

**ETHICAL ISSUES IN SOUTH AFRICAN PSYCHOLOGY: PUBLIC COMPLAINTS,  
PSYCHOLOGISTS' DILEMMAS AND TRAINING IN PROFESSIONAL ETHICS.**

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## **ABSTRACT**

This study examined three perspectives on ethical dimensions of South African professional psychology. These perspectives were derived from three data sets. The first data set comprised a series of public complaints against psychologists; the second a series of ethical dilemmas reported by psychologists themselves, and the third comprised a study of the training of South African psychologists in professional ethics.

Clear patterns emerged in the analysis of each data set, and efforts were made to integrate the findings. Psychologists in particular registration categories, trained at particular universities and working in particular practice contexts were disproportionately more likely to attract complaints. Similarly, patterns of dilemmas experienced by psychologists also emerged. Comparison of complaints with dilemmas suggested that there were significant differences and some similarities in the ethical issues and contexts associated with public complaints and psychologists' own ethical dilemmas. The study of ethics training suggested general dissatisfaction with the relevance and quantity of ethics training nationally.

The main findings were integrated to make recommendations for improving the ethics training of South African psychologists. The limitations of the data are described, along with suggestions for future research to examine in greater depth and specificity several dominant patterns described by the present study.

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Declaration:

This study represents original work by the author and has not otherwise been submitted in any form for any degree or diploma to any university. Where use has been made of the work of others, it is duly acknowledged in the text.

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## FREQUENTLY USED ABBREVIATIONS

APA	American Psychological Association
ASPPB	Association of State and Provincial Psychology Boards (USA & Canada)
Board	The Professional Board for Psychology of the SAMDC or the later HPCSA
BPS	British Psychological Society
CPA	Canadian Psychological Association
CPD	Continuing Professional Development
EFPPA	European Federation of Professional Psychology Associations
HPCSA	Health Professions Council of South Africa (INMDCSA before 1999)
INMDCSA	Interim National Medical and Dental Council of South Africa (HPCSA after 1999)
MPS	Medical Protection Society
PASA	Psychological Association of South Africa (PsySSA after 1994)
PIRSA	Psigologiese Instituut van die Republiek van Suid Afrika (PASA after 1982)
PsySSA	Psychological Society of South Africa (PASA before 1994)
SAICP	South African Institute for Clinical Psychology (SASCP before 1982)
SASCP	South African Society for Clinical Psychology (SAICP after 1982)
SAMDC	South African Medical and Dental Council (INMDCSA after 1994)
SAPA	South African Psychological Association (PASA after 1982)

## UNIVERSITIES:

MEDUNSA	Medical University of South Africa
OFS	University of the Orange Free State
Potch	Potchefstroom University for Higher Christian Education
Pret	Pretoria University
RAU	Rand Afrikaans University
Rho	Rhodes University
Stell	Stellenbosch University
UCT	University of Cape Town
UDW	University of Durban-Westville
UND	University of Natal, Durban
UNISA	University of South Africa
UNIZUL	University of Zululand
UNP	University of Natal, Pietermaritzburg
UPE	University of Port Elizabeth
UWC	University of the Western Cape
Wits	University of the Witwatersrand

## Chapter 1: Introduction

The present work is an examination of an element of professional psychology. It is hoped that this work will contribute to the growing literature which turns the gaze of the researcher towards professional psychology itself, rather than the more familiar and expected gaze of the researcher towards research 'subjects' or 'patients/clients' 'out there'. This study thus examines aspects of professional psychology from within - psychology looking at psychology. The focus will thus mostly be on psychology as a profession rather than on psychology as a scientific and academic discipline. Although this distinction is controversial and not entirely clear (Belloch, 1997), it is generally accepted that professional psychology involves the application of psychological knowledge and skills in the public domain. Scientific or academic psychology, in contrast, has no necessarily direct public engagement, although many scientists are probably motivated by the hope of benefiting society in some way. Professional psychology has a more direct contract with the public at large. As a result, professional psychology in most countries is subject to regulation and disciplinary measures if aspects of its contract with society are violated (Pulverich, 1997).

Such self-examination could be directed at many possible areas and levels. Questions could, and have, been asked about psychology's broader contract with society, whose interests the profession serves (e.g., Albee, 1998; Duncan, van Niekerk, de la Rey & Seedat, 2001; Louw, 2002; Sampson, 1991). The history of psychology is rich with debate about whether psychology serves the forces of social control and oppression, or whether it facilitates liberty and enlightenment. Professionalisation itself has been questioned and some have argued that professionalisation is self serving, power-seeking and acquisitive (Dawes, 1985; Louw, 1988, 1992), while others have argued that professionalisation brings professionals under the auspices of bodies that represent the public interest (Bent, Packard & Goldberg, 1999; Pryzwansky & Wendt, 1999), thus proscribing their powers and delimiting their fields of practice to those in which competence has been demonstrated (DeMers, 1995b). At a more detailed level are debates about professional psychology's efficacy - does the systematic application of psychological knowledge and skills benefit the recipients of such services? There are further questions about the training and education of professional psychologists - is such

training appropriate, adequate, scientifically informed and relevant to service recipients? These questions are perennial and must continually be revisited in the face of ongoing changes in societies, nations and increasing globalization (Fuller, Walsh & McGinley, 1997).

This work attempts to focus on a specific dimension of the interface between professional psychology and service recipients. Professional interactions with service recipients involve technical interventions that have to be informed by careful professional judgement and ethical awareness. Ethical awareness here includes awareness of applicable legal issues and the more aspirational striving to provide a service that is of a high ethical or moral standard. Ethics in this context is assumed to be “those assumptions held by individuals, institutions, organizations, and professions that they believe will assist them in distinguishing between right and wrong and, ultimately, in making sound moral judgements” (Bersoff, 1999a, p. xxi), or as Beit-Hallahmi (1974, p. 124) put it more cynically, “the rules of our game vis-a-vis society”. More specifically, this work examines aspects of what Kitchener (2000a) refers to as applied ethics in professional psychology. Professions are generally regulated by legal statutes that set out the broad legal parameters of professional practice, while higher aspirational moral guidelines are usually set out in more detailed Codes of Conduct, Ethical Codes and Guidelines published by national and/or local professional organisations. There are thus typically combinations of ethical standards and legal prescriptions with which professional psychologists have to comply (Pryzwansky & Wendt, 1999). To complicate matters, mere compliance with ethical codes and legal statutes cannot guarantee ethical practice, as contemporary professional practice confronts many circumstances that lead to ethical dilemmas where ethical standards conflict with each other.

This study intends to explore aspects of South African professional psychology’s apparent compliance with and experience of these prescriptions and standards. Although it might be seen as misleading to confuse legal and ethical standards, the position taken throughout the present work is that ethical standards generally require a higher level of ethical awareness and decision-making than legal standards. Kitchener (2000a) points out that it is increasingly difficult to separate ethical from legal issues and decisions in professional psychology. Thus, while practicing ethically, for the most

part, should ensure that such practice is legal (Allan, 1997a; Koocher & Keith-Spiegel, 1998; Ogloff & Olley, 1998; Reaves & Ogloff, 1996a), this is not always the case (Pope & Bajt, 1988). Historical South African circumstances have generated some complex exceptions to this rule (Dawes, 1985; Steere & Dowdall, 1990; Swartz, 1988) where civil disobedience to unjust laws led to illegal practices that were regarded as ethical. Similarly, slavish adherence to legal mandates might lead to unethical practice. In the broadest perspective, however, ethics and law, nevertheless share two basic goals: "the regulation of behavior and the protection of society" (Ogloff & Olley, 1998, p. 221). Ogloff and Olley (1998) argue that over time the laws and ethical standards applicable to psychological practice will converge and become more congruent through a process of reciprocal influence and refinement. Such a process will need to be based, in part, on empirical studies of ethical dilemmas and reports of professional misconduct.

It is hoped that this work will generate a view of psychology's performance as a legal and ethical profession as viewed through the lens of public complaints against psychologists. This view from the public perspective will be compared and contrasted with a study of the ethical dilemmas experienced and reported by psychologists themselves. The comparison of public complaints with psychologists' own ethical dilemmas may reveal whether psychologists are attending to those aspects of their legal and ethical contexts that trouble the service-receiving public, and to a lesser extent, the other professionals with whom psychologists interact in the performance of their duties.

Hopefully such an analysis, together with an examination of some aspects of the training of South African psychologists in professional ethics, might in the future inform the profession in several ways in three primary domains - training, regulation and guideline development. The results of such an analysis might be of use in tailoring training programmes in professional ethics for psychologists, at both the basic professional training and ongoing Continuing Professional Development (CPD) levels. The analysis might also inform adjudicative bodies about prevalent patterns of public dissatisfactions and the types of psychologists, ethical issues and practice settings that might typically be associated with such patterns. The analysis might also be of use in informing the ongoing development and revision of ethical codes and practices. These three domains - training,

professional regulation and guideline development are developing internationally because of growing bodies of empirical data about elements of professional ethics, together with existing and emerging theories about the development and maintenance of ethical conduct (Rest & Narváez, 1994). This work hopes to make an empirical rather than a theoretical contribution to this field, without negating the role of theory.

Professional work, by definition occurs in interaction with recipients in particular contexts. Professional psychology, since its inception, has been characterised by rapid growth of its application to diverse problems and settings. Such growth brings with it risks of errors due to the innovations required and a lack of established practices and procedures. Professional psychology, although based on the Boulder and Vail model (Pryzwansky & Wendt, 1999), remains a less procedurally clear profession than medicine. Increased pressures for evidence-based interventions (Sechrest, 1987) have added ethical problems of their own (Pope & Vetter, 1992). Such forces may increase ethical uncertainty and the risk of attracting a complaint (Scherrer, Louw & Möller, 2002). Without attempting to list the growing number of contexts in which professional psychologists are increasingly active, it is possible that some contexts may be more fraught with legal and ethical pitfalls than others. This work thus sets out to ask, besides identifying the frequency of particular ethical issues in professional work, whether particular practice contexts are especially ethically hazardous, and what types of ethical issues typically arise in such contexts. It is hoped, as stated above, that the inclusion of practice context in this analysis might further enrich the empirical data available for training, regulation and guideline development - in the spirit of learning from our own mistakes (Rubin & Zoloth, 2000). Our mistakes might be technical, judgmental, or normative (Frader, 2000). Technical errors result from a lack of skill in a particular area, judgmental errors result from incorrect analysis of given data or circumstances, leading to inappropriate interventions, and normative errors result from a practitioner's inability to question his or her own practices and reluctance to seek consultation from more experienced colleagues (Frader, 2000). Such errors can lead to culpable and non-culpable mistakes, and may lead to professional complaints and civil suits. It is hoped that if we study such errors, we might identify patterns that could lead to prevention - through error-informed training and guideline development.

The study of our mistakes might hopefully also help with the identification of patterns and contexts associated with such errors - the systemic dimension - (Leape, 2000) rather than the more usual perception that errors are made solely as “a failure of character of the person responsible” (Frader, 2000, p. 123). The present work thus also hopes, in its inclusion of practice contexts, to identify possible systemic or contextual dimensions of public complaints and our own ethical dilemmas. The analysis is thus not intended to be an exercise in blaming, but an exercise of self-examination and reflection in the interests of better self regulation and higher standards of public service. The comments of Frader (2000, p. 127), writing of medical errors, are pertinent here: “Only by taking self-criticism and self-regulation seriously can we attempt to engender public trust in the profession. In addition, as noted, acknowledging errors can be the first steps toward learning, personal and systemic, and toward corrective and preventive measures”.

In summary, this work hopes to make an empirical contribution to the ethical enterprise of professional psychology through an analysis of reported public dissatisfactions with psychological services, compared and combined with an analysis of psychologists’ own ethical dilemmas and their views on their ethics training. A particular aspect of this work will be an attempt to identify particular professional contexts and settings in which ethical problems commonly arise. In order to find out why psychologists do ‘bad things’ (Bersoff, 1999b), it might help to know what ‘bad things’ the public accuse psychologists of.

The first part of this thesis (ch. 2) outlines the history and role of ethical codes in psychology in general, and in South Africa in particular.

This is followed by a review of studies (ch. 3) that have examined violations of ethical codes by psychologists, against which the present data will be compared. A section (3.4) reviewing studies of psychologists’ own ethical dilemmas follows, again so that the dilemmas elicited by the present study can be situated in the context of comparable international research.

Elements of the training of professional psychologists in professional ethics are then reviewed (ch.

4) to provide a base for consideration of the ethics training data and the training implications, if any, which might arise from the present work.

The following sections outline the exact aims (ch. 5) and methods (ch. 6) used in this study, followed by a description of the samples (ch. 7).

The results of the study are then presented in subsequent sections (chs. 8-10). Because of the high number of variables considered in this work, the results and discussion sections are integrated to avoid duplication of material.

The results section is followed by a summary of the major statistically significant findings, and limitations of the study (ch. 11). This precedes recommendations for training, regulation and guideline development. Several practical, methodological and conceptual recommendations for future research will also be made.

## Chapter 2: The History of Ethical Codes and Regulation in South African Psychology

### 2.1 The International Context

#### 2.1.1 Ethical Codes in Psychology

Psychology is a relatively new profession compared with the traditional professions of theology, medicine and law. The rise of technology and its applications in the past two centuries has witnessed an increase in the number of occupations regarded as professions. The core elements of a profession are summarised by Sinclair, Simon and Pettifor (1996, p.2) as follows:

1. Members individually and collectively render service to members of the public and to society.
2. Members possess a high degree of generalized and systematic knowledge and skills requiring long and difficult education, extended practice, and continuing education.
3. Members develop and promote a code of ethics and function in accordance with this code.
4. Members function as a community that (a) controls entry requirements; (b) trains new members; (c) socializes new members into the attitudes, values and accepted practices of the community; (d) regulates and monitors the professional activities of members; and (e) develops its field of knowledge and skill.
5. Members are accountable, willing to subject their activities to scrutiny both from within their own community and from society at large.

Items 3-5 above emphasise the profession as a moral community that undertakes critical self monitoring and self regulation to honour its obligation to the public which grants the profession its status (Sinclair et al., 1996). The first known example of a professional code of ethics was the Hippocratic Oath, written around 400 B.C., which is still the foundation of many medical ethical codes. Sinclair et al. (1996) point out that the Hippocratic Oath embodies elements such as

autonomy, beneficence, nonmaleficence, and respect for society which are compatible with modern ethical texts, such as the well-known work of Beauchamp and Childress (2001).

Notwithstanding the early work of Lightner Witmer around 1896 (Belloch, 1997), most histories of psychology see professional psychology as emerging during and after World War II (Bent et al., 1999; Pryzwansky & Wendt, 1999; Tipton, 1996), accompanied by efforts to develop ethical codes to guide the profession. A survey to collect descriptions of critical practice and ethical incidents towards the development a code of ethics was conducted in the USA in 1947. The analysis of these items and a series of publications led to the publication of the first provisional ethical standards for American psychologists in 1952 (APA, 1959; Pope & Vetter, 1992; Sinclair et al., 1996). This code has undergone many revisions, some of them informed by further empirical research (Koocher & Keith-Spiegel, 1998). Although the 1992 version (APA, 1992a) remains current, a new draft version (APA, 2001a) has been widely circulated for comment and awaits adoption in August 2002 (APA, 2001d, 2002).

The APA code was adopted in Canada until 1986 when a Canadian code of ethics was adopted by the Canadian Psychological Association. The Canadian code set out to be more explicitly educational and contains guidelines for addressing ethical dilemmas and general decision-making guides. It was developed by collecting responses to ethical dilemmas sent out to members, and analysing the reasoning of the responses into a coherent set of ethical principles (Sinclair, 1998) in conjunction with the existent APA code. The Canadian code has been widely recognised as more coherently and explicitly structured around clear ethical principles than the 1992 APA code (Malloy & Hadjistavropoulos, 1998; Pettifor, 1998; Sinclair, 1998) and is now in its third edition (CPA, 2000). While efforts were thus made in the original development of the APA and CPA codes to elicit dilemmas and responses to ethical dilemmas from psychologists, there was no parallel analysis or collection of data that reflected the views and perceptions of the recipients of psychological services, which is a central aim of the present work.

The proliferation of codes, guidelines and standards of practice over the past four decades has led

to a bewildering array of documents. This in turn has often left psychologists unclear about the relative status of these multiple documents. Sinclair et al. (1996) offer the reassurance that many of these documents remain consistent with the principles that underlie the APA and Canadian codes of ethics. A recent survey of ethical codes for psychology globally (Leach, Wassenaar & Gray, 2002) has found at least 38 accessible ethical codes internationally. Efforts are underway to selectively compare the contents of some of these codes.

Schumacher (1998) questions over-reliance on ethical codes in fostering ethical conduct. He argues that while ethical codes might represent a consensus view of a profession's ethical thinking, they should not in turn suppress the autonomy and the rights of the practitioner. In certain cases a practitioner might exercise his or her moral right to disregard an ethical code. He argues that ethical codes should remain aspirational rather than authoritarian.

### 2.1.2 Legal Regulation of Professional Psychology

Parallel to professionalisation and the developments of ethical codes, governments and states have variously recognised psychology as a profession and have sought to regulate those who enter the profession. Such efforts were deemed to be in the interests of the public to set minimal standards of entry into the profession, set standards of practice which admitted persons must adhere to, and prescribe sanctions against those who default (Bent et al., 1999). Pryzwansky and Wendt (1999) argue that the need for regulation increases with the need to protect the users of services, which in turn rises as the nature of services becomes more intensive and complex. Regulation deals with the inputs into professional training and the quality of the outputs of registered professionals who are accountable to their regulatory bodies (Reaves, 1995a, 1996).

