ETHICAL DILEMMAS IN PSYCHOLOGICAL PRACTICE

A SURVEY OF CLINICAL PSYCHOLOGISTS

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

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ABSTRACT

This study explored a sample of clinical psychologists' preferred resolutions to a series of hypothetical ethical dilemmas and their primary reasons for these choices. The relationship of various professional characteristics to choices and reasons was assessed. Ethical dilemmas volunteered by respondents were analyzed. Results indicated a general lack of consistency in decision making among psychologists in both actions taken to resolve dilemmas and reasons chosen to justify these actions. On the whole, psychologists with different characteristics did not differ in their choice of response to ethical dilemmas or their reasons for these choices. It is argued that diversity in professional decision making, and the ethical dilemmas volunteered by the profession, may serve as useful indices of those ethical issues that pose difficulties for professionals. These results are discussed in the light of similar findings and in the context of current ethical regulations.

CONTENTS

TABLES

1 INTRODUCTION

Recent years have been marked by a general rise in professional awareness concerning the ethical responsibilities of psychologists. Theorists have highlighted that most often psychologists practice at the interface of multiple competing ethical responsibilities (Bersoff, 1995). In this way, ethical decision making in daily practice is typically a complex process (Jordan & Meara, 1990).

Increasingly, therefore, empirical efforts have turned towards investigating the manner in which psychologists make ethical decisions and the factors that influence the decision making process. Such efforts have included investigations of those hypothetical situations upon which psychologists are unable to agree on a consistent course of action (Chevalier & Lyon, 1993; Haas et al., 1986) and those ethical situations that psychologists identify as personally problematic (Lindsay & Colley, 1995; Pope & Vetter, 1992). Such studies have allowed researchers to speculate that diversity in decision making indicates those ethical issues with which psychologists are struggling in the face of unclear guidelines (Chevalier & Lyon, 1993).

Such information is considered critical to efforts aimed at increasing the ability of professional regulations to assist psychologists with ethical decision making (Lindsay & Colley, 1995). Such data may also guide educative efforts at pre-professional and ongoing levels. Unlike their international colleagues, South African psychologists have generally failed to subject ethical issues to empirical scrutiny. There is an absence of comprehensive, systematically gathered data concerning the choices and reasoning of psychologists faced with perplexing ethical situations. The present study aimed to explore the decision making practices of South African psychologists.

2. LITERATURE REVIEW

2.1 ETHICS

Ethics is concerned with several broad areas of inquiry and is the subject matter of diverse disciplines. The investigation of societal moral beliefs and behaviour, and the manner in which such attitudes and conduct may differ from society to society is best known as descriptive ethics and is largely the domain of anthropologists, sociologists and historians (Beauchamp & Childress, 1979). These scholars gather data about the moral tenets of particular groups and identify basic principles of morality (Bersoff, 1995).

Ethics is, however, generally considered the most appropriate and primary subject matter of philosophy and it is this discipline that has subjected ethics to the most thorough scrutiny (Fine & Ulrich, 1988). The study and analysis of the logic of moral reasoning or deliberation, including the nature of ethical justification is best known as metaethics and has been subject to dedicated scrutiny by philosophers concerned with critical ethical terms such as "right" and "responsibility" (Beauchamp & Childress, 1979).

2.1.1 Applied normative ethics

Ethics also subsumes a field of study committed to examining moral theories that formulate and defend a system of moral principles and rules aiming to determine which actions are morally acceptable and which are not. This field of study is known as normative ethics. Ethics to this end is concerned with decisions or judgements about what individuals *ought* to do and what actions are considered morally good or bad supported by sound moral reasoning (Fletcher, Holt, Brazier & Harris, 1995; Pettit, 1993; Steininger, Newell & Garcia, 1984).

Applied normative ethics is concerned with the manner in which moral tenets or general ethical theories are transformed into prescriptive guides that regulate conduct (Bersoff, 1995). It studies the manner in which general ethical theories become organised into rules to assist in decision-making in human relationships (Becker, 1992).

A variety of moral perspectives exist that form a system of justification for ethical decisions and judgements. Such ethical perspectives appeal to principles considered crucial to ethical reasoning (Jordan & Meara, 1990; Steininger et al., 1984). These principles are fundamental moral rules used to justify actions (Fletcher et al., 1995). Utilitarianism and deontology are two general ethical theories that have been applied to many areas of human activity such as biomedicine - (Beauchamp & Childress, 1979) and psychology (Kitchener, 1986; Steere, 1984).

Whether such theories have the internal consistency to yield similar results when used by different people or by the same person in similar circumstances is the matter of some debate, yet both offer a framework within which an individual agent can develop morally acceptable and appropriate actions (Beauchamp & Childress, 1979; Jordan & Meara, 1990). While a comprehensive critique of the philosophical validity of these perspectives would be of interest (Steere, 1983) it is beyond the scope of this thesis and they will only be briefly reviewed.

2.1.2 Utilitarian theory

Utilitarian theory evaluates the moral rightness of actions in terms of one primary feature - the consequences produced by that action. It holds the principle of utility as superordinate, asserting that an ethical action ought always to produce the greatest possible balance of value over disvalue for all persons affected. According to utilitarians ethical action maximises value, which is best translated into the maximisation of the possibility for all affected individuals to realise their preferences (Fletcher et al., 1995; Steere, 1984). While accurate estimates of the preferences of others will necessarily be compromised by limited knowledge and time constraints, utilitarians place the highest value on conscientious attempts to maximise utility (Beauchamp & Childress, 1979).

Critics contend that certain acts that are incompatible with common moral judgement might be justified by their beneficial consequences (Pettit, 1991; Steininger et al., 1984). Accordingly rule-utilitarians renounce the judgement of each individual act by the consequences that follow, and embrace the general observance of rules (a class of acts) in similar situations as this observance has been shown to generally produce value over disvalue (Dyer, 1988). Rules that

maximise general utility enjoy a valuable central place in utilitarian morality and the conformity of any act to a valuable rule determines the moral rightness of that act (Beauchamp & Childress, 1979).

Such "rules" can be conceptualised as the secondary principles of (among others) non-maleficence, beneficence or autonomy (Steininger et al., 1984). From the rule-utilitarian's perspective no rule is ever absolute and the acceptability of any rule depends on the degree to which the rule maximises utility. Accordingly, when certain rules or derivative principles conflict, the choice of action is selected on the basis of the degree to which it conforms with the basic principle of utility. Critics argue that the rule-utilitarian perspective assumes an unrealistic capacity to predict future consequences accurately (Beauchamp & Childress, 1979; Dyer, 1988) and that it is inherently difficult to apply in a thorough-going way especially with regard to indirect effects on individuals at remote spatio-temporal locations (Fairbairn & Fairbairn, 1987).

2.1.3 Deontological theory

Deontological ethicists maintain that the ethicality of any action may not always be, and may not best be, defined in terms of the consequences of that action. They contend that ethical actions are determined by other features inherent in those actions. Subsequently some acts are considered to have "wrongmaking" or "rightmaking" characteristics regardless of their consequences (Fletcher et al., 1995). Certain deontological theories espouse one single principle from which one can derive judgements about what is right and wrong, such as respect for persons. Features of any action that correspond with this valued principle would determine the moral rightness of that action (Fine & Ulrich, 1988).

Other deontologists affirm several basic principles from which to derive judgements about ethicality. These principles are expressed in the moral duties of non-maleficence, beneficence, fidelity, autonomy and justice. Features of actions will be "right-making" insofar as they correspond with certain of these valued principles. Rule-deontologists therefore identify classes of acts that are obligatory, and individual actions are considered morally acceptable to the degree that they conform with such fundamental principles. Whether an ethical agent will be able to

discern if an action inheres a valued property is open to challenge (Pettit, 1991). These duties are, however, conceptualised as *prima facie* binding in that they constitute strong moral reasons for performing the action in question and are always considered morally relevant (Beauchamp & Childress, 1979).

If these *prima facie* duties conflict one is encouraged to consider the weight of all competing *prima facie* duties including the (not superordinate) principle of utility and select one's actual duty based on such a consideration (ibid). This can be seen to amount to a formulation of a fundamental principle asserting that it is always morally right to do whatever one's duty intuits is *prima facie*. Whether this moral intuition may ever provide satisfactory grounds for ethical judgement is open to question (Steininger et al., 1984). Critics maintain that deontological theory ultimately offers little guidance when any two equally important *prima facie* duties come into conflict (Dyer, 1988). The injunction that prima facie duties "always count even when they do not win" is held to give little true guidance in moments of decision-making (Beauchamp & Childress, 1979, p. 45). An ethical agent is faced with a list of moral considerations and is left to decide what matters more in the relevant situation (Dancy, 1991).

Both rule-utilitarianism and rule-deontology establish fundamental ethical principles and obligations as well as accommodate the reciprocal concept of morally justified claims (rights). While utilitarians justify rights as instrumental to the maximisation of beneficial consequences and general utility, and deontologists contend that rights embody certain principles such as respect for persons, both ethical perspectives validate rights and corresponding responsibilities in terms of moral principles and rules.

The end result is that certain similar valuable "rules", duties or general ethical principles are embraced albeit according to disparate reasoning (Steere, 1984). More fundamental differences arise in their guidelines as to how to proceed when ethical duties and principles compete for allegiance. The application of such theories and their limitations to psychological practice will be discussed in a later section.

2.2 ETHICS IN PROFESSIONS

Issues in the field of applied normative ethics have been vigorously debated for centuries by theologians and philosophers. Such debates have centered on moral guides to action that govern whole societies. Comparatively recently attention has focused on specialised moral action guides that regulate special groups such as professionals (Beauchamp & Childress, 1979). A profession has been described as a body of members possessing a unique collection of theory and knowledge, as well as skills and techniques based on this knowledge, who claim as their own a specific area of social difficulty and fulfil socially valued tasks (Keith-Spiegel & Koocher, 1985; Sadler, 1985).

Professions typically restrict entry to those with a minimum standard of education ensuring that candidates are in possession of a level of expertise. Professions typically specify special professional responsibilities in order to promote the degree of public trust requisite for the fulfilment of socially valued ends (Keith-Spiegel & Koocher 1985; Steere, 1984). To this end an over-riding core ethic common to most professions is that of the priority of the client's interest over the interests of all other parties, including the self-interest of the professional. Considerable conflict may result when the professional is also charged with protecting the broader interest of society (Bersoff, 1995).

2.2.1 Professional Ethics codes

The promulgation of an ethics code is considered essential to the development of a profession, forming the basis for self-regulation. The ethics code attempts to capture the moral tenets valued by that group as they have been translated into behavioural prescriptions designed to regulate conduct in relationships with consumers of professional services (Keith-Spiegel & Koocher, 1985). The code of ethics offers a set of guidelines to assist professionals in a range of situations (Fine & Ulrich, 1988).

A code of ethics further assures the public that the profession will take responsibility for consumer protection. In this way, the profession is protected from excessive regulation by higher

external statutory bodies (Welfel & Kitchener, 1992). Ethics codes also specify the responsibilities of professionals in relationship with their colleagues and are therefore critical in the maintenance of professional cohesion (Keith-Spiegel & Koocher, 1995). As a code of ethics specifies the boundaries of acceptable practice and is enforceable by regulatory committees, it accommodates at once the needs of the professional for autonomous practice within peer-established parameters as well as the desire of the public for accountability (Bersoff, 1995).

Ethics codes at their worst may be perceived as symbols of professionalism, entitling professionals to the trust of the public. Insofar as ethics codes have no necessary relationship to the behaviour of professionals, they may be seen as inducing a belief in ethicality without directly reflecting such ethicality (Friedson, 1970 in Bersoff, 1995). In addition ethics codes are rarely developed with the aid of consumers, therefore professional ethics may not always be shared by these consumers (Bersoff, 1995).

Clinical psychology has delineated the area of mental health as a field of expertise. As it is charged with benefitting those who seek help, ethical issues are at the very core of the profession (Bersoff, 1995). Psychologists may exert a powerful influence on the lives and well being of those who seek help (Lakin, 1986). Ethical strategizing is, therefore, necessary to prescribe the manner in which such professionals will work to improve client well-being to ensure that those whose lives are touched by psychologists are respected and protected (Keith-Spiegel & Koocher, 1985). Ethics can be seen as forming a fundamental cornerstone of the helping professions (Dunstan & Shinebourne, 1989).

In practice, psychologists are responsible to numerous parties. Among these are consumers (clients, students, supervisees), the community or society as a whole, agencies or institutions (such as employers) and other professionals. Psychologists operate, therefore, at the interface of multiple competing claims, and corresponding obligations. This ensures that this profession is heavily laced with unavoidable ethical issues as well as clinical, academic, technical and practical ones (Bersoff, 1995; Keith-Spiegel & Koocher, 1985).

2.2.2 Ethics codes in Clinical psychology

A code of ethics in psychology attempts to express the broad value commitments considered fundamental to psychology such as non-maleficence, beneficence, autonomy, and respect for persons. These may be expressed separately and explicitly in a code of ethics (Steere & Wassenaar, 1985) or be interspersed throughout the code (SAMDC, 1992). The abstract level on which ethical principles are formulated, however, may fail to provide adequate bases for behaviour as a psychologist may fail to interpret their spirit or to apply these principles meaningfully in concrete situations (Bersoff, 1995).

Most ethical codes, therefore, go some way towards translating these principles into behavioural terms where such principles interface with practical situations. By applying these principles to practical situations, ethical rules or enforceable standards are derived. They are able to present "instant guidelines" for ethical behaviour across a wide variety of situations (Steere, 1984, p. 10). The psychologist is relieved of repeatedly having to make novel and independent judgements. Furthermore they decrease reliance on each individual practitioner's willingness and ability to make such judgements (Steere, 1984).

Difficulties inhere, however, in attempts to operationalise philosophical concepts and certain of these *prima facie* duties may not be properly translated in the enforceable ethical standards (Bersoff, 1995). Even if they are adequately addressed in a code of ethics, such rules are required to be flexible in order to accommodate the discretion of practitioners taking into account the specific circumstances of a situation (Steere, 1984). By definition, therefore, such rules are often broad and imprecise (Smith et al., 1991).

The code also serves as a reference point to identify unethical acts in order to provide a relatively explicit basis for professional self-regulation (Sieber, 1994). Rules to this end are required to act as yardsticks for unethical behaviour (Steere, 1984). In this way ethics codes also encapsulate the minimal standards of expected practice (Keith-Spiegel & Koocher, 1985) by specifying standards of behaviour that represent the "bottom line below which the psychologist's practice should not go" (Lindsay & Colley, 1995, p. 448). Such standards are less exhortatory than they

are mandatory (ibid.).

The ethical principles and rules that act as guidelines for psychologists are therefore both arguably abstract and imprecise. This advantageously addresses the manner in which a code of ethics cannot speak to every potential ethical issue a professional psychologist may face without becoming inordinately unwieldy (Welfel & Kitchener, 1992). A degree of abstractness ensures the code's usefulness for psychologists fragmented into many different orientations, with various educational backgrounds who function in varied settings (Keith-Spiegel & Koocher, 1985).

The disadvantages of imprecise ethical guidelines lie in the manner in which professionals are forced to judge their relevance in specific situations, interpret and apply them (Gross & Robinson, 1987 in Smith et al., 1991). Such interpretation and application calls on professional judgement which is inevitably subject to individual bias (Jordan & Meara, 1990). Many factors have been hypothesised to affect ethical judgement such as a psychologist's age, experience, theoretical orientation, gender, exposure to ethics training, and work setting (Haas et al., 1988; Hall, 1987; Keith-Spiegel & Koocher, 1985). An exploration of the literature addressing these factors will be discussed in a later section.

Ethics codes generally mutate across time reflecting in each revision pertinent issues as they have emerged within the profession. They are unable, however, to reflect issues that are truly contemporary and are at the cutting edge of the profession (Welfel & Kitchener, 1992). The manner in which ethical principles conflict ensures that the code may appear to contain internal inconsistencies that spell difficulty in application in certain situations (Keith-Spiegel & Koocher, 1985). The code of ethics may acknowledge such conflict as well as incongruence between ethical regulations and legal or organisational demands (Johnson, 1995). Many argue, however, that an effective code of ethics should not merely acknowledge ethical conflict but should provide explicit guidance as to how to act in conflict situations (Seitz & O'Neill, 1996; Sieber, 1994).

Ethics codes may differ in style according to the degree to which they attempt to fulfill different purposes (Lindsay, 1996). Codes that primarily attempt to regulate inappropriate behaviour present minimal standards for acceptable conduct, and delineate those behaviours that are

unacceptable and may justifiably form the basis for a complaint (BPS, 1995). Certain codes attempt primarily to promote the highest standards of practice and consist of guidelines encouraging psychologists to practice, not merely in an acceptable manner, but in an optimal manner (BPS, 1990).

Furthermore, the relationship between ethical principles and culture is a complex one. It has been argued that the manner in which ethics codes typically embody values such as respect for the worth of an individual human being is compatible with, and fundamental to the protection of rights of ethnic minorities (Payton, 1994). In contrast, it has been argued that this ethical principle emphasises the rights of individuals as opposed to groups, and is rooted in an individualistic orientation that is inconsistent with the manner in which certain cultural groups view society (Swartz, 1988). Theorists contend that ethical principles can never be viewed independant of their cultural context (Steere & Dowdall, 1990; Swartz, 1988). The resolution of this debate is beyond the scope of the present work.

2.2.3 South African ethical regulation

Psychologists registered with the South African Medical and Dental Council are bound by regulations drawn up by the Professional Board for Psychology specifying the acts or omissions in respect of which the board may take disciplinary steps. These rules, however, provide fairly minimalist guidelines and are not effective in anticipating or resolving ethically challenging situations (Wassenaar, 1997). The ethics code that serves as the primary reference document for clinical psychologists is the South African Institute for Clinical Psychology's Ethical Principles (Steere & Wassenaar, 1985).

This code directs psychologists to consider the ethical principles of autonomy, beneficence, and non-maleficence when making ethical decisions. In ethical dilemmas where conflicting ethical principles dictate opposing courses of action, psychologists are encouraged to select the action path that inheres least overall harm (Steere & Wassenaar, 1985). Critics have argued that the ethical principles espoused in the code are grounded in an ideology of individualism and voluntarism, which may be in tension with other ideological orientations and that the code fails

to address the social responsibilities of psychologists practising in South Africa (Steere & Dowdall, 1990; Swartz, 1988).

A revised code representing an updated integration of the Steere and Wassenaar (1985) code and statutory provisions of Act 56 of 1974 (SAMDC, 1992) has been provisionally drafted. This code includes statements explicating the value commitments of psychology interspersed with practical rules, ensuring that minimalist standards (geared to consumer protection) are emphasised at the expense of exhortatory guides to the highest standards of conduct. In response to subsequent professional developments (the formation of the Psychological Society of South Africa with an expanded membership) the Steere and Wassenaar (1985) code has, in the interim, continued to serve as the primary document of reference for clinical psychologists in South Africa (Wassenaar, 1997).

2.2.4 Ethical responsibilities

The code of ethics in psychology can be seen to specify the responsibilities of psychologists and the reciprocal rights of the consumers of psychological services (Hare-Mustin, Marecek, Kaplan, & Liss-Levinson, 1979). Certain commentators contend that ethical responsibilities are therapeutic in and of themselves, as they instill a sense of responsibility for therapeutic participation which encourages healthy functioning (Hare-Mustin et al., 1979). Other authors maintain that ethical requisites may often clash with the responsibility of the psychologist to provide effective therapy and that the resolution of the psychotherapeutic with the ethical often involves an inherent dilemma for clinicians (Widiger & Rorer, 1984).

Therapist responsibilities and client rights can be seen to converge on such issues as informed consent, confidentiality, and dual relationships. While these ethical issues are relevant for psychologists in all their professional activities, the following section briefly reviews these issues as they pertain to psychotherapy. These three broad categories of professional ethics are the subject of hypothetical ethical vignettes presented to survey respondents in the present study.

2.2.4.1 Informed consent

The rights of patients or clients to exercise a voluntary and rational choice to participate in research, assessment and treatment (Handelsman, Kemper, Kesson-Craig, McClain & Johnsrud, 1986) has been emphasised in increasingly detailed coverage in professional ethical standards (APA, 1992) and legal standards (Somberg, Stone & Claiborn, 1993; Vasquez, 1994).

While the doctrine of informed consent functions primarily to protect individual autonomy (Beauchamp & Childress, 1979) it is also grounded in the principle of non-maleficence as seeking consent may protect individuals from harm and reduce the likelihood of exploitation (Handelsman et al., 1986). As autonomous agents may, however, select action paths that inhere greater risks than others would select, the principle of autonomy is the strongest justification for seeking first party consent. When seeking consent from second parties designated to act in the best interests of non-autonous agents, the justification on the grounds of non-maleficence is stronger (Beauchamp & Childress, 1979).

Informed consent involves an explanation of the purpose and nature of the envisaged intervention as well as any potential negative consequences (Steere, 1984). An individual must be able to understand a given procedure, to consider the risks and benefits thereof, and be able to reach a decision in the light of this knowledge (Beauchamp & Childress, 1979) free of coercion or undue influence (Everstine et al., 1980). While psychologists may agree on the doctrine of informed consent in principle, research suggests considerable variablity in the application of this doctrine in terms of timing of informed consent, the means by which such information is delivered (Somberg et al., 1993) and the content of consent information (Handelsman et al., 1986; Somberg et al., 1993).

In a survey of APA members, only 59% indicated that they informed their clients about limits to confidentiality (Somberg et al., 1993). A significant minority indicated that the client already had knowledge of confidentiality, which is incongruent with research results suggesting that the grasp of confidentiality is mixed and incomplete (Claiborn, Berberoglu, Nerison & Somberg, 1994). Only 22% informed clients about risks to therapy, and 56% included possible procedures

to be used in psychotherapy which is significant in the light of research indicating that clients may not adequately understand the therapeutic process (Claiborn et al., 1994).

The impact of informed consent on the therapy relationship is a much debated issue. Certain authors acknowledge beneficial effects in terms of increasing a client's sense of control due to power sharing (Somberg et al., 1993). Others maintain that this doctrine is often not smoothly adopted into the psychologist-client relationship and may be incongruent with client-centered therapy, the free association central to classical psychoanalysis (Widiger & Rorer, 1984) and the covert manipulation of paradoxical techniques central to systemic therapy (Brown & Slee, 1986).

Somberg et al. (1993) found that survey respondents reporting their orientation as cognitive-behavioural were more likely to inform clients about length of treatment, procedures, and risks, leading these authors to conclude that the doctrine of informed consent may be more congruent with a behavioural approach.

Concern has been expressed that current guidelines are weakened by the presence of lawerly terms (such as reasonable and feasible) which accomodate professional discretion at the inevitable price of providing loopholes (Vasquez, 1994). Still others maintain that it is impossible to have a "single set of ethical principles that is consonant with existing therapeutic orientations" (Widiger & Rorer, 1984, p. 515) and that individual practitioners would be best left to determine individual guidelines for informed consent (Graca, 1985). Most agree, however, that any move to ethical relativism undermines the objectives of having professional standards of behaviour.

Psychologists are reminded that the application of ethical standards within a unique clinical context presents a constant ethical dilemma for psychologists (Somberg et al., 1993). Despite professional discomfort with a perceived clash of ethical and clinical responsibilities in the arena of informed consent (Widiger & Rorer, 1984), seeking and securing informed consent is in the forefront of legal liability disputes and ethical awareness (Bersoff, 1995).

2.2.4.2 Confidentiality

Confidentiality is defined as the security of personal information (Everstine et al., 1980) and refers to a basic tenet of professional ethics whereby the disclosures of a client may not be revealed without the authorization or expressed informed consent of the client (Miller & Thelen, 1986; Rubanowitz, 1987).

Confidentiality is held to be fundamental to the climate of trust (McGuire, Toal & Blau, 1985; Everstine, et al., 1980) and full disclosure (Bersoff, 1995) necessary for effective clinical intervention. Confidentiality finds further justification in the ethical principle of autonomy which dictates that a client must be allowed to select the content and recipient of disclosed information. The principle of non-maleficence sensitises clinicians to the harm that may occasion to clients with the release of sensitive and private information (Steere, 1984).

Psychologists responding to national surveys reported dilemmas involving confidentiality most frequently (Colnerud, 1997; Lindsay & Colley, 1995; Pope & Vetter, 1991; Sinclair & Pettifor, 1997). Results from national surveys investigating the beliefs and behaviours of psychologists indicated that confidentiality is an area of professional ethics where practice does not match personal ethical standards (Gardner & Marzillier, 1996; Pope, Tabachnick & Keith-Spiegel, 1988).

