, respectively, on the theories of Kohlberg and Gilligan. Individuals with high scores on the Justice subscale show a greater tendency to emphasize individual rights and duties over relationships, while those scoring higher on the Care subscale place greater emphasis on the preservation of relationships and responsibility towards others (Yacker & Weinberg, 1990). It was hypothesized the men would score higher than women on the Justice subscale, and women higher than men on Care. Similarly, White participants were expected to score higher on Justice than Black participants, while the Black group would be higher than the White group on Care.

5.3.1 Moral Orientation and Gender

Non-significant findings

There were no significant gender differences on either subscale of the Moral Orientation Scale (MOS). On the Justice subscale of the MOS, men scored marginally higher than women, while the converse was true for the scores on the Care subscale, where women's scores were negligibly greater on average than men's. Because neither of these differences was significant, the fact that they were consistent with the hypothesized differences does not allow for any conclusions to be drawn. The non-significance of the findings with respect to gender on the Justice and Care subscales, in itself, warrants some discussion.

This study's findings were contrary to the findings of the original study which developed and validated this instrument – where significant gender differences were found and appeared to be even more pronounced with the influence of experience factored in (Yacker & Weinberg, 1990). However, Yacker and Weinberg (1990) also point out that they did not use cut off scores on this instrument precisely because they posited that both types of moral orientation – care and justice- are not mutually exclusive polar opposites, but are exhibited as stronger or weaker tendencies in all individuals. Similarly, Lyons (1983) found distinct differences between men and women in moral orientation, contrary to the current results, but goes on to qualify her findings by saying that the gender-related differences that are evident in her results are not absolute, since men and women use both types of considerations.

Studies that support the null hypothesis – that no gender differences exist – are generally not published, so the theory that men differ from women in fundamental ways in moral orientation

goes unchallenged, despite the fact that men and women have been observed to be more similar than different (Brabeck, 1993). A similar argument has been put forward by Lifton (1985), who highlights the absence of publications of the null hypothesis, and lack of discussion about gender-related differences (or lack thereof) when gender was not the focus of the study. Upon reviewing the literature – including unpublished studies – she concludes that sex differences in moral reasoning are more the exception than the rule. Schminke et al. (2003) also present findings for and against the differences between men and women and suggest that the vast amount of literature dedicated to the exploration of differences between sexes may be more a result of perceptions of gender differences than actual gender differences, and go on to suggest the importance of context in determining difference.

That the current findings on moral orientation between men and women were not significant seems to be consistent with a growing body of research that has failed to find significant gender differences in moral reasoning (Aldrich & Kage, 2003; Gibbs et al., 1984; Krebs et al., 1994). Forsyth et al. (2001) found no significant gender differences and postulated that this could have been because their sample, like the one in the present study, was younger than Gilligan's, or because they used questionnaire methods that differed from Gilligan's interview technique. This, arguably, could have revealed more subtle gender differences. They also suggest, however, that gender differences in moral orientation may not be as pervasive as previously thought, and present other studies that have failed to replicate Gilligan's findings of gender differences. In a repeated series of studies, including a meta-analysis of existing research, Walker and his colleagues concluded that the moral reasoning of males and females appears to be more similar than different (Walker, 1984, 1989; Walker et al., 1987). Indeed, not only did they find that most

individuals seem to use a considerable mix of both justice and care orientations, they also discovered that male adolescents tended to use more care responses than adolescent girls (Walker et al., 1987).

Studies that failed to find significant gender differences in moral orientation have suggested other factors that could account for differences that emerge. Some have argued against viewing men and women as homogenous masses, and point to within-group differences. Weinberg et al.'s (1993) finding of a difference between genders was statistically weak enough for them to seek other possible explanations for the difference, suggesting that moral orientation is a complex and fluid phenomenon that is influenced by a range of factors, including social, cultural, and intrapsychic variables. Similarly, others have found that the variance in moral orientation could be accounted for by other factors like, for instance type of dilemma presented (Wark & Krebs, 1996), role of personality (Glover, 2001), age (Aldrich & Kage, 2003; Gump et al., 2000; Walker et al., 1987), and social status (Puka, 1989; Tronto, 1987).

Pratt et al. (1988) also investigated sex differences in moral reasoning and found that, while there were significant differences between men and women in the middle-adulthood group, the moral orientations of their younger sample were virtually identical. Furthermore, they found that the type of orientation that was elicited seemed to be at least in part dependent on the type of situation or dilemma that was presented. They concluded that the link between gender, self-concept and moral orientation seems to be considerably weaker than Gilligan (1982) and others have suggested. Thus, while most researchers no longer refute the notion that more than one mode of moral orientation exists, there is considerable disagreement about whether these

orientations can be reliably associated with gender, as suggested by the lack of significant differences between men and women on the Care and Justice subscales in this study.

Jaffee and Hyde (2000) conducted an extensive review of the literature, compensating for the absence of null hypothesis publications, and concluded that gender differences in moral reasoning were small to non-existent, lending support to the current findings. However, the marginal differences found in their study were in the expected direction, with men showing a greater tendency towards justice, and women a greater tendency towards care. This supports the results of the present study, since the expected direction of differences between men and women were found on both Justice and Care, but were not significant. Friedman et al. (1987) also found no sex differences and the differences they did find were frequently in a direction inconsistent with theory. It may be, as some have suggested, that men and women possess equal capacities for using care and justice orientations or, possibly, that some men are more articulate in care than women and some women more articulate in justice than men (Cook et al., 2003; Smetana et al., 1991).

> Both Lyons and Gilligan found women in their samples who clearly articulated a justice morality and men who spoke of an ethic of care. Indeed, Broughton (1983) points out that some of Gilligan's (1977) best examples of a different voice were men's voices (Berlin & Johnson, 1989. p. 82).

If both care and justice do co-exist in males and females alike, one implication is that what brings each orientation out, or the way in which they are applied, depends on the context in which moral experiences are articulated (Jaffee & Hyde, 2000; Weinberg et al., 1993). For example, Layton (2004, p. 368) contends that the new version of patriarchal capitalism that typifies society today "often has women identifying with the work ethic of their fathers and

disparaging or not having time for the ethic of caring represented by the traditional relational female." This view is supported by the finding in the present research that women were not significantly different from men on the Care subscale of the Moral Orientation Scale. Similarly, the finding that women's Justice scores were also not significantly different from men's Justice scores, is supported by studies that have shown women to use a justice orientation as much as or more frequently than men (Cook et al., 2003; Jaffee & Hyde, 2000; Self & Olivarez, 1993; Wark & Krebs, 1996).

Although Self and Oliveraz (1993) found that men tend to use justice reasoning more than women, they also found evidence to suggest that, if women do use or are required by the social system to use, a justice orientation, they do so better than men, which is perhaps because women experience more pressure from the social context to become more masculinized and exhibit more male characteristics in order to succeed in the male-dominated professional world. Another reason why women did not score significantly lower on Justice than men in the current study could be that the low social status experienced by oppressed groups – in this case, women - promotes a concern with fairness, rights and justice because these are more likely to rectify the social inequalities that they experience (Beal et al., 1997). This is particularly pertinent in the South African situation, where there is a long history of injustice against women and other groups. What seems evident from the above discussion is that "the truth about different moral orientations of the sexes is a mythical truth rather than an empirical truth" (Brabeck, 1993, p. 45). Indeed, the lack of significant gender differences in the current sample on Justice and Care add weight to this possibility.

5.3.2 Moral Orientation and Race

5.3.2.1 Gender differences within race groups

Non-significant findings

There were no significant differences between White men and White women on the Justice and Care subscales of the Moral Orientation Scale. As hypothesized, White men had higher scores on the Justice subscale than White women, but this difference was not significant. Similarly, as expected, White women scored higher on average on the Care subscale than did White men, although not significantly so. The findings for gender in the White group, although not significant, were more consistent with the predicted hypothesis than were the findings for gender in general on both the Justice and Care subscales, which were in a direction contrary to the hypothesized direction of difference between men and women.

Neither the Justice subscale nor the Care subscale scores for Black men and Black women were significantly different, lending no support to the hypothesis about gender differences within this group. Furthermore, the direction of difference on both subscales was contrary to what was expected: Black women's scores on the Justice subscale were higher than Black men's scores, while Black men's Care scores were higher than Black women's Care scores. This finding may be linked to the results of the previous sections on Relation, where Black women appeared to score lower than expected, and lower than Black men, on Relation and on the RISC, which would then be consistent with these results on Care. In combination, these results seem to contradict the notion that Black women are more relational and focused on interpersonal caring and Black men more autonomous and focused on individual rights.

These findings contradict previous research reporting that gender differences in moral preferences are consistent across cultures – that is, that women exhibit stronger tendencies toward an ethic of care, and men towards an ethic of justice, is applicable across cultures. On finding a gender difference in moral orientation that seemed to be consistent across cultures, Stimpson et al. (2001), for instance, claimed that a caring morality is first biologically rooted and then culturally learned, and is more prevalent in women across cultures. The results of the current study do not support this claim. Conversely, Maqsud (1998) investigated differences in moral reasoning by asking a group of South African Batswana high school students to complete a measure of justice and caring attitudes, and found no significant gender differences in this sample on either care or justice principles. He suggested that this lack of gender differences was a result of socialization practices in Batswana society. According to Maqsud (1998), Batswana parents, teachers, and other significant adults, tend to treat boys and girls equally, and do not expect different moral behaviours from boys and girls. The finding in the current study that the differences between Black men and women on Care and Justice were not consistent with expected gender differences may therefore be partially attributable to differential socialization practices within Black cultures in South Africa. This, too, points to the importance of cultural context in the development and manifestation of moral orientation.

Black women's lower-than-expected scores on the Care subscale supports arguments about the contested nature of the care concept. It has been argued that the care orientation is based on the perspective of White middle class women and does not extend to Black women's experiences (Cockburn, 2005). In South Africa, Black women's experiences have been historically shaped by

the apartheid system, where poverty and legally-entrenched racial inequality forced Black women to take work that led them away from their families. Necessity thus dictated that work outside of the family had to take precedence over the needs of their families, and overshadowed interpersonal relations. “For Black women, it is the absence rather than the presence of the ability to care for one’s own family that structures their experiences” (Cockburn, 2005, p. 80). To some extent, this may also explain the higher-than-expected scores of Black women on Justice, as they have been the victims of consistent and extreme injustice on both a gendered and cultural level.