The first licensing laws for psychologists in the USA were passed in Connecticut in 1945, with many states following suit (Sinclair et al., 1996). In 1972 the Association of State and Provincial Psychology Boards (ASPPB) was established to coordinate the activities of State Boards. In 1995 it established a centralised transferrable licensing procedure for all American states and Canadian

provinces (McGuire, 1998). The ASPPB has published its own code of conduct (ASPPB, 1991) which, where adopted, contains coercive rather than aspirational practice standards as compared with the more aspirational provisions of the APA (1992a, 2001a) and CPA (2000) codes.

Similar developments have taken place in Britain and throughout Europe, although most were much more recent than American and Canadian developments (Pulverich, 1997; Schorr & Saari, 1995). However the formal professionalisation of psychology in Britain and much of Europe occurred more recently than in South Africa, as will be outlined below. Efforts are underway to harmonise ethical codes across Europe, and a European meta-code was adopted in 1995 (EFPPA, 1995).

## 2.2 Ethical Codes and Regulation in South Africa

This subsection will outline the statutory (regulatory) history of professional psychology in South Africa, followed by a brief historical review of ethics developments in voluntary professional associations. This section is an edited and updated version of a review by Wassenaar (1998a).

### 2.2.1 The Statutory Context

Psychology attained legal status as a profession in South Africa after the promulgation of Act 56 of 1974 (Government Gazette, 1974). Before this, psychology was unregulated and practised by a number of persons holding various degrees in psychology but who had no formal registration as professional psychologists. Noncompulsory registration with the South African Medical and Dental Council took place from 1955 (O'Meara, 1983). A further separate voluntary register for clinical psychologists was established in 1964 (Parker, 1986). Because of the lack of formal registration criteria, these psychologists were not subject to any training requirements and were not formally answerable to any disciplinary authority.

The need for formal registration of psychologists arose out of several converging pressures towards professional growth; for example the developments in applied psychology that took place during the

second World War (Biesheuvel, 1987; Louw, 1986; Nicholas 1993), the need for vocational guidance workers to help the burgeoning industrial sector with personnel selection and management (Louw, 1986), and the influence of British-trained psychoanalytically-orientated practitioners who emigrated to South Africa after the War (Parker, 1986).

The promulgation by parliament of Act 56 in 1974 (Government Gazette, 1974) and the consequential introduction of a professional, statutory register of psychologists brought into being public accountability of psychologists who wished to be known as psychologists and who wished to exercise their skills for gain. This Act (hereafter referred to as Act 56) regulates both the use of the title 'psychologist' and certain methods of psychodiagnosis and psychological treatment reserved exclusively for psychologists. The South African Act is thus a title act and a practice act. Most approved training programmes followed the 'scientist-practitioner' or 'Boulder and Vail' model, leading to an approved professional Masters' degree and one-year supervised internship leading to professional registration. Provision was made to register psychologists in one or more of five categories, depending on the focus of the training and internship: clinical, counselling, educational, industrial and research. Regulations specific to psychology arising from Act 56 first appeared in 1977 and are amended from time to time. The statutory link with the controlling South African Medical Dental Council was a cause for some concern at the time (Louw, 1992; Nell, 1992, 1993; PsySSA, 1997), although psychologists, since 1992, enjoy considerable autonomy from structural control by medical professionals (Mina & Wassenaar, 1996). Act 56 empowers the Professional Board for Psychology, affiliated to the Health Professions Council of South Africa, to stipulate minimum standards of training for psychologists and provides for disciplinary enquiries to be held if complaints against psychologists are received. The Board is empowered to take disciplinary action against offending psychologists, up to and including withdrawal of registration and consequent rights to practice. It must be understood that the primary purpose of Act 56 and the structures it empowers is the protection of the public. Act 56 thus stipulates which actions by psychologists might lead to disciplinary action and is constructed as a catalogue of potential offenses (Allan, 1997a). Although Act 56 situated professional psychology within a basic legal framework, Act 56 falls far short of providing psychologists in daily practice with a clear and practically useful set of guidelines

regarding the ethically complicated situations that arise in practice. There has been very little published criticism of Act 56 from the viewpoint of its ethical inadequacies, while the professionalisation of South African psychology has been criticised from a variety of other perspectives, (Berger & Lazarus, 1987; Cloete & Pillay, 1988; Duncan et al., 2001; Kottler, 1988; Louw, 1986, 1988, 1992, 2002; Nell, 1992; Steere & Dowdall, 1990), full discussion of which is beyond the scope of the present work.

Professional psychology in South Africa has developed considerably since the passing of Act 56 in 1974. By 1996 there were more than 4000 registered psychologists in South Africa with a further approximately 800 interns, 1900 psychometrists and 300 psychotechnicians (INMDCSA, 1996b). A survey conducted in 1986 revealed that professional psychology in South Africa had reached a level of development comparable with Australia and America (Manganyi & Louw, 1986), although the research publication output and impact of the discipline were low (Mauer, Marais & Prinsloo, 1991; Pouris & Richter, 2000). Psychologists are recognised by medical aid schemes and legal provision has been made for psychologists to obtain prescription privileges after a period of appropriate training (Lindegger, 1999).

The Board includes public representatives who have voting rights on the Board and on its subcommittees. In addition, the Board has included three professional association (PsySSA) representatives as full members. Further policy recommendations provide for formal representation by traditional healers and by masters-level psychology students (Mina & Wassenaar, 1996).

### 2.2.2 Early Professional Associations: SAPA and PIRSA

These associations were essentially fraternal organisations, representing the discipline of psychology and the interests of psychologists, but were divided along ideological lines, like other academic and research structures in apartheid-era South Africa (Cloete, Muller & Orkin, 1986; O'Meara, 1983; Suffla, Stevens & Seedat, 2001). The South African Psychological Association (SAPA) was founded in 1948 (Louw, 1987; Nicholas, 1990, 1993; O'Meara, 1983), on the initiative of some university

psychology departments with strong support from the predominantly English-speaking National Institute for Personnel Research (NIPR).

A “Digest of Ethical Standards” was published by SAPA in 1962 (cited in PASA, 1987b; SAPA, 1962), but no formal structures appear to have been established to ensure that members conducted themselves ethically. The work of SAPA has nevertheless been credited for contributing to the eventual formal professionalisation of psychology in South Africa (O’Meara, 1983). SAPA kept a register that differentiated psychologists who wished to be regarded as either “professional” or “academic”. By the 1950's psychologists were starting to work in private practice, although at least one was practising before the Second World War (O’Meara, 1983).

The Psychological Institute of the Republic of South Africa (PIRSA) was founded in 1962 after divisions on racial membership issues became critical in SAPA (Louw, 1987; Nicholas, 1990). PIRSA’s membership was largely Afrikaans-speaking. The initiative for the break from the more racially centrist SAPA was in part motivated by the then Prime Minister, H.F. Verwoerd, who was himself a psychologist and an architect of the abhorrent apartheid system. (Louw, 1980, 1987). PIRSA was founded on a “revolt against egalitarianism and racial integration” (Louw, 1987, p. 348). No documentation could be found on PIRSA’s ethics code and policies.

### 2.2.3 The South African Society of Clinical Psychologists

The South African Society of Clinical Psychology (SASCP) was founded in 1977 to promote and support clinical psychologists in a variety of fields of activity (e.g., training criteria, negotiation with medical aid schemes, tariffs, conditions of hospital service, etc.). Clinical psychologists were, and remain, the largest single category of professional psychologists in South Africa. It was felt that the further professional development of the discipline of clinical psychology required the urgent development of an ethical code. This was seen as a fundamental step in building a strong and autonomous professional organisation (Craig, 1993). The other categories of psychologists followed suit and after some time similar societies were formed by counselling, industrial and educational

psychologists. These four societies formally associated in what became the Psychological Association of South Africa (PASA) in 1982, which also absorbed SAPA and PIRSA.

#### 2.2.4 The Psychological Association of South Africa

PASA was constituted as a representative and inclusive association for South African psychologists in 1982. The Institute for Clinical Psychology (SAICP) continued with the previous activities and membership of the SASCP, but became a formal affiliate of PASA.

#### 2.2.5 The SAICP Ethical Guidelines for Clinical Psychologists

In 1984 The SAICP decided to develop an ethical code to supplement the bare legal prohibitions of Act 56. Given the difficulty of drafting an ethical code (Lindsay, 1996; Pargiter & Bloch, 1994; Sinclair, 1995), a relatively expedient method was implemented in drafting the first set of Ethical Guidelines for South African Clinical Psychologists. The document was based on an integrated amalgamation of the American Psychological Association *Ethical Principles of Psychologists* (APA, 1981a), the British Association of Behavioural Psychotherapy *Ethical Guidelines* (undated) and the Ontario Board of Examiners in Psychology *Standards of Professional Conduct* (1985). Other codes were considered but most were based on the APA principles. In addition, all of the provisions of Act 56 were incorporated into the draft document, so that a single document covered legal and ethical standards. The contents were organised according to clinically relevant topics rather than according to abstract principles. Three overarching principles, autonomy, nonmaleficence, and beneficence were adopted as a guide to resolving ethical dilemmas. The publication of the guidelines in 1985 (Steere & Wassenaar, 1985) was followed by regional ethics workshops to introduce clinical psychologists to the guidelines and their application. A reader survey accompanied the publication, but, due to poor response, was never analysed or published.

Although the SAICP code was not without its critics and problems (Seedat & Nell, 1992; Steere & Dowdall, 1990; Swartz, 1988), it served as the primary clinical ethics reference for South African

professional psychologists through to the late 1990's. The SAICP established its own ethics committee to assist clinical psychologists and their clients, which operated from 1986 to 1991. Brief reports of activities of the ethics committee were published annually in the SAICP Chairman's annual reports (SAICP, 1985, 1986a, 1986b, 1987). During this period the Institutes for Counselling, Educational and Industrial psychology also formed their own ethics committees and formally adopted the Steere and Wassenaar (1985) guidelines as their formal ethical code. Thus, from 1987 to 1991, three of the PASA institutes had independent ethics committees, all of which used the clinical ethical guidelines as their major ethical reference.

#### 2.2.6 The PASA Ethical Code

In 1984 PASA established a Disciplinary Committee (PASA, 1984) and the chairperson of this committee tabled a report (Van Niekerk, 1984) which recommended certain disciplinary actions against non-registered persons who were practising in the field of psychology. No PASA Ethical code existed at that time.

In 1985 the PASA executive initiated publication of an ethical code, published in 1987 (PASA, 1987b). This caused confusion among PASA members, most of whom were already using the Steere and Wassenaar (1985) guidelines as their ethical reference. The PASA code was very similar to the old APA Code (Mommsen, 1990), although it showed some (unacknowledged) reference to Steere and Wassenaar (1985). It was inadequate for applied practitioners and was not adopted by the Clinical, Counselling, Educational or Industrial Institutes, although it contained some explicit guidelines for the resolution of ethical conflicts. The PASA code was thus only used, if at all, by research psychologists and unregistered psychology graduates in academic settings. A comparative content analysis (e.g., Leach & Harbin, 1997; Lindsay, 1992; Sinclair, 1996) of the existing South African ethical codes has not been conducted, and is beyond the scope of the present work.

PASA formed an ethics committee in 1988. By consensus the PASA Ethics Committee became the sole point of reference for ethical matters for all member psychologists between 1991 and 1994.

Numerous cases were investigated annually and policy and liaison issues were addressed. The Committee enjoyed recognition from the Professional Board for Psychology and cases were cross-referred and mutual counsel was sought at times. The work of the Ethics Committee was reported on annually at the PASA congress as an item of the Presidential address. No formal ethics reports were published, unlike the APA, and to date no systematic analysis of these complaints has been conducted, which is an aim of the present work.

By 1993 a resolution had been adopted to disband PASA and groundwork was being conducted to form a new, democratic and inclusive psychological association. PASA had been perceived by many as insufficiently responsive to the real mental health needs of most South Africans (Louw, 1992; Nell & Seedat, 1992; Nicholas, 2001; Suffla et al., 2001; Swartz & Gibson, 2001), and was insufficiently critical of apartheid policy. In January 1994, the Psychological Society of South Africa (PsySSA) was founded at the University of the Western Cape. This meant, *inter alia*, that a new Ethics Committee needed to be formed which would have to develop, adopt, and implement a new ethical code. PsySSA remains the dominant voluntary psychological association in South Africa. It has an ethics committee and has adopted an edited version of the APA (1992a) ethical code.

### 2.3 Summary

Essentially, the Board is a statutory organisation which is the highest authority over South African psychologists and with which registration is compulsory. Its primary function is to protect the public consumer of psychological services. It has the power to bar a psychologist from practice. The Board now requires that 10% of annual CPD points be accumulated in professional ethics (Professional Board, 2002). Changes to basic training, registration and professional practice framework are also being implemented (Professional Board, 2001).

The PsySSA Ethics Committee has no statutory powers and can, at the utmost, cancel a psychologist's membership of PsySSA but cannot bar a psychologist from practice. These powers are similar to those exercised by the APA and CPA. The association's ethics committee's primary

function is to offer support and ethical advice to members and, secondarily, to mediate in complaints referred to it.

In summary, formal professional legislation and ethical codes in South Africa are relatively well developed, compared with most European countries, second only perhaps to the USA and Canada (DeMers, 1995a; 1995b; Dobson & Dobson, 1993; Matefi & Haring, 1993; Pulverich, 1997; Schorr & Saari, 1995; Sinclair, 1995). Lively debate about the functions and nature of the profession are also characteristic of South African psychology, as expressed in the literature cited above.

Having hopefully sketched the development of regulatory and ethical frameworks, the next section will examine the literature on violations of such frameworks by psychologists, as further background to the aims of the proposed study.

### **Chapter 3: Ethical Violations, Attitudes, and Dilemmas**

The violation of ethical rules by psychologists involves many formal dimensions and sources of information, which are reviewed separately below. The first source of information comes from cases reported to ethics committees of national psychology associations. The annual reports of psychology associations that publish annual reports of their work are reviewed. Secondly, reports of legal violations to state or national registration boards or authorities are also reviewed. Finally, surveys and reports of psychologists' ethical practices, attitudes and dilemmas are reviewed.

Koocher and Keith-Spiegel (1998) point out that control over professional psychologists is generally enforced by five sources. These are: i) ordinary criminal and civil law, ii) professional peers by ethics committees, iii) profession-specific laws or statutes, iv) civil litigation and malpractice suits, and v) national laws and regulations. This complexity of applicable laws, regulations and codes leads to difficulty in reviewing unethical conduct by psychologists, as a variety of sources have to be monitored, some of which (e.g., malpractice suits) may be settled out of court and are thus not published or made amenable to researchers. In many countries professional regulation and disciplining are multifaceted and may involve a combination of statutory and voluntary professional organisations (DeMers, 1995b). This interplay of voluntary and statutory regulation and discipline makes it difficult to present a coherent picture of disciplinary actions against psychologists. In the sections below, unethical conduct and rule violations by psychologists are reviewed with reference to the different jurisdictions in which psychologists function, and will mainly focus on items (ii) and (iii) in the above list.

#### **3.1 Complaints Reported to Ethics Committees**

Historically the American Psychological Association was the first professional psychology association to establish a formal ethics committee and to publish annual reports on its activities. This section will review developmental trends in some functional concerns of the APA ethics committee, followed by a detailed breakdown of cases reported and adjudicated.

The first report of the APA ethics committee (the Committee on Scientific and Professional Ethics) was published in 1979 (Sanders, 1979). The APA has a central ethics committee and

regional ethics committees, which leads to a lack of uniformity in adjudications and some unreliability of the APA annual ethics reports (Koocher & Keith-Spiegel, 1998). Details of how these various committees interface were outlined by Mills (1984) and are beyond the scope of the present discussion. The review that follows will attempt to highlight salient patterns in the work of these committees and patterns of reported complaints.

### 3.1.1 Complaint Patterns

Complaints reported to the APA Ethics Committee remain the most systematic published accounts of complaints and disciplinary proceedings against psychologists, although they are presented in a simple frequency format and are not subjected to statistical analysis.

The first published APA ethics reports outlined only summaries of selected cases 'informally' adjudicated. Thus, the purpose of these early reports was educational rather than strictly statistical. In 1980 the second report of the ethics committee (Sanders & Keith-Spiegel, 1980) followed the earlier format of outlining selected cases linked to specific principles of the then current APA Code. Both formal and informal adjudications were reported. Informal adjudications were those resolved by the ethics committee itself, while formal adjudications were those matters investigated by the ethics committee and then referred to the APA Board of Directors for ratification, which usually involved recommendations for expulsion. Only 19 of 200 cases reported to the committee after 1977 were mentioned and no details were given of numbers of cases formally and informally adjudicated. The cases were selected to reflect each of the nine ethical principles contained in the then current (1979) version of the APA ethical code. They described the judgements and operations of the committee in both formal and informal adjudications. The procedures of the ethics committee, with case examples, were described more fully in the third publication by the APA ethics committee (Hare-Mustin & Hall, 1981). Essentially, these were described as "educative and constructive for the psychologist involved, (and) must also protect the public" (p. 1494). The distinction between the APA and State licensing boards was also more fully described, comparable with the South African distinction between PsySSA and the Professional Board for Psychology of the Health Professions Council of South Africa, described in the previous chapter. This distinction is essentially the difference between ethical and legal violations, with legal violations resulting in the more severe sanctions.

Reports of the APA ethics committee were published annually and continue to be published to the present time (APA, 1986, 1987b, 1988c, 1990b, 1991b, 1993b, 1994b, 1995, 1996a, 1997, 1998, 1999, 2000, 2001d). It is beyond the scope of this work to present a meta-analysis of these reports, so only salient points are highlighted below.

The fourth report of the APA ethics committee was published in 1983 (Hall & Hare-Mustin, 1983) and for the first time presented a rank ordered listing of the frequency of the types of complaints received - a format that remains current. Further procedural refinements were outlined, in particular a hierarchical outline of levels of sanctions imposed on offenders. Despite this, the report emphasised the primarily educative purpose of the ethics committee - although the educative role of ethics committees was underutilised by psychologists themselves (Keith-Spiegel & Koocher, 1985). The committee furthermore recognised the importance of remaining abreast of emerging issues in professional practice and their ethical dimensions. Three such issues discussed in the 1983 report were bartering as payment for services, the use of sexual surrogates in sex therapy, and the use of commercial collection agencies for recovery of overdue fees.