Research has indicated not only that clients value confidentiality highly (Miller & Thelen 1986) but that they inadequately understand the limitations of client confidentiality (Claiborn et al., 1994) and may expect psychologists to maintain the absolute confidentiality of their disclosures as a general rule (Miller & Thelen, 1986; Rubanowitz, 1987). Furthermore research indicates that while clients desire information about confidentiality (Miller & Thelen, 1986) psychologists may not routinely clarify confidentiality issues for them (Somberg et al., 1993). While some have called for complete confidentiality, the reality is that psychologists can only offer a qualified confidentiality (Allan, 1997). Research has indicated that limited confidentiality does inhibit client disclosure (Nowell & Spruill, 1993). Muehleman, Pickens and Robinson (1985) found, however, that a detailed explanation of confidentiality limits did not inhibit client disclosure more

than a cursory one. In the light of ethical regulations mandating the discussion of the relevant limits to confidentiality, such results are encouraging.

Ethical guidelines regarding confidentiality maintain that psychologists have a primary obligation to respect the confidentiality rights of those with whom they work (APA, 1992; Steere & Wassenaar, 1985). Exceptions to confidentiality are delineated, however, and psychologists are urged to discuss these limits early in the professional relationship. Such exceptions include the existence of imminent danger to an individual in society - even the client themselves (SAMDC, 1992; Steere & Wassenaar, 1985) and the release of information to insurance companies to obtain payment for services (APA, 1992; SAMDC, 1992).

Critics have argued that professional guidelines do not specify those situations which constitute a clear enough danger to warrant breaching confidentiality (Rubanowitz, 1987). Furthermore, authors have argued that the "lack of identifying information" which acts as the criterion for an appropriate presentation of case material is not detailed enough (Gardner & Marzillier, 1996).

2.2.4.3 Dual relationships

A psychologist can function in any number of professional roles consistent with their training (psychotherapist, teacher, supervisor, employer, researcher or expert witness) as well as in various non-professional roles (sexual or business partner, family member, social acquaintance, or friend). Dual relationships are defined as those situations in which a psychologist functions in a professional relationship, as well as in another definitive and intended role. These relationships may be concurrent or consecutive (Sonne, 1994).

Roles carry expectations for how an individual in that role will behave as well as the obligations that accrue to individuals as a function of their role. When an individual is involved in dual (or multiple) roles, expectations and obligations inherent in one role may be incompatible with those inherent in another role. An individual may be unable to adequately honour the demands associated with both roles (Second & Bachman, 1974 in Kitchener, 1988). Such relationships introduce the potential for role conflict and loss of objectivity (Kitchener, 1988).

The stricture against such relationships furthermore rests on recognition of the potentially influential position a psychologists has *vis a vis* consumers (Second & Bachman in Kitchener, 1988). The power differential that characterizes the professional - consumer relationship is held to compromise the objectivity of consumers, placing them at risk for exploitation (Pope, 1990; Pope, 1994). The injunction against dual relationships appears therefore to derive directly from the principle of non-maleficence (Steere, 1984).

2.2.4.3.1 Professional and non-professional roles

Psychologists are urged not to have non-professional contact with persons with whom they share a professional relationship. While sexualized dual relationships tend to enjoy the most attention in the popular and professional literature, psychologists are cautioned to be aware that other forms of non-professional contact (such as social, business) may have deleterious effects on the primary professional relationship. Relationship-related and individual role-related expectations and responsibilities may be compromised by a secondary relationship as well as the client's investment in the primary relationship (Sonne, 1994). Such relationships inhere the risk of loss of objectivity for the psychologist and exploitation for the consumer. Ethical guidelines, therefore, generally offer a broad injunction against such relationships (APA, 1992; SAMDC, 1992).

Those non-professional relationships, however, that have been determined to carry a high risk of harm for consumers, such as sexual relationships with current clients (Pope, 1994) have been afforded an explicit, almost deontological, injunction in psychological ethics codes (APA, 1992; Bersoff, 1995; SAMDC, 1992). Recent revisions of ethical codes (APA, 1992; SAMDC, 1992) allow that after a two year period, sexual involvement may involve no exploitation (Gottlieb, 1993). Other regulations (CPA, 1991) encourage psychologists to refrain from sexual involvement with ex-clients for that time period wherein the power relationship could reasonably be expected to interfere with the client's personal decision making.

Professional unease with this revision is centred around persistent concommitants to the original relationship - such as the power differential. (Buckley, Karasau & Charles, 1981; Gabbard, 1994).

Reservations further centre around research indicating that harm occasions to patients as a result of sexual involvements with their former therapists (Pope, 1994). In the absence of empirical data for lack of harm of such relationships, critics maintain that policy is premature and until such data exists the injunction against such relationships should remain absolute (Gabbard, 1994).

2.2.4.3.2 Dual professional roles

As different roles tend to inhere conceptual and practical differences, psychologists who function in more than one professional role in relation to clients or consumers run the risk of compromising the efficacy of one or both endevours (Greenberg & Shuman, 1997). In response to this concern, psychological organizations have sought to discourage those situations where dual functions are performed by a single psychologist. Specialty guidelines have, for example, been formulated to caution psychologists to the potential conflict inherent in conflicting therapeutic and forensic roles with patient - litigants (ibid). The APA ethics code (APA, 1992) urges psychologists to avoid conflicting roles in forensic matters which may result in compromised professional judgement.

In a similar vein, psychologists are discouraged from engaging in dual therapeutic and supervisory roles with student/supervisees, as the permissive and evaluative nature of these respective relationships are incompatible (Slimp & Burian, 1994). Psychologists describe, furthermore, numerous difficulties associated with functioning as a service provider and organizational employee. In sum, psychologists occupying such dual roles describe an array of institutional demands or constraints that compromise their therapeutic and ethical obligations to their clients (Jeffrey, Rankin & Jeffrey, 1992; Johnson, 1995, Zelig, 1988). The ethical vulnerability associated with such dual professional roles is acknowledged by ethics codes (APA, 1992; SAMDC, 1992). The conflict of interest inherent in these roles will be discussed in more detail in section 2.3.

Despite the injunction against dual relationships in ethics codes (APA, 1992; SAMDC, 1992), psychologists report that this area of professional ethics remains a troubling one (Lindsay & Colley, 1995; Pope & Vetter, 1991). Psychologists maintain that while the stricture against dual

relationships heightens their sensitivity to the potential for harm in such situations, it is of little real assistance in the practical circumstances of practice (Pope & Vetter, 1991). It has been argued that the functional utility of the ethics code could be enhanced if the code described those expectations and obligations associated with the primary professional relationship likely to be compromised by another interaction (Sonne, 1994).

Increased attention to dual relationships in training has also been recommended (APA, 1988). Advocates maintain that attention to psychologists' motivations and needs will ensure that they are better able to recognize potentially exploitative non-professional relationships that are tailored around the interests of the therapist (Borys & Pope, 1989; Pope, Keith-Spiegel & Tabachnick, 1986).

2.2.5 Summary

This section aimed to outline the ethical dimensions of psychology and review important areas of professional ethics. In the course of this review, several difficulties inherent to the ethical practice of psychology, and the ethical regulation thereof, have emerged. It seems appropriate, however, to review in some detail certain discrete areas that have been identified in the literature as posing specific ethical challenges for psychologists. The following section reviews three areas of potential conflict: the manner in which principles may conflict within an ethical system of choice, and the conflict of ethical responsibilities with legal obligations and organisational requirements respectively.

2.3 ETHICAL CONFLICT IN PSYCHOLOGY

2.3.1 Conflict of ethical principles

> "There would be no moral dilemmas if moral principles worked in straight lines and never crossed each other" (Stoppard in Beauchamp & Childress, 1979, p vii).

A discrete number of ethical principles or *prima facie* duties have been identified as the fundamental principles pertaining to psychologists (Bersoff, 1995). These are beneficence, non-maleficence, autonomy (Steere, 1984), justice and fidelity (Welfel & Kitchener, 1992). These ethical principles apply to psychologists in all their professional duties, namely psychotherapy, assessment, and research and often interact with each other in complex ways (Steere, 1984).

2.3.1.1 Autonomy

The moral notion of autonomy refers to an individual's personal liberty of thought and action. An autonomous agent is capable of both deliberation on the basis of principled reason and self-directed action on the basis of their deliberations. Formulated as a principle of autonomy used to guide decisions about how to treat such agents, this principle directs psychologists to allow another the freedom to perform chosen acts (even if considered foolish or involving considerable risk) insofar as such actions do not infringe upon the autonomous actions of others (Beauchamp & Childress, 1979; Welfel & Kitchener, 1992).

Autonomy can be justified on the grounds of respect for persons that by virtue of their personhood have the right to determine their own destiny. Autonomous agents may willingly consult with an authority and autonomously choose to rely on that authority's determinations. Autonomy is, therefore, compatible with the concept of authority as long as such authority is autonomously delegated (Beauchamp & Childress, 1979).

Autonomy is not an absolute concept and some persons are considered non-autonomous due to coercion, or by virtue of their position vulnerable to exploitation by others. Psychologists are encouraged to be aware of the complex interplay between their authority and the autonomy of their clients (Steere, 1984). Some individuals may also be considered non-autonomous due to incapacity and interference in the actions of such persons is validated on the grounds of preventing such persons from harm (non-maleficence) and on the grounds of a principled paternalism whereby they seek to protect others from harm and secure for them the good they are not able to secure for themselves (Steininger et al., 1984).

2.3.1.2 Non-maleficence

The principle of non-maleficence is recognised in both rule-utilitarian and rule-deontological theories as a fundamental and stringent duty not to injure others (Beauchamp & Childress, 1979). It is generally held to be a stronger requirement than beneficence (Colnerud, 1997). Non-maleficence directs psychologists to do no harm either intentionally or through exposing others to risk of harm in the form of adverse psychological or physical consequences (Steere, 1984).

While psychologists are expressly prohibited from intentionally inflicting harm, exposure to the risk of harm is tolerated under special circumstances. Certain psychological activities that inhere the risk of harm are permitted where the likelihood of an action producing positive consequences outweighs the degree of possible harm arising out of such an action (Steere, 1984). This circumstance illustrates the manner in which the distinct principles of beneficence and non-maleficence may come into conflict (Beauchamp & Childress, 1979). Psychologists are encouraged to weigh these two principles carefully in a thorough analysis of detriment/benefit recognisable as the separate principle of utility. Concepts such as psychological benefit or distress are undeniably intangible yet the overriding concern recognised in both ethical and legal standards of care is that sufficient attention has been dedicated to this process (Steere, 1984).

2.3.1.3 Beneficence

The duty of beneficence requires positive steps to help others and is therefore farther-reaching than non-maleficence even while there is no sharp demarcation on the continuum of non-infliction of harm to the production of benefit (Beauchamp & Childress, 1979). Beneficence directs psychologists to undertake positive acts to prevent harm, remove harmful conditions and benefit others through actively contributing to their health and welfare and assisting others to further their interests (Welfel & Kitchener, 1992).

In a situation where a number of alternative action choices are possible, the psychologist is directed to select the action that would provide the most benefits for the client for the lowest cost in terms of harm or loss (Steere, 1984). Beneficence therefore can also be seen to involve a moral

duty to balance beneficence and non-maleficence in conflict situations and weigh the possible benefits against possible harms in a cost/benefit analysis (Beauchamp & Childress, 1979).

2.3.2 Conflict between ethical and legal obligations

While the relationship between client and psychologist inheres a duty to prioritise client welfare, the psychologist is also responsible for promoting community interests as a whole. As such they are bound to laws concerned with the protection of individuals in society based on the familiar principles of beneficence, non-maleficence and autonomy (Steere, 1984). Psychologists faced with such dual responsibilities are headed for conflict when the protection of client welfare may jeopardize the wellbeing of individuals in broader society. This separate duty to individuals in society has become encapsulated by certain societal laws. Among these are legal obligations to report child abuse and to take reasonable steps to protect intended victims from threatened violence (Allan, 1997).

Legal regulation of the activities of psychologists indicates that the law is less willing to tolerate idiosyncratic interpretations of broad ethical guidelines when client actions clearly interfere with the rights of individuals in society (Bersoff, 1976). The responsibility to "comply with the law" has also been encapsulated in ethical codes (APA, 1992). Some have expressed concern that reporting laws juxtapose the duties of autonomy, non-maleficence and beneficence that underly client confidentiality with the duty of beneficence expressed in the responsibility to protect others from harm (Steininger et al., 1984).

It has been argued that obedience to reporting laws effectively redefines professional responsibilities away from a clinical function towards a policing function (Ansell & Ross, 1990; Everstine et al., 1980). Further reservations centre around the lack of empirical validation for the consequences of reporting laws (Pope & Bajt, 1988). Critics maintain that blind obedience to legal duties may amount to a sacrifice of client welfare and therefore does not automatically amount to sound ethical practice.

2.3.2.1 Child abuse reporting

South African psychologists are governed by the Child Care Amendment Act 74 of 1983 and sections of the Prevention of Domestic Violence Act of 1993 (in Allan, 1997) which obligate those who attend to a child in circumstances giving rise to suspicion of abuse to notify a police official, commissioner of child welfare, the Director General or another designated officer. As this act refers only to individuals that evaluate or treat a child, it allows for many cases where there may be no statutory obligation to report (Allan, 1997).

Surveys conducted in the United states indicate that many psychologists fail to comply with reporting laws governing their jurisdiction. In a survey of psychologists respected for their ethical judgement, the majority (57%) reported that they had broken the law on the grounds of protecting client welfare. Of these situations, 21% involved failure to report child abuse (Pope & Bajt, 1988). Professional discomfort with this reporting law centres around the potential for disruption to the therapeutic process, which may not be validated insofar as judgements about the existence of child abuse may be inaccurate (Ansell & Ross, 1990; Kalichman, Craig & Follingstad, 1989 in Kalichman, 1990).

Other psychologists express concern that failure to report child abuse may reduce public trust in psychology and undermine a child's right to investigate and prosecute perpetrators. They argue that in the case of child abuse reporting, legal obedience does amount to ethical practice (Kalichman, 1990). In every event, reporting of child abuse challenges psychologists to balance the best interests of their client, confidentiality rights and legal reporting obligations (Nicolai & Scott, 1994).

2.2.3.2 The duty to warn

The duty to warn has ethical roots in the principle of beneficence which inheres a responsibility to protect community welfare (Mills, Sullivan & Eth, 1987). Psychologists in South Africa are governed by statutory reporting provisions outlined in the Mental Health Act 18 of 1973 (in Allan, 1997) that direct psychologists to report any person who is "mentally ill" to such a degree

that s/he is a danger to others. Since the case of *Tarasoff vs. the Regents of the University of California*, however, it has become generally accepted that circumstances exist where a therapist needs to warn a third party of a threat made by a client (Allan, 1997).

The duty to warn is established when a therapist determines, or should have determined according to standards of professional practice, that a patient or client represents a serious danger of violence to another. In this event, the therapist "bears a duty to exercise reasonable care to protect the foreseeable victim of that danger" (Fulero, 1988, p. 184). This may involve warning the intended victim, notifying the police, or other clinical options, such as the hospitalization of a dangerous client (Monahan, 1993).

The competence of psychologists to predict violence with accuracy or reliability has been questioned (Duckitt, 1988). Furthermore, professionals express concern that this duty may contaminate the therapeutic alliance and initiate the abrupt termination of therapy (Van Eenwyk, 1990). Others argue that warnings *per se* have little effect on the therapeutic alliance. The manner in which they are integrated into the therapy is, however, critical and if this is managed effectively the relationship should endure after a confidentiality breach (Quinn, 1984, in Bersoff, 1995; Brosig & Kalichman, 1992). These legal obligations have, however, raised concerns about the extent to which psychologists have a responsibility to warn individuals at risk of infection with HIV, or report potentially dangerous research subjects (McGuire, Nieri, Abbot, Sherida & Fisher, 1995; Morrison, 1989; Stanard & Hazler, 1995).

Psychologists who fail to comply with this legal mandate stand to be accused of considering themselves beyond the law (Pope & Bajt, 1988). Others maintain that while adherence to the law is an inescapable demand, the psychologist is still charged with inflicting as little harm to the client as possible while fulfilling his/her legal responsibilities (Steere, 1984). This reflects an focus away from examining the legitimacy of the duty to warn, towards considering the limits of that duty (Mills et al., 1987). To this end, warning statements are to be limited in scope to the proper parties, on the proper occasion and delivered in the proper manner (Fulero, 1988). Notwithstanding, balancing obligations to clients and the public interest may involve profound dilemmas for psychologists (Kalichman, 1990).

2.3.3 Conflict between ethical and organisational demands

Certain special work settings may evoke specific ethical difficulties for psychologists. Lindsay and Colley (1995) reported that of the ethical dilemmas volunteered by British psychologists, a large category comprised of concerns about the demands placed upon psychologists "by their role as employees" (ibid, p. 451). In such situations, psychologists are concerned that their ethical obligations to their clients are compromised in some way by their professional role as an organisational member.

These psychologists are essentially acting in dual professional roles and may be faced with conflict when the ethical guidelines governing their practice are contrary to the requirements of their organisational setting (Johnson, 1995). In such situations there is also frequent difficulty in identifying the consumer of psychological services, as in many organisations different client categories may exist with needs that are competitive or even mutually exclusive (Keith-Spiegel & Koocher, 1985).

A psychologist may occupy a position whereby they owe professional duties to three entities, an individual client, an agency, and society as a whole with unclear lines of obligation (ibid). Psychologists may differ in their views of the standing of third parties in relation to ethical issues, which raises the question of whether certain characteristics of work settings may call for the application of speciality ethics (Patterson, 1971; Pattison, Hackenberg, Wayne & Wood, 1976).

A primary difficulty in such settings appears to be person-centred considerations about the confidentiality of client material and organisation-centred directives permitting access to such material. Psychologists are faced with a dichotomous demand whereby adherence to organisational directives ensures disregard of ethical regulations and *visa versa*. The role of military personnel involved in the delivery of psychological services vividly demonstrates this dual allegiance (Johnson, 1995) although such ethical dilemmas apply to a range of organisations, such as correctional facilities (Weinberger & Sreenivasan, 1994) and law enforcement agencies (Zelig, 1988).

Psychologists in these situations are fully accountable for adherence to ethical regulations as well as the requirements of their employing agency in the form of rules placing organisational interests foremost (Keith-Spiegel & Koocher, 1985). Ethical regulations (APA, 1992; Steere & Wassenaar, 1985) urge psychologists to clarify the rights of each party, their ethical responsibilities to each party, and to inform all about ethical constraints (Keith-Spiegel & Koocher, 1985).

Many psychologists, however, appear to cope with this ever-present bind by attempting to adhere to both requirements as fully as possible and allowing the best interests of the client to determine which requirement to compromise in the situation at hand (Johnson, 1995). Encounters with dilemmas of this nature, therefore, almost always involve compromise of either ethical guidelines or institutional rules at considerable risk of sanction for the psychologist (Jeffrey, Rankin & Jeffrey, 1992). Many argue that while professional regulations acknowledge the ethical vulnerablity of occupying such a position, they offer little rigorous guidance (APA, 1992; Sieber, 1994).

2.3.4 Summary

Numerous broad areas of ethical conflict emerge for practising psychologists. As psychologists are forced to weigh competing ethical, legal or institutional demands in such conflict situations, ethical decision-making becomes a complex process subject to numerous sources of bias. The following section affords a more detailed review of efforts to facilitate decision making through formal approaches to ethical analysis and professional guidelines. It also reviews variability in ethical decision making as well as numerous factors that have been identified as influential sources of bias.

2.4 ETHICAL DECISION-MAKING

This section aims to explore the theoretical and empirical literature devoted to ethical decision making in psychology. Formal assistance in form of recommended approaches to ethical analysis and professional regulations are reviewed as are their inherent limitations. The factors

identified in the professional literature as influential to the decision making process such as age, gender, and ethics education are reviewed. Rest's (1984) four stage model of the psychological components crucial to morality forms the conceptual framework for a review of the empirical literature (Welfel & Kitchener, 1992).

2.4.1 Ethical analysis in psychology

2.4.1.1 Principle Ethics

In the previous section, the multiple conflicting responsibilities that practising psychologists may face was reviewed. These responsibilities ensure that psychologists typically face situations where there are sound reasons to take different courses of action (Bersoff, 1995). Many dilemmas present as conflicts between ethical principles, and in such situations more than one course of action could be considered acceptable on the basis of a valued principle (Haas et al., 1986). It is apparent, however, that dilemmas may arise in the form of incongruence between ethical obligations and legal or organisational requirements (Eberlein, 1987). The dominant approach to ethical analysis in the face of competing claims and responsibilities appears to be that of principle ethics (Jordan & Meara, 1990). The following section reviews this approach as well as some of the limitations to this approach that have been identified by critics.

The ethical principles pertinent to psychology are considered universal in that they convey the "ought" of moral obligation and delineate psychologists' ethical obligations in a wide range of circumstances. They are considered to be conceptual tools that organize ethical rights and responsibilities in many situations (Bersoff, 1995; Steininger et al., 1984). These principles all stand in potential conflict and may dictate opposing alternatives with good ethical justification (Steere, 1984). Exclusive reliance on these secondary principles could ensure that a psychologist is placed in a quandary with principles in direct conflict with one another (Jordan & Meara, 1990). How to decide on the most appropriate behaviour when two moral principles conflict is the subject matter of considerable ethical debate (Bersoff, 1995).

Psychologists are generally encouraged to evaluate which *prima facie* principles are competing

and to articulate these conflicting demands and their related responsibilities (Jordan & Meara, 1990). Advancement beyond conflicting principles is recommended by appealing to a more fundamental principle which justifies the prioritisation of one principle over another. While different circumstances may dictate which different principles are to prevail, consistency is maintained by recourse to the fundamental ethical principle (Eberlein, 1987; Fine & Ulrich, 1991; Steininger et al., 1984). While ethical discourse in psychology has typically emphasised the benefits of rule-deontological and rule-utilitarian approaches, these have been seriously criticised and some suggest that their helpfulness is questionable (Bersoff, 1995; Jordan & Meara, 1990).

The rule-deontological approach holds that all principles and duties are equal in importance to each other. The fundamental rule that may be deduced is that it is one's ethical duty to select the *prima facie* duty that one's moral intuition dictates should be primary (Steininger et al., 1984). Critics argue that the psychologist may be forced to decide on a situation-specific hierarchical ordering of ethical principles which is demanding at best and arbitrary at worst. This is argued to depend on a moral intuition that may be inadequate (Fine & Ulrich, 1988; Jordan & Meara, 1990; Steininger et al., 1984). Psychologists that favour a rule-utilitarian approach would hold as primary the directive to maximise the good. On utilitarian grounds a competing principle may be overridden insofar as acting on another principle is judged to produce greater value over disvalue (Steininger et al., 1984; Steere, 1984). Rule-utilitarianism appears generally favoured in psychology (Steere, 1984).

The value of this "principle ethics" approach to ethical analysis lies in the manner in which it describes competing claims and the potential it allows for identifying a full range of alternatives (Jordan & Meara, 1990). Individuals are encouraged to articulate the themes and tensions inherent in complex situations (Eberlein, 1987; Robinson, 1973 in Lakin, 1986). Psychologists are encouraged to consider issues at a critical-evaluative level (Kitchener, 1986; Perez, 1993; Von Stroth, Mines & Anderson, 1995). This approach to ethical analysis is also emphasised in psychology as it is seen to best reflect the reality that ethical problems in psychology most often cluster around several ethical principles (Keith-Spiegel & Koocher, 1985). Furthermore, psychologists are forced to accept that in many ethical dilemmas no response is totally satisfactory (Eberlein, 1987) however some are more satisfactory than others (Dove, 1995).

The application of ethical principles to complex scenarios has, however, been held to have drawbacks. Critics argue that a dispassionate cognitive analysis of rational, universal principles is fostered (Jordan & Meara, 1990). The primary goal is to be able to clarify and articulate ethical issues (Fox, Arnold & Brody, 1995). The use of historically determined virtues such as courage, integrity, humility, prudence and discretion in professional judgement are de-emphasized (Jordan & Meara, 1990).

In contrast, others have argued that this approach emphasises ethical decision making as an intra - individual process which ignores the influence of social relationships on ethical decision making (Cottone, Tarvydas & House, 1994). Critics have further argued that the ethical principles considered relevant to psychology are less universal and context-free than they are context-dependant. As such they are imbued with an implicit ideological orientation that may be inconsistent with another given ideology (Swartz, 1988).

Critics primarily contend that an emphasis on the application of ethical principles and their underlying theories is necessarily idiosyncratic (Jordan & Meara, 1990). The solution to an ethical dilemma will depend on whether a psychologist subscribes to rule-utilitarian or rule-deontological approach. Even within one approach, psychologists can all analyze the same facts and use the same reasoning process yet still come to different conclusions as they ultimately have to choose among contradictory and justifiable solutions (Kitchener, 1984). Blasi (1980) has similarly argued on theoretical grounds that similar reasoning processes may result in multiple different behaviours. The end result is that psychologists end up doing the best that they can (Drane, 1982 in Jordan & Meara, 1990).