Indeed, the finding that women, and Black women in particular, scored higher than expected on the Justice subscale, is supported by other research reporting similar findings. Cook et al. (2003) found that an ethic of justice was articulated more frequently than an ethic of care by the majority of women in their study. However, they also reported that women view’s tended to be more mixed than men’s, with a combination of care and justice occurring more frequently in women. The lack of significant gender differences on the Care and Justice subscales in this study could also be due to a greater combination of both care and justice in women, resulting in a less distinguishable difference between women and men in moral orientation.

Black men’s scores on the Care subscale, although not significantly so, were higher than expected and unexpectedly higher than Black women’s scores on this subscale. Some have argued that membership in a low status minority or oppressed group enhances social identification (Cameron & Lalonde, 2001) which, in turn, leads to greater relational tendencies. This may explain the results of Black men on the Care subscale. It is not supported, however, by

the current results of Black women, who, arguably, are in an even more inferior position in society than Black men. Baumeister and Sommer (1997) claim that the apparent difference in interdependence between men and women is not so much a difference in how much or whether it is valued or desired, as it is a matter of the type of interdependence that is sought.

Building on the idea that all individuals have a fundamental need for belonging, they suggested that men do seek and value interdependence but that men tend to be oriented toward larger social groups/spheres, while women focus more on one-to-one bonds. It is possible that the constructs measured by the Moral Orientation Scale tapped into larger-scale, collective group notions of care and justice for Black women and men. As a result, Black men who, arguably, value larger social group connections, scored higher on the connectedness measure of the Care subscale, while Black women rated items on the Justice subscale more highly because of the experienced injustices that impacted on their more intimate interpersonal relationships. This seems to be consistent with other research that has found that both men and women value interpersonal connectedness, but women focus more on relational interdependence, and men more on collective interdependence (Gabriel & Gardner, 1999). Extending this to the results on the Moral Orientation Scale, if both men and women seek interdependence but in different forms, this could explain the lack of significant differences between men and women across both racial groups on the Care and Justice subscale – particularly if, as suggested above, these subscales do tap into these different forms of interdependence in different ways for men and women.

This theory also has implications for previous discussions of power and its impact on self-construal and individual autonomy. While previous research has suggested that men seek power

as means of obtaining independence from others, Baumeister and Sommer (1997) propose that power actually binds a person to those over whom power is held. "Thus, striving for power reflects a desire for, rather than avoidance of, interdependence, albeit of a particular form" (Chen & Welland, 2002, p. 255). Furthermore, striving for and holding positions of power may actually be men's way of reconciling their desire for independence with their need for human connection (Baumeister & Sommer, 1997). Chen and Welland's (2002) research supports this view, and further highlights the connection between gender, self-construal and power. "…power involves relationship between the powerful and powerless, and self-construals speak to if and how the self is related to others" (Chen & Welland, 2002, p. 265). Because the Care subscale of the MOS reflects concepts associated with connection and relatedness, these theories of power may explain to some extent the higher scores of Black men than Black women on Care in this study.

The connection of power and relationship is further supported by Carli (1999). It is proposed that Carli's (1999) theory about the inequalities in social power between men and women can be extended to explain the effects of inequalities in social power between White and Black groups in apartheid and post-apartheid South Africa. Carli contends that power derives from the possession of structural and external advantages that one group or individual possess over another. Thus, because men have historically possessed more of these advantages of than women, they hold more power. It could be argued that the same can be said for the advantages – and therefore the power - possessed by White groups over Black groups in South Africa. Carli (1999, p. 83) goes on to suggest that "power can be based on the need or desire to maintain relationships, and not just on the possession of external status or resources." She extends this theory to show how groups and individuals who lack access to typical forms of power, can

possess a form of power that derives from their domestic roles and involvement in relationships with others. She uses this to explain why women tend towards a care perspective. Because they have been denied more traditional forms of power, women's power is limited to referent power, which is a product of their involvement in relationships. Similarly, Black groups in South Africa can be argued to have been denied access to many of the traditional forms of power that White individuals have possessed. This could explain why the Black men in this sample scored higher than expected on the Care subscale. It is not supported, however, by the lower scores of Black women on this subscale.

Black women's low scores on the Care subscale do no support the above claims about power and relationships, perhaps because the feminine ethic of care is rooted in a long history of women's social and economic subordination and thus reflects more moral damage than moral virtue (Chang, 1996). Following Carli's (1999) suggestion that women have access to limited forms of power that are based and sustained by their involvement in relationships, it could be argued that a voice of care arises not from women's moral concern for sustaining human connection, but out of necessity for survival in oppressive relationships with men (Card, 1988). Those who argue that the ethic of care was created out of a society of subordination draw parallels between feminine and African moralities, locating an ethic of care within power-laden contexts of human relationships (Chang, 1996). This seems to imply that the apparent gender differences in an ethic of care and an ethic of justice have less to do with choices that men and women make, or preferences that they have, and more to do with ways of dealing with the power disparities in social relationships, both on a cultural and a gendered level.

> Like the Chinese students in this study, the girls and women who speak from the pages of Gilligan's books face a world in which their voices are often silent or go unheard next to

> the powerful Western/male voice justice. Yet as the narratives of Chinese students demonstrate, such silence should not be mistaken as merely a sign of moral difference between men and women. Rather, it more probably signals a disparity in the social value and status attached to the sexes (Chang, 1996, p. 154).

Other studies lend support to this conclusion, reporting that differences in moral reasoning appear to result from differences in current life situations than from stable gender characteristics (Clopton & Sorell, 1993; Hare-Mustin & Marecek, 1988; Mednick, 1989). These and other theorists caution that current theories of gender differences in moral orientation may exaggerate inherent differences in men and women's dispositions, and underplay the differences in social structures that influence men's and women's behaviours. Because men are in the dominant position in society – as Whites have generally been in South Africa – they tend to support the rules, discipline, control and rationality (i.e., the justice approach) that maintain their position, while those in subordinate positions – Black people and women – appeal to mercy, sympathy and understanding (i.e., the care approach) (Clopton & Sorell, 1993). Similarly,

> Harding (1987) and Stack (1986) have argued that Black males who live in conditions of economic deprivation develop a self-concept that emphasizes profound interpersonal connection and that closely resembles the care orientation. Thus the care orientation may be more a reflection of lack of power in current situations than a gender-related difference resulting from mother-only parenting (Clopton & Sorell, 1993, pp. 86-87).

The results of the current study, although not significant, are partially supported by this view, as White men scored higher on Justice than White women, White women scored higher on Care than White men, and Black men obtained higher scores on the Care subscale. However, the result that Black women scored higher on Justice and lower on Care than Black men seems to be inconsistent with the argument presented above.

Other power theories have been presented that may help to explain the higher than expected scores of Black women on the Justice subscale, contrary to the hypothesis. Women – and Black women in particular – have historically been denied equal advantages to men in the South African workplace (Carli, 1999). In spite of their more recent advances in the workplace, women continue to face obstacles because they lack access to the sources of power that their male colleagues possess. Although a woman more behave in a competent and assertive manner, she is often less influential precisely because of this type of behaviour, particularly with men, because she is not perceived as having legitimate power (Carli, 1999). At the same time, however, when a woman masks or does not exhibit exceptional ability, her competence is doubted by both genders and she is less able to influence even women. Black people in the South African workforce, and Black women in particular, are increasingly finding that, because of these perceptions, mere competence is not enough, while exceptional competence appears to undermine their legitimacy. These double standards may be a particular source of frustration and injustice. In South Africa, Black Economic Empowerment programmes have seen the advancement of Black women in the workplace. However, Black women may be encountering explicit and implicit barriers to their advancement because of the perceptions outlined by Carli (1999) above. They may thus be likely to value justice more highly as a means of overcoming the injustices they continue to encounter, despite their apparent advances. Further research is needed to explore this hypothesis.

5.3.2.2 Gender differences between race groups

Significant findings

As was expected, White participants scored significantly higher on the Justice subscale than Black participants. The scores of White men on Justice were significantly higher than the scores of both the Black male and Black female group, as well as the scores of White women.

The mean scores of the Justice subscale scores showed that the scores White men were significantly higher than the scores of Black men. This difference is in direct contrast to the hypothesis. The finding that the White group scored significantly higher than the Black group on Justice, and that White men scored significantly higher than Black men on Justice, carries certain implications about Black versus White experiences in South Africa. These findings will be discussed in further detail below.

Consistent with previous research suggesting that moral development is determined by social, cultural, and historical factors (Gielen & Markoulis, 1994; Huebner & Garrod, 1991; Miller, 1994 in Ferns & Thom, 2001; Tappan, 1997), the investigation by Ferns and Thom (2001) lends support to the hypothesis that Whites would be significantly higher than Blacks on Justice, and offers some explanation for this. Ferns and Thom (2001) applied Kohlberg's justice model to a South African sample and found that, while White South African adolescents' moral development was in line with Kohlberg's theory, Black adolescents exhibited a different pattern. (It should be noted that the current research, while also testing a measure of justice attitudes, did not explicitly use Kohlberg's model as Ferns and Thom (2001) did, so it could be argued that only limited comparisons can be drawn). Like the findings in the current study, their Black group

seemed to score lower on Justice than the White group (Ferns & Thom, 2001). They attribute this to the influence of Western and traditional norms and values, parenting styles, the socialization of Black adolescents to be concerned with the welfare of the group, and the possible effect of historical factors, such as the previous apartheid government system and the current democratic system. Because of the exposure of Black individuals in South Africa to discrimination, where they were regarded as inferior on account of their ethnic identification and their individuality was not recognized, they had to turn to their cultural group on order to experience a sense of belonging and security within the traditional values and norms of their group (Ferns & Thom, 2001).

Although apartheid has been over for more than a decade, the effects of racial separation and discrimination will probably continue for many years to come (Smith & Parekh, 1996). These effects include disorganization of the family and erosion of traditional family values, conflicting family relationships, and loss of respect for parents and other adults (Ferns & Thom, 2001; Wilson & Ramphele, 1989). This, in turn, could have resulted in the loss of suitable role models for Black adolescents, which are necessary for the transfer of moral norms and values (Burman, 1986) – another possible reason for the significantly lower scores of Black participants on measures of the justice orientation than White participants. Educational disparities, another result of the apartheid era, may also explain the variation in moral development found in the current study and by Ferns and Thom (2001), since education and logical capacity are associated with moral development (Colby et al., 1983). Exposure to political violence could also have influenced the moral reasoning of Black adolescents in South Africa in a similar direction (Dawes, 1994; Smith & Parekh, 1996). These views are consistent with the results of the current

study and offer possible explanations for why the results of the Black group were significantly lower than those of the White group on Justice.