The fifth report of the APA ethics committee (Mills, 1984) focussed on the process of case adjudication within the APA and mentioned the possibility of a name change to APA Ethics Committee. In this report the educative function of the committee was described as secondary to the adjudicative function of the committee. The report described the changing and evolving procedures of the Ethics Committee and mentioned that the ethics code itself was subject to periodic revision. A case frequency table was also presented following the format begun by Hall and Hare-Mustin (1983). Regarding the adjudicative process, the 1984 report stated that about half the initial complaints submitted to the committee were not followed up by the complainant and were thus dropped. A revised set of rules and procedures was published in 1985 (APA, 1985) in which the primary concern of the APA Ethics Committee (now formally so named) was “to protect the public against harmful conduct by psychologists” (p. 685) with the educative function then apparently a secondary concern. Complaints about non-APA members were forwarded to state licensing boards.

The 1985 APA Ethics Committee report (APA, 1986) established the format adopted to the

present. Among other things it mentioned the establishment of a task force to develop a curriculum for the training of ethics to post graduates in psychology. The report reflected a series of educational and disciplinary actions by the committee. Difficult areas of adjudication included interactions with ex-patients, advertising, bartering, selling a practice and telephone therapy services. Guidelines for nonsexist language were published in 1977 (APA, 1977).

A report (APA, 1988c) documented a 56% increase in complaints between 1983 and 1987. Considering the rising membership of the APA, it appeared that complaints were filed against about 1% of the APA membership. There was also an increase in the variety of matters complained about. About 75% of the complaints were made by females, also reflecting a rising trend. In contrast, 80% of the recipients of complaints were male psychologists. About 50% of the complaints were adjudicated to be violations, and about 25% of these concerned sexual misconduct - the largest single complaint category. Without commenting on the apparent sharp decrease in complaint rates the 1988 Ethics Committee report (APA, 1988c) shows that complaints were filed against 0,18% of the APA membership (APA, 1990b). The rate was 0.22% in 1990 (APA, 1991b), 0.16% for 1991-1992 (APA, 1993b), and was 0.10% in 2000 (APA, 2001d), with fluctuations in the intervening years.

It is important to note that procedurally, the APA reports (rather than the 'Rules and procedures' (APA, 1996b)) define complaints as those matters that have gone beyond the inquiry phase. The inquiry is the initial communication from the complainant, to which the APA responds by mailing a pro-forma complaint form to the complainant. Once (and if) this form is returned within a stipulated time, the committee considers the matter and decides whether to start a formal complaint process against the psychologist concerned (APA, 1988b). Thus, the term 'complaints' in the APA reports are those matters that have undergone considerable procedural clarification (APA, 1988b). It must be noted that this terminology differs from that used in South Africa (SAMDC, 1991b) and from that used in this study. In South Africa, the initial correspondence received from the complainant is called a complaint. Only after a process involving the solicitation of a written response from the accused psychologist does a subcommittee of the Board decide whether to proceed with formal adjudication. The formal adjudication is called an Inquiry - i.e., the terminology is the opposite to that used by the APA. The reader is cautioned to note this in the reports on APA adjudications which are summarised below.

In 1988 the APA Ethics Committee published a *Casebook for providers of psychological services*, one of a series started in 1981 in an attempt to action its educative function (APA, 1988a). No rationale was given for the particular series of cases selected, but these included child custody evaluation issues, compulsory reporting of child abuse, and the effects of diagnostic labelling.

The 1991-1992 report (APA, 1993b) mentioned a task force to develop a model curriculum for ethics education and was the first to expand the category of dual relationships into the following separate categories: Sexual misconduct adult; sexual misconduct minor; sexual harassment and nonsexual dual relationship (APA, 1993b). These categories cumulatively remain the most frequent types of complaints, followed by child custody complaints (APA, 2001d).

Koocher and Keith-Spiegel (1998) reported the sources of APA ethics complaints roughly as follows: 60% from recipients of services, 25% from other psychologists or allied professionals, (cf. Levenson, 1986) and the remainder from students, supervisees and private citizens. Anger was seen as a motivating factor in most complaints. The average case processing time for the period 1992-2000 was 15 months (APA, 2001d). As mentioned earlier, many issues probably remain unreported, for a variety of reasons, including ignorance of those offended against, reluctance to be drawn into formal investigations and hearings, while many matters may be settled through informal discussions (Koocher & Keith-Spiegel, 1998).

Regarding the 'profiles' of offenders, Keith-Spiegel and Koocher (1985) suggest that offenders generally fall into the following groups:

- i) the uninformed and unaware group;
- ii) the personally troubled group;
- iii) the overzealous group;
- iv) the vengeful group;
- v) the insufficiently trained group;
- vi) the 'slipped' or 'lapsed' group.

The extent to which adjudication outcomes should become public knowledge remains a matter

of debate, except of course outcomes of civil and criminal or formal Board hearings, which are mostly in the public domain.

### 3.1.2 Adjudications

In 2001 the outcomes of complaints against APA members were as follows: Incomplete: 2%, Complaint dismissed: 26%, Reprimand/censure: 29%, Loss of membership: 43% (APA, 2001d).

The adjudications of the APA Ethics Committee are published annually. Only recent findings (APA, 2001d) are reported here. It is important to distinguish complaints from adjudications. Adjudication outcomes for the year 2000 (APA, 2001d) are summarised below.

Apart from cases referred to the APA from other jurisdictions (e.g., state boards, civil courts, etc., which, incidentally, are increasing annually to a record 58% of all APA complaints in 2000), the largest category resulting in guilty adjudications against psychologists was sexual misconduct, accounting for 46% of cases and consistent with earlier report data (APA, 2001d). Of these, 42% involved sexual misconduct with adults and 6% with minors. Non-sexual dual relationship showed a steady increase in misconduct adjudications to 26%, followed by fee issues at 20% and 'other' the remaining 9% of adjudicated misconduct cases.

Until recently, the British Psychological Society (BPS) did not publish details of disciplinary cases beyond a brief statistical report on the activities of its Disciplinary Board. Despite the absence of case details in early formal BPS reports, Lindsay (1995) cited some details of complaint patterns. Most cases concerned "client-related professional psychology" (p. 497) with a minority of science related cases. Mackay (2000) presented the resolution of disciplinary cases as follows: no case: 22%, formal inquiry convened: 18%, carried over: 12%, misuse of descriptions queries: 12%, guidance: 6%, disciplinary committee hearing: 3%, with the remainder being new complaints received and in process. These outcomes used categories different from the APA reports, making comparison difficult. The ethical issues involved in such cases were described in descending order as follows: conduct: 42%, assessment: 23%, competence: 9%, negligence, 9%, general: 6%, research, confidentiality and dual relationships 3% each, and consent: 2%. Noteworthy here was the absence of fee issues. It is assumed that sexual dual

relationships were subsumed under the 'conduct' category. The 2001 BPS Annual Report (BPS, 2001a) describes a 30% increase in complaints received compared with 2000. The areas of practice involved were ranked as follows: clinical 40%, educational, 18%, counselling, 12%, occupational 8%, court reporting and forensic 7% each, academic 4% and a few smaller categories. The nature of the ethical problems was not described. Educational psychology showed the largest increase compared with previous reports.

A report by Koene (1997) on disciplinary procedures and actions in 14 of 26 European psychological associations surveyed in 1996 reported that complaints were received against 0.03% of members. Of these, 20% were dismissed as unfounded, 46% were regarded as acceptable within standards, 20% were in process, and the remainder (15%) were violations. The ethical issues underlying these complaints were ranked as follows: incompetence: 30%, irresponsible conduct: 25%, consent: 19%, confidentiality: 14%, dishonesty: 4%, sexual and non-sexual dual relationships 3% each. Regarding practice settings or contexts, which are not explicitly reported in APA or BPS reports, the European data listed the settings associated with complaints as follows: forensic: 25%, organisational and child/educational: 13% each, psychotherapy: 10%, academic and research settings: 2%, and 'other' 6% (Koene, 1997). Notable is the much lower prominence of sexual misconduct when compared with the American data reviewed above.

The study of ethical violations by South African psychologists has only recently gained momentum. A study by Louw (1997a) of complaints processed by the voluntary psychological association ethics committee in the years 1956 to 1976 (SAPA) and 1988 to 1990 (PASA) reported the following categories of ethical complaints: advertising, 67%; unpaid registration fees, 14%; assessment, 9%; unprofessional conduct, 7%; and fees, 2%. The high ranking of advertising corresponds with early years of APA complaints (Schoenfeld, Hatch & Gonzalez, 2001). The unpaid registration fees are more a legal issue than an ethical issue, as will be discussed below in section 6.1.1.2.

### 3.2 Complaints to Statutory Boards

Montgomery, Cupit and Wimberley (1999) state that "research exploring complaints is new" (p.

405). Reaves (1995d) provided a detailed review of cases against psychologists reported to American State Licensing Boards. As each state has an autonomous licensing board for psychology, it has to date been difficult to obtain and collate this information, and Reaves' (1995d) report is invaluable in this regard. His data show the following reasons for disciplinary actions against psychologists between 1983 and 1995, ranked as follows:

Sexual/dual relationships:	387
Unprofessional/negligent practice:	239
Fraudulent Acts:	126
Criminal convictions:	85
Inadequate/improper supervision:	43
Impairment:	39
Breach of confidentiality:	30
Fraud in license application:	26
Improper/inadequate records:	17
Failure to comply with continuing education requirements:	11

An updated conference paper by Reaves (2000, cited in Schoenfeld et al., 2001) repeated the above rankings. Reaves (1995a) cited a study by Woody which reported that in one state (Florida) an average of 5.5% of registered psychologists had complaints filed against them, but the nature and context of the complaints were not specified. A survey of complaints against licensed counsellors (Neukrug, Healy & Herlihy, 1992) to state licensing boards showed that practising without a license was the most frequent complaint, followed by complaints of sexual misconduct, fee issues and informed consent issues. About 73% of the complaints resulted in some form of disciplinary action, ranging from revoked licenses to letters of reprimand. Montgomery et al. (1999) found that complaints against their survey respondents occurred in the following areas: supervisory issues (22%), child custody work (10%), retaliation (10%), misuse of title (7%), assessment or diagnostic problem and adult therapy (both 6%), followed by a variety of smaller categories. While the prominence of supervisory issues is surprising in comparison to other reports cited above, this survey data should, however, be seen as less reliable than formal analysis of Board data.

An analysis of complaints processed by the South African Medical and Dental Council (Verschoor, 1990) excluded psychologists and thus made no contribution to this field. The Board does not routinely publish statistics on complaints and adjudications but data has been made available to researchers on request. A study by (Louw 1997b) on complaints to the Professional Board for Psychology between 1974 and 1990 found that complaints were lodged against 0.06% of registered psychologists. Guilty verdicts were reached in 14.3% of cases, and most of these (30%) concerned advertising, and 9% were due to sexual misconduct (data for other categories not provided). The pattern of complaints, before adjudication, concerned the following ethical issues in descending order: fees: 40%, advertising: 19%, confidentiality: 8%, sexual misconduct, competence and lack of care for client: 7% each, misuse of tests: 4%, interprofessional problems: 3%, late reports, criminal convictions and custody cases: 2% each. Louw (1997b) listed the sources of these complaints arising from clients or relatives in 63% of complaints, other psychologists in 20%, medical professionals 7%, and the balance from medical aid schemes and other bodies, consistent with patterns reported in the USA (Koocher & Keith-Spiegel, 1998). Most advertising complaints (75%) were from other psychologists.

An important recent study of complaints and disciplinary outcomes against South African psychologists examined records of complaints submitted to the Professional Board between 1990 and 1999 (Scherrer, et al., 2002). Apart from a high number of complaints submitted by the Board itself due to unpaid registration fees (21%), the most frequent public complaints concerned accounts and fees (16%), reports (13%), competence (13%) and improper behaviour (12%, including sexual misconduct). They found that the majority of public complainants were relatives of clients (34%) or clients themselves (26%). They found that 15 % of public complaints were referred to formal disciplinary enquiries, and that thirty of forty-nine such inquiries remained incomplete at the time of the study. The average time for processing inquiries to completion was between two to four years. Of the completed inquiries, 34% led to convictions and sanctions.

Systematic complaints data from regulatory bodies is difficult to access (Pope, 1989; Scherrer et al., 2002), and this is reflected in an appeal by Montgomery et al. (1999) for the systematic publication of such data, in the interests of practitioner education and risk management: "Knowledge concerning malpractice, complaints, and risk management enables the psychologist to practice in a manner that is safe, advantageous, and respectful for both the psychologist and

his or her clients” (p. 409). This statement is consistent with the aims of the present study.

### 3.3 Malpractice Insurance Settlements

More complaints are made to regulatory authorities than to the civil courts (Montgomery et al., 1999). This may be because Board complaints involve no costs and little effort for the complainant. However, they offer no immediate financial reward to the plaintiff unless they proceed with a civil claim based on a successful Board complaint. Many insurance claims are settled out of court and the offending psychologists’ names are not released to the APA or the state licensing Board by the insurer, unless the complainant does so or if the case goes to court (VandeCreek, Knapp & Herzog, 1987).

In a review of malpractice insurance claims for sexual misconduct, Cummings and Sobel (1985) reported a marked increase in the frequency of insurance claims against psychologists. The reported rise in the frequency of such claims was reflected in an annual average rate of 44 claims per year between 1976 and 1981, rising to 153 claims per year between 1982 and 1984 (Wilbert & Fulero, 1988). Of these, there were five claims for sexual misconduct per year in the earlier years, rising to 24 such claims in the second period. In contrast with an earlier report, psychologists sued for sexual malpractice were not exclusively male, with about one in five psychologists charged being female.

Treatment of dangerous patients and protection of others from harm is also an area that generates malpractice suits, particularly since the well-known Tarasoff case (Bersoff, 1976; Ewing, 2002) and its implications for clients with HIV (Anderson & Barrett, 2001; Chenneville, 2000). The essential issue is to ensure that appropriate standards of care exist and are practised - the courts do accept that even flawless management of such cases cannot always prevent harm to others.

With the rising number of malpractice suits in the USA, malpractice insurance premiums for psychologists in the USA increased 800% between 1984 and 1988, although the risk of being sued remained constant at about 0,5%. Wilbert and Fulero (1988) conducted a survey of psychologists’ fears of litigation and attempted to evaluate the prevalence of such litigation. They surveyed 350 psychologists at random and received a 71% response. More than half the sample

reported no concern about being sued, although there was a positive correlation between actual hours of practice and concern about being sued. Two percent of the sample had been sued - of the three cases, two had been dropped and one remained in progress at the time of the study. All three cases involved custody disputes. A further 17% of the sample had been threatened with a lawsuit, and most of these were related to fees and billing issues, therapy of spouses, and custody issues. Despite the generally low reported concern with litigation, 57% of the sample took practice measures to reduce malpractice risks by, for example, using written consent procedures, treatment plans, information brochures, good documentation, consultation and peer review. Other steps taken were to supervise supervisees more closely, to inform clients explicitly about limits of confidentiality, and the exclusion of clients who were seen as potentially litigious - e.g., patients with paranoia, borderlines and those tending to project blame. It can however be argued that excluding certain diagnostic groups from treatment for this reason is unethical unless the practitioner lacks the competence to treat such cases. Better suicide risk management was also practised by more concerned practitioners. In effect, the study showed no widespread litigation phobia among psychologists, but did suggest that malpractice concerns positively affected standards of practice (cf. Bennett, Bryant, VandenBos & Greenwood, 1990). Thus, although there was no real 'epidemic' of litigation against psychologists in the USA, taking steps to prevent this possibility and raise standards of practice seemed prudent. Apart from careful and ethical practice and risk management, malpractice insurance also provides some reassurance to the practitioner and recompense to injured clients. The BPS (1995b, p. 376) regards it as a "moral obligation" for Chartered Psychologists to have malpractice insurance.

There is no data available on malpractice suits against psychologists in South Africa, although malpractice insurance has been available to psychologists for some years. A major insurer described a general trend of increasing claims for South Africa (550 in 1995 to 750 in 1999) (MPS, 1999, p. 8), but did not distinguish medical claims from psychological claims, both of which are covered by its scheme. An insurer's subsequent newsletter (MPS, 2000) stated that it had assisted psychologists in more than 80 cases and that settlements of R 300,000 (\$30,000) had been paid. A problem with this data is that this insurer also covered psychologists' costs in Board complaints, which may have been most of the 80 cases. Nevertheless, such patterns could also be attributed to an "increasingly consumerist approach by society in general" (MPS, 1999, p. 9). Malpractice insurance was purchased by 72% of respondents to a survey in Texas by

Montgomery et al. (1999), while 91% of the remainder signalled intent to do so. At present the number of South African psychologists subscribing to malpractice insurance schemes is unknown, and is a minor aim of the present study.

The APA Ethics Committee (APA, 1988c) reported that 45% of the 15 million dollars paid out in malpractice claims against psychologists concerned sexual misconduct (p. 567), while Reaves and Ogloff (1996b) stated that litigation in the USA had reached “appalling proportions” (p. 117), less so in Canada. Montgomery et al. (1999) cite statistics which show that 0.5% of American psychologists stand a chance of being sued while six percent of their respondents had been sued for malpractice. Their sample ranked the following issues as most likely to lead to litigation or complaint: sexual misconduct, child custody work and client suicide. Teaching outside range of competence and publication credit disputes were seen as least likely to lead to a suit or complaint. Respondents underestimated the extent to which incorrect diagnosis and negligent supervision could lead to litigation or complaints. General risk management guidelines to assist psychologists in avoiding malpractice suits were published by the APA in 1990 (Bennett et al., 1990) and guidelines for specific specialty areas were published in 1998 (Anderson, Needels & Hall, 1998).