The fundamental concern of advocates of principle ethics would appear to be the manner in which this approach encourages a reasoned methodology in the face of ethical conflict facilitating a decision-making process that is "explicit enough to bear public scrutiny" (CPA, 1986, p. 2). Psychologists are therefore encouraged to learn a system of formal analysis for analyzing ethical obligations in complex situations and numerous methods have been delineated (Canter et al., 1994; Fine & Ulrich, 1988; Keith-Spiegel & Koocher, 1985; Kitchener, 1986; Steere, 1984; Tymchuk, 1986).

While mastery of a systematic approach to ethical decision making is recommended to increase consistency in decision making, critics have identified that sources of inconsistency in ethical decision-making can be as fundamental as the idiosyncratic application of prized ethical principles, the use of underlying ethical theory, and even formal methods for ethical analysis (Fine & Ulrich, 1988; Jordan & Meara, 1990). This raises the observation that ethical decision making is a complex process susceptible to numerous factors that may act as sources of influence or bias. Theorists and researchers have posited that ethical decisions may be consistently linked to individual characteristics of the individuals who must make the decisions (Kimmel, 1991) such as age, clinical experience, gender (Gilligan, 1982; Hall, 1985), individual values (Tymchuk et al., 1982) or clinical orientation (Keith-Spiegel & Koocher, 1985). The influence of such factors has been suggested to be strongly facilitated when ethical guidelines are at their most abstract (Tymchuk et al., 1982). To this end a review of the functional role of professional guidelines in ethical decision making is reviewed in the following section.

2.4.1.2 Ethical regulations

Psychologists are wholeheartedly encouraged to be familiar with the ethical guidelines governing their practice in order to facilitate decision-making. Psychologists are further encouraged to know applicable legal regulations and the rules of their organisation (Canter, Bennet, Jones & Nagy, 1994). The code of conduct may, however, contribute little to clarifying appropriate conduct in troubling situations due to the manner in which regulations remain broad, flexible and vague guidelines for conduct (Smith et al., 1987). Psychologists may fail to adequately comprehend the spirit of broad ethical principles or adequately apply them to specific situations (Bersoff, 1995).

It has been argued that the manner in which individuals differ in their ethical appraisals and responses to ethical dilemmas may be traced to the fact that ethical principles are often broadly stated and ambiguous (Kimmel, 1991). When called upon to interpret complex situations, most psychologists generally exercise sound professional judgement (Chauvin & Remley, 1996), however an argument has nevertheless been made to provide "criteria for interpretation" of ethical guidelines (Vasquez, 1996, p. 99). It has been argued that if the philosophical reasoning behind

ethical principles was clarified (Seitz & O'Neill, 1996; Weinberger, 1988), psychologists would be better able to apply such principles consistently to new situations arising in practice (Eberlein, 1988; Seitz & O'Neill, 1996).

Furthermore in the face of actual dilemmas, ethics codes may do little to facilitate ethical decision making (Weinberger, 1988). In many cases ethics codes merely acknowledge ethical conflict and offer little concrete guidance in resolution (APA, 1992; Johnson, 1995; SAMDC, 1992; Sieber, 1994). In order to increase the usefulness of the ethics code in situations where ethical obligations conflict, the Canadian Psychological Association has developed a Code of Ethics (CPA, 1986; 1991) which explicates the reasoning behind ethical principles and ranks these principles in order of the relative weight to be given when they are in conflict (Seitz & O'Neill, 1996). As this code advocates addressing dilemmas by pitting one principle against another, the resolution of situations where multiple principles act in a cumulative loading is not addressed. Furthermore, the conditions under which the ranking of principles can be re-arranged is unclear (Weinberger, 1988).

2.4.2 Ethical decision making

2.4.2.1 Demographics and ethical decision making

The assumption that variations in the attributes and characteristics of psychologists may influence appraisal and resolution of ethical problems reflects a consideration of subjective influences on decision making that is not always overcome by "an objective methodology" or "a set of ethical standards" (Kimmel, 1991, p. 786). Recent attention has turned towards a consideration of the factors that may influence the identification and resolution of ethical dilemmas. The following section reviews selected contributions from theorists pertaining to the influence of individual characteristics on ethical decision making.

2.4.2.2 Cognitive moral development

Cognitive moral development theories assume that complexity of moral reasoning is related to

increasing age (Kitchener, 1986). The contributions of cognitive developmental theorists such as Kohlberg therefore forms the basis of considerations of the influence of age on moral reasoning (Higgs, 1994). Kohlberg (1969 in Daniels, D'Andrea & Heck, 1995) articulated a framework that posits qualitative differences in the manner in which a person reasons about ethical issues across the life span. He maintained that as individuals are privy to increasing social experiences they tend to acquire an evolving understanding of the nature and function of social co-operation (Rest, 1984).

Such "schemes of cooperation" or "stages" of moral reasoning are characterised in terms of a progressive awareness of the possibilities of cooperative arrangements among an ever increasing number of participants (Rest, 1984). Initially young children are aware only of simple schemes of cooperation which involve few people who reciprocate in concrete exchanges. Such schemes gradually evolve into more sophisticated frameworks able to accommodate wide societal networks. Kohlberg (1969 in Daniels et al., 1995) identified a finite number of such schemes and he maintained that individuals progressed through these stages in an orderly predictable developmental sequence characterised by more complex problem-solving abilities at each stage.

The implications of Kohlberg's theory are that ethical agents attempting to identify the moral course of action in a social situation depend on their current scheme of cooperation in order to identify crucial ethical considerations and prioritise conflicting claims. The basic underlying framework of cooperation is maintained to strongly influence the manner in which people will "naturally formulate" their ethical judgements (Rest, 1984, p. 24). Cognitive moral development is held, therefore, to be an individual difference expected to influence ethical decision making (Trevino & Youngblood, 1990).

The application of Kohlberg's theory to ethical decision making has been useful in drawing attention to the fact that psychologists are subject "to their own psychology" when making decisions (Dyck, 1993, p. 60). This application has been criticized, however, for confounding description with prescription, in that Kohlberg's research articulates how people are instead of how they should be. Furthermore, the assumption that the final stage corresponds with the highest levels of moral reasoning is open to question (ibid).

2.4.2.3 Gender

Gilligan (1986 in Daniels, D'Andrea & Heck, 1995) maintained that Kohlberg's theory inadequately considered fundamental gender differences in the manner in which men and women approach and resolve ethical problems. She proposed the notion that men and women have dichotomous orientations to solving ethical problems based on observations of the different manner in which male and female adolescents analyzed and responded to interpersonal ethical dilemmas (Daniels et al., 1995; Gilligan, 1982).

When youngsters were presented with fables containing a moral dilemma and their resolutions solicited, it was found that young males were focused on issues of separation, autonomy, law, fairness and rights (a justice perspective). Young women showed a proclivity to emphasise the importance of attending to needs, and creating and sustaining a caring relationship (a care perspective). As Kohlberg's stage model of moral development is largely equated with an increasing awareness of justice (O'Neill, 1991), Gilligan maintained that Kohlberg's theory vastly underestimated women's capacity for moral reasoning. She maintained that his theory fails to account for a moral perspective where caring is recognised as the primary underlying good (Imre, 1984 in O'Neill, 1991).

Gilligan (1982) explained the gender differences noted in her study by referring to differences in the socialization of males and females from childhood through adolescence. As results of a replication study with Hawaiian male and female students failed to indicate any significant gender differences in the manifestation of a care or justice perspective, her theory has been held to have limited cross cultural utility (Daniels et al., 1995). Others have found empirical evidence for an integrated care and justice perspective (Sherblom, Shipps & Sherblom, 1993). Gilligan's work is, however, considered important for the manner in which it calls attention to the effects of gender and socialization experiences on moral reasoning and development.

2.4.2.4 Ethics education

Formal attention to ethics training has been posited to assist psychologists to make sound ethical

judgements and act in accordance with such judgements (Keith-Spiegel & Koocher, 1985). In line with such reasoning, arguments for comprehensive instruction in ethics training have been forceful (Pope et al., 1986; Sell, Gottlieb & Schoenfeld, 1986). Limits of ethics training "by osmosis" (such as time constraints and sporadic exposure to ethical issues) have been convincingly argued (Handelsman, 1986). Every graduate programme in psychology seeking to be accredited by the American Psychological Association has been required to offer instruction in ethics since the late 1970s (Bersoff, 1995).

Numerous authors have presented models to increase the effectiveness of ethics education such as Kitchener (1986), Eberlein (1987) and Fine and Ulrich (1988). The approach to ethical analysis reviewed in the previous section (whereby ethical principles and underlying theory are applied to ethical dilemmas) appears to be favoured in such recommendations. In a review of the literature on ethics education, however, Welfel (1992) pointed out that American ethics programmes have generally assumed their own adequacy and failed to subject such assumptions to rigorous empirical validation. A review of the research to date of the relationship of ethics instruction to the ability to discern, reason about and implement ethical decisions is discussed in later section. The neglect of ethics education in South African psychology programmes is an issue of some concern (Wassenaar, 1997).

2.4.3 Stages of morality

The conception of morality as a complex process comprising of numerous steps, skills and functions is widely held (Canter et al., 1994). Rest's (1984) four stage model of morality can be viewed as an outline for the process of ethical decision making (Dove, 1995). The available empirical literature investigating the effects of individual characteristics (such as ethics education) on each stage is reviewed here under the relevant section.

Rest (1984) proposed that morality can be considered as a product of four interacting psychological processes: namely ethical sensitivity, ethical reasoning, the selection of an ethical course of action in the face of non-moral considerations, and the implementation of this ethical choice. He maintained that unethical behaviour can be traced to a deficiency at any one of these

phases (Welfel & Kitchener, 1992) and that moral development involves proficiency in all four areas (Kitchener, 1986).

2.4.3.1 Ethical sensitivity

Rest (1984) maintained that the first component of ethicality is that of identifying a given situation as an ethical one. This ethical sensitivity requires an ability to discern the ethical implications or nuances implicit in a given situation along with any clinical, practical or scholarly ones (Canter et al., 1992; Welfel & Kitchener, 1992).

2.4.3.1.1 Research on ethical sensitivity

Little empirical research has directly examined ethical sensitivity despite the fact that ethics scholars have pointed out that unethical behaviour may begin at this most fundamental component (Welfel, 1992). The dearth of research on ethical awareness has been partly attributed to methodological problems inherent in operationalizing this construct. As studies instructing psychologists to attend to ethical issues in case vignettes tend to cue respondents to the presence of inherent ethical dimensions such studies are held to fail to assess this construct directly (ibid).

A study designed by Volker (1983 in Welfel, 1992) and refined by Lindsey (1985 in Welfel, 1992) asked participants to listen to transcribed clinical interviews with inherent ethical implications for the psychologist. Participants were only instructed that they would be questioned at a later stage about the psychologist-client interaction. In both studies, almost 50% of the respondents were unable to perceive the ethical problem implicit in the interview, and almost 25% were unable to do so even when prompted. Such research points to the fact that the skills necessary for ethical sensitivity cannot be assumed to be present in trainee psychologists (Gawthrop & Uhlemann, 1992).

Certain research has focused on the relationship between ethics education and ethical sensitivity. Lindsey (1985 in Welfel, 1992) found that respondents with more ethics instruction performed better on the task of ethical sensitivity, however, the positive association between ethics

education and the ability to identify ethical issues was weak. Welfel (1992) maintained that published research in the area of how ethics training related to ethical sensitivity was generally not encouraging and offered only meagre empirical support for the position that ethics training is able to facilitate ethical awareness.

2.4.3.2 Ethical reasoning

The second stage that Rest (1984) defines is that of ethical reasoning. This involves the capacity to differentiate ethical from unethical choices and decide on the most appropriate course of action often in the face of competing ethical obligations (Welfel, 1992). The ability to integrate various "guides" in the form of the formal code(s) of ethics, legal guidelines and a formal methodology of decision-making is considered essential for this component (Bersoff, 1995; Kitchener, 1986; Tymchuk, 1986).

2.4.3.2.1 Consensus in ethical decision making

Research has indicated that wide variability exists among psychologists who are attempting to identify the ethical course of action in a given situation. Tymchuk et al. (1982) assessed the extent to which a nation-wide sample of clinical psychologists concurred in their responses to a set of hypothetical clinical vignettes and the extent to which these decisions were based on similar considerations. In each hypothetical situation, respondents were asked to agree or disagree with a decision already made for them, as well as indicate the criteria they considered relevant to determining the appropriateness of the decision.

These researchers found that overwhelmingly psychologists failed to agree on the ethicality of the action of the hypothetical psychologist. There was strong consensus only with regard to a minority of the presented issues such as (sexualized) dual relationships, and the duty to warn in the event of a dangerous client. Results indicated that where respondents strongly agreed on the hypothetical action, they also strongly agreed on the criteria considered relevant in making the decision.

The authors suggested that agreement in ethical decision making was related to issues that were visible, current and timely and furthermore that for such issues the profession develops "strategies for thinking" around such issues (Tymchuk et al., 1982, p. 420). For the remaining issues, psychologists' agreement was moderate or low. The authors concluded that for issues that were not in the forefront of professional attention or inadequately guided by ethical standards, strong consensus in ethical decision making was not facilitated.

Haas et al. (1986) similarly investigated the degree to which survey respondents concurred in their choices of the most appropriate ethical action in the face of numerous ethical dilemmas. These researchers found that psychologists most often failed to agree on the best course of action. They were able to agree strongly on the ethical course of action only in response to issues concerned with child sexual abuse, duty to warn and conflicts of loyalty. Furthermore, these researchers found that psychologists' choices were justified in terms of a variety of reasons.

Chevalier and Lyon (1993) investigated the ethical choices and reasoning of school psychologists faced with ethical dilemmas. Respondents were asked to select a preferred choice of action from preselected decisions and indicate their reasons for their choice from a list of rationales. Using a 75% agreement rate as a criterion for consistency, they found a general lack of agreement about the appropriate action to take in the hypothetical situations. They found high rates of agreement in only one vignette concerned with child abuse.

They concluded that consensus in professional decision making was facilitated by the high visibility of certain issues, coupled with legal mandates supporting a course of action. Consistent with previous results, they found considerable variation among psychologists as to the reasons selected to justify their decisions (Chevalier & Lyon, 1993).

Evidence for a lack of consensus as to the most appropriate course of action in the face of an ethical dilemma has been found with medical doctors (Hoffmaster, Stewart & Christie, 1991) and social workers (Swider, McElmurray & Yarling, 1984).

2.4.3.2.2 Ethics education

It has been suggested that variability in ethics training may partially account for the lack of consensus in ethical decision making in psychology (Tymchuk et al., 1982). Research focusing on the impact of ethics instruction on ethical reasoning has, however, yielded largely inconsistent results (Welfel, 1992). Baldick (1980 in Gawthrop & Uhlemann, 1992) found that clinical psychology interns who had received formal ethics instruction were significantly more able to discriminate ethical issues in case vignettes than those who had not. This research has been criticised for methodological limitations such as failure to clarify the nature of ethics instruction (Gawthrop & Uhlemann 1992).

A replication of Baldick's research (Lipsitz, 1985 in Welfel, 1992) indicated no significant relationship between formal ethics instruction (refined into categories reflecting actual teaching practices) and performance on ethical tasks. Haas et al. (1988) found no relationship between hours of formal ethics training and the ethical choices of psychologists for any ethical vignette presented to a nationwide sample of psychotherapists. They concluded that ethics instruction has no apparent effect on the course of action psychologists would select in the face of an ethical dilemma. Chevalier and Lyon (1993) similarly found that preferred courses of action in the face of dilemmas were relatively unaffected by hours of ethics training.

Welfel (1992) maintained that research was unable to verify the adequacy of formal ethics training in improving ethical reasoning. Gawthrop and Uhlemann (1992), however, conducted a study which supported the positive impact of prior exposure to ethics training on performance on ethical tasks. They found that their subjects who received a three hour ethical decision-making workshop, performed significantly better than either of two control groups on ethical decision-making quality as measured by a rating scale. These authors concluded that the specific problem solving approach used to instruct the treatment group was effective in improving the quality of ethical decision-making. The authors do acknowledge that the results of the study describe immediate effects only, and that long term effects remain unclear (Gawthrop & Uhlemann, 1992).

2.4.3.2.3 Theoretical orientation

The available literature on the relationship between clinical orientation and ethical reasoning appears to yield inconsistent results. Research has indicated that psychologists from varying theoretical orientations do not differ significantly in their selection of action alternatives or reasons for their choices in the face of numerous ethical vignettes (Haas et al., 1988). The only difference attributed to clinical orientation was the tendency for systemic therapists to indicate less tolerance of keeping secrets in marital therapy.

Survey research investigating willingness to report child sexual abuse found, however, that respondents indicating their primary orientation as psychodynamic were less likely to report child abuse than psychologists from a behavioural, cognitive or eclectic orientation (Nicolai & Scott, 1994). Research has further indicated that clinical orientation may affect the manner in which psychologists enact ethical responsibilities in practice. Therapists of a cognitive behavioural orientation appear to endorse the discussion of certain consent information (duration, procedures) more than clinicians from other orientations (Somberg et al., 1993).

Orientation appears to affect the perception of the ethicality of certain behaviours and the degree to which such behaviours are engaged in. In a national survey of clinical psychologists, those respondents whose primary theoretical orientation was psychodynamic endorsed the unethical nature of dual relationships to a significantly greater degree than their colleagues from other orientations. They were also likely to report engaging in these activities to a significantly lesser degree than their counterparts from other major orientations (Borys & Pope, 1989).

2.4.3.2.4 Clinical experience

The effect of the amount of experience that has accrued to any professional has been hypothesised to affect ethical decision-making. Morrison, Layton and Newman (1978, in Keith-Spiegel & Koocher, 1985) found that more experienced psychologists reported less ethical conflict than less experienced psychologists. Keith-Spiegel and Koocher (1985) cautioned that the results need not necessarily infer that competence in the face of ethical dilemmas increases

with experience, but that more recently trained American psychologists may be more idealistic and have an increased awareness of ethical issues as a result of post-1970 mandated ethics instruction.

Chevalier and Lyon (1993) found that years of experience as a school psychologist had no significant impact on the course of action selected to resolve an ethical dilemma. Haas et al. (1988) found, however, that survey respondents with greater clinical experience indicated a preference to select less direct action choices in their resolution of certain ethical dilemmas than respondents with less clinical experience. The authors concluded that higher levels of clinical experience could be related to a greater levels of cynicism about an ability to actively intervene in clinical situations.

2.4.3.2.5 Gender

In a survey of clinical and counselling psychologists investigating perceptions of child sexual abuse, a significantly higher percentage of female respondents indicated that they had not reported an instance of child sexual abuse than male respondents. The authors tended to interpret this finding in the light of Gilligan's (1982) work and proposed that women might be less inclined to report as they tend to show concern for the impact of their acts (i.e. reporting) on all relationships involved (Kennel & Agresti, 1995).

In a survey of psychologists exploring the relationship of individual background characteristics and ethical decision making, Kimmel (1991) found that women tended to be more conservative in cost-benefit assessments of ethical vignettes than men. He hypothesised that the tendency to be less approving in their ethical assessments might be related to the tendency of women to have a greater sensitivity to the needs of others (ibid).

In a survey of ethical decision making in the face of ethical dilemmas, Haas et al. (1988), however, found only two differences attributed to gender in the action choices selected by their respondents. They found that women were significantly less likely than men to accept a bartering arrangement in payment for psychotherapeutic services and male psychologists were significantly

more likely to take direct action to report an incident of therapist-client sexual exploitation than female psychologists. On the whole they concluded that men and women appear to be more alike than different in their response to ethical problems and the considerations on which they base such responses. Similarly, Chevalier and Lyon (1993) found no differences in the ethical choices of school psychologists attributable to gender.

2.4.3.2.6 Cognitive moral development

Blasi (1980) reviewed the empirical literature exploring the relationship between level of moral reasoning and certain behaviours. This review found considerable support for the contention that higher levels of moral reasoning are related to resistance to pressure to alter principles in the direction of established norms (Froming, 1977 in Blasi, 1980). A more recent investigation of the ethical decision making of business students found that subjects at the principled stage of cognitive moral development selected more ethical choices when faced with opportunities to endorse kickbacks (Trevino & Youngblood, 1990).

Blasi (1980) has noted, however, that exploring the relationship between level of cognitive development and any particular course of action is inherently difficult as Kohlberg's moral stages "do not seem to be related to any specific course of action, but in any one situation may be compatible with contrasting alternatives" (Blasi, 1980, p. 8). These moral stages concern criteria for action and any action may be supported by different moral criteria.

2.4.3.3 Selection of ethical choice

The third component of Rest's model involves choosing to carry out a morally defensible action in the face of competing non-moral values, such as expediency or pragmatism (Rest, 1984). At this stage the psychologist is able to identify an ethical course of action, however, they must select whether or not to carry out the ethical action despite attractive non-ethical values (Welfel & Kitchener, 1992).

2.4.3.3.1 Research on selection of ethical choice

Research exploring this component of ethical behaviour appears to yield consistent results and generally indicates a discrepancy between what psychologists know to be the ethical ideal and a willingness to carry this out (Bernard & Jara, 1986; Bernard, Murphy & Little, 1987; Smith, McQuire, Abbot & Blau, 1991).

Smith et al. (1991) investigated psychologists' resolution of an ethical conflict as well as the considerations upon which such choices were made. Psychologists presented with ten vignettes were asked to select the behavioural action felt to best reflect what they should do, and select the action that would best indicate what they would actually do if faced with the situation presented. Respondents consistently agreed that they should act more in accordance with ethical codes than they probably would act.

For each *should* and *would* choice, respondents were asked to select a rationale that best described the reason for their choice. While respondents tended to justify what they should do in terms of ethical and legal considerations, they tended to justify what they would do in terms of considerations such as financial needs or personal standards. These results indicate that professionals are likely to think in terms of personal and practical rationales in determining what they actually would do in a dilemma.

When they justified what they actually would do using ethical and legal considerations, this was in response to vignettes where laws and principles clearly supported specific resolutions (Smith et al., 1991). When clinicians justified what they would do in terms of personal or situational reasons, the situations did not involve such a clear violation. This suggests that in the absence of clear rules against which to measure violations, clinicians tend to utilise pragmatic and personal reasons as a basis for their course of action. These results point to the fact that a wide array of situational and pragmatic factors as well as ethical and legal considerations play a functional role in decision-making (Smith et al., 1991).

Smith et al.'s (1991) results are consistent with research conducted with practitioners and

graduate students (Bernard & Jara, 1986; Bernard et al., 1987). A survey of clinical graduate students presented subjects with two hypothetical scenarios depicting a peer and friend clearly violating an ethical standard. Respondents were presented with excerpts of relevant sections of the ethics code and were asked to indicate what they should do in the situation, as well as indicate what they would do from a series of possible responses. Bernard and Jara (1986) reported that approximately 50% of respondents indicated that they would do less than they knew they should do.

This study was replicated with practising clinical psychologists and results indicated that while a greater number of psychologists state that they would do as they should, significant numbers indicated that they would behave less responsibly than they know they should (Bernard et al., 1987). No demographic variable (including ethics instruction), discriminated between the student group that indicated they would do less than they should, and the student group that indicated that they would do what they knew they should do (Bernard & Jara, 1986). There were no significant differences on any demographic variable between psychologists who indicated they would do what they should do, and those who would not (Bernard et al., 1987). This lead the researchers to conclude that ethics training had no bearing on a willingness to translate ethical awareness into behaviour.

2.4.3.4 Implementation

According to Rest (1984) the fourth component of morality involves the ability to execute an ethical action despite considerable pressures to act differently (Welfel & Kitchener, 1992). This component is held to depend primarily on qualities such as character, ego strength and perseverance (Kitchener, 1986). These qualities are expressed when psychologists "move beyond moral reasoning to actually take action" (Stadler, 1995). There is no published research to date examining the relationship between implementation of ethical action and ethics education (Welfel, 1992) or any other psychologist characteristic.

2.4.4 Summary

A review of the empirical literature indicates that psychologists appear to select widely differing choices in the face of ethical dilemmas (Chevalier & Lyon, 1993; Haas et al., 1986; Tymchuk et al., 1982). Furthermore, they appear to justify their choices using a wide range of considerations - both ethical and non - ethical (Chevalier & Lyon, 1993; Haas et al., 1986; Smith et al., 1991). Consensus in ethical decision making appears linked to ethical issues that are in the forefront of professional attention or are additionally legally regulated.