Given these views, Smith and Parekh's (1996) finding of the absence of significant differences between Black and White South African children is surprising. They propose that this may have been because all of the students in their sample, both Black and White, were middle-upper class. Since there is research to suggest that lower scores on Kohlberg's tests are associated with occupying lower social and economic classes (De Vos, 1983 in Smith & Parekh, 1996), the absence of racial differences in Smith and Parekh's (1996) sample could be because they compared children who were all from the middle to upper classes. The one group in Smith and Parekh's (1996) study that did have significant differences in moral reasoning was the 19-28 age group, where White students scored higher on Kohlberg's measure of justice moral orientation than Black students. They attribute the differences in moral reasoning in this age group to disparities in primary and high school educational experiences, with Black students having had a more disadvantaged educational experience. This may be true for the Black and White participants in the current study, and is consistent with the significant differences on the Moral Orientation Scale between Black and White groups.

In contrast, Tudin et al. (1994) hypothesized that a South African sample would show accelerated moral development compared to those growing up in more peaceful, less conflicted, and less socially and politically complex societies. They also hypothesized that increased exposure to social and political complexity within this South African sample would demonstrate higher moral development. Although their results showed trends in this direction, the hypothesis

was not statistically supported. They also found that their Black sample appeared to achieve higher levels of moral reasoning than did Whites on Kohlberg's measure, despite their lower socioeconomic status, which seems to contradict the cultural differences found in the current study.

Some have argued that, while cultural experiences may have resulted in a greater emphasis on care and connection in non-Western cultures, these traditional values may have been undermined in the past few decades by, among other things, acculturative influences (Ward, 1995). Knox et al. (2004) extend this to argue that, given the social injustices experienced by oppressed groups such as women and Black people, they may have developed a greater concern with fairness, rights and justice. This may be particularly true for Black communities in South Africa, a country with a long history of oppression and injustice against non-White groups. (It should be noted that while Black groups in South Africa are not a minority numerically, they have, until recently, been a political and social minority as a result of the long history of oppression and racial segregation in this country). There is evidence to support this view. Aldrich and Kage (2003) found that the women in their non-Western samples were consistently less tolerant of corruption than men, and that female judges enforced the death penalty more consistently than their male colleagues, which is consistent with the results of this study that Black women scored higher than Black men on Justice. Similarly, Coon (1997 in Knox et al., 2004) found that, despite a significantly lower SES, the scores of Black women university students on a measure of justice moral reasoning were significantly higher than White university students.

According to the widely-held theory that traditional Black groups are more care-oriented than White, Knox et al. (2004) hypothesized that Western populations, African-American and African men should be at least as care oriented as White, African American and African women. Using Yacker and Weinberg's (1990) Moral Orientation Scale (the instrument used in the current study) to test this assumption, they found no gender differences in moral orientation. In addition, while predicting that traditional African American cultural groups would exhibit a greater propensity for care, they found instead that most of their African American sample had a justice focus and were significantly more justice oriented than the male law students in Yacker and Weinberg's (1990) original study. This is consistent with Gilligan and Attanucci's (1988) finding that minority students were more likely to exhibit a justice orientation than White students. However, the current study's finding that the White group scored significantly higher than the Black group on Justice challenges theories presented above – i.e., that minority and oppressed groups tend to be concerned with fairness and rights, and score higher on measures of justice. Given these arguments, it is not clear why this would be the case in South Africa, where Black cultures have been consistently subjected to high levels of injustice and would be expected to exhibit a high degree of concern with justice. Further research is needed to explore this, possibly using alternative measures of the justice orientation.

The contradictory findings on these measures in the current study may be partially explained in accordance with the following research: Many of the subjects in Tudin et al.'s (1994) study, as well as samples from previous studies (Kohlberg, 1973 in Tudin et al., 1994), showed a bimodal pattern of reasoning – i.e., they demonstrated moral reasoning consistent with two different levels of Kohlberg's stages of moral development. Kohlberg suggested that the use of bimodal

reasoning is a means of self-protection as the individual begins to re-evaluate his or her previously held level moral reasoning. This would be consistent with the conflict that students in Tudin et al.'s (1994) study and in the current study may be experiencing as they enter university and their modes of moral reasoning begin to be challenged. It is also likely to be a function of the politically and socially conflicted context in which these students have lived, contexts where physical self-protection often becomes a priority and has, of necessity, to be considered in deliberation about complex moral problems (Tudin et al., 1994). Such a situation creates a split in individuals who have to choose between what they consider to be a moral solution to a problem, and what they are in reality able to do given the threats to their personal well-being, leading, potentially, to bimodal moral reasoning. While this cannot be confirmed by the results of the current study, because Kohlberg's measure was not employed to test moral orientation, it can perhaps partially explain the ambiguous and contrary findings on a number of measures, for the Black students particularly.

The difference between White and Black individuals on the Care subscale was significantly different, as expected, with the Black group scoring consistently higher on this dimension than the White group. It was expected that the Black group would score significantly higher than the White group on Care, so it is consistent with the hypothesis that Black men were significantly higher than White men on Care. Black women, however, while higher than both White women and White men, were not significantly different from either of these two groups on Care. It was also not expected that Black men would score higher on average than Black and White women on this subscale. This can perhaps be linked to the scores of Black women and of Black men on the Relation and Autonomy subscales, and on the RISC. Evidence of conflict within Black

women and Black men in South Africa could explain the ambiguous Relation versus Autonomy scores and Justice versus Care scores within this group.

The femininity that is linked to the home and mothering is now in conflict with the new femininity outside the home, which depends on masculine values (Orbach, 1986). Faced with demands to be active mothers and active career women, many women appear to use their bodies as a means through which they can simultaneously fulfill their traditional roles and assert their independence – i.e., rejecting traditional values by becoming thin and thereby defeminizing their bodies (Orbach, 1986). This shift appears to be reflected cross-culturally: in a cross-cultural study of gender roles, it was found that, for both men and women across all cultures, the ideal self was relatively more masculine than the actual self (Williams & Best, 1982 in Williams & Best, 1990).

Furthermore, in cultures that are in transition, Westernizing individuals from traditional cultures may be exposed to norms, values, and beliefs that are in conflict with their own. The amount of psychological distress that these individuals experience is a function of their perceptions of the environmental demands, and their appraisal of their ability to cope with the threats to their psychological well-being (Lazarus, 1984 in Anderson, 1991). But this process of coping is complicated by the conflicting values and attitudes that an individual caught in the juxtaposition of two cultures has available as resources. The post-apartheid social and political transition in South Africa presents a number of challenges to previously oppressed cultures, including urbanization and the upward socioeconomic mobility (Stevens & Lockhat, 1997; Szabo & Le Grange, 2001). Black cultures have also come increasingly into contact with White cultures as a

result of the integration of schools and the dissolution of segregation in general. This could result in the internalization by Black individuals of Western cultural norms, leading to the erosion of traditional values and structures. Black adolescents growing up in apartheid South Africa were exposed to the values of the dominant White culture that encouraged individual achievement and social mobility, but were simultaneously denied access to the resources that would enable them to strive for such goals. This contradiction may in itself have impeded healthy identity development (Stevens & Lockhat, 1997).

Nonetheless, it may have been the shared political consciousness provoked by the pervasive racist sentiment may have fostered a collective racial identity that resisted the negative impact of racism and discrimination in many young Black people (Stevens & Lockhat, 1997). This supports significantly higher Relation and significantly higher Care scores of the Black group over the White group in the current study. The ambiguity of the results in the Black group, however, may be because these individuals are now coming into contact with new role models, economic structures and Western values, and are encouraged to embrace the individualistic social norms and values that many of them were opposed to in the mid-1980s (Stevens & Lockhat, 1997). Stevens and Lockhat (1997) refer to this post-apartheid culture as a 'Coca-Cola' culture, and contend that such contradictions may be contributing to role confusion, rather than healthy identity integration. The problems of role confusion and gender identity that are common among adolescents (Kroger, 2002; Streitmatter, 1993) are thus exacerbated in South Africa, where young Black men in particular have historically been confronted with more social limitations than opportunities, both by Black cultures and by the dominant White society in South Africa (Bloom, 1994).

Furthermore, because the parents are the first representative of a specific cultural group, one can expect that they play a crucial role in the adolescent's identity formation (Myburgh & Anders, 1989). It follows from this that family dysfunction may result in identity confusion – particularly when the values that are transmitted by the parents are in conflict with the dominant socio-cultural value system. Accompanying the pressures of urbanization and modernization, family ties are clearly loosening, and the extended family model is being abandoned in the search for the values of the 'Coco-Cola' culture. In search of their own individuality, the younger generation is rejecting the emphasis on tradition inherent in the African culture. Le Grange et al. (1998) hypothesize that Black individuals, and Black males in particular, are facing new social pressures in South Africa. As a result, this group may be vulnerable to the symptoms of distress, racial identity confusion and conflicting attitudes and values associated with acculturative stress. This has been associated with suicidal behaviours (Wassenaar et al., 1998; Wassenaar, Pillay, et al., 2000). Although Black individuals were found to have significantly lower scores on Justice and higher scores on Care than White individuals, as hypothesized, the differences within the Black group were contradictory and contrary to the expected gender differences. This, and the similar ambiguity in the Relation and Autonomy subscale and the RISC scale results for this group, could be partially explained by the role confusion and conflict described above.

Marais et al. (2003) investigated the association between acculturation and eating disorder symtomatology in Black men and women in South Africa. They found that Black men scored significantly higher than White men on the psychological dimensions of the Eating Disorders Inventory (EDI, Garner et al., 1983), which suggests that there was a higher prevalence in Black

men of the psychopathological traits associated with anorexia nervosa. On the Perfectionism subscale, Black men scored significantly higher than both Black women and White men. Studies that have found a corresponding higher prevalence of perfectionism in Black women in comparison to their White counterparts, have suggested that the social, political and educational inequalities in apartheid South Africa have required Black women to achieve extremely high standards in order to reach the tertiary education level (Wassenaar, Le Grange, et al., 2000). It could be argued that these individuals would show a greater tendency to value justice over care, given the injustices they have encountered in their struggle to achieve equality. This can perhaps be true of all individuals who had to struggle to achieve against the climate of discrimination in this country. But, while this may be part of the reason why Black women obtained higher scores on the Justice subscale than Black men, it does not account for the lower-than expected scores of Black men on Justice. Nor does it explain why the Black group as a whole scored significantly lower than the White group on Justice.