In summary, the above section reveals that complaint patterns are a rich source of information about public dissatisfactions with psychologists’ professional conduct. However, reliable data are difficult to access and compare due to national and international differences in the publication of complaint patterns, and differences in the coding, categorisation and presentation of such information. In South Africa, no systematic data on complaints patterns existed until Louw (1997a, 1997b) examined early records of reports to the Board and the national psychology association, followed by a more recent study by Scherrer et al. (2002). Data from these studies will be reviewed in detail in chapters 7 and 8.

### 3.4 Surveys of Ethical Conduct and Ethical Dilemmas

#### 3.4.1 Surveys of Ethical Conduct

A survey was conducted by Riordan and Marlin (1987) to determine the perceived “frequency, wrongness and recommended sanctions for the unethical research practices of plagiarism and data fabrication” (p. 106). They found that psychologists felt that such behaviours occurred

infrequently, which is consistent with the low frequency of such cases reported to the APA at that time. In contrast, however, a survey in Britain by Lindsay and Colley (1995) found that research issues were very high on the list of ethical concerns surveyed. This possibly reflects the relatively recent professionalisation of psychology in the UK, with relatively few private practitioners (Lunt, 1999).

A major survey of psychologists' beliefs and practices by Pope, Tabachnick and Keith-Spiegel (1988) attempted to establish what psychologists themselves regarded as good and bad professional practice. Obtaining a 45% return of their survey, they found 80% consensus for the following 13 bad practices, five of which were sexual: engaging in sex with a client; engaging in erotic activity with a client; disrobing in the presence of a client; allowing a client to disrobe; engaging in sexual contact with a supervisee. Three boundary breaches were financial: getting patients to refer new patients; going into business with a client; borrowing money from a client. Two items concerned confidentiality: unintentional disclosure of confidential data; and discussing a named client with friends. The remaining three items were breaching confidentiality to manage child abuse and suicide risk. Practices rated as difficult to judge ethically included bartering, terminating with payment defaulters, use of collection agencies, advertising, media interviews, use of sexual surrogates, engaging in sexual fantasies about a client, and feeling sexually attracted to a client. There was little consensus on a range of items, including birthday and holiday greetings; use of computer testing; accepting gifts worth more than \$5.00; attending client weddings (etc.); helping a client file a complaint against a colleague. These findings showed a trend towards 'stricter' ethical standards by psychologists compared with earlier studies. The exception to this trend was the issue of altering a diagnosis on an account to facilitate medicare payment - seen by many as being to the benefit of the client. The study suggested, like that of Jensen and Bergin (1988), that psychologists had a fairly high consistency of beliefs about acceptable standards of practice. No attempt was made by the authors to relate these findings to the ethics training of the respondents nor to patterns of reported violations.

#### 3.4.1.1 Sexual Contact

The issue of sexual contact between psychologists and clients is undoubtedly the ethical issue that generates the most published work in professional ethics. In collecting material for this study

the present author found more than 160 references on this topic between 1970 and 2002. It is beyond the scope of the present work to review this issue in detail. The focus here will be to outline the frequency and characteristics of this problem as one of a variety of ethical issues that occur in professional practice.

An early study of state licensing board disciplinary actions (Gottlieb, Sell & Schoenfeld, 1988) involving psychologist-patient sexual relationships addressed the issue of whether post-termination relationships could be sanctioned after a time limit or 'statute of limitations' had lapsed. They obtained a 79% return from state licensing boards. The survey showed a sharp (41%) increase in sex complaints to state licensing boards between 1984 and 1985, with a 276% increase between 1982 and 1985. They attributed this increase to greater public awareness of professional misconduct as a response to public education efforts by the APA. There was a corresponding trend of complaints concerning sex between psychology educators and students, along with increasing trends in other types of violations (e.g., fraud, disclosures, etc.). However, the findings of disciplinary hearings showed a reducing rate of proven violations (37% to 20%) for 1984 and 1985 respectively. About half the defendants denied the contact, while a smaller percentage admitted that the contact began concurrently with treatment. Violations were upheld even if sex occurred after termination, and the licensing boards felt that the time lapse after termination (even one case of a 4-year lapse) was not relevant. This finding anticipated and recommended the later ruling by the APA (APA, 1992a) that sexual relationships between psychologists and ex-clients are unethical.

A review by Pope (1988) showed that 8.3% of all male therapists (including psychiatrists and social workers) and 1.7% of female therapists report sexual activity with clients, but noted that the rates for psychologists as a specific group appeared to be declining - perhaps as an artefact of stricter state laws, leading to less disclosure in sex surveys. Lamb and Catanzaro (1998) reported the prevalence of sexual boundary violations by psychologists at 5-6%. Sexual relationships occurring after termination of the professional relationship were found to be less harmful. A controlled study of client characteristics and contextual factors associated with sexual boundary violations was conducted by Somer and Saadon (1999) who found that clients who were sexually exploited by therapists (including non-psychologists) were more likely to have been traumatised in the past, had been 'parental children' or exposed to emotional abuse. A

history of sexual abuse in childhood significantly differentiated exploited clients from non-exploited comparison patients. Exploited clients had also been significantly more frequently sexually assaulted as adults. The exploiting therapists were more likely to be middle-aged men in solo private practice. The sexual contact developed gradually (the 'slippery slope') and followed verbal self disclosures, then physical contact with the therapist leading to changed appointment schedules to ensure privacy. Psychologists who reported sexual boundary violations were significantly more likely to have many non-sexual dual relationships than those reporting no sexual boundary violations. Sexual issues in professional practice are increasingly becoming a specific focus of professional ethics training in the USA (Hamilton & Spruill, 1999; Samuel & Gorton, 1998; Schover, Levenson & Pope, 1983; Sonne & Pope, 1981). An unpublished South African study showed that almost half the 485 psychologists sampled felt that they had not been adequately trained to deal with sexual attraction in their work (Stevenson, 1999). Scherrer et al. (2002) found that complaints for sexual misconduct comprised 4.8% of formal complaints against South African psychologists, which is much lower than reported in the USA by Reaves (1995d) and the annual APA reports cited above.

#### 3.4.1.2 Psychology Educators and Students

Sexual relationships between psychology educators and students or supervisees over which educators have direct or evaluative authority were first prohibited in the 1992 version of the APA ethics code (Kitchener, 2000b). A primary study in this area was conducted by Pope, Levenson and Schover (1979) who found that about 25% of female PhD students surveyed reported sexual contact with at least one of their psychology educators during their training. A more detailed anonymous survey of 464 female graduate students by Glaser and Thorpe (1986) revealed that between 20 and 25% of female graduate students had sexual relationships with their psychology educators, mostly concurrent with a working relationship. While many respondents reported feeling positive about the contact at the time, respondents reported increasingly negative feelings of exploitation with the passage of time. Lamb and Catanzaro (1998) found that about 3% of psychology supervisors had sexual relationships with students or supervisees. They also found that 12% of psychologists reported that sexual boundary violations had occurred during their personal therapy or supervision. Most of this group were women. They found no statistical association between reported experienced sexual boundary violation as a client and likelihood

of committing such violations once in professional practice. They also found that supervisees and students were less likely to feel negative about sexual boundary violations with supervisors than did therapy clients. Kitchener (2000a) reported a decline in the number of such relationships, perhaps due to the prohibitive rule and its impact on psychologists trained more recently. Sexual relationships occurring after termination of the supervisory relationship were found to be less harmful than those that occurred during the professional relationship, although Kitchener describes these as “unwise” rather than unethical (Kitchener, 2000a, p. 153).

Non-sexual dual relationships between students, supervisors and supervisees are also complex (Holemes, Rupert, Ross & Shapera, 1999; Kitchener, 2000a; Lamb & Catanzaro, 1998; Swain, 1996), mainly because of their boundary role modelling implications. On the one hand, for example, socialising with students may be seen as part of ordinary human sociality as well as their socialisation into the profession, while on the other, shifting relationships, expectations and obligations can generate role confusion.

With regard to ethical misconduct amongst trainees, a study of critical incidents at American and Canadian training universities ( $N=243$ ) which obtained a 31% response rate ( $n=75$ ) found that the rate of ethical violations by trainees was low. The most frequent ethical violations were the following: confidentiality violations (25%), sexual and non-sexual boundary violations (20%), plagiarism (15%), welfare<sup>1</sup> (10%), procedural breach (10%), competence (9%), dishonesty (8%) and self-misrepresentation<sup>2</sup>. Over 54% of the transgressing students had completed an ethics course (Fly, van Bark, Weinman, Kitchener & Lang, 1997).

### 3.4.2 False Complaints

Just as many violations are probably not reported, some complaints against psychologists may be false. There are increasing accounts of abuses of psychologists by clients and by licensing boards and disciplinary committees (Pryzwansky & Wendt, 1999; Williams, 2000). It seems logical to expect that such false complaints would be included in the relatively high number

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<sup>1</sup> Equivalent to the ‘inappropriate practice’ category used in the present study.

<sup>2</sup> Coded as ‘advertising’ in the present study

(around 40%) of complaints dismissed or deemed groundless by regulatory authorities described above. It is, however, also possible that some false complaints proceed to the formal investigatory stage and furthermore lead to convictions that may or may not be overturned on appeal. No South African data on false complaints exists, but Scherrer et al. (2002) reported that the accused psychologists' explanations were accepted in 53% of complaints. The proportion of false complaints within this percentage remains unknown and warrants further study.

All justice systems are fallible (Williams, 2000). The intense personal and professional impact of the complaints process upon psychologists, whether based on false or sustained complaints, has been highlighted by several authors (Bernet, 1995; Chauvet & Remley, 1996; Montgomery et al., 1999; Scherrer et al., 2002; Schoenfeld et al., 2001; Wilbert & Fulero, 1988; Williams, 2000). Circumstances likely to lead to false complaints were "(a) malingering and fraud, (b) revenge, (c) psychopathology, (d) 'recovered' memory, (e) doctrinaire suggestions from a subsequent therapist, and (f) escape from unwanted treatment", reviewed by Williams (2000, p. 77). Williams suggested that courts and ethics committees should routinely consider these factors when adjudicating complaints, as not all complaints may be legitimate appeals for justice. In contrast, "A certain degree of risk is inherent in doing business with the public" (p. 81).

Schoenfeld et al. (2001) compared psychologists who had been found guilty ( $n=21$ ) with a sample ( $n=113$ ) who had been found not guilty of a complaint. No significant demographic or practice preference differences differentiated the two groups. Both groups reported high costs and high rates of psychological, physical and interpersonal symptoms as a result of the complaints process, but these were predictably higher for those who received guilty adjudications. They go on to recommend that psychological associations should monitor Board disciplinary proceedings and generally be more supportive to psychologists and act as "monitors of fairness in the adjudication process" (p. 495).

### 3.4.3 Ethical Attitudes

Many studies have been conducted on the ethical attitudes of psychologists, some of which are reviewed by specific ethical issues below. The methodology of most of the studies reported below involved asking respondents to rate the perceived frequency and seriousness of the ethical

dilemmas embedded in vignettes of clinical situations provided by the researchers. In analysing the data, researchers scored the perceived frequency and seriousness of the responses, and the degree of consensus on each ethical issue.

Confidentiality is viewed as a critical component of psychology practice. However, many psychologists are inadequately aware of legal and ethical issues around confidentiality (Miller & Thelen, 1986). Miller and Thelen (1987) surveyed the views of non psychologists, psychology students and former mental health service clients on confidentiality issues. Sixty-nine percent believed that confidentiality was absolute, while only 20% believed that special circumstances might require breach of confidentiality, especially to protect others. Ninety-seven percent of the sample felt that confidentiality issues should be explicitly discussed before any professional service provision, although they also felt that being told of the limits of confidentiality might limit their frankness. The survey thus revealed tension between clients who expect to be treated with absolute confidentiality and ethical requirements requiring that the limits of confidentiality be explained before service provision. Miller and Thelen (1987) pointed out that there appeared to be no clear guidelines on when breaching confidentiality is appropriate. Furthermore, they cited research suggesting that psychologists would not breach confidentiality even when they know that doing so might be legally appropriate. Client disclosure may be influenced by the degree to which confidentiality is assured.

Pope and Tabachnick (1993) surveyed therapists' anger, hate, fear and sexual feelings to establish how often therapists experienced these feelings and under what circumstances they typically occurred. They also asked therapists to rate their training regarding these experiences. While the above feelings in themselves are not unethical, they all carry the risk of leading to unethical actions by psychologists if they are acted upon inappropriately. There was a 47% ( $N=285$ ) response to their survey which suggested that more than 80% of the psychologists surveyed reported some degree of fear, anger and sexual feelings in their work. The strongest fear reported was of client suicide, followed by fears of client deterioration, anger at client non cooperation, and fears of client attacks on third parties. Over half (57%) of the sample reported feeling sexually aroused in the presence of a client: 47% of these with female clients and 34% with male clients. As for experiencing sexual attraction to clients, 87% reported feeling sexual attraction to clients - 66% of these with female clients and 53% to male clients. Most fears about client

suicide concerned female clients, although data show that almost universally most completed suicides are committed by males (Canetto & Lester, 1995). With the greater incidence of sexual attraction towards female clients this suggests that gender differentials in treatment require more explicit attention in training. More than 11% of respondents reported that complaints had at some stage been filed against them, more than 66% of these against male therapists. Most respondents felt that their training in these areas had been inadequate, independent of theoretical orientation. These data may have reflected the opinions of an ethically troubled subgroup, as the number of respondents who reported having been complained against was much higher (over 10%) than the annual percentage of APA members complained against to the APA Ethics Committee (less than 0.5%). The study did not examine years of experience as a variable.

### 3.4.4 General Ethical Issues Research

#### 3.4.4.1 Knowledge and Compliance with Ethical Principles

Haas, Malouf and Mayerson (1986) conducted a survey returned by 294 (59%) respondents. Dilemmas were rated on frequency and seriousness by respondents. No dilemmas were of more than “occasional concern” (p. 319), but 11 of the 17 problems presented in the questionnaire were rated as either “serious” or “extremely serious”. Rated as most serious were breaches of confidentiality and sexual misconduct. Rated as least serious were media appearances and advertisement. Problems more frequently encountered were confidentiality issues in family therapy and the conduct of other professionals. The authors concluded that while psychologists regarded many ethical issues as serious, they did not encounter them often. The variability of responses and the reported low level of formal training in ethics underlined the need for formal, reality based, ethics training and problem-solving in professional psychology programmes.

A series of studies was conducted which tested the hypothesis that psychologists know ethical principles (concerning unethical conduct by a colleague) but do not necessarily act in accordance with such knowledge. Bernard and Jara (1986) presented psychology graduate students with a series of case vignettes and an update on ethics principles. There was a 68% response rate. In most vignettes the students would do less about unethical behaviour than they knew they should do. They concluded that ethics training was inadequate and should focus on practical decision-making rather than rule learning. In a similar study of clinical psychologists, Bernard, Murphy

and Little (1987) obtained a 50% response rate. Although more prepared to act than the graduate students, there was still a disquieting discrepancy between what the respondents knew they should do and what they would actually do. The knowledge/action discrepancy widened with the seriousness of the offense in the vignette. Bernard et al. (1987) speculated that personal values rather than ethical training might be a factor in this phenomenon.

Pope, Tabachnick and Keith-Spiegel (1987) sought to explore further the relationship between beliefs and compliance with ethical principles. A comprehensive questionnaire was sent to 1000 psychologists, of whom 45.6% responded. The findings suggested much greater concordance of ethical beliefs and behaviours than did the earlier studies. It must be mentioned that the earlier studies focussed on the reporting of unethical behaviour by a colleague rather than on ethical behaviour by the respondent *per se*. Most knowledge/action discrepancies concerned unintentional lapses of confidentiality (cf. Peel 1998). Reported sexual intimacies were much lower (1.9%) than other reports. After considering methodological and other issues the authors suggest that this might “indicate an actual decrease in the percentage of psychologists engaging in sexual intimacies with their patients” (p. 999). This could be consistent with a slight lowering of sexual misconduct adjudications by the APA in 2000 (APA, 2001d; 46% compared with an average of 56% for the preceding eight years. Vinson (1987) however argued that most sexual misconduct remains unreported and stated that 6000 patients were involved in sex with psychologists annually in California alone. In contrast, only 12 psychologists were disciplined, suggesting that only 0.2% of sex violations reach ethics committees. She further reported apparent unconcern among professional authorities at this under-reporting, many of whom blamed the clients for failure to take appropriate action. Vinson (1987) however found that most violated patients in her sample were unaware of complaint procedures, and most had sought civil actions, but feared the psychologist’s anger. In conclusion Vinson argued that clients must be advised of their rights by waiting-room documentation and access to a toll-free number. Such resources might also, she argues, inhibit therapist-patient sex by heightening therapist awareness of clients’ access to disciplinary committees. She stated that complainants should be assisted in the formulation, processing and prosecution of sex complaints against psychologists.

A study of psychotherapists (including psychologists, psychiatrists and social workers) conducted by Conte, Plutchik, Picard and Karasu (1989) attempted to establish the extent to which certain

practices were regarded as unethical. A 50% return was obtained. In contrast to Pope et al. (1987) and Jensen and Bergin, (1988), they found much variance in responses to items covering a variety of areas of clinical practice. Consensus of 30% was reached on only 10 of the 49 items. Consensus was highest on issues of sexual misconduct, homicide, suicide risk management and plagiarism. Gender and training discipline did not differentiate responders' attitudes, but psychotherapy orientation tended to show that responders describing themselves as 'psychoanalytic' were more conservative on sexual issues. However, 'non-psychoanalytic' therapists were stricter than psychoanalytic therapists on a variety of non-sexual issues, e.g., prolonging treatment beyond the client's expressed wishes, publishing case material and termination for failure to pay. Years of experience also affected certain ratings but not in a consistent way. These findings show the interrelatedness of ethical issues with theoretical orientation, type of service and context in which the service is delivered. The study concluded with a note of concern about the low consensus on unethical behaviours and advocated vigorous training in professional ethics, particularly addressing some misconceptions commonly held. The authors however acknowledged that there was nevertheless scope for some "genuine disagreement over inherently complex and ambiguous issues" (Conte et al., 1989, p. 41).