Studies exploring the effects of demographic variables on ethical decision making have yielded inconsistent results. Certain results support the contention that characteristics such as gender and ethics instruction have an important impact on ethical decision making and are involved in differential responding to ethical problems (Gawthrop & Uhlemann, 1992; Kimmel, 1991; Nicolai & Scott, 1994). Other studies indicate that differences in background characteristics do not substantially influence the ethical choices that psychologists make or the reasons they use to justify these choices (Bernard & Jara, 1986; Bernard et al., 1987; Chevalier & Lyon, 1993; Haas et al., 1988). Researchers agree that a lack of consensus in decision making may point to the complex and varied nature of situations with which psychologists are confronted (Chevalier & Lyon, 1993; Kimmel, 1991). Variability in decision making has also, however, been held to be a useful index of those areas of professional ethics with which psychologists are struggling in the face of unclear guidelines (Chevalier & Lyon, 1993; Haas et al., 1988; Tymchuk et al., 1982). Once identified, these areas are able to be targeted by attempts to reduce inconsistency in decision making through education, debate, and refined ethical guidelines (Haas et al., 1986).

The present study aimed to identify those areas of ethical decision making that pose special difficulties for South African psychologists. It aimed to illuminate those situations which elicit wide variability about the preferred course of action. In order to clarify the inconsistent application of ethical guidelines to dilemmatic situations, the impact of background characteristics on ethical decision making is of import. This study further aimed to assess which, if any, demographic attributes influence the ethical judgements of psychologists.

3 AIMS AND HYPOTHESES

The literature reviewed in the previous section indicated that despite ethical and legal guidelines and numerous existing systems of formal ethical analysis, psychologists generally fail to agree on the most appropriate course of action when confronted with troubling ethical situations. This study aimed to explore the ethical decision making of clinical psychologists by examining the action choices selected in the face of numerous ethical dilemmas and the reasons used to justify these choices. It primarily aimed to identify areas of ambiguity in professional decision making as measured by a low consensus in agreement. This study further aimed to assess those areas where consensually agreed upon action choices exist.

As the literature reviewed in the previous section suggests, the characteristics that may account for the inconsistency observed in the ethical judgements and actions of psychologists remain to be clarified. This study, therefore, additionally aimed to assess whether characteristics such as gender, years of experience, theoretical orientation and primary work setting, are systematically associated with particular choices, and reasons for choices in responses to hypothetical dilemmas.

Hypothesis 1: Psychologists presented with hypothetical ethical dilemmas will generally show low consensus on the most appropriate course of action (Chevalier & Lyon, 1993; Haas et al., 1986; Tymchuk et al., 1982).

Hypothesis 1a: Psychologists will tend to agree on the most appropriate course of action in response to dilemmas representing high visibility ethical issues or issues subject to additional legal regulation (Chevalier & Lyon, 1993; Tymchuk et al., 1982).

Hypothesis 2: Psychologists will justify their action choices in terms of a variety of rationales (Chevalier & Lyon, 1993; Smith et al., 1991).

Hypothesis 2a: A significant association will exist between action choices and reasons used to justify choices (Haas et al., 1988).

Hypothesis 3: Psychologists with different characteristics such as gender, clinical experience, theoretical orientation, and work setting will differ in the choices they select to resolve dilemmas (Kimmel, 1991).

Hypothesis 3a: Psychologists with different characteristics such as gender, clinical experience, theoretical orientation, and work setting will differ in the reasons they cite to justify their action choices.

Hypothesis 4: The frequency with which psychologists encounter certain ethical issues will affect the course of action selected in the face of dilemmas.

Hypothesis 4a: Psychologists' perceptions of the seriousness of ethical issues will affect the course of action selected in the face of dilemmas.

4 METHOD

4.1 Instrument

The questionnaire utilised in this study was obtained by request from the principal author of the original study (Haas et al, 1986) and consisted of five sections. In the first part of the questionnaire psychologists were requested to supply information regarding their age, gender, years of experience, primary work setting, and major theoretical orientation (See Table 1). The questionnaire did not solicit the individual participants' names or other identifying information. The second part of the questionnaire asked respondents to indicate the source and extent of their ethics education, including the number of hours spent in various categories of ethics training, such as coursework or internship supervision.

The third section of the questionnaire consisted of 10 vignettes. Each vignette represented an ethical dilemma where more than one alternative could be considered justifiable on the basis of ethical, legal or other grounds. For each ethical scenario, respondents were presented with fixed alternative ways to respond. They were encouraged to select one of the provided responses and to avoid rearranging the dilemma by making some change in the essential conditions of the scenario. In certain cases the action choices were reduced to two alternatives: action or inaction. The vignettes and alternatives are listed in Table 2.

Respondents were requested to select a primary reason for their choice of alternative from 8 possible rationales. These included the following: upholding the law, upholding the code of ethics, protecting society's interests, protecting the client's rights, upholding personal standards, safe-guarding the therapy process, financial considerations, or "other". In the fourth section, respondents were asked to indicate the frequency with which they had encountered 17 ethical or legal issues in their practice (such as concerns about the legality of their actions, or concerns about the conduct of their colleagues). They were also asked to rate the seriousness of each issue (See Table 11).

Lastly, respondents were encouraged to describe an ethically troubling issue that they had

encountered in their practice. They were requested to describe the relevant events, their analysis of the ethical principles involved, their attempts to resolve the difficulty, their reasons for doing so, and any outcome of their actions. These volunteered dilemmas are presented in Tables 17 and 18.

Unfortunately, due to resource constraints, this questionnaire was not first tested in a pilot study so reliability is questionable. The dilemmas were drawn from a pool of 150 vignettes compiled by L. Haas (Haas et al., 1986) derived from actual cases described by students or participants at professional ethics workshops. The vignettes were selected to represent several broad categories of professional ethics as they related to psychological practice, including confidentiality, informed consent, conflicts of interest, dual relationships and reporting of collegial misconduct ("whistle-blowing").

4.2 Procedure

Clinical psychologists registered with the Professional Board for Psychology of the Interim South African Medical and Dental council were identified by random computer selection. The sample size of 487 psychologists represented 35% of registered clinical psychologists. A survey questionnaire, a cover letter, and a return envelope was posted to each individual. The cover letter explained the nature of the research, however, it did not inform the sample of how they had been selected in order to establish the anonymity of their responses. A total of 122 questionnaires were returned, yielding a 20% response rate. Of these, two respondents erroneously or incompletely filled out their questionnaires and these were eliminated from the data analysis. Procedures to increase response rate such as the mailing of additional surveys and reminder letters to non-respondents were not undertaken due to time and resource constraints and would probably have increased the percentage return.

5 RESULTS

The purpose of this section is to present the results obtained from this study. Characteristics of the sample will be presented, followed by analyses of data conducted in service of the hypotheses. All results were obtained with the use of SPSS 6.1. statistical package. Raw data can be obtained from the author and was not included due to length.

5.1 Characteristics of respondents

The mean age of respondents was 43 years. The mean number of years since completion of their degree was 13 years. The sample comprised of 43% male and 57% female respondents. Overall, the sample had substantial experience, worked largely in private practice, and were largely comprised of Masters level practitioners. See Table 1 for characteristics of the sample such as highest degree obtained, primary therapeutic orientation, primary work setting, and amount of time spent conducting psychotherapy.

ITEM	PERCENTAGE	NO.
Highest degree obtained		
Masters	74.6%	91
Doctoral	22.2%	27
Other	3.2%	4
Primary therapeutic orientation		
Interpersonal/systemic	31.5%	38
Analytic	26.6%	32
Other	12.9%	16
Multiple	12.1%	15
Humanistic	8.9%	11
Cognitive	5.6%	7
Behavioural	2.4%	3
Primary work setting		
Multiple	43.2%	53

ITEM	PERCENTAGE	NO.
Private	41.6%	51
Hospital/psychiatric	5.6%	7
Other	5.6%	7
Academic	2.4%	3
Public mental health/community	1.6%	2
Research	-	-
Hospital/medical	-	-
Court/prison	-	-
Mean years since degree	13.5y	-
Mean hours per week conducting therapy	20.4h	-
Mean percentage per week conducting therapy	57.9%	-
Mean age	43.y	-
Male subjects	42.9%	-
Female subjects	57.1%	-

Table 1: Characteristics of respondents.

5.2. Responses to ethical dilemmas.

The results presented in this section pertain to hypotheses 1 and 1a of this study. Hypothesis 1 predicted that psychologists would generally fail to agree on the most appropriate course of action in the face of hypothetical ethical dilemmas. Using a 75% agreement rate as a criterion for consistency suggested by Haas et al. (1986), the results indicated that for the majority of ethical dilemmas (six out of ten), psychologists did not strongly agree on the preferred resolution to the dilemmas. These results provided support for hypothesis 1.

NO	VIGNETTE	CHOICE	N	%
1	You are a therapist in a community health centre. You are about to move to another province and must terminate or refer your caseload. Your clinical director tells you to refer a particular individual to a therapist whose ability you do not respect.	Refer the patient	15	12.1
		Refer yet indicate reservations	18	14.5
		Refuse to refer	91	73.4
2	A client of yours tells you that she is still quite upset at her previous therapist for, among other things, making sexual advances towards her. This is the third time you have heard such allegations about this particular therapist	Discuss patient's anger but not professional standards	12	9.8
		Call therapist and tell him his behaviour violates professional standards	7	5.7
		Tell patient she has the right to bring charge to ethics committee / professional board	91	74.7
		Call the ethics committee or professional board	12	9.8
3	A psychologist you have met at occasional meetings but do not know well appears in a TV advertisement endorsing a local health resort. He says, "As a child psychologist I find relaxation important. I go to the Palm Spa to get my head and body together".	Call psychologist and indicate that you think ad violates professional standards	20	16.1
		Call ethics committee and report incident	43	34.7
		Do nothing	61	49.2
4	You have been treating a married couple conjointly for about six months. The wife arrives early for the session and tells you that she is thinking of leaving her husband as she has been involved with another man. She also asks you not to tell her husband. You have not previously discussed your policy regarding secrets.	Do not agree to keep secret	53	44.5
		Agree to keep secret	66	55.5

NO	VIGNETTE	CHOICE	N	%
5	The mother of a twelve-year old boy comes to pick him up after his initial appointment with you. She asks you if he is taking drugs. He has in fact revealed to you that he has been sniffing glue.	Tell her what you know	33	28.2
		Tell her information is her son's to reveal or not	84	71.8
6	A man with no previous experience in therapy contacts you and asks for sex therapy. While you understand the general principles of sex therapy, you would not consider it your area of expertise. He looks, however, like an interesting prospective client.	Accept him as a client	7	5.6
		Accept him as a client only after discussing your qualifications	48	38.4
		Do not accept him as client, and refer	70	56
7	You are treating a war/combat veteran with a history of impulsive antisocial actions. You and he have established a good therapeutic relationship (his first after three previous attempts in therapy). At the end of the session, he discloses he is planning to kill his current girlfriend, because she has been dating another man.	Contact his girlfriend or police without informing him	6	5
		Plan to discuss further at next session	10	8.4
		Inform him you must warn his girlfriend and/or police	103	85.6
8	During the course of your treatment of a forty-five year old man who has drinking problems, his wife telephones and tells you he has been sexually molesting his seven-year old step-daughter (her daughter of a previous marriage).	Report case to child protection unit	16	13.4
		Encourage her to report matter to CPU	98	82.4
		Reflect her concern but take no further action	5	4.2
9	A client of yours who is a chartered accountant suggests that he prepare your tax return in partial repayment for therapy. You have been preparing your own taxes and find it increasingly burdensome.	Accept his offer	13	10.5
		Decline his offer	111	89.5

NO	VIGNETTE	CHOICE	N	%
10	You work in the emergency centre of a community mental health centre located within a general hospital. You are about to admit a man best diagnosed as paranoid schizophrenic; his insurance will cover the cost of the hospitalisation. The diagnosis may make it difficult for him to obtain other kinds of insurance (e.g. life insurance) later. You suspect that learning of this will make him resist hospitalisation since he cannot afford it without insurance.	Inform him of the risks	87	72.5
		Do not inform him, diagnose as indicated	23	19.2
		Do not inform him, give 'milder' diagnosis	10	8.3

Table 2: Percentage of respondents endorsing each alternative for each vignette in the order presented.

The following results pertain to hypothesis 1a which predicted that psychologists would tend to agree on the most appropriate course of action in response to dilemmas representing high visibility issues or subject to additional legal regulation. Psychologists strongly agreed on the most appropriate course of action when confronted with dilemmas relating to dangerous clients (vignette seven); child sexual abuse (vignette eight); non sexual dual relationships (vignette nine) and sexual dual relationships (vignette two). These results provided support for hypothesis 1a.

Psychologists reached moderate rates of agreement for the following ethical scenarios: a superior's order to refer a client to a therapist considered incompetent (vignette one); confidentiality with minor clients (vignette five); and confidentiality and reporting of potentially counter-therapeutic diagnoses to insurance companies (vignette ten).

Psychologists reached low levels of consensus in response to the following issues: confidentiality in marital therapy (vignette four); competence to handle certain problems or perform certain psychotherapeutic techniques (vignette six); and product endorsements (vignette three).

5.3. Reasons for choices

The results presented in this section pertain to hypothesis 2 that predicted that psychologists would justify their choices in terms of a variety of rationales. The results for reasons chosen to support decisions made are presented in Table 3. As with preferred actions there was considerable variability among respondents, both within and across vignettes. These results suggest that when faced with ethical dilemmas, clinical psychologists apply a range of rationales to justify their behaviour. These results provided support for hypothesis 2.

The most frequently chosen reason for adopting a course of action was protecting client rights (average % = 29.2). Safeguarding therapy (average % = 18.6) and upholding the code of ethics (average % = 16.4) represent the next most frequently cited reasons. Financial reasons (average % = 0.96) and upholding the law (average % = 2.56) were the least frequently cited reasons.

Reasons	Vignettes										
	1	2	3	4	5	6	7	8	9	10	Av.%
Protecting client rights	52.8	45.6	1.6	38.4	41.6	36	5.6	13.6	2.4	54.4	29.2
Protecting society's interests	3.2	8.8	16	0	8	1.6	61.6	42.4	0.8	7.2	14.96
Upholding personal standards	2.4	2.4	11.2	10.4	5.6	28	4.8	3.2	22.4	7.2	9.76
Financial	0	0	1.6	0	0	2.4	0	0	5.6	0	0.96
Upholding the law	0	0	0	0	0	0	7.2	15.2	2.4	0.8	2.56
Upholding ethics code	10.4	30.4	32	4.8	8.8	16.8	7.2	12	24.8	16.8	16.4
Safeguarding therapy	28.8	10.4	0.8	45.6	29.6	9.6	7.2	9.6	36	8.8	18.4
Other	2.4	0.8	28.8	0	2.4	4	4	2.4	5.6	3.2	5.36

Table 3: Percentage of respondents endorsing each reason for alternatives selected in each vignette.

5.4. Reasons and actions

The following results pertain to hypothesis 2a which predicted that a significant association would exist between action choices and reasons used to justify these choices. Following the procedure of Haas et al. (1986; 1988), this study specifically investigated whether psychologists would justify their decisions based on adherence to a formalised code or mandate, or based on reasons reflecting a personal value structure. Accordingly, respondents were asked to indicate which of the following reasons was the primary rationale for their choice of action in each vignette:

1. Upholding the law;
2. Upholding the code of ethics;
3. Protecting society's interests;
4. Protecting client's rights;
5. Upholding personal standards;
6. Safeguarding the therapy process;
7. Financial considerations;
8. Other.

Following the procedure of Haas et al. (1986; 1988) reasons 1 and 2 were collapsed into a category termed "codified" reasons and reasons 3, 4, 5, 6, 7 & 8 were collapsed into a category termed "noncodified" reasons. Chi-square tests on action choice by reason (categorised into codified and noncodified reasons) were performed for each of the ten vignettes. An analysis of the distribution of reasons across action choices revealed a significant association between response choice and reason for choice for 7 out of the 10 vignettes. These results provided support for hypothesis 2a. These results have been summarised in Table 4. Significant results have been indicated in bold type with effect sizes in the right hand column.

ACTIONS X REASONS	PEARSON	SIG	DF	CRAMER'S V
VIGNETTE 1	26.46577	**.000**	2	.61054
VIGNETTE 2	15.51564	**.0143**	3	.47080
VIGNETTE 3	23.63512	**.0001**	2	.57697
VIGNETTE 4	11.92067	**.00056**	1	.44949
VIGNETTE 5	6.26190	**.01234**	1	.31038
VIGNETTE 6	1.70177	.42704	2	
VIGNETTE 7	3.81052	.14878	2	
VIGNETTE 8	18.35886	**.0010**	2	.44671
VIGNETTE 9	.12784	.72068	1	
VIGNETTE 10	12.18087	**.00226**	2	.38080

Table 4: Chi square results of choices and reasons for choices.

Analysis of the standardised residuals revealed that in vignette one there was an over-representation of codified reasons for response 1 and an under-representation of codified reasons for response 3. In vignette one (the decision whether or not to refer a client to a therapist whose ability is not trusted because it is ordered by a superior) psychologists who would refer the patient were likely to do so for codified reasons. Respondents who would refuse to refer the patient tended to do so for noncodified reasons.

In vignette two there was an over-representation of codified reasons for response 1 and an under-representation of codified reasons for responses 2 and 4. For vignette two (a present client is angry at a previous therapist for making sexual advances) respondents who would discuss the patient's anger were likely to do so for codified reasons. Those who would call and confront the offending psychologist directly tended to do so for noncodified reasons. Those who would call the ethics committee or professional board tended to do so for non codified reasons.

In vignette three there was an over-representation of noncodified reasons for responses 1 and 2 and an under-representation of noncodified reasons for response 3. In vignette three (a psychologist using his credentials to endorse a health spa) respondents who would call the psychologist directly or the ethics committee and indicate that the advertisement violated ethical standards were likely to do so for noncodified reasons. Those who indicated that they would do nothing tended to do so for codified reasons.

In vignette four codified reasons were over-represented for response 1 and under-represented for response 2. For vignette four (the decision of whether or not to keep a secret in marital counselling) psychologists who indicated that they would not keep the spouses's secret were likely to do so for codified reasons. Respondents who would agree to keep the secret tended to do so for noncodified reasons.

In vignette five codified reasons were over-represented for response 1 and under-represented for response 2. In vignette five (a mother requests that the psychologist treating her son reveal the son's confidences) respondents who would break confidentiality were likely to do so for codified reasons. Psychologists who would not tell the mother her son's confidences were likely to do so for noncodified reasons.

In vignette eight codified reasons were over-represented for response 1 and for response 3 and codified reasons were under-represented for response 2. In vignette eight (a wife alleges to the psychologist that her husband - the psychologist's client - is sexually abusing his 12 year old daughter) respondents who would report the sexual abuse directly to the child protection unit were likely to do so for codified reasons. Psychologists who would encourage the mother to report the abuse were likely to do so for noncodified reasons. Psychologists who would reflect her concern are likely to do so for codified reasons. For vignette ten codified reasons were over-represented for response 2. In vignette ten (the dilemma of whether to inform a potentially counter-therapeutic diagnosis to a patient) psychologists who indicated that they would not inform the client of the risks but would diagnose him as indicated tended to do so for codified reasons.

5.5. Demographics and choices

The following results pertain to hypothesis 3 of this study which predicted that psychologists who differed in terms of background characteristics would differ in the choices they selected to resolve the presented dilemmas. The following characteristics of respondents were analyzed in terms of their impact on choices: gender of respondents, years of experience, theoretical orientation and clinical setting. Hours of formal ethics training was excluded from the analysis due to missing

and spoiled answers. Years of experience and clinical setting were excluded from the analysis due to insufficient sample size yielding incomplete data necessary for contingency table analysis. For the majority of vignettes psychologists with certain characteristics did not differ in response choices to the ethical dilemmas. These results did not provide support for Hypothesis 3.

Gender and action choice

Chi square tests of gender by action choice were conducted for each vignette. These results are summarised in Table 5. Significant results have been indicated in bold type with effect sizes in the right hand column.

Vignette	Pearson	Sig	df	Cramer's V
Vignette 1	.87015	.64722	2	
Vignette 2	4.48799	.21336	3	
Vignette 3	1.02595	.59871	2	
Vignette 4	.00352	.95266	1	
Vignette 5	1.89935	.16815	1	
Vignette 6	4.66718	.09695	2	
Vignette 7	.17672	.91543	2	
Vignette 8	1.89548	.38762	2	
Vignette 9	**4.4435**	**.03503**	**1**	**.1893**
Vignette 10	.42259	.80953	2	

Table 5: Results of chi square tests of gender by action choice.

Chi square analyses of the relationship between gender of respondent and choice of alternative yielded a significant difference on only one vignette. On vignette nine (a client offers to do tax returns in partial repayment for therapy) an inspection of the standardised residuals revealed that men indicating that they would accept the offer are over-represented in comparison to women who are under-represented. Female respondents would be much more likely to decline the client's offer whereas male respondents would be much more likely to accept the client's offer.

Theoretical orientation and action choice

Chi square tests assessing the relationship of theoretical orientation to action choice were conducted for each vignette. These results are summarised in Table 6. Significant results have been indicated in bold type with effect sizes in the right hand column.

Vignette	Pearson	Sig	df	Cramer's V
Vignette 1	10.04508	.61201	12	
Vignette 2	12.78082	.80443	18	
Vignette 3	9.51647	.65830	12	
Vignette 4	1.05439	.98347	6	
Vignette 5	7.72396	.25903	6	
Vignette 6	21.10160	**.04891**	12	.29288
Vignette 7	5.58943	.93535	12	
Vignette 8	12.94777	.37285	12	
Vignette 9	5.26907	.50980	6	
Vignette 10	6.08128	.91193	12	

Table 6: Results of chi square tests of orientation by action choice.

Chi-square tests assessing the relationship of theoretical orientation to response choice showed a significant association for vignette six. An inspection of standardised residuals revealed that respondents indicating that they would accept the client for therapy were under-represented by analytic psychologists, and over-represented by cognitive psychologists. Psychologists indicating that they would accept the client only after discussing their qualifications were under-represented by those who identified their orientation as multiple.

This suggests that respondents identifying themselves as analytic were least likely to accept the client for therapy whereas those identifying themselves as cognitive were most likely to accept the client for therapy. Psychologists who identified multiple categories as their orientation were

least likely to accept the client for therapy after discussing their qualifications.

5.6 Demographics and reasons

The results in the following section pertain to hypothesis 3a of this study which predicted that psychologists with different background characteristics would differ in the reasons cited to justify their choices. The following characteristics of respondents were analyzed in terms of their impact on reasons for choices: gender of respondents, years of experience, theoretical orientation, and clinical setting. Hours of formal ethics training was excluded from the analysis due to missing and spoiled answers. For the majority of vignettes psychologists with different characteristics did not differ in their reasons for these choices. These results did not support Hypothesis 3a.

Gender and reasons for choice

Chi-square tests exploring the relationship between gender and reasons for each vignette yielded certain significant associations when reasons for choices were collapsed into these codified and noncodified categories. These results are summarized in Table 7. Significant results have been indicated in bold type with effect sizes in the right hand column.

REASONS	PEARSON	SIG	DF	CRAMER'S V
VIGNETTE 1	.78744	.37487	1	
VIGNETTE 2	.43436	.50986	1	
VIGNETTE 3	.77822	.37769	1	
VIGNETTE 4	.85091	.35629	1	
VIGNETTE 5	.00897	.92456	1	
VIGNETTE 6	3.87786	**.04893**	1	.20643
VIGNETTE 7	1.66303	.19720	1	
VIGNETTE 8	.53695	.46370	1	
VIGNETTE 9	.86194	.35320	1	
VIGNETTE 10	.00025	.98743	1	

Table 7: Results of chi square tests of gender by reasons for choice.

In vignette six (decision to accept a client despite lack of competence for problem) an inspection

of the standardised residuals revealed that male respondents were under-represented on noncodified reasons in comparison to female respondents. This indicated that male respondents were less likely to base their considerations on noncodified reasons and were more likely to base their considerations on codified reasons in comparison with female respondents who were more likely to base their action choices on noncodified reasons and less likely to base their choices on codified reasons.

Theoretical orientation and reasons for choice

Chi-square tests exploring the relationship between orientation and reasons for choice for each vignette yielded certain significant associations when reasons for choices were collapsed into codified and non-codified categories. These results are summarized in Table 8. Significant results have been indicated in bold type with effect sizes in the right hand column.

REASONS	PEARSON	SIG	DF	CRAMER'S V
VIGNETTE 1	1.42981	.96402	6	
VIGNETTE 2	9.99538	.12485	6	
VIGNETTE 3	5.11846	.52871	6	
VIGNETTE 4	2.83549	.82919	6	
VIGNETTE 5	11.49013	.07436	6	
VIGNETTE 6	2.43867	.87527	6	
VIGNETTE 7	16.20628	**.01269**	6	.40057
VIGNETTE 8	10.10915	.12013	6	
VIGNETTE 9	5.79969	.44600	6	
VIGNETTE 10	2.32635	.88737	6	

Table 8: Results of chi square tests of orientation by reasons for choice.