The results of Marais et al.'s (2003) study also suggest that the demands facing Black men and women in South Africa's rapidly changing society are more overwhelming than those facing White men and women. Black men and Black women have scored consistently higher than White men and women on an Interpersonal Distrust subscale (Hooper & Garner, 1986; Wassenaar, Le Grange, et al., 2000), which is indicative of a sense of alienation and general reluctance to form close relationships, consistent with the context of racism and discrimination that have punctuated the lives of Black individuals in South Africa (Marais et al., 2003; Szabo & Le Grange, 2001). This would suggest that Black individuals may not score as high on measures of connectedness and care than would be expected, which is contrary to the results of the current

study. However, the fact that the White men in Marais et al.'s (2003) South African sample had higher scores on the psychological dimensions of the EDI than a Canadian sample (Garner & Olmsted, 1984) may be indicative of a greater degree of psychological distress amongst all South Africans, associated with post-apartheid social and political transition. This could account for why White men scored significantly higher than Black men, and higher on average than all other groups, on Justice, and significantly lower than all other groups (Black men, Black women, White women) on Relation – but higher than Black women and Black men on the measure of a relational interdependent self construal, which suggests a degree of conflict in this group.

5.4 Correlations between Autonomy, Self and Ethical Orientation and Gender (and Race)

5.4.1 Correlations by Gender

Significant findings

In direct contrast to what was expected, there was a significant positive correlation between men's scores on the Autonomy subscale and the RISC scale. The correlation between men's Relation subscale and the RISC scale was also significant and positive, consistent with the hypothesis. Taken together, however, these findings could be indicative of problematic constructs as measured by the Autonomy and Relation subscales of the RBS. As was expected, there were significant negative correlations between the Justice and Care scores of both men and women. The lack of significant positive correlations between the relevant subscales of the RBS and MOS, and between the relevant subscales of the MOS and the RISC for both men and women suggest that the expected correlations between autonomy, self and moral orientation cannot be confirmed.

Non-significant findings

There were no significant correlations, positive or negative, between subscale scores of the RBS, MOS and the RISC of women, which again suggests that the constructs measured by each of these scales were not as strongly associated as had been expected. There were also no significant correlations between the measures of relation / autonomy and justice / care for men, as well as contradictory correlations between measures of self and relation / autonomy for this group. The problem may lie in the construct validity of the individual scales, or in the combination of these particular scales and the associated assumptions about the potential interrelation of the constructs measured.

5.4.2 Correlations by Race

Significant findings

Significant positive correlations between Autonomy subscale scores and RISC scores were found for Black men, White women, and White men. This is contrary to the hypothesis that Autonomy scores would correlate negatively with Relational Interdependent Self Construal scores. The Relation subscale scores and RISC scores of White men, and of the White group as a whole, were significantly positively correlated. However, the Autonomy and Relation subscale scores of the RBS for White women and Black men, as well as for the Black group as a whole, showed a significant positive correlation. Considering that these are polar subscales on the same scale, this result suggests that findings associated with this scale require further investigation and should be interpreted with caution. Significant negative correlations between Justice and Care were found

for all groups, which lends further support to the satisfactory reliability and validity of the Moral Orientation Scale.

Non-significant findings

There were no significant correlations between the scores of Black women on all three scales. There were also no significant correlations between the Justice and Care subscales and any of the other subscales (Relation and Autonomy, and RISC). In summary, there was little support for the assertions made at the beginning of this study that the Autonomy and Justice subscale scores of men would be significantly positively correlated with each other and negatively correlated with men's RISC scores. Conversely, the assumption that women's scores on Relation, Care, and the RISC would all be significantly positively correlated was not sufficiently supported by the results of this study. Possible reasons for this could lie in potential problems with individual measures; in the attempt to combine measures that are not sufficiently linked in terms of their constructs; or in poor comprehension by participants of various items on each of the scales, particularly the RBS which showed low reliability. These limitations will be discussed in further detail below.

5.5 Summary, Limitations and Implications

5.5.1 Summary

Keeping ethics at the forefront of health research means ensuring that the bioethical principles developed in the Western world are relevant in the developing world. This means not simply or

unconsciously employing standard conceptions of autonomy and informed consent, but paying careful attention to context and the unique particularities that individuals in developing countries bring to the research setting. Ultimately, context plays a major role in the interpretation and meaning of bioethical principles, particularly the sociocultural context in which women in circumstances of poverty and vulnerability live, where they are disempowered on a number of levels, with limited personal, social, economic freedom. It is among this population that the risk of HIV is particularly high, and it is thus with non-Western women that much HIV vaccine research should be conducted. This makes it particularly important to ensure that all research that is conducted is ethical and respectful of each individual within their own lived realities. Conventional conceptualizations of the principle of autonomy have been criticized for being too individualistic. It is a principle which seems to encapsulate isolation and detachment - concepts which, research has shown, are foreign to many women and to women in non-Western cultures in particular.

This study has attempted to make a contribution to the re-conceptualization of the principle of autonomy to ensure its applicability in these contexts – to help rectify the gender and Westernized bias of the conventional principles employed in human subjects' research by supplementing it with feminist approaches, where care and connectedness are primary concerns. In this study's critique of the individualism underlying standard principles of autonomy, it has critiqued the individualistic concepts of the self and the ethic of justice / moral orientation that are closely related to principled notions of autonomy. The primary focus of this research was to examine gender and how autonomy, self and moral orientation are experienced. A secondary

investigation looked at how race influences the experience of autonomy, self and moral orientation.

In the analysis, the only significant gender differences that were found were on the Relation subscale and the RISC scale, with women scoring significantly higher than men in both cases. This seems to support the notion that women have a more relational sense of autonomy and a more interdependent, relational self construal than men, who have more independent self construals and a more independent sense of autonomy. However, no evidence was found to support the hypothesis that men exhibit a more independent sense of autonomy than women, lending somewhat contradictory evidence to the gender differences on Autonomy / Relation hypothesis. No support was found for the hypothesis that women have a greater tendency towards a care moral orientation compared with men, who were expected to have a more independent sense of autonomy than women, combined with a greater tendency towards a justice orientation.

Significant differences between the Black and White groups on the RISC were contrary to expectation, with Whites scoring higher than Blacks, suggesting that White (Western) individuals have a more relational interdependent self-construal than Black (non-Western) individuals, in direct contrast to predictions based on previous research. As expected, Whites showed a greater tendency than Blacks towards a justice orientation, while scores of the Black group indicated a stronger tendency towards a care orientation. The contradictory findings on the Relational Being Scale, with the significant difference between Black and White individuals on the measure of relational autonomy and the absence of significant differences between race

groups on the measure of independent autonomy, do not allow for any conclusions to be drawn about what differential experiences these groups may or may not have of these particular variables.

In summary, the notion that relational autonomy, interdependent self-construal and a care orientation would be significantly positively correlated for women, and significantly higher than these parallel dimensions in men, was not supported by this study. However, given the limitations of this study discussed below, the lack of significance in expected differences does not mean that there are not some implications that can be drawn from this study, as discussed in the following section. The findings suggest that although there are gender differences in the experience of autonomy, self-construal, and ethical orientation, these differences may not be as distinct in South Africa tertiary education populations as much research suggests. It is likely that including race as a variable, albeit in a secondary analysis, impacted considerably on the results.

5.5.2 Limitations of this Study

Treating the variables as too distinct and the groups as too homogenous may have produced problematic results. As suggested by some researchers, the similarities between men and women may actually be greater than their differences, while there may be more differences within each group than is usually alluded to. Furthermore, the poor reliability and validity of the Relational Being Scale may have negatively influenced the results of this study. Concepts for the Autonomy subscale of this scale were not defined directly from theories of autonomy but were instead inferred from work on relatedness, based on the assumption that autonomy and relation are

disparate concepts. This raises questions about the validity of the Autonomy subscale. It is noteworthy that the two subscales on which the majority of unexpected and often contradictory results were found, were the Autonomy and Relation subscales of this Relational Being Scale. This suggests, primarily, that results based on this scale in particular should be interpreted with caution, and secondly, that an alternative measure could yield richer and more reliable results with respect to autonomy and relationality. Moreover, because all of the measures used were developed and tested for reliability and validity on populations from Western, developed countries, the applicability of the measures used in the South African context may also have affected the validity of the results.

A relatively poor response rate was a major factor in the difficulty in obtaining a larger sample of questionnaires for this research. Furthermore, there were hundreds of incomplete or incorrectly answered (scored) questionnaires that were returned and could not be used. Two hundred and fifty spoiled questionnaires were returned. The response rate was 45%, and of the 1500 sets of questionnaires that were distributed, 346 were returned fully completed. The author found that giving out the questionnaires herself was valuable in itself in that it brought to her attention a number of problems with the questionnaire which, in retrospect, if altered would have yielded more valid data. The biggest confounding factor appeared to be understanding, particularly with respect to comprehension, of some of the terminology by second language English speakers. A list of words which had to be explained to many of the respondents was recorded (see Appendix D).

While administering the questionnaires in the data collection stage, a number of observations were made about the responses of each group to aspects of the questionnaires, and to the research process itself. In response to the description of the research, the potential gender differences in findings seemed to spark the most interest in both male and female groups. White men were, on the whole, the most unresponsive group. The majority of this group appeared reluctant and apathetic about completing the questionnaires, and generally spent little time filling them out, as reflected in response rates. Male students from Agriculture were more responsive and more verbal amongst themselves while filling in the questionnaires. It is possible that the sex of the researcher may have influenced these behaviours to some extent. Black men appeared to take the task more seriously but had the highest percentage of spoiled questionnaires.

Language was a major contributing factor: second language English speakers seemed to have difficulty understanding particular words (*adolescent; detachment, prone),* phrases (*As an adolescent, my growing sexuality was a source of satisfaction to me),* and ranking choices (for example, the visual analogue scale). The researcher was available for the duration of the task to answer questions, but Black men seemed more reluctant than Black women to request assistance, preferring instead to turn to their peers for clarification. It is believed that this language barrier was a major confounding variable on the results of this study and could seriously have impacted on the validity of the results. The length of the questionnaire was also a confounding factor – students complained that it was too long and many semi-completed questionnaires were returned. The contradictory correlations found on many of the subscales could be accounted for by the length of the questionnaires, as students may have checked off responses without properly attending to the questions, simply to finish the task more quickly. Various qualitative comments

that students from each subgroup made to the researcher after completing the questionnaire highlighted certain ambiguities in responses to some of the questions.

5.5.3 Implications of this Study

The findings of this study have been discussed in relation to the theories and research presented in the literature review. It is hoped that the arguments presented in this study, particularly the critique of principled autonomy, will be of value in improving components of informed consent procedures in clinical health research, and, specifically, in HIV vaccine trials. A comprehensive understanding of how people perceive their own agency, and the conditions that must be in place for them to be able to make fully autonomous decisions should guide a revision of the principled autonomy that is currently employed in most informed consent procedures. It is hoped that the findings of this study will facilitate further research that will ultimately inform a more gender- and culture-sensitive approach to the ethical resolution of autonomy issues – one that maximizes the protection of participants' rights and ensures that participation in health research is in participants' best interests. This may involve a revision of many of the components of the informed consent process, including the relationship between researchers and participants, and between science and society. In addition, reviewing notions of autonomy from mainstream and feminist perspectives necessarily involves exploring participants' conceptions of themselves in relation to others, and how this impacts on their decision-making processes.