The low consensus on ethical issues described above can be expected to lead to variability of actual implementation of ethical principles. The discrepancy between ethical ideals and ethical practice was studied by Smith, McGuire, Abbott and Blau (1991). They obtained responses from 102 'mental health professionals' (44% response rate) on a questionnaire containing clinical vignettes based on the surveys of Haas, Malouf and Mayerson (1986, 1988). Respondents were also asked to describe their ethics training and rate the usefulness of various ethics training formats. Predictably, they found greater clarity and consistency on ethics ideals than on measures of actual ethical actions. Ideals were based on published principles while actions were justified by personal, professional and client circumstances. In other words, theoretical responses were based on codified rationales, while actions were based on codified and non codified rationales. This was consistent with the utilitarian nature of most ethical codes and standards that are not detailed rules of conduct. The discrepancy however does allow for ethical complacency and deficits in integrity and honesty. The authors suggested that the discrepancy be addressed by ethical principles that are applied between published ethical standards and ethical action.

Ethical issues in South African psychology have not generated many publications, particularly in comparison with a spate of publications in the USA in the 1980's. Some recent studies have, however, investigated psychologists' attitudes towards and practices regarding erotic and non-erotic physical contact with clients (Trent & Collings, 1997), issues associated with client confidentiality (Peel, 1998; Voigt, 1995), and sexual attraction in psychotherapy (Stevenson, 1999). Ethical issues in authorship credit were reviewed by Louw and Fouché (1999). Psychologists' preferred resolutions to hypothetical ethical vignettes and their primary reasons for these choices were studied by Slack (1997; Slack & Wassenaar, 1999), as have complaints and inquiries received by South African psychological regulatory bodies (Louw, 1997a, 1997b; Scherrer et al., 2002), reviewed earlier.

In summary, these studies have shown that psychologists generally disagreed on the most appropriate action in the face of hypothetical ethical vignettes (Chevalier & Lyon, 1993; Haas, Malouf & Mayerson, 1986; Slack, 1997; Tymchuk, Drapkin, Major-Kingsley, Ackerman, Coffman & Baum, 1982). Such diversity in decision making is considered an index of those professional situations that psychologists are facing without the benefit of clear ethical guidelines (Chevalier & Lyon, 1993). As these results were based on preselected hypothetical scenarios, they may have failed to capture the complexity of actual situations psychologists face in their daily practice (Nicolai & Scott, 1994). Subsequent research has focussed on the direct solicitation of situations that psychologists identify as personally problematic and these are reviewed below.

### 3.4.5 Surveys of Ethical Dilemmas

#### 3.4.5.1 Ethical Dilemmas

In contrast to the methodology used in most of the above studies, Pope and Vetter (1992) attempted to elicit ethical dilemmas experienced by professional psychologists, rather than ask respondents to rate given vignettes. In contrast to asking psychologists to rate and interpret standard written scenarios, it was felt that eliciting ethical vignettes derived directly from psychologists' own experience would generate data more congruent with the realities of practice and better assist psychologists with ethical decision making (Lindsay & Colley, 1995), training and guideline development. This methodology is similar to that used in the present study and has

also been used in an international collaborative effort initiated by Pettifor and Sinclair of Canada (Antikainen, 1997; Colnerud, 1997b; Lindsay & Clarkson, 1999; Lindsay & Colley, 1995; Odland, 1997, 1999; Orme & Doerman, 2001; Pope & Vetter, 1992; Sinclair & Pettifor, 1997), including a South African study (Slack & Wassenaar, 1999). This collaboration included data from Canada, Colombia, Finland, Great Britain, Norway, South Africa, Sweden and the USA. Such international comparisons reflect the growing globalization of professional issues in psychology, as expressed, for example, in the movement to develop a European meta-code of ethics for psychologists (EFPPA, 1995). Such data may further guide the development of specialty guidelines to ease decision making in specific ethical areas and guide educative efforts at pre-professional and continuing education levels.

A South African study (Slack & Wassenaar, 1999) which solicited ethical dilemmas from a sample of South African clinical psychologists ( $N=51$ ) established that the following ethical issues occurred most frequently: confidentiality (29%), non-sexual dual relationships (14%), fee issues (14%), academic/training issues (8%), and sexual issues (8%). When the South African data was integrated and averaged with vignettes from the other six countries studied ( $N=1632$ ), the following emerged as the most frequent ethical issues overall: confidentiality (26.2%), non-sexual dual relationships (11.7%), fee issues (6%), colleagues' conduct (5.6%), questionable intervention (2.8%), research issues (2.2%), sexual issues (2.1%), academic/training (1.8%). It should be noted from the above that the coding used in these studies did not distinguish ethical issues from the contexts in which they arose (cf. e.g., academic, research). It is hoped that the present study will develop this distinction more clearly.

The most frequent ethical issues appearing across all the studies cited above are discussed briefly in descending order below.

**Confidentiality:** Dilemmas concerning confidentiality comprised 29% of those volunteered by South African survey respondents, making this the largest category of ethically problematic issues. Of these, the largest cluster involved legal obligations to release client records through a subpoena or court order, reflecting a conflict between ethics and law. The next most substantial trend concerned confidentiality dilemmas with minor clients. Respondents described attempts to use the child's "best interests" and identification of those "who are clearly concerned with the

case” (Steere & Wassenaar, 1985, p.35) as the yardstick for the degree of parental (or other) involvement in treatment. They were attempting to balance many considerations (such as child and parental concerns; the child’s cognitive capacity; the presenting problem, etc.) to decide the appropriate degree of confidentiality with minor clients (Goldberg, 1997; Gustafson & McNamara, 1987; Jensen, McNamara & Gustafson, 1991; McGuire, 1974) in the absence of generic or speciality guidelines (cf. Kitchener, 2000a; Koocher & Keith-Spiegel, 1998).

A further cluster of confidentiality dilemmas involved legal obligations to report child abuse, which remains a difficult practice globally (Brosig & Kalichman, 1992; Government Gazette, 1983; Nicolai & Scott, 1994; Renninger, Veatch & Bagdade, 2002; Small, Lyons & Guy, 2002). Further dilemmas involved queries about professional responsibility in the event of a client threatening harm to others. Respondents were aware of the duty to breach confidentiality in circumstances of clear danger to others (Steere & Wassenaar, 1985) or protect others from harm (SAMDC, 1992b). Respondents seemed unable to use these guidelines to assess the degree of the patient’s risk, to establish when risk constitutes grounds for a breach of confidentiality or how best to communicate risk assessments (Anderson & Barrett, 2001; Ewing, 2002; Monahan, 1993; Monahan & Steadman, 1996).

The remaining ethical dilemmas described difficulties establishing the parameters of confidentiality in multi-person (marital and family) therapy (Marsh & Magee, 1997). Respondents were aware of the need to clarify the limits of confidentiality early in therapy, yet felt that confidentiality limits in such cases were a matter of personal discretion and theoretical orientation. A recent paper warns that ethical issues should not be secondary to theoretical orientation (Williams, 2000).

In summary, most confidentiality dilemmas emerged at the interface of conflicting legal and ethical responsibilities. Most psychologists were aware of legal obligations to breach confidentiality in specified instances, but found guidelines unhelpful in determining the exact parameters of these situations or in guiding their actions so as to least compromise their ethical obligations to their clients. In keeping with these findings, confidentiality dilemmas were consistently dominant for APA (Pope & Vetter, 1992) and BPS members (Lindsay & Colley, 1995) and also Swedish (Colnerud, 1997a, 1977b), Norwegian (Odland, 1997, 1999), Canadian

(Sinclair, 1997) and Finnish respondents (Antikainen, 1997). Confidentiality issues were the primary ethical issues of concern to psychologists in the seven countries surveyed. This suggests that guidelines for responding to subpoenas in the South African context would help psychologists who may be faced with this legal scenario (APA, 1996c). Psychologists may benefit from guidelines concerning legal obligations to protect third parties from threatened harm (Anderson & Barrett, 2001; Monahan, 1993; Monahan & Steadman, 1996). There might be a need for specific ethical guidelines and training regarding confidentiality with minor clients (children and adolescents) and with multi-person (family and marital) interventions (Lakin, 1986, 1994; Marsh & Magee, 1997). Educative efforts focussed on recognising situations that trigger an obligation to protect (such as “foreseeable” harm to an identifiable victim), options available to psychologists (such as warning victims, treatment intensification, hospitalisation) and guidelines for exercising such options in a way that protects clients throughout such a process may be of assistance. Psychologists may benefit from education concerning legal obligations to report child abuse with attention to features that dictate an obligation to report (such as directly attending to the child in question) and procedures for meeting such obligations that minimise harm to clients.

Non-sexual dual relationships: Dilemmas concerning non-sexual dual relationships comprised 14% of incidents reported by South African clinical psychologists (Slack & Wassenaar, 1999). Psychologists reported conflicting obligations inherent to dual professional roles, for example, where confidentiality of service recipients may be compromised by their role as organisational employee in law enforcement or military institutions (Johnson, 1995; Orme & Doerman, 2001). They appeared aware of ethical obligations to clarify their role, but experienced a lack of guidance in resolving these dilemmas. They also described concerns with dual professional and nonprofessional roles, for example, concern that social contact with current clients may be harmful to them. They were aware that such situations were ethically dubious, but were unclear about how to evaluate and manage them. Similar dilemmas ranked second for APA members (Pope & Vetter, 1992), and for members of the Canadian (Sinclair, 1997), Finnish (Antikainen, 1997) and Swedish (Colnerud, 1997a) psychological associations, as well as for psychotherapists in Britain (Lindsay & Clarkson, 1999). While BPS members indicated that this issue comprised only 3% of dilemmas (Lindsay & Colley, 1995), most of the dual relationship dilemmas described by these respondents (concerns about the legitimacy of their interventions largely due

to restrictions placed upon them by the role of an organizational employee) appear to have been coded as “Questionable Intervention”. This data again suggested strong similarities between South African clinical psychologists’ ethical concerns and those of the international psychological community. The prevalence of non-sexual dual relationship dilemmas suggests that ethical guidelines should sensitise psychologists to factors specific to the professional role (such as specific role-responsibilities and role-expectations) that are likely to be compromised through *any* other interaction. Such guidelines may help psychologists to assess the potential harm to clients posed by any dual relationship (Anderson & Kitchener, 1998; Baer & Murdock, 1995; Brownlee, 1996; Sonne, 1994).

Fee issues: Twelve percent of the dilemmas reported by South African psychologists involved fee issues. These dilemmas included concern at requests from clients that amounted to an abuse of medical aid schemes, and the effects of nonpayment on the therapeutic relationship. For American (Pope & Vetter, 1992) Finnish (Antikainen, 1997) and Norwegian (Odland, 1997) psychologists, fee issues also ranked third. The international similarity of these concerns may point to the long history of professionalization in these countries. In comparison, the low rate of concern about fees for BPS members and Swedish psychologists probably reflected the relatively small (but growing) number of privately practising psychologists in those countries (Lindsay & Colley, 1995; Persson, 1995). Fee dilemmas suggest that psychologists may benefit from education in this area (HPCSA, 2001a; Koocher, 1994; Landman, 2001; Lasky, 1999; Parvin & Anderson, 1999; Peterson, 1996; Valentine, 1999). Psychologists may benefit from attention to billing practices and procedures that support frank discussion of nonpayment or extended payment plans, and relationships with third-party reimbursers (Koocher & Keith-Spiegel, 1998).

Collegial conduct: Ten percent of the South African responses involved the unethical conduct of colleagues, such as misrepresenting their training and registration category to potential clients, and unprofessional behaviour, such as subtle coercion of patients, or conducting “rushed” interventions. While many respondents were aware of the route to lodging a formal complaint against colleagues if there were a clear breach of the code, many described concern at how to approach colleagues effectively in the event of conduct that was less clearly a breach. Most described this scenario as so aversive as to be consistently avoided. In total, 27% of dilemmas comprised 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. However Slack and Wassenaar (1999) re-coded this category according to the specific ethical issue or conduct concerned - e.g., sex, fees, confidentiality etc., rather than in the collegial conduct category. If they were coded primarily as 'colleagues' conduct', this became the second largest category, which corresponds to the ranking identified by Odland (1997, 1999). In most other studies collegial conduct concerns were ranked highly. For the Swedish sample such concerns provided 8% of dilemmas (Colnerud, 1997a), for Norwegian psychologists such issues provided 10% of reported dilemmas (Odland, 1997, 1999) and for the Canadian sample these dilemmas showed an incidence of 11% (Sinclair, 1997). These dilemmas, however, comprised only 4% and 7% of incidents described by the APA (Pope & Vetter, 1992) and BPS membership (Lindsay & Colley, 1995) respectively. These results suggest that South African psychologists consider these concerns as troubling as do their international counterparts. Descriptions of collegial conduct dilemmas suggest that ethical guidelines that explicitly include the concept of "extended responsibility" (CPA, 2000) may sensitise psychologists to their obligation to approach colleagues. Additionally, ethical guidelines that include a reciprocal obligation to cooperate with a colleague's attempts to address improper conduct informally may remedy the imbalance in responsibility for peer monitoring imposed by current guidelines (Weinberger, 1988). Education concerning the role non-ethical considerations (such as expediency or therapeutic orientation) can play in compromising the ethical course of action may be of benefit to psychologists (Koocher & Keith-Spiegel, 1998).

The remaining categories contained dilemmas of relatively low frequency, such that conclusions could not be drawn from them. These were concerns about sexual issues, concerns about the safety and legitimacy of treatment approaches used by colleagues and referring psychologists (questionable intervention), the issue of moving beyond areas of expertise (competence), concerns about ethics committees and ethical codes, academic or training issues, and medical issues. Categories were created to fit dilemmas concerned with consent and reporting practices, however, the number of vignettes generated in these categories was negligible.

### 3.5 Summary and Conclusions

Although based on a relatively small sample, this comparative South African study (Slack &

Wassenaar, 1999) suggested that South African clinical psychologists experience ethical dilemmas that are similar to those reported internationally. These results strongly suggest that certain ethical problems may be endemic to the experiences of psychologists (Colnerud, 1997b). The only study that did not report confidentiality as the most frequent dilemmas was that of Orme and Doerman (2001) who studied psychologists in military settings and found that conflicts between ethics and organisational obligations (i.e. non-sexual dual relationships) were primary, with confidentiality second. Overall, the South African sample seemed more similar to the APA sample than to the BPS sample, perhaps indicative of our longer history of professionalisation and increased focus on private practice.

The findings of previous research on this topic have been regarded as useful to the planning of ethics education for psychologists and the updating of ethical guidelines to ensure that they are more relevant to the practice realities of psychologists (Lindsay & Colley, 1995). In this regard, for example, efforts to revise the 1992 APA ethical Code and the BPS Code are currently in progress (APA, 2001a, 2002; BPS, 2002).

Some respondents referred to the difficulties they experienced in interpreting guidelines. They were anxious to identify behavioural choices which reflected the spirit of the guidelines. These psychologists seemed to lack “criteria for interpretation” (Vasquez, 1996, p. 99) that would allow them to apply guidelines to their specific situations accurately and consistently, which has implications for ethics training.

While not directly supported by the design of the studies reviewed above, it could be argued that psychologists might benefit from ethical guidelines that make the reasoning underpinning ethical guidelines explicit, so that psychologists faced with a unique situation not specifically addressed in ethical codes could consistently apply the reasoning behind valued ethical principles to the presenting situation (Pettifor, 1995b, 1996; 1998; Seitz & O’Neill, 1996; Sinclair, 1996, 1999). This conceptual approach is embodied in the Canadian Psychological Association’s code of ethics (CPA, 2000; Sinclair, 1999). As the reasoning underlying each section of the Canadian code is delineated, statements become those upon which professionals can base decisions (Seitz & O’Neill, 1996). This conceptual approach to regulations may provide interpretive criteria for psychologists attempting to extrapolate from imprecise guidelines to specific situations (Vasquez,

1994).

In contrast with studies reviewed earlier (section 3.4.4.1) suggesting that there is inconsistency in psychologists' ethical thinking, the 'dilemmas' studies begun by Pope and Vetter (1992) reviewed above suggest that there is high international consistency in the frequency of ethical dilemmas of concern to psychologists themselves. However, although the South African data reported above fitted the international patterns closely, it represented only clinical psychologists. A more representative sample of all categories of South African psychologists should be included in future studies, which is one aim of the present work. Furthermore, no effort was made to relate these findings to patterns of ethical issues in complaints about psychologists, nor did any of the dilemmas studies cited above subject their data to statistical analysis beyond simple frequency distributions. None of the studies reviewed attempted to relate their findings to particular practice preferences of psychologists, their registration categories or practice contexts.

Many of the studies, however, made recommendations for the ethics training of professional psychologists, which are included in the next chapter.

## Chapter 4: Training in Professional Ethics

### 4.1 Introduction

“Unethical psychologists were trained somewhere” (Kitchener, 1992, p. 193-194).

Koocher and Keith-Spiegel (1998) outlined the increasingly complex environment in which professional training occurs. Multiple pressures, complex role demands, large classes, shrinking resources, cultural pluralism and a climate of litigiousness complicate the task of promoting ethical and technical competence in graduates. They pointed out that ethics codes offer less guidance on teaching and training than on other areas of professional activity. In addition, ethics training must incorporate a knowledge base with problem-solving and decision-making skills (Knauss, 1997).

In contrast to the voluminous and burgeoning literature on ethical violations in professional psychology, the literature on training in ethics is more sparse, despite the requirement that applicants for Board licensure in the USA pass an examination that includes questions on professional ethics (Hess, 1977; Knauss, 1997). This section will attempt to review the literature on ethics training in professional psychology to provide a background to the training survey conducted as part of the present study.