For vignette seven (a client with a history of violence threatens to harm his girlfriend) respondents who identified their primary orientation as systemic/interpersonal were under-represented for noncodified reasons relative to codified reasons. Systemic psychologists were less likely to base their actions on noncodified reasons and were more likely to base their actions on codified reasons.

Work setting and reasons for choice

Chi-square tests exploring the relationship between work setting and reasons for each vignette yielded certain significant associations when reasons for choices were collapsed into codified and non-codified categories. These results are summarized in Table 9. Significant results have been indicated in bold type with effect sizes in the right hand column.

REASONS	PEARSON	SIG	DF	CRAMER'S V
VIGNETTE 1	1.42140	.84047	4	
VIGNETTE 2	.84705	.97394	5	
VIGNETTE 3	1.70007	.79071	4	
VIGNETTE 4	6.11979	.10593	3	
VIGNETTE 5	11.72764	**.03872**	5	.40642
VIGNETTE 6	3.16563	.53050	4	
VIGNETTE 7	6.21850	.28553	5	
VIGNETTE 8	9.68353	.08472	5	
VIGNETTE 9	3.18942	.52664	4	
VIGNETTE 10	3.91748	.41729	4	

Table 9: Results of chi square tests of work setting by reasons for choice.

For vignette five (the issue of keeping the confidences of a child client) respondents who indicated their primary work setting as multiple were under-represented on noncodified reasons relative to codified reasons. They were less likely to base their choices on noncodified reasons and more likely to base their choices on codified reasons.

Years of experience and reasons for choice

One way analysis of variance tests for reasons for choice and years of experience were conducted. The results of the ANOVA are summarised in Table 10 below with significant results ($p<0.05$) indicated in bold type. Effect sizes have been reported in the right hand column adjacent to significant interactions only.

VIGNETTE 1	F(1,71)=.3812,p<.6839
VIGNETTE 2	F(1,69)=4.2778,**p<.0424**
VIGNETTE 3	F(1,69)=8.5203,**p<.0048**
VIGNETTE 4	F(1,59)=.0157,p<.9008
VIGNETTE 5	F(1,69)=.0411,p<.8399
VIGNETTE 6	F(1,88)=.1627,p<.6877
VIGNETTE 7	F(1,100)=5.0638,**p<.0266**
VIGNETTE 8	F(1,91)=.0193,p<.8899
VIGNETTE 9	F(1,43)=1.5568,p<.2190
VIGNETTE 10	F(1,83)=.0129,p<.9100

Table 10: ANOVA results of years of experience and reasons for choices.

Significance levels and means of post-hoc analyses with Student-Newmans-Keuls tests were calculated for significant interactions in Table 10.

For vignette two (a client alleges sexual advances by previous therapist), psychologists with more experience (mean years = 19.4) tended to base their action choices on noncodified reasons in contrast with psychologists with less experience (mean years = 11. 96) who tended to base their action choices on codified reasons. For vignette three (a psychologist uses his credentials to endorse a health spa) psychologists with more experience (mean years = 15.3) tended to justify their actions in terms of noncodified reasons in contrast with psychologists with less experience (mean years = 8.4) who tended to justify their actions in terms of codified reasons. A similar trend was noted for vignette 7 (a client threatens violence to his girlfriend) where the more experienced psychologists (mean years = 17. 95) tended to select noncodified rationales as opposed to less experienced psychologists (mean years = 12.8) who utilised codified rationales.

5.7 Frequency and seriousness ratings

Subjects were asked to rate the frequency with which 17 ethical issues had presented difficulties for them in the last year and to rate the overall seriousness of these problems, irrespective of how frequently they had personally encountered them. Frequency scale ratings ranged from 1 (never a concern) to 5 (constantly a concern). Seriousness scale ratings ranged from 1 (not at all serious) to 5 (extremely serious).

In terms of mean frequency ratings, no ethical issue was rated as more than "occasionally a concern". None of the issues were rated to be more than "slightly serious" or "somewhat serious". Respondents rated confidentiality as the most frequently encountered ethical concern and the appropriateness of the actions of colleagues as the next most frequently encountered difficulty. Confidentiality was rated as the most serious ethical concern and colleagues' sexual conduct was rated as the next most serious concern. Overall, the issues that appear to be considered the least serious involve means of generating referrals (for example through advertising); and media appearances (such as talk shows or interviews). Table 11 presents these 17 areas of potential ethical difficulty along with mean ratings of frequency and seriousness.

Area of concern	Frequency	Seriousness
Confidentiality	3.336	3.590
Informed consent	2.615	3.132
Rights of minors	2.717	3.441
Conflicting interests	2.752	3.361
Advertising; generating referrals	1.748	2.137
Talk shows, media appearances	1.849	2.154
Colleagues sexual conduct	1.790	3.483
Appropriateness of collegial actions	2.554	3.420
Own sexual impulses or conduct	1.462	2.649
Legality of own actions	1.856	2.816
Own malpractice liability	1.610	2.690
Competence	2.504	2.992
Insurance company requests	1.782	2.615
Involuntary commitment	1.500	2.527
Employee or supervisee conduct	2.060	2.699
Testing	2.347	2.974
Research	1.814	2.816

Table 11: Mean ratings of frequency and seriousness for ethical issues.

5.8 Additional Analyses

The following results pertain to hypothesis 4 and hypothesis 4a which predicted that the frequency of encountering certain ethical issues and the perceived seriousness of these ethical issues would affect the course of action selected in the face of dilemmas. A factor analysis of the 17 ethical issues psychologists were asked to rate in terms of their frequency and seriousness was conducted. A number of factors related to frequency ratings and a number of factors related to seriousness ratings were found (these results are presented in more detail in Tables 12 and 13 below). The relationship of the frequency and seriousness factors to the ethical choices selected for each vignette was explored through a series of ANOVAS's with action choice as the independent variable and the factor score as the dependent variable.

5.8.1 Factor analysis of frequency and seriousness ratings

Regarding the frequency with which areas of potential ethical difficulty were encountered, five factors were selected on the basis of eigenvalues greater than 1, and these were rotated othagonally by the varimax method. The five factors explained 27.6, 9.9, 8.9, 7.9, and 6.6 percent of the variance respectively, accounting in total for 60.9% of the variance. These five factors were interpreted as follows: Factor 1 centred around competence and legal liability (questions 10, 11, 12, 15 & 16). Factor 2 centred around sexual conduct - of colleagues and respondents themselves (questions 7, 8 & 9). Factor 3 centred around rights of clients in the form of rights of minors, confidentiality, informed consent and conflicting interests (questions 1, 2, 3 & 4). Factor 4 centred around requests for information from the public and third parties (questions 6, 13 & 17). Factor 5 centred around generating referrals (question 5).

Regarding the seriousness with which areas of potential ethical difficulty were encountered, four factors were selected on the basis of eigenvalues greater than 1, and these were rotated orthagonally by the varimax method. The four factors accounted for 51.6, 8.2, 7.3, and 6.0 percent of the variance respectively, accounting in total for 73% of the variance. These four factors were interpreted as follows: Factor 1 centred around competence and legal liability (questions 10, 11, 12 & 16). Factor 2 centred around rights of clients (1, 2, 3 & 4). Factor 3

related to the actions of colleagues (questions 7 & 8). Factor 4 related to communication with the public in the form of advertising and personal media appearances.

		Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
1	Confidentiality	.29711	-.06275	.59146	.13844	.33902
2	Informed consent	.26255	.21567	.55752	.14210	.13110
3	Minors' rights	-.04364	.09278	.65886	.29188	-.03551
4	Conflict of interests	.08854	.24072	.72358	-.02026	.07430
5	Advertising	.07570	.05196	.17125	.02592	.79978
6	Media appearances	-.06685	.01885	.29895	.72458	.15878
7	Colleagues sexual conduct	.01396	.81358	.09788	.12915	.05836
8	Collegial actions	.16075	.75711	.28963	-.06202	-.15348
9	Own sexual impulses or conduct	.20382	.59648	.07015	.02630	.50891
10	Legality of own actions	.75112	.24596	.02705	.06582	.20524
11	Own malpractice liability	.72576	.32322	-.20643	.22899	.09218
12	Competence	.61918	.02340	.19040	.25315	.15575
13	Insurance company requests	.18035	.35464	-.12257	.63983	-.35528
14	Involuntary commitment	.21852	.44850	.14492	.30947	.08716
15	Employee or supervisee conduct	.61359	.24705	.33395	-.00596	-.34353
16	Testing	.75947	-.07346	.25151	-.02228	-.06048
17	Research	.25026	.02260	.14189	.62884	.02997
	SS loadings	4.69299	1.67816	1.50662	1.34015	1.12844

Key	
Factor 1	Questions 10,11,12,15,16
Factor 2	Questions 7,8,9
Factor 3	Questions 1,2,3,4
Factor 4	Question 6,13,17
Factor 5	Question 5

Table 12: Factor analysis of frequency ratings

		Factor 1	Factor 2	Factor 3	Factor 4
1	Confidentiality	.26855	.63487	.10220	.43908
2	Informed consent	.42467	.71671	.14766	.18745
3	Minor's rights	.25358	.68645	.36968	.26329
4	Conflict of interest	.16462	.81207	.30191	-0.2875
5	Advertising	.26854	.09415	.22644	.66539
6	Media appearances	.13501	.14539	.12720	.78264
7	Colleagues sexual conduct	.13390	.24694	.68454	.35007
8	Collegial actions	.11563	.24842	.80583	.24115
9	Own sexual impulses or conduct	.68671	.12432	.46649	.29947
10	Legality of own actions	.81589	.21835	.20166	.30043
11	Own malpractice liability	.81339	.08889	.20917	.31397
12	Competence	.78014	.29838	.09947	.31751
13	Insurance company requests	.50863	.33046	.55342	-.20936
14	Involuntary commitment	.57925	.16737	.55761	.03666
15	Employees or supervisees' conduct	.67653	.35306	.29447	-.02827
16	Testing	.81549	.31762	-.00554	.06750
17	Research	.54268	.22375	.49659	.28354
	SS loadings	8.76783	1.39279	1.24308	1.01194

Key	
Factor 1	Questions 10,11,12,16
Factor 2	Questions 1,2,3,4
Factor 3	Questions 7,8
Factor 4	Question 5,6

Table 13: Factor analysis of seriousness ratings.

Frequency by action choice

The following results pertain to hypothesis 4 which predicted that the frequency of encountering certain ethical issues would affect the course of action selected in the face of the ethical dilemmas. An ANOVA of frequency factors by action choice was conducted for each vignette. The results of the ANOVA are summarised in Table 14 below with significant results ($p<0.05$) indicated in bold type. Effect sizes have been reported adjacent to significant interactions only. Three significant results were obtained which provided partial support for Hypothesis 4.

VIGNETTE ONE	
LEGAL LIABILITY FACTOR	F(2,118)=.7831,p<.4594
SEXUAL CONDUCT FACTOR	F(2,119)=.1411,p<.8685
CLIENT RIGHTS FACTOR	F(2,119)=2.5997,p<.0786
INFORMATION FACTOR	F(2,116)=1.2492,p<.2906
REFERRALS FACTOR	F(2,116)=2.4244,p<.0931
VIGNETTE TWO	
LEGAL LIABILITY FACTOR	F(3,116)=1.0406,p<.3775
SEXUAL CONDUCT FACTOR	**F(3,117)=3.3646,p<.0212,$\hat{r}^2$=.0813**
CLIENT RIGHTS FACTOR	F(3,117)=.1960,p<.8990
INFORMATION FACTOR	F(3,114)=1.9290,p<.1290
REFERRALS FACTOR	F(3,114)=1.9014,p<1335
VIGNETTE THREE	
LEGAL LIABILITY FACTOR	F(2,118)=.3538,p<.7028
SEXUAL CONDUCT FACTOR	F(2,119)=.4439,p<.6426
CLIENT RIGHTS FACTOR	F(2,119)=.8951,p<.4114
INFORMATION FACTOR	F(2,116)=.2843,p<.7531
REFERRALS FACTOR	F(2,116)=.6714,p<.5130
VIGNETTE FOUR	
LEGAL LIABILITY FACTOR	F(1,113)=2.7542,p<.0998
SEXUAL CONDUCT FACTOR	F(1,114)=.0041,p<.9491
CLIENT RIGHTS FACTOR	F(1,114)=3.3256,p<.0709
INFORMATION FACTOR	F(1,111)=1.4057,p<.2383
REFERRALS FACTOR	F(1,111)=.0312,p<.8600
VIGNETTE FIVE	
LEGAL LIABILITY FACTOR	F(1,112)=.2216,p<.6388
SEXUAL CONDUCT FACTOR	F(1,112)=.0008,p<.9776
CLIENT RIGHTS FACTOR	F(1,112)=.0876,p<.7678
INFORMATION FACTOR	F(1,110)=.0331,p<.8559
REFERRALS FACTOR	F(1,110)=1.2695,p<.2623
VIGNETTE SIX	
LEGAL LIABILITY FACTOR	F(2,119)=.7643,p<.4680
SEXUAL CONDUCT FACTOR	F(2,120)=1.4380,p<.2414
CLIENT RIGHTS FACTOR	F(2,120)=.0416,p<.9593
INFORMATION FACTOR	F(2,117)=1.6516,p<.1963
REFERRALS FACTOR	**F(2,117)=6.1317,p<.0029,$\hat{r}^2$=.0964**
VIGNETTE SEVEN	
LEGAL LIABILITY FACTOR	F(2,113)=.8092,p<.4478
SEXUAL CONDUCT FACTOR	F(2,114)=1.8150,p<.1676

VIGNETTE EIGHT	
LEGAL LIABILITY FACTOR	F(2,114)=1.0099,p<.3676
SEXUAL CONDUCT FACTOR	F(2,115)=.0930,p<.9112
CLIENT RIGHTS FACTOR	F(2,115)=.8627,p<.4248
INFORMATION FACTOR	F(2,115)=1.1949,p<.3066
REFERRALS FACTOR	F(2,112)=.1036,p<.9017
VIGNETTE NINE	
LEGAL LIABILITY FACTOR	**F(1,119)=5.4233,p<.0216,$\hat{\lambda}^2$=.0439**
SEXUAL CONDUCT FACTOR	F(1,120)=1.8187,p<.1800
CLIENT RIGHTS FACTOR	F(1,120)=.4012,p<.5277
INFORMATION FACTOR	F(1,117)=.0001,p<.9905
REFERRALS FACTOR	F(1,117)=.6239,p<.4313
VIGNETTE TEN	
LEGAL LIABILITY FACTOR	F(2,116)=.2387,p<.7880
SEXUAL CONDUCT FACTOR	F(2,116)=.0237,p<.9765
CLIENT RIGHTS FACTOR	F(2,116)=.1067,p<.8988
INFORMATION FACTOR	F(2,114)=.7965,p<.4535
REFERRALS FACTOR	F(2,114)=1.1617,p<.3167

Table 14: Results of ANOVA of frequency factors by action choice.

Significance levels and means of post-hoc analyses with Newmans-Keuls tests were calculated for significant interactions in Table 14. These are shown in tables 14a to 14c below. Table 14a summarises the first of these results pertaining to the sexual conduct factor.

GROUP	MEAN
1	1.7955
2	2.5
3	1.7388
4	1.5833

Table 14a: Frequency factor scores for psychologists grouped according to selected action alternative (vignette two)

For vignette two (a present client alleges that her previous therapist made sexual advances)

psychologists who selected the alternative to directly contact the offending psychologist (alternative 2) tended to report encountering the sexual conduct factor more frequently than psychologists who indicated that they would discuss the patient's anger (alternative 1); tell the patient her right to bring charges (alternative 3) or report the psychologist directly to the ethics committee (alternative 4).

GROUP	MEAN
1	2.3571
2	1.6739
3	1.4769

Table 14b: Frequency factor scores for psychologists grouped according to selected action alternative (vignette six)

On vignette six (the decision to accept or not accept a prospective client for sex therapy with little competence in this area) psychologists who indicated that they would accept the client (alternative 1) tended to report encountering factor five (concerns of generating referrals) more frequently than psychologists who indicated that they would accept the client only after discussing the issue of qualifications (alternative 2) or would refuse to accept the client (alternative 3).

GROUP	MEAN
1	1.5692
2	2.0897

Table 14c: Frequency factor scores for psychologists grouped according to selected action alternative (vignette nine)

For vignette nine (a client offers to prepare tax returns in partial repayment for therapy) psychologists who indicated that they would not accept the client's offer (alternative 2) reported

encountering factor one (competence and legal liability) more frequently than psychologists who indicate that they would accept the client's offer (alternative 1).

Seriousness by action choice

The following results pertain to hypothesis 4a which predicted that psychologists' perceptions of the seriousness of ethical issues would affect the course of action they selected in the face of the ethical dilemmas. ANOVAs of seriousness factors by action choice were conducted for each vignette. The results of the ANOVA are summarised in Table 15 below with significant results ($p<0.05$) indicated in bold type. Effect sizes have been reported adjacent to significant interactions only. Two significant results were obtained which provided partial support for Hypothesis 4a.

VIGNETTE ONE	
LEGAL LIABILITY FACTOR	F(2,118)=.2507,p<.7787
CLIENT RIGHTS FACTOR	F(2,119)=1.4335,p<.2426
COLLEGIAL CONDUCT FACTOR	F(2,119)=.2522,p<.7775
COMMUNICATION FACTOR	F(2,119)=.1821,p<.8338
VIGNETTE TWO	
LEGAL LIABILITY FACTOR	F(3,116)=.3116,p<.8169
CLIENT RIGHTS FACTOR	F(3,117)=.3399,p<.7965
COLLEGIAL CONDUCT FACTOR	F(3,117)=.3437,p<.7937
COMMUNICATION FACTOR	F(3,117)=2.1379,p<.0993
VIGNETTE THREE	
LEGAL LIABILITY FACTOR	F(2,118)=.9371,p<.3947
CLIENT RIGHTS FACTOR	F(2,119)=.2947,p<.7453
COLLEGIAL CONDUCT FACTOR	F(2,119)=.2876,p<.7506
COMMUNICATION FACTOR	F(2,119)=.0545,p<.9470
VIGNETTE FOUR	
LEGAL LIABILITY FACTOR	F(1,113)=2.9179,p<0.0904
CLIENT RIGHTS FACTOR	**F(1,114)=6.2139,p<.0141,$\hat{\eta}^2$=.0521**
COLLEGIAL CONDUCT FACTOR	F(1,114)=1.6571,p<.2006
COMMUNICATION FACTOR	**F(1,114)=4.0476,p<.0466,$\hat{\eta}^2$=.0346**
VIGNETTE FIVE	
LEGAL LIABILITY FACTOR	F(1,112)=.3204,p<.5725
CLIENT RIGHTS FACTOR	F(1,112)=.0005,p<.9828
COLLEGIAL CONDUCT FACTOR	F(1,112)=.7458,p<.3897
COMMUNICATION FACTOR	F(1,112)=.0534,p<.8176
VIGNETTE SIX	
LEGAL LIABILITY FACTOR	F(2,119)=.0725,p<.9301
CLIENT RIGHTS FACTOR	F(2,120)=.0707,p<.9317
COLLEGIAL CONDUCT FACTOR	F(2,120)=.2268,p<.7974
COMMUNICATION FACTOR	F(,120)=.2980,p<.7428
VIGNETTE SEVEN	
LEGAL LIABILITY FACTOR	F(2,113)=1.3387,p<.2664
CLIENT RIGHTS FACTOR	F(2,114)=2.5439,p<.0831
COLLEGIAL CONDUCT FACTOR	F(2,114)=1.0223,p<.3631
COMMUNICATION FACTOR	F(2,114)=.7495,p<.4750
VIGNETTE EIGHT	
LEGAL LIABILITY FACTOR	F(2,114)=.0134,p<.9867
CLIENT RIGHTS FACTOR	F(2,115)=.0235,p<.9768

VIGNETTE NINE	
LEGAL LIABILITY FACTOR	F(1,119)=.7789,p<.9876
CLIENT RIGHTS FACTOR	F(1,120)=.3266,p<.5687
COLLEGIAL CONDUCT FACTOR	F(1,120)=.6104,p<.4362
COMMUNICATION FACTOR	F(1,120)=.5003,p<.4808
VIGNETTE TEN	
LEGAL LIABILITY FACTOR	F(2,116)=.4074,p<.6663
CLIENT RIGHTS FACTOR	F(2,116)=.1107,p<.8953
COLLEGIAL CONDUCT FACTOR	F(2,116)=.1971,p<.8214
COMMUNICATION FACTOR	F(2,116)=2.2103,p<.1144

Table 15: Results of ANOVA of seriousness factors by action choice

Means of post-hoc analyses with Newmans-Keuls tests were calculated for significant interactions in Table 15. These are shown in tables 15a to 15b below. Table 15a summarises the first of these results pertaining to the client rights factor.

GROUP	MEANS
1	3.5337
2	3.0397

Table 15a: Seriousness factor scores for psychologists grouped according to selected action alternative (vignette four)

For vignette four (the decision whether or not to keep a spouse's confidences in marital therapy) respondents who indicated that they would not agree to keep the secret (alternative 1) rated factor 2 (client rights in informed consent and confidentiality) as more serious than psychologists who indicate that they would agree to keep the secret (alternative 2).

GROUP	MEAN
1	2.7885
2	2.4021

Table 15b: Seriousness factor scores for psychologists grouped according to selected action alternative (vignette four)

For the same vignette respondents who indicated that they would not agree to keep the secret (alternative 1) rated factor 4 (concerns of generating referrals) as more serious than psychologists who indicated that they would agree to keep the secret (alternative 2).

5.9 Critical Incident Results

The following section reports additional findings not specifically predicted in the hypotheses. Psychologists were requested to describe a personally encountered ethical dilemma. A proportion of respondents who returned their questionnaires did not volunteer ethical dilemmas (76). The remaining 49 respondents described 51 ethical dilemmas. This amounted to response rate of 3.2% of registered clinical psychologists. Those members who reported ethical dilemmas comprised of 45% male and 55% female respondents. They identified private practice as their primary work setting and academic settings comprised the second largest milieu. They tended to identify individual psychotherapy as the work they were most involved in, followed by assessment, marital/couples therapy and academic work.

Those who did not respond with an ethical dilemma comprised the same percentage of male and female respondents (45% and 55% respectively) and were similar to respondents in their primary work setting and the type of work they conducted (See Tables 16a and 16b). It would appear that clinical psychologists who experience ethical dilemmas cannot be differentiated from those who do not on the basis of work setting and type of work conducted. The results are, however, confounded by the fact that the decision to volunteer a dilemma was left to the discretion of individual respondents.

	Respondents		Non-respondents	
Setting	No	%	No	%
Private	41	83.67	59	77.63
Academic	8	16.32	16	21.05
Hospital-psychiatric	8	16.32	9	11.84
Court prison	6	12.24	1	1.32
Public mental health	5	10.20	12	15.79
Hospital-medical	5	10.20	5	6.58
Research	2	4.08	2	2.63
Other: Organizational	4	8.16	11	14.4

Table 16a: Clinical settings of respondents and non-respondents.

	Respondents		Non-respondents	
Work	No	%	No	%
Individual therapy	41	83.67	64	84.21
Assessment	18	36.73	30	39.47
Marital	10	20.40	18	23.68
Academic	7	14.28	16	21.05
Training	6	12.24	5	6.58
Family therapy	6	12.24	4	5.26
Counselling	5	10.20	4	5.26
Supervision	4	8.16	4	5.26
Forensic	3	6.12	6	7.89
Neuropsychology	3	6.12	2	2.63
Sport psychology	1	2.04	2	2.63
Consultation	0	0	4	5.26
Organizational psychology	0	0	6	7.89
Group therapy	0	0	3	3.95
Hypnotherapy	0	0	2	2.63
Sex therapy	0	0	2	2.63

Table 16b: Work conducted by respondents and non-respondents.

The 51 ethical dilemmas reported by psychologists were analyzed and allocated to one of the 23 categories utilised in a prior study (Pope & Vetter, 1992). The results in Table 17 are presented in order of frequency as found in this study with corresponding BPS and APA data from two previous studies (Pope & Vetter, 1992; Lindsay & Colley, 1995) for direct comparison. Two additional categories (Informed consent; reporting practices) were devised to categorise dilemmas determined not to be accommodated in any Pope and Vetter category.

Category	% SA	% APA	% BPS
Confidentiality	26	18	17
Dual relationship (non-sexual)	14	17	3
Payment issues	12	14	3

Category	% SA	% APA	% BPS
Collegial conduct	10	4	7
Sexual issues	8	4	6
Questionable intervention	4	3	8
Competence	4	3	3
Ethics codes/committees	4	2	2
Research	2	4	10
Academic/training	2	8	3
Medical	2	1	1
Termination	2	1	0
Miscellaneous	2	11	9
School	0	2	7
Assessment	0	4	6
Organizational	0	1	5
Supervision	0	2	3
Forensic	0	5	2
Publishing	0	2	1
Advertising	0	2	1
Ethnicity	0	1	1
Records	0	1	1
Helping financially stricken	0	2	0
(Informed consent)	4	-	-
(Reporting practices)	4	-	-
	N = 49	N = 679	N = 172

Table 17: Percentages of ethical dilemmas reported in each category by SA psychologists, APA and BPS members.