This study has yielded information about how women and men experience themselves which, in turn, is likely to influence whether they experience autonomy more relationally, or more

independently of interpersonal relations. It has also shown that an individual's gender and race is likely to influence his or her ethical orientation towards justice or care. Similarly, this study has demonstrated that the extent to which individuals view significant others as integral parts of their self concepts could affect whether they approach moral or ethical dilemmas from a justice or a care perspective. When viewed in the context of individual informed consent, these could make a valuable contribution to understandings of how potential participants make the decision to participate in clinical trials, which will further enhance the informed consent process. This research has made a step towards examining autonomy, self, and moral orientation in the South African context. The contrary findings, particularly with respect to racial differences, suggest that South Africa may offer a unique amalgamation of Western and non-Western cultures where men and women from both groups have a somewhat idiosyncratic experience of these concepts: autonomy, relation, self, justice and care. Further research is needed to illuminate these differences.

6. CONCLUSION & RECOMMENDATIONS

6.1 Key Conclusions

The main conclusion that can be drawn from this study is that women do appear to be more relational than men, based on their significantly higher Relation and Relational Interdependent Self Construal scores than men. However, none of the other predicted gender differences in terms of autonomy, self construal and moral orientation were significant. Consequently, the key finding of this study was that, contrary to the central hypothesis, women do not appear to exhibit a more relational sense of autonomy, combined with a greater tendency towards a care moral orientation, compared with men, who were expected to have a more independent sense of autonomy, combined with a greater tendency towards a justice orientation.

In the secondary analysis of race and gender, White individuals appeared to have a significantly and unexpectedly more relational interdependent self-construal than Black participants. This was in direct contrast to the significantly higher scores of the Black group on the Relation subscale of the MOS than the White group. However, no significant differences were found between White and Black groups on independent autonomy, as measured by the Autonomy subscale of the MOS. No categorical conclusions can thus be drawn about gender or racial differences in the experience of an independent or relational autonomy, or in the tendency of men and women (both Black and White) towards a justice or a care moral orientation.

6.2 Recommendations for Future Research

Further research is required to determine the exact nature of the association between gender and autonomy, self-construal, and ethical orientation, and the effect of race on these variables. However, it is recommended that initial investigations examine gender and race separately, and not include them as independent variables in the same study. It is thus suggested that the association of gender with autonomy, self construal and moral orientation be given further attention in future research. This is particularly important given that the gender differences in the White group in this sample were consistent with other Westernized populations on all of the variables, while the gender differences in the Black group on almost all of the variables were contrary to the expected differences. This, in turn, suggests a significant influence of race on the findings. It would therefore be of value to investigate similar measures treating race as the primary variable. Further research which looks at the differences within each group – male and female – with respect to the variables above is also expected to be particularly illuminating. This would require research that treats women and men as heterogeneous groups and examines how women and men may differ amongst themselves with respect to autonomy and relatedness, independence and connection, justice and care.

Given the contradictory findings within the Black group on many of the variables, further investigation is recommended on the experience of autonomy and interpersonal connection within this group. Against the backdrop of the historical legacy of apartheid and South Africa's unique political and social situation, it is expected that the results of such an investigation could

be particularly revealing – and provide a unique example of a non-Western population that may not behave in a way that other non-Western groups have been found to behave. The finding in the current study, for example, that the White group exhibited a significantly greater tendency towards a relational interdependent self than the Black group - contrary to expectation - requires further investigation and analysis. Further research could also test Kohlberg's model and Gilligan's model on Black and White South African adolescents to see what trends are revealed in their moral development. In particular, further research is needed to investigate further why the Care scores of Black men were higher than expected and higher than all other groups in this sample. Perhaps a study using cross-culturally adapted and validated measures of Gilligan's care orientation and Kohlberg's justice orientation would be useful in confirming or refuting the results of the current study that Black men seem to be more care-orientated and more relational than Black women. Conversely, further examination of Black women's responses on these measures of care versus justice is needed, given their tendency in this study to be higher on Justice than Black men.

Replication of this study in an urban population that is not at a tertiary education level, as well as in a rural population, is expected to yield different results. The specific changes that accompany increased contact between cultures may have had a greater acculturative effect on the results of the more urbanized, Westernized sample in the current study than they would on a more rural population. The inclusion of a measure of acculturation could have yielded more conclusive support for this hypothesis. Separating the variables out and studying each of them separately – autonomy, self, and moral orientation - would be of great value, as it is possible that the combination of all these dimensions in the current study could have confounded the results.

Furthermore, finding and using alternative measures of each of these variables may be necessary, since the findings of the current study suggest that the validity of the measures employed may have been questionable. Furthermore, validating different measures within the South African setting would be of particular importance for future research.

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APPENDICES

APPENDIX A: REVIEWED QUESTIONNAIRES

	SCALE	MEASURES	JOURNAL & DATE	SUBSCALE vs. GLOBAL SCALE SCORES	RELIABILITY & VALIDITY DATA	SAMPLE SIZE & DESCRIP	STUDY MEANS & STD DEVIATIONS	PROS	CONS
AUTONOMY 1	**Autonomy, the Caring Perspective (ACP) (Boughn, 1995)** Permission to use (have scale)	Measures autonomy-related attitudes and behaviors specific to women…i.e., autonomy through caring and affiliation. "Historically, there has been a misunderstanding of how women manifest autonomy due to the tradition of defining autonomy based on the male model, i.e., autonomy through power and separation" (p.106).	Journal of Nursing Education 1995	Items: 50 Subscales: Advocacy & Activism for Self; A&A for Women; A&A for Nurses; Regard for Self; Regard for Women; Regard for Nurses GLOBAL SCORE	Reliability: Pearson's correlation coefficient for pre-posttest scores r = 0.90 Cronbach's alpha = 0.84 Validity: Content validity: 0.76 Construct validity:	400 nursing students (89 freshmen; 143 sophomores; 83 juniors; 85 seniors) over a period of 3 years	No individual group means Freshmen-Sophomore group: Mean: 136.5 SD: 15.2 Junior-Senior group: Mean: 141.2 SD: 15.3	Construct measured closely matches the conception of autonomy being examined in this study Overlaps / links with ethic of care	Specific focus on nurses Questions very specific to nurses only

	SCALE	MEASURES	JOURNAL & DATE	SUBSCALE vs. GLOBAL SCALE SCORES	RELIABILITY & VALIDITY DATA	SAMPLE SIZE & DESCRIP	STUDY MEANS & STD DEVIATIONS	PROS	CONS
SELF 1	**Relationship Self Inventory (RSI) (Pearson, Reinhart et al., 1998)** Permission to use (have scale)	Measures 2 general self-orientations, the separate self and the connected self, as well as two manifestations of connection (self and other care) – but also involves the care and justice orientations, equating the separate-self orientation with the justice orientation, and the connected-self orientation with the care orientation (Gilligan versus Kohlberg but focuses more on *self-orientation* than on *moral-orientation* {self = more broad?})	Journal of Personality Assessment 1998	Items: 60 Subscales: Separate Self; Connected Self; Primacy of Self Care; Primacy of Other Care NO GLOBAL SCORE	Reliability: Cronbach's alpha on each for F & M: SS (.85, .77); CS (.76, .76); POC (.67, .68); SOC (.78, .77)	Total Sample: 1145 (927F& 218M) ages ranging from 26-78 Sub-samples: 32F, 18M high school student 350F, 184M undergrad psych students 29F, 8M separated / divorced 516F, 8M adult enrichment prog	CS (T): 4.1, .51 CS (F): 4.1, .51 CS (M): 3.9, .49 SS (T): 2.6, .53 SS (F): 2.5, .51 SS (M): 2.7, .58 SOC (T): 3.9, .49 SOC (F): 3.9, .50 SOC(M): 3.9 .45 POC (T): 3.2, .50 POC (F): 3.2, .51 POC(M): 3.2 .49	Overlaps with ethic of justice and ethic of care, with a focus on the self Good subscales – relating to what this study is measuring	Marginal gender differences Length

	SCALE	MEASURES	JOURNAL & DATE	SUBSCALE vs. GLOBAL SCALE SCORES	RELIABILITY & VALIDITY DATA	SAMPLE SIZE & DESCRIP	STUDY MEANS & STD DEVIATIONS	PROS	CONS
AUTONOMY 2	**The Autonomy Scale (Bekker, 1993)** Permission to use (still corresponding w/ author)	Measures autonomy (in the psychological-concept sense of the word), with emphasis on the self (identity) and on gender identity – measuring a more "relational" form / experience of autonomy than the independent way that traditional autonomy has been construed	European Journal of Personality 1993	Items: 50 Subscales: Self-Awareness (COG); Self-Awareness (BEH); Sensitivity to Others (COG); Sensitivity to Others (BEH); Need & Capacity for Affection & Separation; Capacity for Managing New Situations GLOBAL SCORE?	Reliability: Cronbach's alpha for total scale: 0.89 Cronbach for Self-Awareness: 0.85 Cronbach for Sensitivity to Others: 0.81 Cronbach for Capacity for Managing New Situations: 0.80 Construct Validity: Established using correlational studies	3 separate studies: 1) 227 psychology students 2) 444 psychology students (284F, 156M, 4 unknown) 3) 440 psych students, 114 wheelchair users & 53 complaint-free adults Mean age = 23.8 years	Study 1: Self-Awareness: F: 4.6, 0.71 M: 4.7, 0.70 Sensitivity to Others: F: 3.6, 0.75 M: 4.2, 0.73 Capacity for Managing New Situations: F: 4.5, 0.97 M: 4.5, 1.01 Study 2: Self-Awareness: F: 4.69, 0.75 M: 4.81, 0.70 Sensitivity to Others: F: 3.47, 0.56 M: 3.81, 0.57 Capacity for Managing New Situations: F: 4.46, 0.91 M: 4.62, 0.86	Concept of autonomy measured matches the concepts being studied here Specific focus on autonomy & the self, and on women / gender Cross-validation Relates autonomy to gender identity Based on Chodorow's theory	Too much emphasis on autonomy as a psychological construct, focusing on psychoanalytic and developmental theories, and on autonomy vs. dependence Scoring problems Language problem: translated from Dutch