A survey of the teaching of ethics in American higher education found that with “the exceptions of medicine and law, it is difficult in any of the professional-school areas to find more than a handful of members for whom ethics (or ‘professional responsibility’ as it is often called) is a major academic and teaching interest” (Hastings Center Staff, 1980, p. 161). At best, ethics in professional schools was seen as a secondary concern competing with already overcrowded curricula. Specifically regarding psychology, the survey found that attitudes towards ethics teaching had shifted in the 1970's “from outright hostility to wariness and scepticism” (p. 166). The authors expressed their concern at this resistance to ethics education in view of rising levels of public dissatisfaction with professional regulation and control.

May (1980, p. 206) expressed the state of ethics education in the 1970's as follows: “The

twentieth-century university has responded handsomely to the challenge of providing the professional with technical training, but only marginally or not at all to questions of his or her moral sophistication”.

Although the APA has long advocated ethics education as the best way of fostering ethical behaviour, it was only in 1984 that the APA Committee on Scientific and Professional Ethics and Conduct (later known as the Ethics Committee) began to serve an explicitly educative function besides adjudication. It began publishing examples of cases adjudicated (Mills, 1984), articles in the *APA Monitor*, running workshops and educative presentations at national APA conventions. In spite of this Keith-Spiegel and Koocher (1985) argued that ethics committees neglected their educative and advisory functions. For this reason they published one of the earliest texts for psychologists devoted exclusively to professional ethics. They argued that knowledge of the ethical code alone is insufficient and that the goal of ethics training should be the capacity to exercise ‘professional judgement’, which reflects a combination of technical and ethical thinking and their application. They outlined components of good judgement, which should include the following: i) time to collect sufficient information, ii) involvement of all relevant parties, iii) proper identification of the party to whom allegiance is owed, iv) freedom from pressures that might inhibit objectivity, and v) ongoing self evaluation. They acknowledged that much professional work in psychology occurs under conditions that mitigate against such careful considerations.

Professional psychology was not the only discipline to be struggling to formulate a coherent model of ethics teaching by the mid-1980's. Similar concerns were expressed in psychiatry by Hundert (1987) who argued that no model of ethical problem solving was taught, despite rising levels of reported violations.

The literature on training in professional ethics in psychology can be separated into three main areas, which cover models of ethics education, approaches to ethical problem solving, and the ethics of teaching in psychology. A section on ethics teaching in South African psychology will also be presented. These areas are reviewed separately below.

## 4.2 Models of Ethics Education

Abeles (1980) sought to go beyond mere 'indoctrination' and argued that ethics education involved direct and critical confrontation of values. He described a 30-hour seminar course for postgraduate professional students. The course included readings, the discussion of several vignettes containing ethical dilemmas that included therapeutic and assessment issues, the idea of normality, research issues and professional/guild issues. While providing some interesting topics for discussion and providing a stimulus for ethics training, no attempt was made to evaluate the course.

Callahan (1980), without specifically focussing on psychology, provided a useful list of elements of what he described as nonoptional courses for students in applied professions. He advocated a thorough knowledge of the regulations and official codes of ethics governing the profession, an understanding of the history of such regulations, an understanding of the relationship of the ethical code to broader social morality, and specific technical dilemmas pertinent to the profession. He stated that students should understand the values upon which professional codes are based.

Sider and Clements (1982) proposed that ethics education should include a balance between the rational and nonrational factors that determine human behaviour. Training should thus focus on attitude change and on imparting technical skills. A useful schedule for ethical self evaluation was provided by Peterson (1996) which could be used by students in training.

### 4.2.1 Ethics Training Surveys

A 1956 survey by de Palma and Drake (1956) found that only 6% of professional psychology programmes in the USA had separate ethics training modules. By 1973 a study by Jorgensen and Weigel (1973, cited in Welfel, 1992) found ethics courses in 14% of professional programmes. After the APA formally required ethics education in psychology training in 1979, a survey by Tymchuk, Drapkin, Ackerman, Major-Kingsley, Coffman and Baum (1979) found that only 65% of the professional (clinical) psychology programmes that responded to their survey offered training in ethics, despite the APA stipulation. Because of this lack of ethics training in

professional coursework, Newmark and Hutchins (1981) surveyed internship programmes to establish whether more ethics training occurred during the internship. Using similar methodology to Tymchuk et al. (1979), they established that 79% of the respondent internship settings offered ethics training, although only 45% of these described their ethics training as 'formal' and of these settings only 2% evaluated ethics by examination. The remaining 55% discussed ethics only in case supervision. The majority (55%) of academic and internship settings in the USA before 1981 were thus not in compliance with APA ethics training requirements. Of the 45% that did offer a formal module, these typically consisted of a workshop of 4-12 hours' duration. Seventy-eight percent of the respondents from the internship settings reported that they felt formal ethics education should precede the internship and felt that practical integration of ethics teaching should occur in the internship. By 1990, 69% of professional programmes offered separate ethics courses within professional programmes, averaging 20 hours per course (Vanek, 1990). In Canada a study by Pettifor and Pitcher (1982) found that 55% of programmes surveyed had formal ethics courses while 29% had informal or supervisory training in ethics. They also found that clinical programmes were more likely to include ethics training, but questioned the ethics decision-making competence of graduates.

A study by Tymchuk, Drapkin, Major-Kingsley, Ackerman, Coffman and Baum (1982) found little consistency in psychologists' responses to ethical dilemma vignettes, attributed in part to the inconsistency and variability of ethics training programmes. The majority (69%) of their respondents indicated that their ethics training had occurred mainly in supervision and only 35% had formal ethics coursework. Other ethics training was in case conferences (48%), seminars (37%), professional conferences (21%) and workshops (5%). The authors did not attempt to link specific types of response variability with the respondents' specific university of training. Most respondents expressed dissatisfaction with their training in ethics even though 99% of them were familiar with the current APA Ethical Standards, and 89% stated that ethics should be a formal part of the pre-internship training, using a variety of teaching methods.

Handelsman (1986a) found that while 87% of masters programmes in psychology reported some training in ethics, only 29% taught ethics as a specific module. Of those that offered no formal course in ethics, the rationales given (in order of frequency) were that ethics was best taught in practical supervision, that there was no time, and that there was no need for such training. While

masters programmes for psychologists in the USA offer a lower-level of training and qualification than the approved doctoral programmes, these data do not differ much from a survey of doctoral training conducted by Tymchuk et al. (1979). Handelsman (1986a) argued that ethics training be formally included in masters and doctoral curricula and that students should become as skilled in ethics as they are required to be in therapeutic, assessment and research skills. He argued that ethics training by supervision alone was insufficient as it does not necessarily cover the broad range of circumstances that ethical codes cover, and does not teach a systematic approach to ethical problem-solving. "It is necessary to treat ethical thinking as a skill that must be developed" (Handelsman, 1986b, p. 371). He argued for specific ethics modules in training, and ascribed the absence of ethics training in psychology programmes as due to overloaded curricula and a lack of staff competent to teach ethics. He, like Vanek (1990), advocated a multi-method approach to ethics teaching, including formal literature, team discussions and case vignettes. Hall (1987) found that the percentage of American psychology programmes teaching professional ethics increased from 9.6% in 1956 to 67% by 1979, although many of them were optional and not compulsory.

The complexity of ethics teaching was emphasized by Bernard and Jara (1986) who found that even when graduate students showed good formal knowledge of the ethical code and identified a correct course of action, many students stated that in practice they would not act in compliance with their knowledge of what they should ethically do, particularly in response to unethical conduct by a colleague. This suggests that ethical knowledge alone was insufficient and that other practice and contextual variables need to be included in training for ethical decision making. Application and contextual implementation of ethical knowledge needs to be part of professional training. The study was replicated with qualified psychologists (Bernard, Murphy & Little, 1987) and supported the contention that "violators know that what they do is unethical, but they do it anyway" (p. 489). A later study by Pope et al. (1988) found some improvement in psychologists' beliefs about ethical and unethical practice, and found that younger, more recently trained psychologists made stricter judgements of ethical and unethical practice than their older colleagues. Using similar methodology, Close (1998) reported that postgraduates were more likely to take ethical action than undergraduates, while both groups were more likely to take ethical action if a situation concerned themselves rather than a colleague.

A study of therapists' experience of anger, hate, fear and sexual feelings (Pope & Tabachnick, 1993) found that psychologists who reported the greatest professional exposure to these challenging emotions rated their graduate training in addressing such feelings as poor or inadequate. The discomfort associated with these feelings may, in part, be why they are often neglected in training programmes.

Relatively little on training in professional ethics appears to have been published in Great Britain, probably due to the comparatively new status of professional psychology in Britain and the absence of statutory registration. A study by Lindsay and Colley (1995) mentions that ethics training "will include education in ethical principles and experience of decision making when faced by ethical dilemmas. Such training may either be systematic, grounded in a taught course, for example, or designed to be covered as part of a tutorial system for the supervision of practical work" (p. 448). Lunt (1995) described ethics as a key area in which British psychologists will have to be competent under a proposed new vocational qualifications system. A recent report (BPS, 2001a) outlines plans to hold national ethics training workshops and "undertaking work to expand ethical awareness of postgraduate students" (p. 19).

There is a need to know more about the form and content of ethics courses in psychology (Eberlein, 1987), and their relationship to standards of practice.

#### 4.3 Approaches to Training in Ethical Problem-solving

An early study by Morrison and Teta (1979) which aimed at teaching humanistic attitudes to nursing students resulted in greater awareness of ethical conflicts. The discrepancy between ethical knowledge and ethical action was addressed by an ethics problem solving model proposed by Hundert (1987). His model proposed that students be taught to list competing ethical values on opposing sides of a drawing of a balanced scale, for each case. This listing will force explicit confrontation of ethical dilemmas and begin to weigh the decision in a particular direction and thus begin to clarify the best course of action. The sophistication of the listing should develop as the practitioner gains more practical experience in this "difficult balancing act" (p. 843). As a model for ethics training, it bridged theory and practice and focussed on ethical problem-solving processes rather than merely on the content of ethical codes.

Eberlein (1987) presented an ethics problem-solving model based on the Canadian code of ethics. The Canadian code differs in its development from the APA code in that it was based on a series of dilemmas (Sinclair, Poizner, Gilmour-Barrett & Randall, 1992), presented in a questionnaire to licensed psychologists. Like Hundert (1987), Eberlein agreed that code-learning is an insufficient basis for actual ethics problem solving, especially in developing fields of application. Ethical reasoning is thus more important than mere code-learning. The Canadian code therefore embodies principles and a hierarchy of values as rated by sampled psychologists. Eberlein (1987) argued that the Canadian code was consequently “a better educational tool” (p. 354) than the APA code. He reviewed several approaches to ethics training, and argued for a six stage problem-solving model similar to the steps used in developing the CPA code, and described the readings and workshop format of his course. In a follow-up report, Fine and Ulrich (1988) described a 37.5 hour (2.5 hours per week for 15 weeks) ethics course for psychology graduates which aimed to develop ethical reasoning, knowledge of ethics frameworks and the ability to distinguish legal from ethical issues in professional practice. They argued for the importance of integrating philosophical, practical and process aspects of ethical problem solving, particularly in view of the complexity of psychological work and “the existence of more than one ethically justifiable course of action in many situations” (p. 546). The educational merits of the CPA code were expounded more fully by Eberlein (1988) and O’Neill (1998) and were evaluated empirically by Gawthrop and Uhlemann (1992). Working on the assumption that ethical decision making is a teachable skill, they examined the ethics decision-making abilities of matched groups of undergraduates who received or did not receive a 3-hour workshop training in ethics decision-making based on Eberlein’s (1987) problem-solving approach. The results showed that the students participating in the ethics training workshops showed better quality ethical decision making than control participants. The authors emphasised the importance of both formal and participatory learning in the teaching module. They acknowledged that there was no data to show how such learning might generalise outside the teaching situation.

An applied problem-solving focus was also advocated by McGovern, (1988) who saw training in professional ethics as compatible with liberal arts teaching outcomes such as “critical thinking; literacy in writing, reading, and listening; historical consciousness; appreciation for science; analysis of values; and a sensitivity to multicultural experiences” (p. 23). McGovern applied a pre-and post-test to his students to evaluate the attainment of ethics course objectives empirically.

The course included learning of applicable codes, case studies, simulations and self evaluations of ethical conflicts. After the post-test, students were encouraged to evaluate their ethical development. Educator evaluation was also built into the course.

While most of the ethics teaching literature in psychology is focussed on postgraduate professional programmes, a credit-earning course for teaching ethics to undergraduate counselling students was described by Lamb (1991). The rationale for teaching ethics at undergraduate level was twofold: firstly, it provided a base for those students who go on to graduate training in psychology, but more importantly it creates ethical awareness for those students who do not go on to graduate training but end up working in related helping fields, such as school counselling, volunteer work, crisis intervention, and personnel work (cf. Wilson, Richter, Durrheim, Surendorff & Asafo-Agyei, 1999). Particular emphasis was given to problems of dual relationships - whether between therapists and clients or staff and students. The course earned high ratings by participating students. Welfel (1992) concluded that the results did not provide conclusive empirical evidence that students who have received ethics training are better at ethical judgements or behaviour. Her own study found that psychology teachers reported better ethics problem solving in students who had completed professional ethics courses, particularly where major issues like confidentiality and dual relationships were concerned. Problem-solving ratings were lower in issues such as HIV, cultural diversity and gay and bisexual lifestyles.

A model for assessing the effectiveness of professional ethics education programmes was proposed by Rest and Narváez (1994) who found that moral judgement correlated with years of schooling and years of graduate education, particularly in 'liberal arts' settings. A combination of experiential learning with guided reflection integrated across courses and staff was most effective in promoting moral judgement. They stated that there is a need to develop profession-specific evaluations of moral judgement and links to behaviour. A useful four stage model was proposed by Rest (1982; Welfel & Kitchener, 1992) who argued that ethical behaviour requires that i) the situation is identified as one which requires moral sensitivity, ii) that moral reasoning takes place, iii) that action decisions are then made and iv) that the moral action is then implemented. Ethical decision-making in trainees was found to be influenced by interpersonal processes (Cottone, Tarvydas & House, 1994), particularly the number and type of relationships involved. They argued that ethics training should thus incorporate relational and systemic

variables, rather than absolutise standards. These ideas were developed further by Cottone (2001). The importance of including emotional and contextual factors in fostering ethical willingness was also emphasised by Betan and Stanton (1999).

A model for thinking critically about ethical issues was developed and evaluated by Allegretti and Frederick (1995) who described a five-part model which focussed on ethical dilemmas in psychology. They cited the work of Toulmin, Rieke and Janik (Toulmin, et al., 1984 cited in Allegretti & Frederick, 1995) and processed each of the following stages in processing an ethical dilemma: argument; claim; evidence; general rule; backing, qualifier, and rebuttals. Circular sequences of exploration were monitored in their model. Participating students showed good long-term post-test scores, although no control group was used. Myyry and Helkama (2002) found, in contrast to earlier studies, that younger students acquired moral sensitivity skills more readily than older students or postgraduates. A useful overview of a variety of ethical decision-making models was provided by Pryzwansky and Wendt (1999) and Cottone and Claus (2000).

#### 4.4 Ethics of Teaching in Psychology

The *Journal of Nervous and Mental Disease* noted that the ethics of teaching mental health practitioners was a neglected area (Editorial, 1980b). The editorial advocated the extension of the clauses of the Hippocratic Oath to the teacher-student interface. Teachers of mental health practitioners were urged to adhere to the following ethical principles: nonmaleficence; competence; non-exploitation; respect and dignity; confidentiality and privacy; informed consent; and equity. Examples were given of the application of the above principles to the teaching situation. The editorial highlighted a dilemma in professional training, which is the fact that few professional supervisors in psychology have been trained to train, or trained to supervise. This issue was linked to the principle of competence: are supervisors competent to supervise? Competence as practitioners or as academics does not necessarily make for competent supervisors. The Editorial (1980b) urged teachers of mental health professionals to develop supervision training programmes, and to request feedback from their students. To further explore the attitudes towards ethics by educator psychologists, a major survey was conducted by Tabachnick, Keith-Spiegel and Pope (1991). They noted the relative paucity of literature on the ethics of university teaching overall, and in psychology in particular. They found a general

accordance of behaviour with ethical beliefs, thus reporting less discrepancy between behaviour and belief than found in earlier studies of graduate students (Bernard & Jara, 1986) and clinical practitioners (Pope et al., 1987). Some work has emerged which advocates specific ethics training for supervisors (cf. Bremer, 1998; Clarkson, 2000; Stone, 1994, p. 30). Koocher and Keith-Spiegel (1998) and Kitchener (2000a, 2000b) provide comprehensive reviews of ethical issues that arise in the teaching of psychology.

Probably the area receiving the most attention in the ethics of professional education is the question of sexual intimacy between psychology educators and students. Sexual intimacy between psychology educators and students was first proscribed in the 1981 Ethical Standards (APA, 1981a). Pope, Levenson and Schover (1979) found that 10% of professional psychology graduate students had sexual relationships with their educators, and that 13% of educators reported having had sexual contact with students, although only 2% of educators believed that such relationships could be beneficial to both parties. A subsequent study by Glaser and Thorpe (1986) found that in a sample of 464 female clinical psychologists, 17% had sexual contact with their psychology educators. More recent graduates reported higher rates of sexual contact than less recent graduates, although recent graduates reported that their training had involved more ethics education than reported by earlier graduates. Only 12% of the entire graduate sample stated that they had received ethics training on sexual conduct and dual relationships. Most of the respondents reported that their perception of the sexual contact moved from neutral to more harmful with the passage of time (cf. Anonymous, 1991). The authors argued for studies to determine the possible temporal trends in the relationship between enhanced ethics education and unethical conduct between students and educators. A detailed model for management of dual relationships between educators and students was outlined by Biaggio, Paget and Chenoweth (1997), who proposed a clear framework for evaluating and fostering ethical training relationships.