As the reported dilemmas appeared to cluster around several ethical issues at once, most dilemmas were assigned not only to a primary category but to secondary and tertiary categories as well. This deviates from the Pope and Vetter (1992) classification system which cited only primary categories. Table 18 represents these primary categorisations plus additional columns

to represent secondary and tertiary categorisations found to be useful. Column three therefore represents a cumulative total.

Category	Primary %	Additional %	Total %
Confidentiality	28.57	34.6	36.73
Dual relationship	14.25	18.36	18.36
Payment issues	12.24	12.24	12.24
Collegial conduct	10.20	14.28	26.5
Sexual issues	8.16	8.16	8.16
Questionable intervention	4.08	6.12	6.12
Competence	4.08	10.20	10.20
Ethics codes/committees	4.08	8.16	8.16
Research	2.04	2.04	2.04
Academic/training	2.04	2.04	2.04
Medical	2.04	4.05	10.20
Termination	2.04	4.08	4.08
Miscellaneous	2.04	4.08	4.08
School	0	0	0
Assessment	0	0	0
Organizational	0	0	0
Supervision	0	0	0
Forensic	0	6.12	10.20
Publishing	0	0	0
Advertising	0	0	0
Ethnicity	0	0	0
Records	0	4.08	4.08
Helping financially stricken	0	0	0
Informed consent	4.08	4.08	4.08
Reporting practices	4.08	4.08	4.08

Table 18: Percentages of ethical dilemmas reported in primary, secondary and tertiary categories by SA clinical psychologists.

The largest category of reported ethical dilemmas involve confidentiality. The second largest category clustered around non-sexual dual relationships. Table 18 indicates that the (mis)conduct of colleagues is also a frequent source of ethical dilemmas.

6 DISCUSSION

6.1 Introduction

Results of this study provided support for the hypotheses that considerable variability exists in the professional decision making of clinical psychologists with regard to the choices they select in the face of ethical dilemmas and the reasons they supply to justify their choices. Support was provided for the hypothesis that consensus in decision making is facilitated for issues that are subject to high levels of professional attention and regulated by legal guidelines.

Little support was provided, however, for the hypotheses that psychologists with different characteristics differ in their choice of response or their primary justifications for these choices. Partial support was provided for the hypothesis that psychologists' perceptions of the seriousness of certain ethical issues and the frequency with which these are encountered affect the decisions they make when confronted with a troubling ethical situation. These results, and their limitations, are discussed in more detail below. These findings are compared with other research. The implications of the present findings for ethical regulations, and suggestions for future research, are discussed.

6.2 Responses to ethical dilemmas

6.2.1 Consensus in decision making

> "Consistency of decision making is desirable to ensure that regardless of circumstances, psychological standards will be fairly and equitably applied, and individual rights will be guaranteed to all people seen by psychologists" (Tymchuk et al., 1982, p. 413).

Psychologists indicated that they favour a diverse range of responses in order to resolve the ethical dilemmas presented to them in this study. In response to six out of ten of ethical

dilemmas, psychologists did not attain high levels of consensus in decision making as measured by a 75% concordance rate. Overall, these results are consistent with the considerable variability documented in previous research investigating professionals' preferred resolutions to ethical dilemmas (Chevalier & Lyon, 1993; Haas et al., 1986; Tymchuk et al., 1982).

In this section the actual choices psychologists selected to resolve dilemmas are described in some detail. These are discussed in terms of prior research and theoretical considerations. Sections 6.3 and 6.4 discuss the reasoning typically associated with particular action choices more fully.

6.2.1.1 High consensus in decision making

While psychologists disagreed on resolutions for the majority of dilemmas, consensus on how to behave was achieved for a small, discrete series of situations. In four out of ten vignettes, psychologists' agreement was marked by high consensus as measured by a 75% concordance rate.

Two such vignettes involved situations where legal guidelines have a direct bearing on the activity of psychologists. Namely a *Tarasoff*-like situation (Tarasoff v. Regents of the University of California, 118 Cal. Rptr. 129, 529 P.2d 533, 1974 in Allan, 1997) invoking legal obligations to take measures to protect third parties from their clients' potential for violence (vignette seven); and a situation involving suspected child abuse that called upon psychologists to apply relevant statutory requirements (vignette eight).

These results support previous contentions that consensus in professional decision making is aided by pertinent legal regulations that shape responses due to the relatively unambiguous manner in which they are phrased (Chevalier & Lyon, 1993; Tymchuk et al., 1982). Legal guidelines regulating the activities of psychologists have been held to indicate that the law is less willing to tolerate idiosyncratic interpretations of broad ethical guidelines (resulting in a broad range of professional behaviour) where client actions are seen to clearly interfere with the rights of individuals in society (Bersoff, 1995). Relevant legal guidelines have further been held to

effectively usurp professional judgement and rob psychologists of a wide range of clinical options. This effect of legal guidelines is seemingly reflected in these results.

For the reasons cited above, legal regulation of psychologist's activities have been controversial. It is possible that this controversy has contributed to the heightened attention paid to dangerousness and child abuse (which are compelling issues in and of themselves) in the professional literature. Tymchuk et al. (1982) and Chevalier and Lyon (1993) maintain that issues in the forefront of professional attention tend to elicit consensual strategies for responding that have emerged out of professional exposure, awareness and debate.

Psychologists also reached strong agreement in response to a vignettes delineating issues of dual relationship (sexual and non-sexual). Psychologists were able to strongly agree on the best course of action when faced with allegations by a current client of sexual contact with a previous psychologist (vignette two) and a client's request to provide professional services in repayment for therapy (vignette nine).

Tymchuk et al. (1982) and Chevalier and Lyon (1993) further maintained that strong consensus in decision making is facilitated by clear ethical guidelines. Recent code revisions provide relatively unambiguous deontological injunctions against sexual relationships with clients and ex-clients (APA, 1991; SAMDC, 1992). This may have contributed to consensus amongst psychologists as to the most appropriate response to the dilemma outlined in vignette two.

In line with this reasoning, it is possible that the formulation of a specific position on bartering with clients in recent code revisions (APA, 1992) contributed to the consistent course of action selected by psychologists in response to the dilemma outlined in vignette nine. While code revisions do not directly prohibit bartering, psychologists are cautioned against entering into such arrangements and the potential for harmful consequences are explicitly detailed. Furthermore, increasing attention to the harmful consequences accruing to clients as a result of sexual involvement with their therapists in both the professional literature (Pope, 1994), lay literature and media may be responsible for the consistency of professional responses to vignette two.

Confidentiality and the duty to warn

Assessment of violence risk and the initiation of measures to protect third parties from harm have become required professional abilities for all clinical psychologists (Grisso & Tomkins, 1996). It has become critical for psychologists to understand the criteria relevant to determinations of dangerousness and their responsibilities regarding those determinations (Schopp, 1996). The obligation to combine risk assessments with warnings or actions intended to protect public safety automatically accrue to psychologists confronted with a potentially dangerous client (Grisso & Tomkins; Schopp, 1996).

Psychologists responding to this study strongly agreed on the most appropriate course of action in the event of a client threatening harm to a third party (vignette seven). These results are consistent with previous research documenting consensus in responses to hypothetical ethical dilemmas (Haas et al., 1986; Tymchuk et al., 1982). Eighty-six percent of psychologists in the present survey indicated that in the event of threatened violence by their client, they would elect to inform him that a disclosure to the threatened party or the police was necessary. Haas et al. (1986) similarly found that 87% of their respondents would select this course of action in similar circumstances.

While a small minority of respondents (5%) indicated that they would disclose the threat to relevant parties without informing the client, more often than not psychologists would elect to inform their clients of their intentions. This enhances the likelihood of integrating such warnings into the therapeutic relationship (Quinn, 1984 in Bersoff, 1995). On the whole these results indicate that the overwhelming majority (91%) of respondents would act in a manner consistent with legal mandates requiring a limited breach of confidentiality in the event of foreseeable harm to others (Allan, 1997; Truscott, Evans & Mansell, 1995). Furthermore, they would act in accordance with existent ethical guidelines legitimizing a breach in confidentiality in order to protect others from harm (SAMDC, 1992; Steere & Wassenaar, 1985).

As legal obligations only establish a duty to exercise reasonable care to protect intended victims, warning potential victims or relevant authorities is only one of several options available to

psychologists (Monahan, 1993; Stanard & Hazler, 1995). It is likely that forcing respondents to select from a limited number of responses obscured preferred clinical options such as treatment intensification or hospitalisation. Despite these limitations, the results reassuringly suggest that those charged with evaluating risk and determining appropriate action select the course of action most congruent with existing legal and ethical guidelines.

Confidentiality and child abuse reporting

Given the pervasiveness of child abuse, psychologists come into contact with such cases with some regularity (Brosig & Kalichman, 1992). They are in a position to assist not only with the early identification and treatment of abused children, but with their protection (Beck & Ogloff, 1995). Legislative responses to child abuse have ensured that psychologists faced with such cases must of necessity weigh clinical and treatment considerations against relevant legal guidelines regulating their conduct.

In response to a mother's allegation that her child is being sexually abused by the psychologist's client (vignette five) psychologists strongly agreed on the best course of action. Eighty-two percent of respondents indicated that the course of action they would favour would be to encourage the mother to report the abuse to the child protection unit. Only 13.3% of respondents indicated that they would report the case directly. A small minority (4.2%) indicated that they would reflect the wife's concern of her child's sexual molestation but would take no further action.

Haas et al. (1986) found that this vignette did not elicit high levels of agreement from psychologists. Only 60% of their respondents agreed that to encourage the mother to report the case was most appropriate, whereas 25% felt that they should report the matter directly. They concluded that despite the prevalence of mandatory reporting laws their results indicated that "uncertainty about this complex issue is still widespread" (ibid, p. 320). While this may well be the case, it is possible that the lack of consensus identified in their research could be traced to differences in statutory wording requirements for reporting of suspected child abuse governing the many jurisdictions in which the sampled psychologists resided (Brosig & Kalichman, 1992).

South African psychologists are, however, governed by two regulations pertaining to child abuse that are national and therefore apply to all psychologists equally. These regulations espouse reporting requirements that are fairly narrow in nature. Psychologists are obligated to report child abuse only if they directly attend to, or treat the child in question; that is, if the child is their client (Child Care Amendment Act of 1983; Prevention of Domestic Violence Act of 1992 in Allan, 1997). In the event that the child is not the psychologist's client there may be no statutory obligation to report and the psychologist's primary duty may be to ensure that they take steps to address the matter in therapy (Allan, 1997).

In response to this dilemma psychologists were able to agree on a relatively consistent course of action. Furthermore, psychologists in this study appear to be acting within the boundaries of their legal obligations while simultaneously treating the matter with seriousness demanded by the popular and professional awareness around the harmful effects of child abuse.

Non-sexual dual relationships

Psychologists strongly agreed that it would be most appropriate to decline a client's offer to barter for services (vignette nine). Ninety percent of respondents agreed that it would not be appropriate to trade psychological services for professional services. Only 10% indicated that they would accept the client's offer. Haas et al. (1986) similarly found that 93% of psychologist-respondents would decline the client's offer.

It would appear that psychologists are aware of broad injunctions to avoid dual relationships that could impair their professional judgement and increase the risk of exploitation (SAMDC, 1992; Steere & Wassenaar, 1985). They appear cognizant of the risks posed to role-related obligations through the addition of a secondary non-professional relationship (Kitchener, 1988). Recent code revisions (APA, 1992) clarify the reasoning behind the injunction against bartering in a way that is most helpful for psychologists faced with such decisions. The potential for conflict and distortion is clearly delineated and it is made clear that bartering is to be exercised as an option only if the relationship is not exploitative (Canter et al., 1994).

Sexual dual relationships and whistleblowing

The majority of respondents (75%) agreed that the most appropriate course of action in the face of a client's allegation of sexual contact with her former therapist would be to inform her of her right to bring charges to the ethics committee or professional board. Haas et al. (1986) found that this was an ethical issue that prompted a wider spread of responses, with only 57% of psychologists agreeing on the above course of action. Ten percent of psychologists in the present study indicated that they would report the psychologist directly to regulatory bodies and a further 6% reported that they would contact the therapist directly to discuss his misconduct. It is likely that the majority of respondents allowed client rights to confidentiality to direct the manner in which collegial misconduct was handled (Haas et al., 1986).

While informal peer monitoring is an ethical responsibility incurred by all psychologists, current ethical guidelines caution that any effort towards informal monitoring of peers be carried out with sensitivity to the confidentiality issues involved (Steere & Wassenaar, 1985). These results suggest that psychologists respond to this ethical dilemma in a manner most congruent with ethical regulations.

6.2.1.2 Moderate consensus in decision making

Psychologists did not strongly agree on a consistent course of action for six out of ten ethical dilemmas. These results suggest that a substantial number of areas of professional decision making are coloured by relative ambiguity for psychologists. This section reviews the responses elicited by vignettes involving confidentiality with minor clients, third party access to confidential information and conflicts of loyalty in the form of conflicting obligations to clients and organizational demands.

Confidentiality with minor clients

A general lack of clarity surrounds the rights of children and adolescents regarding confidentiality

(Gustafson & McNamara, 1987). Current ethical regulations tend to provide statements of guidance (Lindsay, 1996) directing that confidentiality practices primarily be informed by the best interests of the child (Steere & Wassenaar, 1985). Further direction is given by delineating that information receivers be clearly connected to the case (ibid; APA, 1992). Seventy-two percent of psychologists agreed that it would not be appropriate to break the confidentiality of a minor client in the face of requests for information by the client's mother (vignette five). A substantial minority (28%), however, indicated that they would break the child's confidentiality in order to meet the mother's request for information. Haas et al. (1986) similarly found that while 72% of respondents would refuse to break confidentiality, 24% would do so in this situation.

It is apparent that the majority of psychologists in the present study are of the opinion that minors should be accorded the same rights of confidentiality as adults (Myers, 1982 in Gustafson & McNamara, 1987). On the other hand, an appreciable percentage appear to feel that the mother is clearly connected to the case and that it is essential to discuss information with her (Pardue, Whichard & Johnson, 1970 in Gustafson & McNamara, 1987). It is likely that the ambiguity of current generic guidelines contributes to wide variation in interpretation of this ethical issue (Koocher, 1994a). Psychologists' individual determinations of the child's best interests and measures that will safeguard these interests are adequately reflected in the variability of confidentiality practices endorsed in these results.

Confidentiality and third party access

Ethical guidelines legitimize the disclosure of confidential information in order to obtain payment for services. In such instances the disclosure is limited to the minimum necessary to achieve this purpose (APA, 1992; SAMDC, 1992). As access to diagnostic information on the part of non-clinical insurance personnel may inhere risks to clients, the obligation to discuss these implications necessarily attaches to psychologists determined to secure adequate informed consent. The interplay of clinical concerns with ethical responsibilities, however, commonly ensures considerable variability in the application of doctrines such as informed consent.

In vignette ten psychologists are faced with the dilemma of a patient requiring hospitalisation whose (accurate) diagnosis may compromise his ability to qualify for certain forms of insurance. The majority of respondents (73%) indicated that they would inform the client of the risks yet 19% reported that they would diagnose the client as indicated without informing him of the risks. Eight percent indicated that they would give him a less severe diagnosis. Haas et al. (1986) found that this dilemma elicited diverse responses from psychologists. Fifty percent of respondents elected to inform the client of the risks. Another 30% indicated that they would prefer to proceed with the diagnosis and admission without his informed consent and a further 18% selected to 'soften' his diagnosis without his consent.

It is reassuring that the majority of psychologists appear aware of their obligation to include potential negative consequences as a part of consent information. Current guidelines do not, however, explicitly direct psychologists to include risks of evaluation and treatment as a part of securing informed consent (Steere & Wassenaar, 1985). It would appear that a substantial minority of psychologists counter general guidelines to encourage joint decision-making regarding these issues (Steere & Wassenaar, 1985) with (benevolent) clinical considerations.

Conflicts of loyalty

Survey research requesting respondents to detail ethical dilemmas has indicated that numerous psychologists perceive conflicts between ethically appropriate actions and the contrary demands of their employees (Lindsay & Colley, 1995; Lindsay, 1996). Reconciling dual allegiances to institutional requirements and ethical regulations appears to be a potent source of ethical quandaries for psychologists (Johnson, 1995).

The majority (74%) of psychologists indicated that they would refuse to refer a client to a therapist whose ability they did not respect on the orders of a superior. On the other hand, a substantial minority (27%) would agree to do so - 12% would do so without informing the client of their misgivings while 15% would include their reservations. Haas et al. (1986) found that psychologists strongly agreed (79%) that such a referral would be inappropriate. The results of the present study indicate that psychologists tend to resolve the conflict between organisational

demands and their ethical responsibilities to their clients in favour of their ethical duties to clients. That 12% of psychologists indicated that they would comply and refer the client illustrates the pressure that organisational roles and demands may exert on psychologists (Lindsay & Colley, 1995).

6.2.1.3 Low consensus in decision making

Psychologists reached low levels of consensus for three vignettes. These vignettes involved issues of advertising (vignette three); confidentiality in marital therapy (vignette four) and competence (vignette six). Haas et al. (1988) similarly found that psychologists were almost equally split in their action choices in response to vignettes involving issues of advertising (vignette three); and competence (vignette six).

Advertising practices and whistleblowing

Ethical guidelines regulating the commercial aspects of professional psychology have undergone periodic revision. A comparison of code revisions pertaining to advertising and promotional practices indicate considerable changes largely in the direction of liberalising advertising practices (Canter et al., 1994). This is largely a result of challenges by the United States Federal Trade Commission (FTC) who posited that professional prohibitions on advertising posed impermissible restrictions on the presentation of useful consumer information. Such restrictions frustrated consumer rights to unrestrained freedom of choice (Koocher, 1994a). For a more detailed review on the impact of the FTC's actions on advertising, the interested reader is referred to Koocher (1994a; 1994b).

Ethical guidelines typically prohibited psychologists from participating for personal gain in advertisements recommending the use of products or services when that participation was based solely upon their identification as psychologists (APA, 1981; Steere & Wassenaar, 1985). The use of psychological qualifications to endorse non-psychological products was considered inappropriate in that it legitimized the use of professional stature in a manner that was not only irrelevant but also potentially misleading to the public (Keith-Spiegel & Koocher, 1985).

Haas et al. (1986) found that psychologists failed to agree on the most appropriate course of action in the face of a colleague's product endorsement (vignette three). While 42% indicated they would call the ethics committee to report the psychologist and 25% elected to contact the colleague directly, 33% of psychologists indicated that they would do nothing. Haas et al. (1986) concluded that a substantial proportion of psychologists would not fulfil peer monitoring responsibilities even in the face of a clear ethical violation.

While current regulations (APA, 1992; SAMDC, 1992) pay specific attention to issues of deceptive public statements, solicitation of client testimonials and requirements for media presentations, no reference is made to product endorsements. The context clearly indicates that "advertising may include any information that it not prohibited" (Canter et al., 1994, p. 83). While certain ethical regulations (CPA, 1991) have retained relatively restrictive advertising guidelines, recent code revisions relevant to South African psychologists reflect a modernization of advertising standards. The diversity of responses to this vignette requires interpretation in this context.

A large percentage (35%) of psychologists in this study reported that they would call the ethics committee to report their colleague. Sixteen percent indicated that they would prefer to call the colleague directly whereas 49% indicated that they would do nothing. The diversity of responses elicited by this vignette may point to some confusion over the current status of regulations regarding advertising. It is also possible that despite relaxed standards, psychologists may remain mindful of historical professional considerations urging tastefulness (Keith-Spiegel & Koocher, 1985) and professional dignity (Koocher, 1994) in advertising practices.

Confidentiality in marital therapy

Ethical regulations have been criticised for inadequately addressing the manner in which classical ethical concerns (such as confidentiality) are expressed in multiperson therapies (Lakin, 1994). Recent code revisions merely admonish psychologists to clarify their role with couples or family members (APA, 1992; Lakin, 1994) and inform clients of the limits to confidentiality in multiperson (group, marital, family or organisational) interventions (SAMDC, 1992).

Vignette four depicted a common dilemma in marital therapy, namely, whether to safeguard the confidences of all members or to rule that no confidences will be kept. An appreciable percentage (45%) of psychologists indicated that they would agree to keep the confidences of one spouse whereas another large proportion (55%) of psychologists indicated that they would refuse to do so. Haas et al. (1986) found that 65% of psychologists agreed to keep the secret as opposed to 30% who indicated that they would not.

The results suggest that many psychologists would elect to treat the spouse's confidences as though they were an individual client. On the other hand, the remaining psychologists may be mindful that respecting confidences in this way is likely to encourage the formation of an alliance which would be damaging to the overall effectiveness of therapy (Margolin, 1982). Current regulations implicity recognize that family relationships may cause complications for the therapist. Psychologists are, however, essentially required to translate generic ethical concepts (reflecting a dyadic therapy model) to multiperson contexts without guidance from ethical regulations (Lakin, 1994). The diversity of responses to this vignette adequately emphasises the wide variation in interpretation to which such a translation is subject. The limits of confidentiality essentially become a matter of professional discretion (Margolin, 1982). Psychologists may well benefit from speciality guidelines regulating practice with minor clients.

Competence

In the delivery of services to clients, a primary obligation of any professional is to function competently (Canter et al., 1994). The overarching goals of restricting one's practice to areas of competence is to ensure that clients directly benefit from their contact with psychologists and are at the very least protected from harm.

Despite the fundamental nature of this standard, however, psychologists responded to the competence vignette (vignette six) in a variety of ways. Only 6 % of psychologists indicated that they would accept a prospective client for sex therapy despite their lack of competence in this area. Thirty-nine percent of psychologists indicated that they would accept the client only after informing that client of their qualifications. Fifty-six percent of respondents indicated that they

would refuse to accept the client. Haas et al. (1986) similarly found that this dilemma elicited varying responses in that 45% indicated that they would accept the client after discussing their qualifications whereas 49% indicated that they would refuse to accept the client.

These results indicate that an appreciable percentage (45%) of psychologists are willing to provide services beyond their demonstrated areas of expertise. Psychologists are directed to maintain knowledge of current professional information as a part of demonstrating competence (APA, 1992; SAMDC, 1992; Steere & Wassenaar, 1985). An understanding of the general principles of sex therapy is unlikely to correspond to this guideline. Ethical guidelines direct that the onus is on psychologists to recognise the boundaries of their particular competencies (APA, 1991; SAMDC, 1992). Agreeing to accept the client after discussing their qualifications with them essentially legitimises client determination of competence which is contrary to ethical guidelines. The ability of any client to accurately determine the competence of a therapist can be seriously questioned (Haas et al., 1988).

6.2.2 Summary

A central finding of this study was a high degree of variability among professionals in their preferred resolutions to numerous ethical dilemmas. These results are highly similar to Haas et al (1986) and Chevalier and Lyon (1993). These results suggest that the broad spectrum of actions typically favoured in such situations is considerably reduced in dilemmas relating to dangerousness, child abuse and dual relationships. These results support conclusions drawn from previous research that consensus in professional decision making is facilitated for issues that are high profile (Chevalier & Lyon, 1993; Haas et al., 1988; Gawthrop & Uhlemann, 1992); and are additionally regulated by clear legal mandates (Chevalier & Lyon, 1993; Tymchuk et al., 1982) or clear ethical standards (Tymchuk et al., 1982).

Diverse responses were elicited for dilemmas relating to the appropriate limits of confidentiality in child and marital therapy, and third party access to confidential information. The issue of competence (theirs and others) also elicited divergent responses from psychologists. Lastly psychologists' responses to advertising practices were diverse.

These results indicate that several areas of professional decision making are ambiguous for psychologists. Such ethical issues may deserve added professional scrutiny and consideration (Haas et al., 1986) in the form of intensified ethics instruction at pre-professional and ongoing levels.

A number of dilemmas eliciting diverse responses from psychologists appeared to be regulated by flexible and imprecise guidelines, subject to wide interpretation (such as confidentiality with regard to minors and marital therapy), or conflicting guidelines (such as advertising practices). These results tend, therefore, to confirm previous results suggesting that variability in decision making is indicative of attempts to address complex ethical issues in the absence of clear guidelines (Chevalier & Lyon, 1993; Haas et al., 1986; 1988; Tymchuk et al., 1982). The relationship between consistency of professional decision making and the clarity of guidelines raises practical implications for the content and style of ethical regulations. Intuitive appraisal, however, that "professional codes of ethics should become more specific or that attempts should be made to address more issues in legal terms" does not necessarily follow (Chevalier & Lyon, 1993, p. 353). The limitations of increased specificity of ethical regulations are considered to be appreciable (Lindsay, 1996; Seitz & O'Neill, 1996). Critics of rule specificity argue that it is not to be confused with code clarity or utility. The practical implications of these results for the ethical regulations are discussed in a later section.