	SCALE	MEASURES	JOURNAL & DATE	SUBSCALE vs. GLOBAL SCALE SCORES	RELIABILITY & VALIDITY DATA	SAMPLE SIZE & DESCRIP	STUDY MEANS & STD DEVIATIONS	PROS	CONS
AUTONOMY 3	**Relational Being Scale (RBS) (McChrystal, 1994)** Permission to use (have scale)	The Relational Being Scale (RBS) (was) devised specifically for this research to measure the qualities of relatedness and autonomy as defined by Miller et al. The RBS consists of 28 items divided into two subscales, the Relational (R) scale and the Autonomy (A) scale…The items devised by isolating key concepts in the Relational Being theory: the maintenance of relationships over adherence to abstract concepts of justice	Counselling Psychology Quarterly 1994	Items: 28 Subscales: Relatedness Subscale (high scores indicate high degree of relatedness – but no indication of what classifies as high Autonomy Subscale (high scores indicate high degree of autonomy) NO GLOBAL SCORE (Visual analogue scale)	Pilot study: Reliability: Cronbach's alpha for R subscale: 0.77 Cronbach's alpha for A subscale: 0.68 Validity: Established using interscale correlation, showing no correlation btwn the 2 scales	Total: 53 34F & 19M postgrad counselling students & postgrad accountancy students 57% married, 35% single, 7% divorced or widowed Mean age = 34 Ages ranged from 20.5 – 59.4 years	Relational Being Subscale: F: 74.82, 15.36 M: 71.00, 25.49 (Difference NOT significant) Autonomy Subscale: F: 61.16, 9.78 M: 58.52, 15.51 (Difference NOT significant)	Good link between the self-in-relation concepts measured and the theoretical background of this study: Autonomy vs. Relational subscales Overlap with both autonomy and self concepts Links self & autonomy development Visual analogue scale	No significant differences between men and women Specific focus on self-in-therapy & women's psycholo-gical development No links to care or justice theory or concepts Small sample size No cut-offs

	SCALE	MEASURES	JOURNAL & DATE	SUBSCALE vs. GLOBAL SCALE SCORES	RELIABILITY & VALIDITY DATA	SAMPLE SIZE & DESCRIP	STUDY MEANS & STD DEVIATIONS	PROS	CONS
SELF 2	**Relational-Interdependent Self-Construal (RISC) Scale (Cross, Bacon & Morris, 2000)** Permission to use (have scale)	Independent vs. interdependent self-construals	Journal of Personality & Social Psychology 2000	Items: 11 No subscales GLOBAL SCORE (High scores on the RISC indicate higher levels of the interdependent self-construal – but no cut-offs indicated)	Study 1: Combined samples reliability: Coefficient alpha: 0.88 Test-retest: 0.73 Convergent validity: Established Discriminant validity: Established Study 2: Cronbach's alpha: 0.89 Study 3: Cronbach's alpha: 0.84	Study 1: Eight samples of psych undergrad students Total American citizen group: 2374 Total non-American citizen group: 109 Study 2: 266 psych undergrad students, 145F, 120M Study 3: 181 female psych undergrad students	Study 1: American: 54.89, 10.11 Non-American 50.85, 9.52 Sample 1 (eg): (T) 54.10, 9.29 (F) 55.11, 10.03 (M) 52.89, 8.07 Sample 8 (eg) (T) 56.08, 9.58 (F) 57.78, 9.50 (M) 54.48, 9.38	Reputable journal and powerful statistics & results – extensive validation Has links to care and justice theories/ concepts Focus on cultural differences (Western vs. non-Western) Includes emphasis on decision making Length	

	SCALE	AUTONOMY (Care / Justice Orientation)	JOURNAL & DATE	SUBSCALE vs. GLOBAL SCALE SCORES	RELIABILITY & VALIDITY DATA	SAMPLE SIZE & DESCRIP	STUDY MEANS & STD DEVIATIONS	PROS	CONS
ETHIC 1	**Moral Orientation Scale (MOS) Using Childhood Dilemmas (Yacker & Weinberg, 1990)** Permission to use (have scale)	Measures moral orientation / reasoning: the care ethic (places emphasis on responsibility towards others and the preservation of relationships) versus the justice ethic (places emphasis on individual rights). (Gilligan versus Kohlberg, with focus more on *moral(ity)* / personal *ethic*s than on *self*). {c/f Knox, Fagley & Miller, 2004}	Journal of Personality Assessment 1990	Items: 12 dilemmas No subscales but scored according to Justice response versus Care response NO GLOBAL SCORE (have either a justice-orientation or a care-orientation)	Reliability: Test-retest coefficient: 0.71 Discriminant validity: Established	Total sample: 99 graduate students 29M law, 22F law, 20M social work, 28F social work Mean age = 27 Ages ranged from 20 – 42 Majority Caucasian from middle-class SE backgrounds	M (law): 5.62, 2.4 F (law): 5.95, 2.2 M (soc): 5.90, 2.8 F (soc): 6.86, 1.8 (but should distinguish between the two different orientations & doesn't!) Care(F): 6.46 Care(M): 5.73 Care(F)soc: 6.86 Care(M)law: 5.62	Gender differences in the development of care and justice orientations Based on Kohlberg & Gilligan's theories & concepts Focuses on relationships Uses childhood dilemmas – universal Reflects ways of thinking	Emphasis on morality & *moral* development / reasoning No mention of / explicit links to autonomy concepts

	SCALE	MEASURES	JOURNAL & DATE	SUBSCALE vs. GLOBAL SCALE SCORES	RELIABILITY & VALIDITY DATA	SAMPLE SIZE & DESCRIP	STUDY MEANS & STD DEVIATIONS	PROS	CONS
ETHIC 2	**Moral Justification Scale (MJS) (Gump, Baker & Roll, 2000)** Permission to use (have scale)	Measures the care and justice (moral) orientations, primarily, moral reasoning (Gilligan versus Kohlberg)	Adolescence 2000	Items: 6 vignettes each with 8 questions Subscales: Justice Subscale Care Subscale NO GLOBAL SCORE	Reliability: Internal consistencies: Cronbach's alpha for Justice subscale: 0.64 Cronbach's alpha for Care subscale: 0.75 Split-half reliabilities: Justice: 0.60 Care: 0.72 Test-retest reliabilities: Justice: 0.69 Care: 0.61 Construct validity: High Concurrent validity: Sound	Total sample = 80 undergrad psych students 20F Anglo-Americans 20M Anglo-Americans 20F Mexican-Americans 20M Mexican-Americans Mean age = 18.9, ages ranged from 18-25 years	No data!	Focus on moral orientation	Focus on moral reasoning and development: *morality*

	SCALE	MEASURES	JOURNAL & DATE	SUBSCALE vs. GLOBAL SCALE SCORES	RELIABILITY & VALIDITY DATA	SAMPLE SIZE & DESCRIP	STUDY MEANS & STD DEVIATIONS	PROS	CONS
SELF 3	**Self-Construal Scale (TCS) (Singelis, 1994)** Permission to use (have scale)	Singelis (1994) designed the 24-item quantitative SCS Likert-type scale to measure the complex structure of thoughts, feelings, and actions that comprise independent and interdependent self-construals as separate dimensions	Personality & Social Psychology Bulletin 1994	Items: 30 Subscales: Independent Subscale Interdependent Subscale NO GLOBAL SCORE	Reliability: Original Cronbach's alpha on each subscale ranges from 0.60-0.70 Grace et al: Independent subscale: 0.76 Interdependent subscale: 0.75	Grace et al: 324 undergrad psych students 115M, 209F Mean age = 22 ages ranged from 18-55	Grace et al: INTER Total: 4.63, 0.74 European: F: 4.653, 1.053 M: 4.554, 0.726 Non-European: F: 4.530, 0.775 M: 4.572, 0.775 INDEPENDENT Total: 4.98, 0.76 European: F: 4.820, 1.026 M: 4.746, 0.785 Non-European: F: 4.823, 0.827 M: 4.963, 0.822 (Also see data from other studies)		

APPENDIX B: INSTRUCTIONS TO RESEARCH ASSISTANTS

Instructions

I have given you each a lecture schedule for you to see which lectures we have been given permission to go into for the last 10 minutes to give out the questionnaires. Please go only to the lectures on your schedule because other assistants have been assigned to other lectures and we don't want the questionnaires to be repeated at the same lectures.

However, this doesn't mean that you only have to give the questionnaires you have out at the lectures you have been assigned to. I am not being specific about what fields of study students are doing – so you can give the questionnaires out to anyone (as long as they match the race & gender criteria) you come into contact with – in res, elsewhere on campus, undergrad or postgrad. But please do make sure that the people you give them to ARE STUDENTS here at UKZN.

VERY IMPORTANT: When you give the questionnaires out in the lectures we've got permission for, please make sure you are there 15 minutes before the lecture and indicate to the lecturer concerned that you are there. We will have informed the lecturer in advance that you are coming to that specific lecture. We are allowed to use the last 10 minutes of those lectures to briefly explain to what the research is about and get them to fill out the questionnaires. **PLEASE MAKE SURE YOU STAY AT THE LECTURE AND GET EVERY QUESTIONNAIRE BACK FROM THE STUDENTS YOU GIVE IT TO**. Try not to let them leave with the questionnaire (even if they promise to bring it back) because we will never get it back. This also applies to questionnaires you give out to people outside of lectures – make sure that they sit and do it while you wait.

Instructions / Explanation for students about the research: Please give a brief explanation to the students in the lectures you go to before asking them to fill out the questionnaire. You can tell them something along the lines of:

"Hello – my name is xxx. I am helping one of the Psychology Masters students with the research for her thesis. The broad topic of her research is: "(Re)constructing the autonomous self: A feminist inquiry into gender and the autonomy ideal." Her research is broadly situated in the context of the ethical conduct of research (specifically, HIV vaccine trials) involving women in developing countries. The main focus of her study is to investigate how men and women experience their own autonomy. Once her study is completed, she will come to your lecture and give you feedback on the results.

As part of this research, we are asking students to complete a questionnaire and I would like to use the last 10 minutes of your lecture to ask you to each take a questionnaire, complete it here, and give it back to me. This is not compulsory and will not affect your evaluation for this course in any way. If you agree to complete a questionnaire, please do not leave the lecture theatre before returning it to me. Important note: If you have received one of these questionnaires at another of your lecture and already completed it, PLEASE DO NOT TAKE ANOTHER ONE TO COMPLETE. If you have any questions about this research, or would like to know more about it, you can find Debbie Marais downstairs in the psychology department. Thanks very much."