A related study by Pope, Keith-Spiegel and Tabachnick (1986) confirmed that most psychologists received no or inadequate training for dealing with sexual attraction to clients. This concurs with unpublished South African data (Stevenson, 1999). This is significant since sexual behaviour between psychologists and clients constitutes the most frequent type of complaint received by the APA about psychologists (cf. section 3.4.1.1). Most training warned against

countertransference but few programmes dealt directly with the phenomenon of sexual attraction to clients, which was acknowledged by 95% of male therapists and 76% of female therapists. Pope et al. (1986) found that 55% of respondents received no formal education about sexual attraction to clients, 24% had received 'very little' and only 9% reported receiving 'adequate' formal coverage of this topic. Those respondents who received training on sexual attraction were more likely to seek supervision when such problems arose in their clinical work. Fifty-seven percent of respondents had sought supervision for such attractions. Regarding training, Pope et al. (1986) suggested that ethical concerns rather than a fear of negative consequences was a primary factor inhibiting sexual acting out with clients, pointing to the importance of ethics training. Sexual attraction, as a basic human phenomenon, rather than merely a manifestation of countertransference, requires frank discussion in psychology training programmes. Ethics education in this area should involve, the authors argued, training in ethics, case discussion, discussion of sexual attraction, case vignettes and role plays. Sexual attraction needs to be distinguished from sexual acting out with clients.

Pope et al. (1979) emphasised that ethics education should also be based on empirical data about ethics training practices, conduct of practitioners, and patterns of complaints and violations - the subject of the present study. In partial response to the above findings, Vasquez (1988) outlined a series of training strategies to prevent sexual intimacies between psychologists and their clients. The course aimed to impart ethical sensitivity to sexually problematic situations, develop self awareness, boundary awareness and factual knowledge in a teaching climate conducive to open and frank discussion. Her course advocated multi-method teaching, including readings, case discussions, role plays and supervision. Students should be provided with clear guidelines on their own rights, responsibilities and procedural courses of action to assist them in resisting sexual intimacies with educators and with their own subsequent clients (Vasquez, 1988). Two such programmes are described by Rodolfa, Kitzrow, Vohra and Wilson (1990), both of which used a workshop rather than didactic teaching method. A more recent study (Samuel & Gorton, 1998) sought to establish whether universities explicitly addressed the prevention of sexual exploitation. They obtained a 56% response rate. Of these, more than 99% reported that their training specifically addressed sexual misconduct and that most had introduced these topics after 1994. The authors noted that the effectiveness of such programmes remains to be shown. Housman and Stake (1999) found that although most professional training programmes offered

six hours of training in sexual ethics, most graduates showed deficient knowledge of basic principles. Schoener (1999) provided an inventory of training resources that can be used in programmes to reduce sexual misconduct and boundary violations.

Kitchener (1992) advocated that teaching psychologists pay particular attention to two areas: firstly, their own interactions with students should be ethical, and secondly, they should act responsibly when students engage in unethical conduct. She noted that training programmes with excellent ethics teaching modules could be undermined by unethical conduct of teaching staff. She advocated careful application of the principles of beneficence, nonmaleficence, fairness, autonomy and relationship integrity in interactions with students. She cited Vanek (1990), who found that 31% of professional psychology programmes had no formal separate ethics module. Regarding students' ethical compliance, she outlined the importance of clear procedures for responding to unethical conduct by students. These procedures should initially be remedial in orientation, but if necessary, disciplinary processes should be in place for dealing with the violation.

Dual relationships in psychology training and in the internship were discussed by Slimp and Burian (1994) who detailed the variety of dual relationships to which psychology supervisors need to be alert. These included sexual, social, business and therapy relationships. It was argued that transference issues and the power differential between supervisor and intern raised the question whether an intern is competent to consent to any form of dual relationship or boundary crossing. They recommended "extensive and applied" (p. 43) training throughout the professional curriculum, with a particular focus on boundaries in professional relationships. They advised systematic ethical scrutiny of dual relationships of any sort between interns and educators, because of the high potential for negative impact on the working relationship. They did, however, acknowledge that in the internship year the power differential between interns and staff decreases, and noted the general acceptance that the potential for harm is generally proportional to the size of the power differential. They argued that these issues arose because they were inadequately recognised and addressed in ethics training programmes. They suggested that each training site set up an ethics committee comprising faculty and interns. Such a committee should include an outside consultant and should generate explicit written guidelines for role relationships in the programme. In addition, clear complaint procedures, processes and

consequences need to be specified, within the context of national codes and statutes. The committee could offer advice on specific boundary crossing situations and make helpful preventive recommendations. This would also provide good ethical modelling to graduate students. They recommended that ethics training should be offered throughout the academic and applied postgraduate curriculum and that ethics should also be part of ongoing education programmes for psychologists.

Vasquez (1992) argued that supervision should attend to technical, ethical and personal aspects of the supervisee's progress. The personal dimension should sensitise supervisees to areas or stages of personal impairment, recognition of which is important throughout a psychologist's professional career (Clarkson, 2000; Lamb, Presser, Pfof, Baum, Jackson & Jarvis, 1987; Vasquez 1992). Wood, Klein, Cross, Lammers and Elliot (1985) found that psychologists who had received ethics courses were more aware of professional impairment and appropriate courses of action than ethically untrained peers. A procedure for dealing with severely impaired interns was described by Vasquez (1992). Furthermore, supervisors have a responsibility to be competent in the areas in which they offer supervision, and fluent in different models of supervision. The supervisor's ethical responsibilities towards the supervisee parallel those a professional has towards a client.

Ethical issues in research supervision have also begun to be focus of concern. Goodyear, Crego and Johnston (1992) documented a series of issues described by survey respondents. They argued that guidelines for research supervision were scanty, "ambiguous and even contradictory" (p. 203). Without rank ordering their results, they found the following concerns expressed by experienced research supervisors: incompetent supervision; inadequate supervision; supervision abandonment; intrusion of supervisor values; abusive supervision; exploitive supervision; dual relationships, and authorship issues that include plagiarism, failure to give expected credit and giving unwarranted credit. For most of these issues they recommended an informed consent procedure in which a contract of mutual roles and expectations is clarified prior to research supervision. Training schools should monitor these contracts and have policies for dealing with variations, both warranted and unwarranted. Their article includes a useful appendix of guidelines (p. 210) for research supervision regarding authorship.

The ethical role modelling responsibilities of psychologists in senior educational administrative positions were outlined by Canon (1992) who argued for the development of an 'ethical community' which assumes close ethical scrutiny by peers and students.

A comprehensive review of the ethical responsibilities of educator psychologists was presented by Keith-Spiegel (1994a). She described the major ethical problems in academic psychology departments as including "grade inflation; overblown promotional schemes to attract students; overuse of teaching assistants to conduct undergraduate classes; the tenure system; emphasis on research to the neglect of students; and runaway academic dishonesty amongst students to name a few" (p. 362). She critically pointed out that the 1992 version of the APA Ethics Code contains fewer explicit guidelines for teachers of psychology than the earlier 1990 version and remarks that those issues which are retained occur infrequently and are of least concern.

A casebook detailing common ethical problems for teachers of psychology was published by Keith-Spiegel, Wittig, Perkins, Balogh & Whitley (1993) which offered case studies and response guidelines on several difficulties.

In summary, Swain (1996) stated that ethical issues begin as, or even before, a lecturer enters the classroom. He takes the normative view that the power differentials are easily abused, that dual relationships are unavoidable and that sexual attraction is inevitable unless denied. Early recognition of these realities, according to Swain, will promote ethical teaching and training of psychologists and prevent exploitation.

#### 4.4.1 Ethics in Student Conduct

The issue of ethics in student conduct, referred to above, may also be related to subsequent ethical conduct by psychologists. Rubin (1986) reported on cheating in examinations by graduate students, and faculty variation in the seriousness with which this was viewed. He pointed out that the APA ethical standards do not include guidelines on cheating by students. Undergraduates receiving an ethics course engaged in less cheating than those who had not completed the course, but they adopted less stringent views on what they classified as cheating (Ames & Eskridge, 1992). Davis and Ludvigson (1995) found that cheating has become a major concern in university

education, with 70% of their university sample ( $N=2153$ ) reporting cheating in high school and 40-60% reporting some form of cheating at university. Higher proportions of males than females reporting cheating. The possible corrective influence of curricula with long-term low-reinforcement tasks as opposed to low-effort high reinforcement tasks in curricula was discussed. Disciplinary procedures should be more active and visible. No consideration was given to the introduction of ethics courses, however. A survey of critical incidents found that psychology educators reported a low rate of ethical violations by students and trainees, using categories similar to those used in the present study (Fly et al., 1997). They suggested that ethics training follow Rest's (1984) four stage model, involving moral sensitisation, action formulation, deciding, and implementing ethical action, similar to the model proposed by the CPA (1992) and Treppa (1998). Koocher and Keith-Spiegel (1998) stated that plagiarism and cheating were on the increase in American universities, and that insufficient guidelines and procedures were in place to deal with these.

Trainee-client sexual misconduct was studied by Hamilton and Spruill (1999). They found that contextual training factors were more influential than particular trainee variables. They recommended that training programmes should emphasise appropriate recognition and response to transference issues, sexual attraction to clients, and the consequences of sexual misconduct.

This last section underlines the need for course guidelines to contain contractual explanations of ethical standards, department policy and procedures for processing unethical conduct by students, which may impact not only on student conduct in the short term but provide a positive ethical orientation for their professional conduct in the long term.

#### 4.5 Ethics Training in South Africa

Relatively little has been published concerning ethics training in South African psychology (cf. Scherrer et al., 2002). Although some professional associations did publish ethics codes (cf. section 2.2), there is relatively little data on university or professional association activity to promote awareness of and application of these codes.

One of the most cited local works is that of Steere (1984) who published a review of psychology

ethics and some implications for South African psychology. The following year, Steere and Wassenaar (1985) published the first ethical code for South African Clinical psychologists, followed by a series of workshops run by Jane Steere in all the main centres of South Africa. This was the first documented national project to enhance ethics training in South African professional psychology. Subsequently, an ethics workshop was presented at the annual PASA congress in 1986 (Wassenaar, Gillmer & Dowdall, 1986), also to private practitioners at the 1988 PASA congress (Wassenaar, 1988) and a workshop by Wassenaar and van Vuuren (1993) at the 11th PASA congress. A presentation on ethical issues in forensic work was presented by Wassenaar (1989a) at the PASA congress in Durban. A paper on ethics in the training of psychologists in South Africa (Wassenaar 1989b) was presented at a special symposium held by PASA on the training of psychologists. After the formation of PASA in 1982, regular ethics items and an ethics quiz began to appear in the quarterly *PsiMonitor*. More recently, national ethics workshops have been run by Allan (1997b), and Malcolm, Naidoo, Olivier and Watts-Runge (2000). The first national ethics workshop for CPD was advertised in 2002 (Cooper et al., 2002).

Beside these workshops and presentations, there is little published data on ethics training in South African professional psychology programmes and professional associations. A review on “relevance” in South African psychology (Retief, 1989) underlined the importance of ethical issues in determining ‘relevance’, but no case was made for training in ethics. A study of trends in South African psychology by Manganyi and Louw (1986), for example, found that South African clinical psychologists reported a high degree of satisfaction with their training, but did not specifically assess respondents’ satisfaction with their training in ethics. While the journal *Psychology in Society* has published several critical articles on professionalisation in South African Psychology, none of these explicitly focussed on ethics education.

An unpublished study by Mommsen (1990) examined factors in South African psychologists’ ethical decision making. He studied masters curriculum outlines for information on the teaching of ethics in South African professional psychology programmes. Regarding the seven responding universities, only two specifically mentioned ethics in their curricula (Potchefstroom and OFS). The five others offered courses with titles like professional issues and forensic issues, neither of which necessarily incorporate formal coverage of professional ethics. Although Mommsen estimated that on average the seven responding universities spend about 16 hours on professional

ethics, this was based on speculative interpretations of curricula. The actual time spent on teaching professional ethics was probably much less than 16 hours, as Mommsen's estimates include course items labelled 'professional issues' and 'forensic issues'. A study of one professional training programme (Viljoen, Beukes & Louw, 1999) did not assess ethics training. Essentially, no reliable data appear to exist on the teaching of professional ethics in South African psychology programmes, let alone information on what, how, why and how effectively it is taught. Similarly, an overview of clinical and counselling psychology at another South African university fails to mention ethics training (Fourie, 1995).

A survey of published research interests of South African psychologists from 1985 to 1990 by Mauer et al. (1991) revealed that 'professional issues' had one of the lowest publication rates. Ethics would presumably be included in this category. They concluded their review by arguing that South African psychology needs to explicitly address public interest issues by "being ethical in an ethical place" (p. 95) without advocating training or research in professional ethics.

#### 4.6 Summary and Recommendations

Ethics education in professional psychology has enjoyed relatively little exposure in the literature, particularly in comparison with surveys of ethical dilemmas, decision-making and sexual boundary violations.

General articles on professional training in South Africa often omit discussion of ethics (e.g., Fourie, 1995; Radebe, 1996; Viljoen et al., 1999) in the curriculum, or mention it only obliquely. Similarly, in a major Award Address to the APA on professional psychology training for the next millennium, Fox (1994) argued that a true profession must rely on "professional judgement" (p. 202) in applying itself to new and developing fields of application, but did not mention the importance of ethics as a vital component of such judgement.

Existing studies provide little factual information on ethics training courses and their duration and content, although some inferences can be made. "A major difficulty with most reported ethics education surveys is that they do not consider the philosophy or approach used in teaching ethics; they report only the number of hours spent on the subject or whether a course is offered"

(Eberlein, 1988, p. 208). A review by Welfel (1992) concluded that although many psychology training programmes now conduct ethics education, little is known about the content and short- and long-term outcomes of these ethics modules. Even less is known about such courses in South African professional training.

A body of literature suggesting some models and practical approaches to ethics training has begun to emerge, and their recommendations will be discussed more fully in the conclusions of this study. In essence, however, most of the proposals reviewed had most of the following aspects in common:

- professional ethics training should comprise more than just rule learning alone or supervision alone
- professional ethics education should ideally be done using a combination of teaching approaches, including sensitization efforts, formal exposure to codes and rules, readings, workshops, case discussion, simulations and membership of departmental ethics committees
- professional ethics education should be more formal in the academic year of training and be followed up and complemented by ethical issues in case supervision in the internship year
- professional ethics education should include practical strategies for resolving ethical dilemmas, preferably through a system of value clarification.

More specifically, in the South African situation, the following integrated model ethics curriculum is proposed from the literature cited above. While it may seem premature to make recommendations at this stage, these are based only upon the literature reviewed above. The recommendations are revisited in chapter 10 below where they will be integrated with the results of the present study.

#### 4.6.1 Undergraduate Level

The main aim of undergraduate ethics teaching would be to promote ethical sensitivity. Studies suggest that younger, non-degreed persons respond more readily to such teaching (Myrsky & Helkama, 2002; Rest & Narváez, 1994). The course would outline only basic ethical principles, such as the four basic principles of the CPA (2000) code. No detailed standards need be taught

at this level. Based on reports, undergraduates require a focus on student misconduct, such as plagiarism and other forms of academic dishonesty. Basic principles could be reviewed, followed by a series of case vignettes requiring students to make their own judgements about academic dishonesty, and its consequences. This would involve application of the principles to specific case materials, in discussions and written assignments.

Furthermore, detailed and explicit structures should be in place in teaching departments which are capable of taking remedial or disciplinary action in the event that academic dishonesty occurs. This would model response systems to deal with actual ethical misconduct. Such structures should be endorsed by all teaching staff. Staff should in turn actively be encouraged to conduct themselves ethically as teachers and researchers (Koocher & Keith-Spiegel, 1998). There should be a regular forum in which department or school staff review ethical issues in a proactive way and not just in reaction to problems which arise. Ethical issues in teaching and research should be a focus of staff colloquia at such a level. Structures for responding to ethical concerns amongst staff should also be in place which encourage informal resolution of conflicts in an informative way, but further disciplinary steps should also be explicitly described and available for activation should serious problems arise or should informal resolution of a staff problem not be appropriate. This framework would apply to academic staff teaching at all academic levels through to postgraduate professional training. Academic departments or schools should invest in developing ethics teaching capacity in one or two staff members to drive this process with the consent and support of the whole school in an integrated and consensual manner.

#### 4.6.2 Junior Postgraduate Years

The focus here would be to emphasise and further develop ethical sensitivity to common issues in academic misconduct, especially plagiarism and cheating. Principles and their application to various scenarios should be applied in a context which itself supplies a response framework should actual ethical infringements be suspected or detected. This postgraduate level generally allows more class discussion and interactive learning than the undergraduate years. Actual ethical violations should be locally published and circulated in a format that is educational and need not reveal the identity of the transgressors, subject to local legal requirements.

#### 4.6.3 Professional Ethics Training

Based on the literature reviewed, the professional training programme should be based on some of the basic principles and ethical sensitivity encouraged at undergraduate and junior postgraduate levels.

The teaching and training context should be one in which a clear response framework is explicitly available should actual infringements occur - whether by staff or trainees. At this level, such a framework should encourage the frank discussion of ethical concerns, whether they be in students' own experience, their training experiences, or in their interactions with or observations of their peers and teachers and supervisors.

Clear guidelines should be provided for management of staff-student interactions, with an explicit focus on dual relationships, sexual attraction and sexual boundary violations (Biaggio et al., 1997; Fly et al., 1997). A climate of open recognition and discussion of such issues needs to be promoted (Hamilton & Spruill, 1999; Samuel & Gorton, 1998).