6.3 Reasons for choices

On the whole, psychologists cited a variety of reasons to support their decisions. The results indicate that ethical dilemmas not only elicit variable behavioural responses but diverse justifications (see Table 3). These findings are highly similar to those of Haas et al. (1986) and Chevalier and Lyon (1993) and support previous results suggesting that professional behaviour is frequently grounded in a wide array of considerations (Smith et al., 1991).

Psychologists were able to reach moderate consensus for only one vignette. The highest rate of consistency for cited reasons occurred for vignette seven (a client threatens harm to a third party). Almost two-thirds (61.6%) of psychologists indicated that their decision in this case was based

on a desire to protect society's interests. Overall, psychologists appeared to favour protection of client rights above other considerations as this was the most frequently cited reason for decisions.

Chevalier and Lyon (1993) similarly found that psychologists selected this rational most frequently for all presented vignettes barring one. While this appears to be a powerful rationale for psychologists, for the remaining vignettes, psychologists favoured different reasons, suggesting that professional reasoning is far from "monolithic" (Haas et al., 1988, p. 39). It would appear, however, that numerous psychologists are concerned to protect client rights to deliberate and act freely, recognizable as the principle of autonomy (Kitchener, 1992).

Psychologists often justified quite diverse action choices in terms of the same rationale. These results are highly similar to those of Haas et al. (1988) and Chevalier and Lyon (1993). They support Blasi's (1980) contention that generally moral reasoning is non-equivalent insofar as moral agents may justify dissimilar actions in terms of the same rationale and justify the same ethical action in terms of disparate ethical reasons.

6.4 Reasons and actions

This study undertook to investigate whether psychologists would justify their action choices on the grounds of adherence to a formalised code or mandate - codified reasons - or because it was part of their own "value structure" - noncodified reasons (Haas et al., 1988, p. 36). Analysis of the distribution of action choices across reasons (categorised into codified and noncodified reasons) revealed a significant association between choices and reasons for the majority of vignettes.

In vignette one (the decision whether or not to refer a client to a psychologist whose ability is not trusted on a superior's orders), psychologists who indicated they would refuse to refer the patient tended to do so for noncodified reasons. Respondents apparently based their refusal on considerations such as protecting the client's rights (to effective services), and safeguarding the therapy process. Psychologists who indicated they would refer the patient to an incompetent

psychologist tended to do so for codified reasons. It is possible that psychologists who selected this course of action were invoking their obligations as organisational employee to justify this behaviour.

For vignette two (a present client is angry at a previous therapist for making sexual advances) respondents who indicated they would discuss the patient's anger tended to do so for codified reasons. These psychologists may have based their considerations on ethical responsibilities to benefit their client by processing residual harmful effects of previous sexual contact. Ethical regulations further direct that client preferences for confidentiality take precedence over addressing the unethical behaviour of one's colleagues (Steere & Wassenaar, 1985).

Psychologists who indicated they would call and confront the offending psychologist directly were likely to do so for non-codified reasons. Similarly, those who reported they would call the ethics committee or professional board directly tended to do so for non-codified reasons. Psychologists who indicated they would circumvent ethical obligations to respect client autonomy based their actions on non-codified reasons.

In vignette three (a psychologist uses his qualifications to endorse a health spa) psychologists who indicated that they would do nothing tended to do so for codified reasons. It is likely that psychologists justified their inaction on the grounds of relaxed ethical regulations regarding endorsements (APA, 1992; SAMDC, 1992). Respondents who indicated they would call the psychologist directly or the ethics committee directly to complain about their colleagues behaviour tended to do so for noncodified reasons. It appears that psychologists who elected these courses of action considered their colleague's behaviour, if not illegal or unethical per se, at odds with personal or professional standards.

For vignette four (the decision of whether or not to keep a secret in marital therapy) psychologists who indicated that they would not keep the spouse's secret were likely to do so for codified reasons. It is possible that these psychologists considered the potential for unequal alliance-building as inconsistent with an ethical obligation to benefit the client system in marital therapy. Respondents who indicated that they would agree to keep the secret tended to do so for

noncodified reasons. This may be related to the fact that the psychologist in this particular vignette had failed to clarify a position on confidentiality prior to the spouse's disclosure. Psychologists who selected this course of action may, therefore, have justified this response on grounds of protecting the client's rights or upholding personal standards.

In vignette five (a mother requests that the psychologist treating her son reveal the son's confidences) respondents who indicated they would breach confidentiality tended to do so for codified reasons. It is likely that these respondents justified their behaviour in terms of ethical guidelines directing that confidential information be discussed only with those clearly concerned with the case and for the professional purposes of securing the client's best interests (Steere & Wassenaar, 1985). They may well have determined that to disclose confidences to the mother fulfilled both of these requirements. Psychologists who indicated that they would not tell the mother her son's confidences were likely to do so for non-codified reasons. Psychologists who selected this course of action indicated a tendency to do for reasons of protecting the client's rights or safeguarding the therapy process. As such they appear to subscribe to traditional justifications for maintaining confidentiality with adult clients.

In vignette eight (a wife alleges to the psychologist that her husband - the psychologist's client - is sexually abusing his 12 year old daughter) respondents who indicated that they would report the sexual abuse directly to the child protection unit tended to do so for codified reasons. It is likely that while these psychologists are aware of legal obligations to report child abuse, they are perhaps unclear of the statutory wording requirements that require direct attendance in order for a duty to report to exist (Child Care Amendment Act 74, 1983 in Allan, 1997). They are perhaps unsure of the parties to whom such a report is owed.

Psychologists who indicated they would reflect the mother's concern were likely to do so for codified reasons. It is possible that these respondents justified non-interference on grounds of ethical obligations to their primary client. Psychologists who indicated that they would encourage the mother to report the abuse were likely to do so for non-codified reasons. These respondents justified their actions on grounds of serving society's interests and safeguarding the therapy relationship with the client.

In vignette ten (the dilemma of whether to inform a client of the risks inherent in a particular diagnosis to which insurance companies have access) psychologists who indicated that they would not inform the client of the risks but would diagnose him as indicated tend to do so for codified reasons. It is possible that such psychologists justified the benefits of hospitalization on the grounds of ethical obligations to secure the best treatment for their client.

The finding that certain choices are systematically associated with particular reasons is consistent with previous research (Haas et al., 1988). Haas et al. (1988) found, however, a consistent relationship between taking direct action in the face of an ethical dilemma and doing so for reasons of upholding the law or ethics code. No such association was found in this research. Psychologists indicated that they would confront a (sexually) offending psychologist directly for codified reasons (vignette two) and would report child abuse directly for codified reasons (vignette eight). They were, however, equally likely to discuss the patient's anger for codified reasons (vignette two) and reflect the mother's concern (vignette eight) for codified reasons. They were also likely to justify direct action on noncodified grounds, such as calling the ethics committee for noncodified reasons (vignette two). The results of this study do not sustain the contention that there is an automatic relationship between direct action and codified reasons.

This is perhaps explained by the observation that the categorisation of reasons into codified and noncodified categories is conceptually indistinct. The protection of client rights is an explicit concern of most ethical regulations. Indeed, an ethics code may be seen to specify the rights of clients and the reciprocal responsibilities of psychologists (Hare-Mustin et al., 1979). Most ethical regulations also make explicit provision for responsibilities towards society. Furthermore, such responsibilities form the primary impetus behind societal laws governing shared living. Safeguarding the therapy process is not only a clinical or therapeutic concern but an ethical one as well and catered for by many ethical standards such as confidentiality and informed consent.

The so called non-codified considerations utilised in this study, and the original, are not clearly expressions of the personal "value structure" of psychologists (Haas et al., 1988, p. 36). Nor are they clearly conceptually distinct from the values encoded in formalised legal or ethical codes. These limitations should be taken into account in interpreting these results and in future

investigations of the reasoning underlying important areas of professional decision making. Despite these difficulties, this study attempted to explore and describe the reasoning underlying major areas of professional decision making.

6.5 Demographics and actions

Theorists have posited that ethical decisions may be consistently linked to individual characteristics of decision makers (Hall, 1985; Gilligan, 1982; Keith-Spiegel & Koocher, 1985; Rest, 1984; Tymchuk et al., 1982). On the whole, the results of this study did not show that psychologist attributes are systematically associated with differential responding to dilemmas. Only in response to certain vignettes were significant results found. These results and their limitations are discussed more fully below.

Gender

On vignette nine, more men than women indicated that they would accept the client's offer to prepare the psychologist's tax return in partial repayment for therapy. Females were predominantly more likely to refuse to trade therapy for accounting services. This result is consistent with the results from the original study undertaken by Haas et al. (1988).

This finding may be explained by gender theories of moral development that posit that when faced with a moral dilemma females have a tendency to focus on relational issues (Gilligan, 1982). It is possible that female psychologists may be more sensitive to the impact of the bartering arrangement on the relationship with the client (Kimmel, 1991), specifically the potential for future conflict and distortion of the primary professional relationship (APA, 1992; Congress, 1992). Female psychologists may tend to be more attuned to the potential for feelings of exploitation on the client's behalf (in the event that inaccurate value is ascribed to their work) and the psychologists behalf (in the event of the client's unsatisfactory performance of the agreed-on service).

It has been noted that the tendency of females to assume a care perspective when faced with

moral dilemmas (Gilligan, 1982) inheres a sensitivity towards, and a commitment to take into account the needs of all major participants (Dugan, 1987). As dual relationships are most often tailored around the needs of therapist (Borys & Pope, 1989) it is possible that female psychologists may be more sensitive to their needs in this situation than male psychologists.

On the whole, however, only one vignette in the present study showed an effect attributable to gender of respondent. Haas et al., (1988) similarly found only two effects attributable to gender of respondent. These results appear to indicate, therefore, that generally male and female psychologists may not be very different from each other in the choices they make in response to ethical dilemmas. Caution should be exercised, however, in interpreting these results. It is conceivable that the manner in which respondents were requested to select their responses from a forced choice format may have obscured differences in the options male and female psychologists would naturally select in their resolution of ethical dilemmas (Haas et al., 1988).

Theoretical orientation

For vignette six respondents who identified themselves as analytic tended to refuse to accept the client for therapy whereas psychologists who identified themselves as cognitive tended to accept the client for therapy. It is possible that the principles of sex therapy correspond most closely to cognitive therapy ensuring that these psychologists are most likely to accept this client with only a basic understanding of the general principles of sex therapy. The reverse may be true of analytic psychologists.

Psychologists who identified multiple categories instead of one primary orientation were least likely to accept the client for therapy after discussing their qualifications. It is possible that such psychologists subscribe to a broad working understanding of several orientations. The limitations of their qualifications may be accentuated in the discussion of specialised theory, procedure and technique that forms part of informed consent information.

For nine of the ten vignettes psychologists with different theoretical orientations did not differ significantly in the alternatives they selected. Haas et al. (1988) found no relationship between

orientation and choice of alternative. These results suggest that psychologists of similar theoretical orientations do not generally agree with each other regarding preferred resolutions to dilemmas more than psychologists of other orientations. It is possible, once again, that the forced choice format for identifying theoretical orientation and for selecting alternative actions may have prevented subtle differences between clinicians from different theoretical orientations from emerging (Haas et al., 1988).

Years of experience

No relationship was found between the respondents' years of experience and their preferred alternatives for any of the vignettes. This is in contrast to the results of the original research where the relationship between years of experience and preferred alternatives was significant for three of the vignettes (Haas et al., 1988). Haas et al. (1988) found that psychologists with greater experience were less likely to deal actively with issues. The differences in the mean years of experience of psychologists with "greater experience" in Haas et al.'s (1988) sample and that of the present study did not exceed four years.

Haas et al. (1988) found that respondents with the most experience were the most likely to report they would do nothing for vignette three (in response to a colleague endorsing a health spa). They tended to report that they would discuss the client's threat further in vignette seven (a client threatens to kill his girlfriend) and to reflect the mother's feelings in vignette eight (a mother alleges that psychologist's client is sexually abusing his step-daughter). Haas et al. (1988) maintained that less experienced psychologists' choices may have reflected the manner in which recent years have clearly defined therapist's duties to actively intervene. Furthermore, they tended to interpret this finding as evidence of a cynicism that accrues to experienced psychologists with regard to their ability to alter circumstances. In line with this reasoning, the results from this study are encouraging in that the entire sample of South African psychologists indicated a tendency to be active about ethical issues.

Work setting

Certain of the vignettes presented concerns of private, public and other specialised settings. No relationship, however, was found between psychologists' work setting and choice of alternative. These results replicated those of the original authors (Haas et al., 1988). These results tend to suggest that situational pressures unique to special settings (Patterson, 1971) are overridden by subscription to a common professional ethic. The fact that psychologists are trained in a common body of knowledge, and exposed to similar ethical regulations may counteract pressures to apply specialty ethics tailored to meet demands of a clinical setting (Haas et al., 1988).

6.6 Demographics and reasons

Theorists have suggested that clinician characteristics might significantly determine criteria central to decision making (Keith-Spiegel & Koocher, 1985). This study found that, on the whole, identifiable background characteristics were not systematically associated with the reasons cited by psychologists's to support their actions. Only in response to certain vignettes were significant results found. These results and their limitations are discussed more fully below.

Gender

When reasons for actions were collapsed into codified considerations (those based on the law and the code of ethics) and noncodified considerations (such as upholding personal standards or protecting the client's rights), chi square tests on gender and reasons for choices revealed a significant relationship for one vignette. For vignette six (the decision whether or not to accept a client for sex therapy despite a lack of competence in this area), female psychologists tended to base their choices on noncodified considerations. Male psychologists, on the other hand, were more likely to base their choices on codified reasons.

Gender theory of moral development offers a useful framework for interpreting these results. Such theory posits that in the face of a moral dilemma males tend to focus on issues of autonomy, fairness and law - the so called justice perspective (Imre, 1984 in O'Neill, 1991). The proclivity

of male psychologists to justify their actions in terms of legal and ethical considerations may reflect this perspective insofar as it reveals a tendency to "judge by the letter of the law, to discern right from wrong and to let the chips fall where they may" (Kennel & Agresti, 1995, p. 614). It is possible that female psychologists are more attuned to the relational impact of their lack of competence in terms of the possibility for harm in this situation than male psychologists. As such, they may be inclined to justify their actions on such grounds as safeguarding the therapy relationship. The limitations of the codified and noncodified categories discussed in section 7.3 should be borne in mind in interpreting these results.

Theoretical orientation

Chi square tests exploring the relationship between orientation and reasons for choice for each vignette yielded a significant result when reasons for choices were collapsed into codified and noncodified categories. On vignette seven (a client threatens harm to an identifiable third party) psychologists who identified their primary orientation as systemic or interpersonal tended to base their actions on codified considerations (based on upholding the law or the code of ethics), as opposed to noncodified considerations (such as upholding personal standards or safeguarding the therapy process).

This author will speculate that psychologists from a systemic orientation may see their role and responsibilities in a manner consistent with what the law requires in instances of foreseeable harm to third parties. The law legitimises active intervention, and assumes individuals have responsibilities to others in broader society. As systemic psychologists view the relational context as critical to pathology and health, and are typically active and directive, it is likely that legal and ethical regulations urging active intervention are congruent with how systemic psychologists view their role.

For nine of the ten vignettes, psychologists of different theoretical orientations did not differ in the considerations on which they based their choices consistent with prior research (Chevalier & Lyon, 1993). Once again, caution must be exercised regarding these findings in that subjects were given a forced choice format for indicating their theoretical orientation and choice of

consideration which may have prevented differences in reasoning from emerging.

Years of experience

With regard to years of experience, three of the vignettes showed a relationship between years of experience and reasons for choices. For vignette two (a client alleges sexual advances by previous therapist), vignette three (a psychologist uses his credentials to endorse a health spa) and vignette seven (a client threatens violence to his girlfriend) therapists with more experience tended to base their action choices on noncodified reasons in contrast with psychologists with less experience who tended to base their action choices on codified reasons.

Stoltenberg and Delworth (1987, in Neukrag et al., 1996) maintain that psychologists in training tend to move from simple memorization of ethical guidelines towards an integration of ethics with personal and professional values and identity. It is possible that psychologists with less experience may require the supportive structure that an ethical code or legal guidelines can provide (Neukrag et al., 1996). More experienced psychologists, on the other hand, may adhere less rigidly to codified guidelines as these come to serve as a tool in a decision making process that is markedly reflective and complex (ibid).

Work setting and reasons for choices

Chi square tests exploring the relationship between work setting and reasons for choices (categorised into codified and non-codified categories) yielded a significant relationship for one vignette. For vignette five (the issue of keeping the confidences of a child client in the face of requests for information from the client's mother), psychologists who identified multiple work settings as opposed to one setting tended to base their choices on codified as opposed to noncodified reasons. It is possible that the complex demands of multiple work settings encourage psychologists to ground their actions in ethical and legal guidelines.

6.6.1 Summary

With a few exceptions, this study did not show that psychologist demographics are systematically associated with ethical choices selected in the face of dilemmas or reasons provided for these choices. Limitations of the forced choice format for selection of choices, reasons and psychologist demographics have been discussed. It is furthermore possible that demographic variables are so broadly defined as to be little practical usefulness in teasing out differences in ethical judgement (Welfel & Lipsitz, 1984). It is possible that other background characteristics not specifically addressed in this study, such as a history of facing a formal ethics complaint, may have revealed a significant relationship with particular choices and reasons. Furthermore, due to missing and spoiled answers, the relationship of ethics instruction to choices and reasons is unclear.

Furthermore, it is possible that, as certain vignettes presented in this study carried strong legally charged connotations or certain treatment knowledge components, the very content of the cases may have obscured differences in the decision making process related to clinician demographics (Cottone et al., 1994). Despite these limitations, the results of this study suggest that demographic variables may contribute less to the diversity of psychologists' responses (Welfel & Lipsitz, 1984) than other considerations, namely, the nature of ethical dilemmas and ethical guidelines. This will be discussed in a later section.

6.7 Frequency and seriousness ratings

Subjects were asked to indicate the frequency with which certain ethical issues had presented difficulties for them during the past year. On the whole, psychologists did not report encountering problems with these ethical issues often in practice. Whether these results represent a true absence of difficulties or merely a lack of sensitivity to the ethical dimensions of practice is unclear. Overall, these results are consistent with those of Haas et al. (1986).

Confidentiality was the most frequently encountered ethical concern, however, psychologists indicated that this issue presented difficulties only occasionally. Haas et al. (1988) similarly

found that their respondents rated confidentiality as only *occasionally of concern*, yet more so than any other issue. Psychologists in this study reported that concerns (in ranked order) of conflicting interests, the rights of minors, informed consent, collegial conduct, competence, testing, and employee/supervisee conduct presented problems for them only rarely. Insurance company requests, advertising issues, malpractice liability, involuntary commitment and their own sexual impulses or conduct were rated as posing difficulties even less frequently.

An examination of the rankings of frequency ratings from both studies indicated that the same issues (with a few exceptions) were ranked in a similar order by both sets of clinical psychologists. This suggests that despite differences in context, clinical psychologists' encounters with certain ethical issues are not dissimilar.

Respondents in this study rated confidentiality as the most serious of presented ethical concerns. However, mean ratings indicated that this issue is perceived as only *somewhat serious*. A comparison with Haas et al's. (1988) study indicated that collegial sexual conduct was rated as the most serious of ethical concerns, followed closely by confidentiality. Issues that were further reported to be *somewhat serious* involved (in ranked order) collegial sexual conduct, rights' of minors, collegial conduct, conflicting interests, and informed consent. The remaining issues were rated as only *slightly serious*, with media presentations and advertising rated as the least serious of issues.

A comparison of the order in which these ethical issues were ranked reveals few differences between the two samples. On the whole, however, Haas et al.'s (1986) results reveal a tendency for their respondents to rate ethical issues as more serious than respondents from this study (only two issues were rated as slightly serious). This may point to a heightened professional awareness of the salience of ethical issues among American psychologists attributable to pre-professional ethics instruction that is possibly more comprehensive in scope than that enjoyed by South African trainees.

A comparison of psychologists' perceptions of the seriousness of ethical issues with responses to certain of the vignettes revealed that while psychologists perceive certain areas of professional

decision making as serious, they endorse widely divergent responses in the face of such issues. These results appear similar to those of Haas et al. (1988). This suggests that the issues psychologists perceive as warranting concern, such as confidentiality, rights of minors and conflicting interests, are correspondingly the very areas for which they are unable to reach consensus and may be struggling in the face of unclear guidelines.

6.8 Additional analyses

Frequency of encountering ethical concerns

For certain vignettes, psychologists grouped according to the action alternatives they selected in the face of dilemmas were significantly different from each other on measures of the frequency with which they reported encountering certain ethical issues. Psychologists who elected to directly contact the offending psychologist in vignette two (client allegations of sexual contact with previous therapist) had a higher frequency of encountering sexual conduct concerns than psychologists who selected other alternatives.

Results discussed in section 6.7 indicated that collegial actions (sexual and other) were generally reported to be only of occasional concern and only somewhat serious. Personal sexual impulses and conduct were rated as infrequent and only slightly serious. These results suggest, however, that such experiences for certain psychologists are related to direct confrontation of colleagues. Ethical regulations maintain that client rights to confidentiality supersede responsibilities to monitor peers and urge that psychologists manage such issues sensitively. It is possible that psychologists are struggling to manage issues of sexual impulses and conduct (personal and collegial) and may benefit from increased attention to these issues in professional training (Pope, Keith-Spiegel & Tabachnick, 1986).

Psychologists who elected to accept the client for therapy on vignette six (client request for sex therapy despite the therapist's lack of expertise in this area) reported a higher frequency of encountering concerns of generating referrals than those psychologists who selected any other alternative. As discussed (section 6.7) psychologists reported that issues of advertising and

generating referrals presented problems infrequently and rated this as the least serious of ethical concerns. Despite psychologists' perceptions, however, these results suggest that the need to attract referrals acts as a powerful rationale in the professional decision making of certain psychologists, effectively overriding ethical considerations (Rest, 1984; Smith et al., 1991).

Psychologists who indicated that they would not accept the client's offer for vignette nine (a client offers to prepare tax returns in payment for therapy) reported encountering concerns of competence and legal liability more frequently than those who indicated that they would not accept the client's offer. It would appear that frequent encounters with these concerns may serve to steer certain psychologists in the direction of more conservative alternatives in troubling ethical situations.

Contrary to previous research (Chevalier & Lyon, 1993) the results of this study suggest that in some cases psychologists' preferred resolutions to ethical dilemmas are affected by variables such as the frequency of certain ethical encounters. While results of this study revealed no differences in action alternatives for years of experience *per se*, these results indicate that certain specific experiences may have an effect on the action choices psychologists select in the face of ethical dilemmas.

Seriousness of ethical concerns

For certain vignettes, psychologists grouped according to the action alternatives they selected in the face of dilemmas were significantly different from each other on measures of the seriousness with which they regarded certain ethical issues. Psychologists who indicated that they would not agree to keep the secret for vignette four (the decision whether to keep a spouse's confidence in marital therapy) perceived issues of client rights in informed consent and confidentiality as more serious than those who indicated that they would keep the secret. It is possible that psychologists who hold strong judgements about the saliency of rights extend these to the entire client system and not to individuals alone.

For the same vignette psychologists who selected to refuse to keep the secret perceived concerns

of generating referrals as more serious than psychologists who indicated that they would agree to keep the secret. These results support previous contentions that ostensibly ethical actions may be grounded in rationales that are purely pragmatic in origin (Smith et al., 1991). Contrary to previous research (Chevalier & Lyon, 1993) these results provide some support for the fact that psychologists' perceptions of the seriousness of certain ethical issues are related to the choices they make in the face of ethical dilemmas.

6.9 Critical Incident results

Direct solicitation of the situations psychologists identify as ethically troubling has been identified as a rich resource in the ongoing attempt to bolster the relevance and applicability of an ethics code to the population it serves (Pope & Vetter, 1992) and facilitate congruence between guidelines and the experiential realities of practice (Lindsay & Colley, 1995). This section aims to discuss the ethical dilemmas volunteered by respondents in the present study. Ethical dilemmas have been categorised according to content areas (see Table 17). Trends within each category of ethical dilemma are identified and discussed in the context of current ethical regulations (Steere & Wassenaar, 1985) and the most recent provisional draft code of conduct (SAMDC, 1992) and relevant theoretical literature.