Payment to my research assistants (you!): R2 per completed questionnaire. You will each get 100 questionnaires to give out. Please bring them back to me as you collect small piles so I can see how many of each of my sample groups we've collected and how many more we need. I need questionnaires completed by: 100 Black Men, 100 Black Women, 100 White Men and 100 White Women. Please be aware of this and keep checking how many you're getting back from each of these groups – I don't need to get 400 questionnaires back from Black Women only!!

Thanks for helping me with this! If you need to get hold of me about questions students are asking, or about the lecture schedules, my office number is 260 6162. You can also pop in at any time or email me at maraisd@ukzn.ac.za if you have any questions.

Debbie.

APPENDIX C: AUTONOMY-SELF QUESTIONNAIRES

Thank you for completing this questionnaire. You are assured that all the details and responses that you give will be treated as confidential. I will be looking at overall (group) trends and will not focus on individual responses / questionnaires. You are not required to put your name on this questionnaire. The following data will be of great value to me, however. Before turning over, please complete the following details. Thank you for your assistance.

Sex: Male ☐ Female ☐

Age in Years: _____

Home Language: _____

Race Group: _____

Your Occupation: _____

Marital Status: _____

Place of Residence: _____

Current Course of Study (if student): _____

Year of Study (1st, 2nd, 3rd, postgraduate): _____

A) Relational Being Scale (McChrystal, 1994)

The following pages contain 28 statements. Please look at each one and then put a cross at the place on the line which indicates how accurate or inaccurate you feel the statement is for you. There are no right or wrong answers since everyone's attitudes about themselves and others vary considerably. Try not to think for too long about each statement, just answer what is right for you.

A1. As a child I was encouraged to consider other people's feelings.

Very Accurate _____ Very Inaccurate

A2. In my professional capacity, I can do my best for my clients/customers when they are aware of my professional status.

Very Accurate _____ Very Inaccurate

A3. It is easy for me to put myself in other people's shoes.

_____

Very Accurate _____ Very Inaccurate

A4. I can usually achieve important goals for myself.

Very Accurate _____ Very Inaccurate

A5. On the whole I find people very forgiving.

Very Accurate _____ Very Inaccurate

A6. As an adolescent my growing sexuality was a source of satisfaction to me.

Very Accurate _____ Very Inaccurate

A7. I am not usually assertive.

Very Accurate _____ Very Inaccurate

A8. I find it hard to do what I know to be morally right if my action will hurt others.

Very Accurate _____ Very Inaccurate

A9. As a child my attempts at independence were usually encouraged.

Very Accurate _____ Very Inaccurate

A10. It is difficult for me to make amends when I have had a disagreement with a friend.

Very Accurate _____ Very Inaccurate

A11. I get most out of life when everything is going well with family, friends and colleagues.

Very Accurate _____ Very Inaccurate

A12. I am generally confident about myself and my abilities.

Very Accurate _____ Very Inaccurate

A13. When a friend lets me down, I usually feel as if I were to blame in some way.

Very Accurate _____ Very Inaccurate

A14. I find it easier to achieve things for others than for myself.

Very Accurate _____ Very Inaccurate

A15. I expect other people to be able to put themselves in my shoes.

Very Accurate _____ Very Inaccurate

A16. As a child my friends of the same sex as me were very important.

Very Accurate _____ Very Inaccurate

A17. I strive for autonomy in all areas of my life.

Very Accurate _____ Very Inaccurate

A18. During my adolescence the possibilities of life opened up before me.

Very Accurate _____ Very Inaccurate

A19. I find that a good argument clears the air.

Very Accurate _____ Very Inaccurate

A20. I am prone to feelings of depression.

Very Accurate _____ Very Inaccurate

A21. I value my ability to be objective.

Very Accurate _____ Very Inaccurate

A22. As an adolescent my growing sexuality caused problems for myself and others.

Very Accurate _____ Very Inaccurate

A23. When I am in a dispute with another person I am usually very clear about who is in the wrong.

Very Accurate _____ Very Inaccurate

A24. I have feelings of self doubt.

Very Accurate _____ Very Inaccurate

A25. A sense of detachment helps me to function better in a stressful situation.

Very Accurate _____ Very Inaccurate

A26. During adolescence I became increasingly aware of the future limitations of my life.

Very Accurate _____ Very Inaccurate

A27. I find it difficult to lose my temper as I know this will hurt those around me.

Very Accurate _____ Very Inaccurate

A28. I am usually satisfied with the way I solve interpersonal problems if I know I have acted justly.

Very Accurate _____ Very Inaccurate

B) Relational-Interdependent Self-Construal Scale (Cross et al., 2000)

Please read the 11 statements below and indicate the extent to which you agree or disagree with each of the statements. Your responses can range from "strongly disagree" (score = 1) to "strongly agree" (score = 7), as shown on the scale here:

1	2	3	4	5	6	7
Strongly Disagree	**Mostly Disagree**	**Slightly Disagree**	**Neutral**	**Slightly Agree**	**Mostly Agree**	**Strongly Agree**

B1. My close relationships are an important reflection of who I am.

1	2	3	4	5	6	7

B2. When I feel very close to someone, it often feels like that person is an important part of who I am.

1	2	3	4	5	6	7

B3. I usually feel a strong sense of pride when someone close to me has an important accomplishment.

1	2	3	4	5	6	7

B4. I think one of the most important parts of who I am can be captured by looking at my close friends and understanding who they are.

1	2	3	4	5	6	7

B5. When I think of myself, I often think of my close friends and family also.

1	2	3	4	5	6	7

B6. If a person hurts someone close to me, I personally feel hurt as well.

1	2	3	4	5	6	7

B7. In general, my close relationships are an important part of my self image.

1	2	3	4	5	6	7

B8. Overall, my close relationships have very little to do with how I feel about myself.

1	2	3	4	5	6	7

B9. My close relationships are unimportant to my sense of what kind of person I am.

1	2	3	4	5	6	7

B10. My sense of pride comes from knowing who I have as close friends.

1	2	3	4	5	6	7

B11. When I establish a close friendship with someone, I usually develop a strong sense of identification with that person.

1	2	3	4	5	6	7

C) Yacker & Weinberg's Scale (1990)

The following scale is a measure of moral reasoning style for adults using 12 dilemmas encountered by children between the ages of 8 and 10 years. In completing the scale, it is important that you imagine yourself to be the parent of an 8-to-10 year old child. As you respond to each dilemma, think about how you would help your child (imaginary or real) decide what to do. That is, what you would most want your child to consider when deciding what to do.

After each dilemma, there are four options you might consider when helping your child decide what to do. Please rank them from 1 to 4 in order of your preference. Specifically, assign the ranking of 1 to that option which comes closest to your own thinking on the matter, the one you most likely want "your child" to consider. Assign a ranking of 2 to that option you would next want your child to consider and so on. The ranking of 4 would be assigned to that option you would least likely want your child to consider.

Please place your ranking of each possible option in the boxes along side each option. Even if none of the options matches exactly what you would say or do, please rank them to fit your thinking as closely as possible. Be sure to rank each option. Of course, there are no right or wrong answers for any question. All responses will be kept confidential.

C1. Your child is having a birthday party and wants to invite most of the children in the class. One classmate, who lives down the street, is not popular with your child, or the other children in the class. Your child does not want to invite the neighbour child.

RANK	
	Since the other child lives on the block, I would explore how my child would feel when he /she saw the child in the future if the child were not invited to the party, and how the other child would feel after being left out
	I would explain to my child that if most of the class is invited, the unpopular child must be as well. It is not fair to leave our one or two.
	I would remind my child that there are times when neighbours help each other. Especially because the child is unpopular, it would be best to be friendly with the neighbour child and invite him / her to the party.
	I would want my child to consider the reasons why the child is not popular. If the child is just shy, she / he should be invited. If the child is out of control or abusive, it would be unfair to the other children to include the child.

C2. Your child accidentally broke a toy that belonged to another child. No one saw your child do this and your child does not wish to confess.

RANK

	I would explain to my child that honesty is the best policy and that the thing to do is to admit having broken the toy.
	I would want my child to consider that by not confessing, someone else might get blamed and punished for breaking the toy.
	I would discuss how difficult it might be for my child to play with the other child in the future, having to live with the guilt about the toy.
	I would want my child to know that in this case there are no questions. If you break it, you offer to replace it.

C3. Your child and another child were misbehaving in school while the teacher was out of the room. When the teacher returned, your child was caught misbehaving, but the other child was not. Your child wonders what to do.

RANK

	I would want my child to be concerned about his / her own behaviour only, and to understand that this would not have happened if my child had behaved properly in the first place.
	I would expect my child not to tattle. As for the other child, it is a matter between that child and the teacher.
	I would help my child understand that it would be unkind to get the other child in trouble and that the upset and anger at the other child for not being caught will not last long.
	I would explore with my child what would happen to their relationship if my child told on the classmate.

C4. Your child agreed to participate in an extra-curricular event which requires after-school preparation. As the day of the event nears, the weather becomes better for outdoor play. Your child no longer wishes to participate in the event or help in its preparation.

RANK

	I would want my child to consider the potential disappointment of others, as they are depending on his / her participation in the event.
	I would help my child understand that a commitment is a commitment and that one must honour responsibilities that one agrees to.
	My child made a promise. I would want my child to consider how he /she would feel if someone broke his / her word to my child.
	I would want my child to be concerned with the selfishness of his /her wishes and I would point out that acting this way can make a person feel bad about herself / himself later.

C5. Your child often plays with two other children and all three are close friends. For some reason, one of the friends becomes unhappy with the other, and wishes your child to break off relations with that friend also. Your child feels caught in the middle and wonders what to do.

RANK

	I would encourage my child to remain friends with both children, even if all three do not play together at the same time.
	I would want my child to consider whether the two children could become friends again by helping my child understand what went wrong.
	I would want my child to consider whether it is fair for someone else to determine who his/her friends should be.
	I would want my child to consider how she / he would feel if she / he were in the position of the third friend. I would want my child to treat others the way she/he wants to be treated.

C6. Your child agrees to pay for a relatively inexpensive household item that she / he broke despite warnings “not to touch.” Your child is saving a portion of his / her allowance to do this. As the savings increase, your child wishes very much to spend the money on something he / she has wanted for a long time.

RANK	
	I would explain to my child that life is like this sometimes; we often have to do things we don’t want to do. It’s not always easy to play by the rules.
	I would want my child to know that we can accommodate each other. I would allow a small portion of the saved money for his / her own purchase, even though it will take a little longer to pay back for the broken item.
	I would want my child to consider the importance of priorities and to understand that the prior obligation must be satisfied before his / her wishes.
	I would impress upon my child that even though the item was small, it was important to me and that for the sake of my feelings, I would like him / her to replace it before making his / her own purchase.

C7. Your child admires a toy that belongs to a friend. The friend accidentally leaves the toy at your house. Because the friend does not seem to miss the toy or ask for its return, your child wants to keep the toy.

RANK	
	I would want my child to consider how the child who owns the toy feels about now having it. I would point out that just because the other child doesn’t seem to care about the toy, this may not be the case.
	I would want my child to consider how she /he would feel if someone kept a toy that was his /hers. The principle of not doing to others what you would not want them to do to you is key in this case.
	I would want my child to consider who owns the toy. Regardless of the circumstances, the toy still belongs to someone else and the important thing is to return it.
	I would want my child to consider the good feelings she / he would get from returning the toy, and the problems that might occur between the children if the friend remembers the toy later and it wasn’t returned.

C8. An afternoon has been set aside for the whole family to give the home a thorough cleaning. On the appointed day, your child wishes to watch a special programme on television. There is no video recording machine in the household.

RANK	
	I would want my child to realize that watching the TV show would not be very considerate to the other members of the family, and to imagine how they might feel.
	I would want my child to understand that she / he is no more privileged than any other member of the family, and that therefore, he / she has to participate in the family chores.
	I would stress all the important aspects of responsibility, togetherness, and belonging that go with “family” as well as the need to be able to depend on one another.
	I would want my child to consider that a commitment has been made to the family in an almost contractual way. And that It would not be fair to change his / her mind at the last minute.

C9. Your child finds a bag in the street containing some small items that Intrigue her /him. Your child wishes to keep some or all of the contents of the bag.

RANK	
	I would want my child to understand that ownership is an important concept. People have a right to their belongings, even though kids often say, “Finders keepers, losers weepers.”
	I would remind my child of the “Golden Rule”: do unto others as you would have them do unto you.
	I would want my child to consider that if he / she kept the bag without trying to locate the owner, she / he might feel guilty about keeping something that somebody else might need.
	I would remind my child that these items are probably considered special to the person they belong to and that person would want them back.

C10. Your child promises another child to help him / her with a school project due the next day. When your child tells you this, you remind your child that this was the day that the family had planned to visit friends who live in a town an hour away. Your child does not know what to do.

RANK	
	I would want my child to consider that promises made are promises kept unless good reasons prevent you from keeping your word. Since the commitment to the other family was made first, it takes precedence.
	I would want my child to consider that membership in the family is important and that when the parents make plans, I would like for us all to be together.
	I would discuss the problem of an individual's freedom within the group and that when the family makes plans, one family member does not have the right to make separate plans.
	I would want my child to consider the predicament of the other child. If the friend really needs help, I could see where my child might have to stay home and help the friend.

C11. Your child has made long standing overnight plans with a good friend who moved out of town and who your child sees infrequently. On the afternoon of the appointed evening, a neighbour calls to say there is an extra ticket to the Ice Capades (or other special event) that night and invites your child to attend. Your child does not know what to do.

RANK	
	I would want my child to consider that not only is the friend looking forward to the visit, the adults in the families had to make special plans for the overnight.
	I would want my child to consider the friend's feelings and find out if it might be possible to change the overnight plans without upsetting the friend.
	I would want my child to understand that the first commitment takes precedence.
	I would want my child to consider his / her priorities. Which is more important – friend or event?

C12. Your child was punished by one of the teachers in the school for a perceived misbehaviour that your child really did not commit. Your child wishes to explain, but fears being further scolded for "talking back."

RANK	
	I would want my child to understand that justice is justice and that taking blame unnecessarily need not be tolerated.
	I would want my child to consider how important it is to communicate with the teacher, not only to clear him / herself, but to maintain integrity and self-esteem.
	I would want my child to consider that teachers are human beings and they sometimes make mistakes. Unless my child was very upset, I would advise him / her to leave things alone this time.
	I would want my child to consider the importance of having the truth be known even when you think people don't want to hear it.

Thank you.
Debbie Marais
February 2005

APPENDIX D: TERMINOLOGY REQUIRING CLARIFICATION

Adolescent

Assertive

Autonomy

Detachment

Dispute

Prone

APPENDIX E: TABLES OF MEAN SCORES BY RACE

Means for Relational Being Scale Subscales by Race

		RACE	
		Black	White
AUTONOMY	Mean	90.83	88.93
	n	195	151
	Std Deviation	14.27	11.35
RELATION	Mean	94.46	91.57
	n	195	151
	Std Deviation	13.59	13.67

Means for Relational-Interdependent Self-Construal Scale Scores by Race

		RACE	
		Black	White
RISC	Mean	54.82	58.8
	n	195	151
	Std Deviation	10.15	10.47

Means for Moral Orientation Scale Subscales by Race

		RACE	
		Black	White
JUSTICE	Mean	6.71	7.26
	n	195	151
	Std Deviation	1.79	1.69
CARE	Mean	5.28	4.76
	n	195	151
	Std Deviation	1.81	1.67

APPENDIX F: CORRELATION MATRIX TABLES

Table 4.19
Correlations between RBS, RISC & MOS Scores by Race

RACE			Autonomy	Relation	RISC	Justice	Care
Black	Autonomy	Pearson Correlation	1	.183(*)	.124	.037	-.020
		Sig. (2-tailed)	.	.010	.085	.607	.785
		N	195	195	195	195	195
	Relation	Pearson Correlation	.183(*)	1	.062	-.003	.023
		Sig. (2-tailed)	.010	.	.388	.971	.753
		n	195	195	195	195	195
	RISC	Pearson Correlation	.124	.062	1	-.140	.113
		Sig. (2-tailed)	.085	.388	.	.051	.115
		n	195	195	195	195	195
	Justice	Pearson Correlation	.037	-.003	-.140	1	-.941(**)
		Sig. (2-tailed)	.607	.971	.051	.	.000
		n	195	195	195	195	195
	Care	Pearson Correlation	-.020	.023	.113	-.941(**)	1
		Sig. (2-tailed)	.785	.753	.115	.000	.
		n	195	195	195	195	195
White	Autonomy	Pearson Correlation	1	-.147	.201(*)	.118	-.117
		Sig. (2-tailed)	.	.071	.013	.149	.153
		n	151	151	151	151	151
	Relation	Pearson Correlation	-.147	1	.338(**)	-.035	.040
		Sig. (2-tailed)	.071	.	.000	.670	.623
		n	151	151	151	151	151
	RISC	Pearson Correlation	.201(*)	.338(**)	1	-.024	.022
		Sig. (2-tailed)	.013	.000	.	.767	.784
		n	151	151	151	151	151
	Justice	Pearson Correlation	.118	-.035	-.024	1	-.997(**)
		Sig. (2-tailed)	.149	.670	.767	.	.000
		n	151	151	151	151	151
	Care	Pearson Correlation	-.117	.040	.022	-.997(**)	1
		Sig. (2-tailed)	.153	.623	.784	.000	.
		n	151	151	151	151	151

* Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).

Table 4.20
Correlations between RBS, RISC & MOS Scores by Gender and Race

Gender by Race			Autonomy	Relation	RISC	Justice	Care
Black men	Autonomy	Pearson Correlation	1	.213(*)	.205(*)	-.059	.061
		Sig. (2-tailed)	.	.038	.046	.569	.560
		n	95	95	95	95	95
	Relation	Pearson Correlation	.213(*)	1	.058	-.146	.143
		Sig. (2-tailed)	.038	.	.579	.159	.168
		n	95	95	95	95	95
	RISC	Pearson Correlation	.205(*)	.058	1	-.123	.133
		Sig. (2-tailed)	.046	.579	.	.233	.200
		n	95	95	95	95	95
	Justice	Pearson Correlation	-.059	-.146	-.123	1	-.995(**)
		Sig. (2-tailed)	.569	.159	.233	.	.000
		n	95	95	95	95	95
	Care	Pearson Correlation	.061	.143	.133	-.995(**)	1
		Sig. (2-tailed)	.560	.168	.200	.000	.
		n	95	95	95	95	95
Black women	Autonomy	Pearson Correlation	1	.154	.047	.132	-.096
		Sig. (2-tailed)	.	.126	.643	.192	.341
		n	100	100	100	100	100
	Relation	Pearson Correlation	.154	1	.063	.145	-.098
		Sig. (2-tailed)	.126	.	.534	.150	.332
		n	100	100	100	100	100
	RISC	Pearson Correlation	.047	.063	1	-.154	.092
		Sig. (2-tailed)	.643	.534	.	.125	.361
		n	100	100	100	100	100
	Justice	Pearson Correlation	.132	.145	-.154	1	-.887(**)
		Sig. (2-tailed)	.192	.150	.125	.	.000
		n	100	100	100	100	100
	Care	Pearson Correlation	-.096	-.098	.092	-.887(**)	1
		Sig. (2-tailed)	.341	.332	.361	.000	.
		n	100	100	100	100	100
	Autonomy	Pearson Correlation	1	-.222(*)	.244(*)	.067	-.055
		Sig. (2-tailed)	.	.038	.022	.532	.612
		n	88	88	88	88	88

			Autonomy	Relation	RISC	Justice	Care
White women	Relation	Pearson Correlation	-.222(*)	1	-.002	-.024	.030
		Sig. (2-tailed)	.038	.	.984	.824	.782
		n	88	88	88	88	88
	RISC	Pearson Correlation	.244(*)	-.002	1	.002	-.006
		Sig. (2-tailed)	.022	.984	.	.987	.953
		n	88	88	88	88	88
	Justice	Pearson Correlation	.067	-.024	.002	1	-.998(**)
		Sig. (2-tailed)	.532	.824	.987	.	.000
		n	88	88	88	88	88
	Care	Pearson Correlation	-.055	.030	-.006	-.998(**)	1
		Sig. (2-tailed)	.612	.782	.953	.000	.
		n	88	88	88	88	88
White men	Autonomy	Pearson Correlation	1	.012	.276(*)	.139	-.152
		Sig. (2-tailed)	.	.924	.029	.278	.233
		n	63	63	63	63	63
	Relation	Pearson Correlation	.012	1	.489(**)	.016	-.007
		Sig. (2-tailed)	.924	.	.000	.902	.956
		n	63	63	63	63	63
	RISC	Pearson Correlation	.276(*)	.489(**)	1	.000	.003
		Sig. (2-tailed)	.029	.000	.	1.000	.982
		n	63	63	63	63	63
	Justice	Pearson Correlation	.139	.016	.000	1	-.995(**)
		Sig. (2-tailed)	.278	.902	1.000	.	.000
		n	63	63	63	63	63
	Care	Pearson Correlation	-.152	-.007	.003	-.995(**)	1
		Sig. (2-tailed)	.233	.956	.982	.000	.
		n	63	63	63	63	63

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).