Confidentiality

Dilemmas concerning confidentiality comprised 29% of those volunteered by survey respondents, making this the largest category of troubling incidents. This is consistent with prior research showing that confidentiality concerns comprise the largest category of troubling incidents for APA members (Pope & Vetter, 1992); BPS members (Lindsay & Colley, 1995); Swedish psychologists (Colnerud, 1997) and Canadian psychologists (Sinclair & Pettifor, 1997). Of these 14 dilemmas, the largest cluster (5) involved legal obligations to release client records through a subpoena or court order. Psychologists were aware of procedural guidelines regulating the manner in which such information should be released (SAMDC, 1992; Steere & Wassenaar, 1985). They appeared, however, distressed at the challenge to their ethical obligations to maintain client confidentiality. Furthermore, respondents appeared unaware of available

strategies for responding to requests to release information in the legal context (APA, 1996).

The next most substantial issue concerned confidentiality with minor clients (4). These dilemmas described attempts to establish confidentiality in the face of requests for information from school teachers, social workers and parents. Clearly these psychologists were attempting to use ethical guidelines - the child's best interests and identification of those who are clearly concerned with the case (Steere & Wassenaar, 1985) - as the yardstick for the degree of parental (or other) involvement in treatment. They appeared aware, however, that the definition of such terms was largely a matter of individual discretion or clinical judgement.

The remaining vignettes in this cluster involved balancing client confidentiality with legally mandated responsibilities to report child abuse (Child Care Act 74, 1983 in Allan, 1997). While respondents were aware of this duty, they felt constrained by inadequate knowledge of risk to the child and the deleterious effects of reporting on the therapeutic relationship. The individual determination of harm to others encapsulated in ethical regulations (Steere & Wassenaar, 1985; SAMDC, 1992) and relatively narrow reporting requirements (requiring direct attendance and interaction with the child) may have contributed to the under-reporting of abuse (Brosig & Kalichman, 1992) described in these dilemmas.

Two vignettes involved ethical or legal responsibilities in the event of a client threatening harm to others and volunteering information about illegal activities. In the former case the respondent was aware of her duty to breach confidentiality in circumstances of clear danger to others (Steere & Wassenaar, 1985) and to protect others from harm (SAMDC, 1992) yet seemed unable to use this guideline to determine the extent of the patient's risk or whether this situation constituted grounds for a breach of confidentiality. The remaining ethical dilemmas involved deliberate violations of confidentiality and the issue of confidentiality in marital therapy. In the latter case the psychologist was aware of the need to clarify limits to confidentiality early in therapy (Steere & Wassenaar, 1985) yet was cognizant that the actual limits to confidentiality were at her personal discretion and in accordance with her clinical orientation.

In summary, the majority of dilemmas around confidentiality emerged at the interface of

conflicting legal and ethical responsibilities. Nine out of fourteen dilemmas involved legally imposed constraints to confidentiality (compelled court testimony, mandatory reporting of child abuse and dangerousness). In most cases psychologists were aware of their duty to abridge confidentiality in the face of legal requirements. They were, however, often unsure how to determine the parameters of these situations or how to best fulfil these requirements with the least compromise of ethical responsibilities to their clients. While ethical regulations had clearly sensitised them to their responsibilities, respondents appeared to find existing guidelines inexact and difficult to apply to their specific situation.

Non-sexual dual relationships

The second most frequently described incidents involved non-sexual dual relationships. Pope and Vetter (1992) similarly reported that difficulties maintaining clear professional boundaries formed the second largest category for APA members. BPS members indicated, however, that this issue presents difficulties relatively infrequently and comprised only 3% of reported dilemmas (Lindsay & Colley, 1995).

The majority of dilemmas in this category centered around the conflicting expectations and obligations of dual professional roles. Respondents were concerned that ethical obligations (particularly confidentiality) to individual recipients of their psychological services were compromised by their role as organisational employee. Ethical guidelines had encouraged them to clarify the nature of the conflict between organisational demands and ethical responsibilities (Steere & Wassenaar, 1985). They appeared, however, to find that such guidelines offered inadequate assistance with the actual resolution of these dilemmas. This was reflected in the use of informal strategies, such as refusing to accept referrals in order to avoid anticipated breaches of confidentiality.

While such solutions reflect sincere attempts to resolve such dilemmas they inevitably raise new ethical questions (Johnson, 1995). The remaining dilemmas in this subcategory described the inherent role conflicts anticipated in dual forensic and therapeutic roles (APA, 1992; Greenberg & Shuman, 1997). The remaining dilemmas in this category were concerned with the blurring

of professional boundaries due to extra-professional contact, a prior non-professional relationship and possible boundary crossings (such as receiving gifts). Respondents described attempts to weigh up the ethical acceptability to act on requests for social contact from a former client or requests for therapeutic services from a family member.

While they seemed aware of the ethical vulnerability of these positions, psychologists appeared uncertain as to what criteria to use to decide the degree of possible harm to the client, former client or professional relationship. Ethical regulations that include a description of factors inherent in the professional role (such as specific role-responsibilities and role-expectations) that are likely to be compromised through another interaction may assist psychologists to assess the risk to consumer welfare posed by any dual relationship (Sonne, 1994; Greenberg & Shuman, 1997).

Payment issues

Twelve percent of the dilemmas reported dilemmas involving payment issues. Pope and Vetter (1992) reported that incidents involving payment methods and settings comprised the third largest category of dilemmas. Lindsay and Colley (1995) reported that these issues formed only 3% of dilemmas for BPS members. This is probably due to the lower number of private psychologists in the United Kingdom. The majority of dilemmas expressed concern at inadequate reimbursement for services from medical aid schemes, and requests from clients that amounted to an abuse of such schemes such as "putting through" family members on their medical aid. Other dilemmas described the detrimental effects of client failure to pay fees on the therapy relationship, and being accused of overcharging for services rendered.

Collegial conduct

Ten percent of the responses described dilemmas involving difficult relationships with colleagues, and problems in confronting colleagues engaging in unethical or unprofessional behaviour. These dilemmas comprised 4% and 7% of incidents described by APA and BPS members respectively. Such dilemmas described colleagues "stealing" clients, commenting on

the efficacy of their interventions or misrepresenting their training and registration category. Respondents also described generally "unprofessional behaviour" such as the subtle coercion of patients and doing "rush jobs". In the majority of these dilemmas the respondents appeared to have followed the course of action recommended in the ethical guidelines (Steere & Wassenaar, 1985). They had attempted to informally resolve the issues by contacting the psychologist, or had reported the behaviour to the Professional Board for Psychology.

In total 13 out of the 49 dilemmas (27%) comprised of situations where the (mis)conduct of colleagues was observed and described, or the reporter perceived him/herself to be in a dilemma due to the behaviour of colleagues. These dilemmas were accommodated in the primary categories of sexual issues, competence and questionable interventions. When accommodated in the Collegial Conduct category (see Table 18), these dilemmas comprised the second largest category of dilemmas reported by clinical psychologists in this study.

In the majority of these latter cases, respondents did not report attempts to resolve the issue through contacting the colleague or regulatory bodies. They appeared to have resorted to their own solutions (such as ceasing to refer clients to the other professional), reported feeling constrained by impotence to address the issue, or had somehow rationalised their own inaction (Keith-Spiegel & Koocher, 1985). These observations highlight that ethical regulations advocating responsible redress of collegial misconduct are best bolstered by attention to the non-ethical considerations (such as expediency) that compromise the ethical course of action.

Sexual Issues

Eight percent of the reported dilemmas involved concerns about sexual issues. All of the dilemmas in this category described sexual misconduct by colleagues. The majority (three out of five) of the scenarios involved a treating psychologist being informed by current clients of sexual relationships with their former therapists. Every respondent was aware of their ethical duty to address the issue, however, in most cases (four out of five) the matter was not taken further largely out of request for client preferences and client confidentiality in accordance with ethical guidelines. While the respondents generally accepted the obligation to respect the

autonomy of their clients as stronger than their duty to report collegial misconduct, they reported feeling dissatisfied with this resolution.

Other

Four percent of dilemmas involved concern about the safety and legitimacy of treatment approaches utilised by colleagues and referring psychologists (so called questionable interventions). Psychologists expressed concern that their colleagues were engaging in techniques that they considered harmful or "dangerous" such as "brainwashing" or "abreaction". Four percent of dilemmas involved the issue of moving beyond designated areas of expertise or competence. Reported dilemmas described the use by colleagues of interventions, treatment methods and assessment devices for which they were inadequately trained and had inadequate expertise. Four percent of the dilemmas reported concerns about ethics codes or committees such as the presence of unethical professional in such structures, or criticism of the verdict of cases processed by the Professional Board.

Two percent of dilemmas described concerns with the lack of formal ethics instruction during post-graduate education. Two percent of the dilemmas focused on medical issues such as observations by psychiatrists considered detrimental to the therapeutic process. Two percent of dilemmas described difficulties in conceptualising and securing adequate termination for clients. A number of dilemmas were not accommodated by any previous categories (miscellaneous) and described such difficulties as raising difficult subject matter in psychotherapy. Four percent of reported dilemmas involved informed consent issues such as failure to secure adequate informed consent for HIV testing, and difficulties with securing informed consent for research participation - particularly with disclosing costs (time, energy) and benefits (where direct benefits were obscure) as a part of consent information. Four percent of reported dilemmas involved concern with reporting practices such as adjusting test results or clinical recommendations in order to secure the best interests of one's client or in response to client demands.

6.9.1 Summary

Due to the low response rate yielding a particularly small sample, the results of this section of the study are best considered exploratory. However, several tentative conclusions can be drawn. Consistent with prior research confidentiality (Colnerud, 1997; Lindsay & Colley, 1995; Pope & Vetter, 1991; Sinclair & Pettifor, 1997) and dual relationships (Pope & Vetter, 1991) emerged as the most troubling of ethical issues in psychologists' daily practice. Sub-trends within these categories showed that confidentiality dilemmas emerged most frequently at the interface of ethical and legal demands (compelled court testimony, child abuse reporting and dangerousness). Dual relationship dilemmas indicated that reconciling ethical and institutional demands is frequently of concern to psychologists, consistent with previous research (Lindsay & Colley, 1995). Dilemmas surrounding the conduct of colleagues (competence, the use of questionable interventions, and sexual misconduct with clients) emerged as an important and frequent category of ethical dilemmas in this study.

Psychologists described dealing with a variety of complex problems using broad guidelines that required interpretation. Respondents were cognizant of a lack of "criteria for interpretation" that would allow them to accurately and consistently apply these guidelines to their unique situation (Vasquez, 1994, p. 99). More refined generic guidelines and speciality guidelines specifically addressing marital, child and forensic work appear needed.

6.10 Study limitations

Before major conclusions drawn from the present study are presented, study limitations will be discussed. Results of this study are limited by problems endemic to survey research including participant response rate. Due to the low rate of return and small sample size, caution should be exercised in generalising the study findings to the broader population of South African clinical psychologists.

As the reliability of the questionnaire was not established, the extent to which this instrument would yield similar results on another testing occassion is unknown. The extent to which the

results were influenced by fluctuating factors such as fatigue or mood is also unknown. The dependability of the results is, therefore, questionable.

In addition, clinicians who responded to the survey may have been biased in some systematic manner (Nicolai & Scott, 1994). Responses may represent those of clinicians with greater concern over ethical issues, thus biasing the results (Brosig & Kalichman, 1992). Furthermore, there is the possibility that participants gave responses biased in terms of social desirability even on an anonymous survey. It is possible that the automatic tendency for respondents to present a positive picture of themselves influenced their responses in the direction of selecting alternatives that corresponded most closely to ethical regulations. Such a 'set' may have influenced the results so that they reflect more ethical choices and reasoning than psychologists would display in everyday practice. The manner in which questionnaire design may have further distorted responses in the direction of social acceptability is discussed below.

Further limitations of this study centre around the questionnaire used to assess ethical decision making. As mentioned in section 4.1 the author was unable to establish the reliability of the questionnaire. Some initial care was, however, taken in the selection of the vignettes to simulate plausible problem situations and to ensure that they would be representative of dilemmas psychologists face in daily practice. As hypothetical vignettes only approximate an actual dilemma, however, it has been argued that they may not capture the complexity of multifaceted situations which clinical psychologists face (Nicolai & Scott, 1994).

An informal comparison of concerns from volunteered ethical dilemmas, ratings of the frequency and seriousness of related ethical issues and the hypothetical ethical dilemmas presented to psychologists, tends, however, to provide some support for the saliency of the hypothetical dilemmas. It is still possible, however, that some respondents could not relate to the problems presented, thereby lowering their relevancy (Chevalier & Lyon, 1993).

Further limitations of analogue studies are relevant here. These results represent psychologists reflecting on how they might behave as opposed to their actual behaviour in clinical situations. Whether or not decisions based on hypothetical cases reflect actual decisions psychologists would

make is not known (Brosig & Kalichman, 1992). The correspondence between what psychologists say they would do and what they actually do is known to be questionable (Bernard et al., 1987).

Furthermore, the concept of ethical decision making is arguably an abstract summary for an innumerable set of cognitive, affective and interpersonal attitudes and behaviours. For research purposes, any concept must provide adequate indicators (De Vaus, 1986). For the purposes of this research, ethical decision making was captured only in indicators defining behavioural choice and justifications. Such indicators may arguably exclude valid dimensions of this complex process.

Furthermore, the manner in which the questionnaire presented forced choices for selecting responses and justifications essentially limited more complex, multifaceted responding (Haas et al., 1986; 1988). Whether these results represent the courses of action psychologists would actually take when faced with such dilemmas or accurately represents their considerations is questionable. These forced choices were far from exhaustive and may have excluded responses and considerations psychologists consider crucial and utilise daily in response to, and as justification for their ethical decisions.

As the original authors note, however, it is precisely this forced choice format that injects a much needed degree of specificity into the complexity of ethical decision making by ascertaining which actions psychologists would initiate in concrete situations and for which reasons. Furthermore, it is precisely the specificity into which respondents are forced that allows an investigation of which issues elicit widespread agreement and which do not (Haas et al., 1986).

It can be argued, however, that the measures used in this research to assess ethical decision making may have benefitted from re-wording to improve their conceptual clarity. As discussed in section 6.4 reasons such as serving society's best interests and protecting the client's rights may not be relevant measures of the concept of noncodified justifications. Failure to ensure these measures were clearly relevant to the distinction between codified and noncodified responses limits the usefulness of the results.

As these dilemmas were constructed to reflect the manner in which dilemmatic situations lend themselves to numerous ethically acceptable responses, the forced choice action alternatives did not present psychologists with many opportunities to endorse definitively unethical choices. This format was arguably responsible for biasing responses in the direction of ethically acceptable responses. The use of the exact measures utilised in previous research, however, enabled direct comparison of results which facilitates the accumulation of a body of knowledge (De Vaus, 1986). Such advantages may counteract certain limitations of the questionnaire.

Results from this survey were used to identify areas of ethical decision making that present difficulties for psychologists (to be discussed more fully in the following section). Data from psychological committees that receive ethics complaints from consumers (such as the PSYSSA ethics committee or the Professional Board for Psychology) could be used to confirm whether these areas of professional difficulty correspond with consumer complaints. Such data would serve as a counterweight to data received exclusively from psychologists. Such work is currently in progress (Wassenaar & Slack, unpublished). Despite the above limitations, the results of this study provide information about the professional decision making of South African psychologists. The results provide practical implications for the content and style of current ethical regulations. These implications are the focus of the following section.

6.11 Implications for ethical regulations

It is conceivable that the general lack of consistency in psychologists' preferred resolutions to these dilemmas is an artefact of the nature of dilemmatic situations themselves (Kimmel, 1991). In spirit of dilemmas, respondents in this study were not faced with a search for an easily identifiable, single, correct response but instead were faced with numerous justifiable courses of action (Dove, 1995). The manner in which psychologists were able to reach high consensus on certain issues yet only low consensus on others does, however, suggest that other factors are contributing to this variability in decision making.

In accordance with explanations offered in previous research, this author speculates that these results may be partially accounted for by the specific limitations of ethical guidelines identified

in the literature. Two notable attributes of regulations are relevant here. Firstly the manner in which they are often broadly stated, flexible and imprecise. Secondly, the manner in which ethical regulations often fail to give concrete guidance in the resolution of dilemmas.

It is to the former issue that attention now shifts. Numerous commentators agree that ethical regulations most often represent broad guidelines for conduct designed to accommodate consideration of variables specific to the psychologist's situation. All appear to agree that as decision - makers are called upon to interpret these guidelines and apply them to their situation (Smith et al., 1991) the potential for idiosyncratic interpretation is high.

In line with this reasoning, it is this author's speculation that individual interpretation of broad guidelines contributed to the variable decision making observed in these results. Furthermore, ethical dilemmas detailed by respondents contained numerous references to the difficulties they experienced in interpreting guidelines in such a way that they could be confident that their behavioural choices reflected the spirit of these regulations. Psychologists appeared cognizant of a lack of criteria (Vasquez, 1996) against which to measure their actions to ensure they were faithfully fulfilling the dictates of these guidelines.

The debate essentially seems to become one of how to retain the flexibility of guidelines while reducing their ambiguity and the concomitant manner in which they are misinterpreted and misapplied. Efforts to reduce the wide variation in interpretation of guidelines appear in some cases to have taken the form of increasing the specificity of ethical regulations. In line with this reasoning, regulations take the form of provision of increasingly comprehensive lists of exemplars demonstrating the application of the valued generic principle to numerous practical situations (Lindsay, 1996).

For example, the current APA code (APA, 1992) runs to fifteen pages comprising of Contents, Introduction, Preamble, six General Principles and 102 Ethical standards. In the ethical standards, specific behaviours are delineated in some detail. Such exemplars are held to assist psychologists to understand the interpretation of a particular clause and to assist them to identify the range of applications of a particular element (Lindsay, 1996).

It stands to reason that the provision of certain specific exemplars are essential for psychologists and form critical content in generic guidelines, as well as specialty guidelines regulating the provision of services in unique settings, with certain populations and in special modalities. Results from this study indicate that ethical regulations specifically addressing psychological services with minors, and multiple persons (family and marital) are needed.

It is arguable that an approach embracing increased specifity will assist psychologists to formulate a course of conduct only insofar as the exemplars closely correspond to the psychologist's situation. This result is a document that is not easily generalizable to situations other than those explicitly outlined (Seitz & O'Neill, 1996). Most fundamentally, it can be argued that such a document fails to address the central issue: that of assisting psychologists to understand and apply valued ethical principles accurately to their situation.

It has been argued that if a code of ethics undertakes to make the reasoning underpinning ethical principles explicit, psychologists who are faced with a unique situation not specifically addressed in ethical regulations will be able to apply the reasoning behind valued ethical principles to the presenting situation in a consistent manner (Pettifor, 1989; Seitz & O'Neill, 1996). This conceptual approach is the one specifically embraced by the Canadian Psychological Association's code of ethics (CPA, 1991). As the reasoning underlying statements made in the code is delineated, statements become those upon which professionals can base decisions (Seitz & O'Neill, 1996). This conceptual approach to regulations may provide the interpretive criteria psychologists appeared to be calling for in their efforts to extrapolate from imprecise guidelines to specific situations (Vasquez, 1994).

A code of ethics structured along these lines has intuitive appeal and could be borne in mind by those charged with increasing the utility of ethical regulations. Furthermore, recent attempts to explore the relative efficacy of regulations in decision making have borne out the claims made for increased conceptual clarity and ease of application of such regulations (Pettifor, 1997).

Attention now turns to the functional utility of ethical regulations in the resolution of dilemmas. Such resolution inherently involves the prioritisation of competing claims, through recourse to

a system of justification. Psychologists in the present study were asked to participate at a point in the decision making process where selection from numerous alternatives was necessary.

Current ethical regulations (Steere & Wassenaar, 1985) endorse the resolution of dilemmas through a utilitarian system. This system recommends that the course of action ultimately selected should inhere the least overall harm and the most benefit for all individuals affected by the decision (Steere & Wassenaar, 1985). The ability of any system of justification to withstand the idiosyncratic interpretations of users and yield consistent results for different decision makers has been questioned (Jordan & Meara, 1990). It can be argued that the rationale for such a system is not to ensure that all psychologists resolve situations identically, but to provide a means of streamlining the decision making process in a way that is helpful for psychologists faced with a paralysing number of alternatives. To this end, some systems may be more helpful than others.

Commentators have argued that functional utility of an ethics code is considerably enhanced when ethical principles are explicitly ranked in order of the weight they are to be given in situations where they compete (Seitz & O'Neill, 1996). The CPA code of ethics (CPA, 1991) is specifically structured in this way. Psychologists are directed to favour the course of action most congruent with the most highly valued principle (Seitz & O'Neill, 1996). It has been argued that such a hierarchy cannot unfalteringly yield good decisions (Bersoff, 1995).

Psychologists may, however, benefit from a code that provides clear direction as to how to reconcile competing alternatives by encouraging selection of a course of action "loading" strongly onto the principle to be given precedence (Seitz & O'Neill, 1996). Such direction arguably still accommodates individual discretion and creativity insofar as two alternative courses of action may be constructed that would serve the primary principle equally well. Once again, recent attempts to explore the utility of regulations in resolving dilemmas have borne out claims made for this conceptual approach (Pettifor, 1997).

6.12 Future research

More research is needed about the types of decisions psychologists make when confronted with

a variety of ethical dilemmas. As the range of dilemmas confronting psychologists are likely to change and expand, future research might sample a wider range of ethical situations. Future research might also investigate the ethical decision making practices of psychologists registered in categories other than clinical psychology.

Future research could further explore the specific reasoning processes underlying important areas of ethical decision making. Research that allows psychologists to justify choices in terms of a broader range of reasons may well reveal potent considerations that were not accommodated in this study. The relationship between reasoning and actions also deserves additional study. Research utilising reasoning categories clearly reflecting personal as opposed to ethical/legal categories might illuminate more clearly the relevance of certain reasons in arriving at particular choices (Haas et al., 1988).

More information is needed to determine the scope and content of ethics instruction psychologists are receiving, as well as psychologists' perceptions of the efficacy of such instruction. Research exploring the relative impact of ethics education on the choices and reasoning of psychologists faced with ethical dilemmas would be valuable.

No attempt was made to assess which code of ethics psychologists were consulting as their primary ethical text in this study. Future research could assess psychologists' judgements of the efficacy of regulations in resolving ethical dilemmas. Research that investigates the relative impact of specific regulations on the choices and reasoning of respondents would also be of considerable value.

7 CONCLUSION

Despite methodological shortcomings, findings from the present study allow the following conclusions to be drawn. Psychologists endorsed a diverse number of action alternatives designed to resolve dilemmas, consistent with prior research (Chevalier & Lyon, 1993; Haas et al., 1986; Tymchuk et al., 1982). Psychologists tended to justify their action choices in the face of dilemmas in terms of a variety of rationales, which is consistent with prior research (Chevalier & Lyon, 1993; Haas et al., 1988).

Psychologists were able to agree on a consistent course of action in response to dilemmas representing client dangerousness, child sexual abuse and dual relationships. High levels of agreement appeared to be associated with ethical issues subject to much professional attention and regulated by legal guidelines, consistent with prior research (Chevalier & Lyon, 1993; Haas et al., 1986; 1988; Tymchuk et al., 1982). Psychologists reached lower levels of consensus on the most appropriate course of action for a range of ethical issues. They reached only moderate consensus for issues relating to conflicting loyalties, confidentiality and third party access and confidentiality with minor clients. Psychologist's responses were most diverse for dilemmas involving competence, advertising practices and confidentiality in marital therapy.

With a few exceptions, results of this study did not show that identifiable background characteristics of respondents were systematically linked with certain choices or reasons for choices. On the whole, psychologist characteristics did not account for much variability in responses to dilemmas. These findings are consistent with prior research (Chevalier & Lyon, 1993; Haas et al., 1986; 1988; Tymchuk et al., 1982).

Results from volunteered ethical dilemmas indicated that psychologists often have difficulty applying regulations to complex situations. Psychologists described that confidentiality issues presented dilemmas most frequently which reflects international trends (Colnerud, 1997; Lindsay & Colley, 1995; Pope & Vetter, 1991; Sinclair & Pettifor, 1997). Non-sexual dual relationships formed the next most frequently described category of personally encountered dilemmas. These results are consistent with prior research (Colnerud, 1997; Pope & Vetter, 1992). Collegial

misconduct (sexual misconduct, competence and questionable interventions) emerged strongly as an area of ethical challenge for South African psychologists.

It is speculated that findings of diverse responses to vignettes may be associated with unclear guidelines regulating these issues. Psychologists further reported struggling to apply inexact generic guidelines to personally encountered dilemmas. An argument is made for regulations that explicate the reasoning behind valued ethical principles in a way that provides code users with criteria for interpretation (Vasquez, 1996) enabling them to apply this reasoning to novel situations clearly, accurately and consistently (Seitz & O'Neill, 1996).

It is further argued that ethical regulations that direct psychologists as to how to weight competing principles dictating alternative courses of action may go some way towards streamlining the decision making process at little cost to individual creativity (Seitz & O'Neill, 1996). The value-linked structure of the Canadian Psychological Association's code of ethics (CPA, 1991) offers a useful model for revision.

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