Formal professional teaching should follow this creation of a climate of ethical sensitivity. A curriculum based on an overview of common, relevant and local (e.g., national) ethics and regulatory structures needs to be followed by case statistics which outline the most frequent practice dilemmas and violations. National bodies should be encouraged to publish annual reports on the numbers and types of complaints received, modelled on the format used by the APA for almost two decades (APA, 2001b). Such reports should outline patterns and need not disclose the identities of the respondents. The detailed, revealing format adopted by the BPS (e.g., Bromley, 1999) is punitive above and beyond the sanctions imposed by the disciplinary committee, and is likely to obstruct professional rehabilitation. Summarised reports can be linked to practice contexts and practice specialities if this information is available (e.g., school and military settings, clinical, forensic, organizational etc.). Detailed ethical standards should supplement the basic principles covered in the earlier academic years, based on the current CPA (2000) or draft APA (2001a) ethical codes. Attention can be drawn to speciality practice guidelines in specific practice areas.

A decision-making framework needs to be promoted, based on one or more of the models mentioned above (Cottone & Claus, 2000; Knauss, 1997; Pryzwansky & Wendt, 1999; Rest & Narváez, 1994; Treppa, 1998). The CPA (1992, 2000) framework for ethical decision making embodies most of the stages outlined by various authors, and strikes a balance between simplicity and impractical complexity. Once the framework has been internalised in formal teaching, the framework can be applied to hypothetical teaching vignettes in a workshop format. The goals would be to respond to the vignettes using a decision-making model and making justifiable ethics decision about the cases. The cases should be based on realistic local data about ethical violations and practice dilemmas. The literature suggests that in discussion, the steps of decision-making, emotional and contextual factors need to be identified which influence ethical judgements and action outcomes (Cottone, 2001). The literature reviewed above suggests that the professional postgraduate component of ethics training should involve around 25 hours of contact time, combining directed reading, formal didactic inputs, and workshops on applied decision making.

This needs to be followed by the creation of a regular forum in which students can discuss ethical issues arising in their training and applied work in an ongoing manner, in case conferences and research seminars. An institutional framework must be in place for real responsiveness to ethical problems or violations which might arise, based on a continuum from informal response through to a formal complaint process and adjudication (Callahan & Bok, 1980).

Although very little literature exists on whether such a format and process will improve ethical problem-solving capacity and reduce ethical violations in qualified professionals, such a structured curriculum creates further research and outcome evaluation opportunities.

The present study aims to explore empirical data on complaint patterns and the experienced dilemmas of South African psychologists and their training in professional ethics so that these may be of use in detailing actual complaint patterns, psychologists' dilemmas and some of the contexts in which they arise. Attitudes towards and patterns of ethics training will also be examined. The following chapters outline the aims and method of the present work.

#### 4.7 General Summary

The above four chapters outline the development of ethical codes in professional psychology and in South African psychology in particular. Research and theory examining ethical violations, ethical decision making and ethics training were reviewed. To date these remain rather discrete areas with little evident attempt to integrate them. However, it seems clear that efforts to improve ethical guidelines, ethics training and ultimately psychologists' ethical decision making might benefit from a study of public complaints, psychologists dilemmas and ethics training in the South African context. The present study is an effort to conduct such an analysis, integrate the findings and make recommendations for the future ethics training of professional psychologists in South Africa.

## Chapter 5: Aims

The general aims of this study were to examine ethical issues relevant to South African psychologists. This was done through analysis of two primary data sets. The first data set, hereafter referred to as 'Complaints' is a consecutive series of complaints submitted by the public to psychological authorities in South Africa. The second data set, hereafter referred to as 'Dilemmas' involved a questionnaire inviting a sample of psychologists to submit examples of ethical dilemmas they had themselves experienced. The resulting data sets provided a dual perspective of ethical issues in psychological practice - one based on public dissatisfactions, and another based on psychologists' own dilemmas. This study comprises an analysis of public dissatisfaction with psychologists' services, (Complaints) together with an analysis of psychologists' own accounts of ethical dilemmas experienced by them (Dilemmas). It was hoped that this description and comparison of public (external) and professional (internal) perceptions of ethical issues would provide a clear impression of prevalent ethical issues in South African psychology.

A secondary aim was to explore aspects of the professional ethics training of South African psychologists.

Finally, a third aim was to explore some interrelationships between the data sets to develop suggestions for future training, codes of conduct and practice guidelines.

Specific aims for each data set are described briefly below.

### 5.1 Complaint Patterns

To establish a profile of complaint patterns (Complaints) against psychologists reported to psychological authorities in South Africa. More specifically;

- 5.1.1 To determine a profile of matters of concern to the complainant users of psychological services in South Africa.

- 5.2.2 To determine a profile of those psychologists most likely to attract complaints from users. Variables studied were age, gender, years of experience, university of training and registration category.
- 5.2.3 To determine a profile of the practice contexts in which complaints against psychologists commonly arose.

This data set will be referred to as the Complaints data set throughout the remainder of this study.

## 5.2 Ethical Dilemmas

To determine a profile of the ethical issues (Dilemmas) identified by South African psychologists themselves as matters of professional concern. More specifically;

- 5.2.1 To establish a profile of ethical issues which were of concern to South African psychologists.
- 5.2.2 To sample the professional profile of the respondent psychologists, including age, gender, years of experience, university of training, registration category, and their rating of their ethics training.
- 5.2.3 To determine the practice contexts in which ethical dilemmas arose. Variables considered were the settings in which dilemmas arise and the type of professional activity commonly associated with experienced dilemmas.

This data set will be referred to as the Dilemmas data set throughout the remainder of this study.

## 5.3 Survey of Aspects of University Training in Professional Ethics

This study also surveyed aspects of training in professional ethics provided at those South African universities that train professional psychologists.

## 5.4 Interrelationships

The study also aimed to examine some selected interrelationships between the above data sets, including the following:

- 5.4.1 A comparison of Complaints reported by the public with ethical issues (Dilemmas) of concern to psychologists themselves.
- 5.4.2 A comparison of the practice settings in which Complaints arise with the practice settings in which psychologists themselves experience ethical Dilemmas.
- 5.4.3 An attempt was made to establish whether there is a relationship between the university of training of psychologists most likely to receive complaints and the ethics training profile of their university of training. Elements of the survey of universities were related to elements of the complaint patterns data to establish whether patterns of training in ethics at particular universities were related to complaint patterns against psychologists from those universities.
- 5.4.4 Wherever possible the results were compared with available international data on complaint patterns, psychologists' dilemmas and descriptions of training in professional ethics in psychology.

It was hoped that the resulting data would provide a comprehensive picture of ethical issues relevant to psychologists, from the perspective of both the public (Complaints) and psychologists themselves (Dilemmas). Such a picture, combined with some analysis of training issues in psychology in South Africa, might be helpful in providing an empirical basis for training programmes in professional ethics, and for the development of revised codes of conduct and practice guidelines. Selected theoretical implications will also be explored.

## Chapter 6: Method

From the aims described above, this study can be seen as basic research of a descriptive and exploratory nature (Durrheim, 1999; Dyer, 1995) in that the primary goal was to identify and describe the ethical issues impacting on South African psychologists. Dyer (1995) argues that exploratory research is appropriate under two conditions: first, if relatively little data exists upon which to base hypotheses, and second, if there is no clear theory upon which to base hypothesis-driven research. Both conditions applied, to some extent, to the present study. There is a dearth of local data on public complaint patterns against psychologists (Scherrer et al., 2002). While important data on South African complaint patterns has recently been published, no statistical analysis was conducted on the data (Scherrer, et al., 2002). Relatively more data are emerging on dilemmas experienced by psychologists themselves, as reviewed in section 3.4.5.1 above. No study to date has attempted to compare and integrate Complaints, Dilemmas and ethics training data systematically.

For this reason, a secondary aim was to analyse selected interrelationships between these ethical issues and several other demographic, contextual and training variables. Analysis of the data was primarily inductive in that this study attempted to identify and categorise ethical issues and practice contexts and explore possible interrelationships between these, as opposed to being a study which is primarily hypothesis or theory driven (Durrheim, 1999; Dyer, 1995; Holsti, 1969; Terre Blanche & Kelly, 1999). It was hoped, however, that the resulting data might provide a base from which more specific hypotheses could be generated and tested in future studies of the relationship between Complaints, Dilemmas and training.

The study comprised several distinct components consistent with the aims described in the previous section. These components are discussed separately below.

### 6.1 Complaints

#### 6.1.1 Procedure

Permission was obtained from the Board to study complaints submitted to it by the public at

large (copy of letter available on request).

This 'Complaints' data set comprised 242 complaints received from the public between January 1990 and September 1998. All Complaints were recorded consecutively for this period and no complaints were omitted. The entire Complaints data set comprised more than 10,000 pages of written material documenting these complaints and the responses of the psychologists. Typically, each complaint consisted of a letter to the Board and a response from the psychologist concerned and/or their legal representative. Documentation for each complaint varied in length from two to 250 handwritten or typed pages, with an average of 30 pages per complaint.

Procedurally, these complaints, once received by the Board, are routinely referred to the psychologist concerned with an invitation to respond in writing to the complaint. The complaint and response are considered by the Committee for Preliminary Inquiry of the Board. This committee decides further action to be taken. The case can be closed, the psychologist may be called for a face-to-face consultation, and/or the matter may be referred for a formal, legal disciplinary inquiry. In reaching its conclusions, the committee need not explicitly code or describe the specific violation according to a standardised coding schema (e.g., 'breach of confidentiality') such as that used by the APA. Such detail is mentioned only as substantiation of the more general legal charge of 'unprofessional conduct'. The full powers of the Committee for Preliminary Inquiry are described elsewhere (SAMDC, 1991b), but this committee may itself take steps against a psychologist based on a complaint and/or the psychologist's written or in person representations to this committee.

It should be noted that the data used in the 'Complaints' part of this study was concerned with public complaints, and not with the adjudicated outcomes of formal disciplinary proceedings arising out of such complaints. A complaint is therefore not *prima facie* evidence of an ethical violation; indeed, some complaints are known to be false. Similarly, many valid complaints may remain unreported (Williams, 2000). The outcomes of South African Board complaints and disciplinary inquiries are described by Scherrer et al. (2002) are beyond the scope of this work. The useful data from Scherrer et al. (2002) will, however, be referred to where appropriate. The Complaints data set, furthermore, excludes civil actions against psychologists.

In addition, permission was obtained from the Psychological Association of South Africa (PASA) to study complaints submitted to their Ethics Committee (copy of letter available on request). Although this association, which was superseded by PsySSA in 1994, had no statutory powers to take disciplinary actions against psychologists, it has been argued that the public frequently do not distinguish between statutory and non-statutory (voluntary) psychological authorities when deciding to submit a complaint against a psychologist (Wassenaar, 1998a). Fifty-six complaints submitted to PASA between 1990 and 1994 were included in the Complaints data. This data was combined with the complaints to the Board and was regarded as a single 'Complaints' data set.

The Complaints data set thus comprised a total of 298 complaints, of which 242 (81%) were directed to the Board and 56 (19%) were directed to PASA.

In requesting permission to access this information from both the Board and PASA, the researcher emphasised that the identity of all individuals (complainants and respondents) would be regarded as confidential. As the average complaint comprised 30 pages of documentation, it was decided not to attempt to provide sample vignettes here, as was done in section 6.2.2.1 below for Dilemmas.

### 6.1.2 Coding of Complaints

The correspondence concerning each complaint was coded by the researcher. These records did not include any prior coding of the complaints, as mentioned in section 6.1.1 above. No formal, standardised framework exists for the coding of complaints against psychologists or other mental health professionals (Neukrug, Milliken & Walden, 2001; Scherrer et al., 2002). Regarding the coding and categorisation of ethics complaints, the Board is empowered to adjudicate complaints on any criteria judged appropriate by the relevant committees. In practice these committees referred to the relevant sections of the Act (Government Gazette, 1974), the APA ethical code (APA, 1992a), the CPA ethical code (CPA, 1991), and the ASPPB *Code of Conduct for Psychologists* (ASPPB, 1991). The PASA committee formerly referred to the Steere and Wassenaar (1985) ethics booklet, but the PsySSA Ethics Committee has more recently referred

to the CPA and APA codes in their ethical decision-making (Naidoo, 2000, personal communication). This unsatisfactory lack of uniformity (Wassenaar, 1998a, 1998b) has relatively recently been improved by the Board's adoption in 2000 of its own *Ethical Code of Professional Conduct* (Professional Board, 1999a) for psychologists, based largely on the 1992 version of the APA code (APA, 1992a). Scherrer et al. (2002) described 17 categories in coding their study of Board complaints, but did not describe how the categories were derived. Their data will be referred to where applicable in chapters 8 and 9 which follow.

In an early attempt to code the Complaints data, the author attempted to apply the categories used by the APA Ethics Committee in structuring their Annual Reports (APA, 2001d), and preliminary coding was conducted in this manner. This coding clearly did not consider practice and contextual variables. Indeed, the structure of the APA Ethics Code itself blurs some distinctions between ethical issues and practice contexts (e.g., confidentiality, child custody. Cf. also Sinclair, 1996, 1998), while other studies code only ethical violations without regard to context (e.g., Neukrug, et al., 2001). During further efforts to develop a coding system, the author became involved in an international study of ethical dilemmas with members of other international psychology associations (cf. Lindsay & Clarkson, 1999; Sinclair, 1999; Slack & Wassenaar, 1999; Wassenaar & Slack, 1997). At several international conference symposia, problems of coding complaints and ethical dilemmas were identified as a matter of common concern (Antikainen, 1997; Colnerud, 1997a; Odland, 1997, 1999; Sinclair, 1997). Because of this international collaboration, the author decided to use the method of coding initially developed by Pope and Vetter (1992) and modified through discussion at various international congress workshops. Changes made to the Pope and Vetter (1992) system by the author of the present study arose from these discussions. These changes are hopefully reflected below in attempts to distinguish the primary ethical issue more clearly from the practice context in which it arose. For example, the ethical issue of breach of confidentiality might commonly arise in the practice context of child psychotherapy; similarly, the ethical issue of plagiarism might commonly arise in the practice context of research publication (cf. examples of coding of Dilemmas, section 6.2.2.1 below).

Thus, in developing the coding system used in the present study, the author was part of an

international project aimed at improving the coding of ethical complaints and dilemmas that at the time of writing have not yet been standardised (Pettifor, 2000, personal communication). It was hoped that the present work might make a contribution to this process.

The coding of Complaints involved the categorisation and sub-categorisation of the information outlined in sections 6.1.2.1 to 6.1.2.3 below. Reliability issues are discussed in section 6.1.2.2.

#### 6.1.2.1 Demographic Details

Details of the psychologists about whom complaints had been received were obtained from the Register of Psychologists (INMDCSA, 1998) maintained by the Board. Sub categories used were:

University of training: This was taken from the Register as the university where the psychologist obtained their postgraduate professional training. Categories were created for each South African university that arose - as reflected in section 7.8 to follow. Additional categories for non-South African graduates were also created.

Year of first registration with the Board: This information was taken from the Register that lists each registered psychologist's first date of registration. The number of years between the date of first registration and the date of the complaint was calculated and referred to as the number of years of experience for the psychologist in question at the time the complaint occurred. Years of experience were further coded into four 5-year groups of experience for ease of analysis, as reflected in section 7.5 below.

Primary category of registration: All psychologists in South Africa are required to register in at least one of five registration categories: clinical, counselling, educational, industrial or research<sup>1</sup>. The registration category for each psychologist in the Complaints sample was obtained from the Register. The category was also usually evident from the correspondence between the Board and each psychologist - this information helped in determining the category in which a psychologist was functioning if they had more than

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<sup>1</sup>There are additional categories for interns, psychometrists and psychotechnicians.

one category of registration. Only the primary registration category was recorded for this study although about 7% of psychologists on the Register are registered in dual categories (Richter, Griesel, Durrheim, Wilson, Surendorff & Asafo-Agyei, 1998). The documentation (letterheads, etc.) associated with each complaint and information from the Dilemmas demographic data sheet allowed for identification of the primary registration category of each psychologist, as reflected in section 7.4 below.

#### 6.1.2.2 Primary Ethical Issues

The categories into which ethical issues were coded are described briefly below. The categories were essentially derived from the work described in section 6.1.2 above and are consistent with categories evident in most international ethical codes in psychology (APA, 1992a; ASPPB, 1991; CPA, 2000). These categories will be referred to throughout the remaining sections of this study and are presented below in alphabetical order.

Coding each protocol involved careful reading and re-reading of each Complaint (or Dilemma) and identifying the primary, central ethical issue. Where more than one issue emerged, these were coded into primary and secondary issues. The present analysis concerned only the ethical issues coded as primary - analysis of permutations of combined or concurrent ethical issues was beyond the scope of the present work and may form part of a later analysis of the data.

The sheer volume of this data set made rating by a second rater impractical. However, ambiguous ( $n=14$ ) cases were verified by a second reader who was competent in ethical issues in psychology who has contributed to a related study (Slack & Wassenaar, 1999). The few differences that arose ( $n=9$ ) concerned combined ethical issues and whether to code these as primary or secondary. Discussion leading to consensus followed, as described by Lindsay and Colley (1995). Reliability might have been improved if the second rater had been asked to randomly re-code 10% of the complaints rather than deal only with ambiguous cases identified by the researcher. However, the researcher had been involved in adjudicating such cases formally for several years, hopefully contributing to the reliability of the coding.

The primary ethical categories used are listed alphabetically below.

Advertising: This concerns verbal and written public statements and paid advertisements of various kinds. During this study the regulations concerning advertising and public statements were relaxed by the Board in 1994 (Allan, 1996; SAMDC, 1994a). This was the only regulatory or code change that occurred during this study. Essentially, the change in this category involved a shift from a near-absolute prohibition on advertising to one in which advertisements were permitted if certain stipulations were complied with. These were that “prospective patients (and indeed, other practitioners) need to have ready access to accurate, comprehensive and well-presented information about the practitioners practising in their area” (SAMDC, 1994c, p. 2). Detailed guidelines were set out in a seven-page booklet in 1994 (SAMDC, 1994c). For the purposes of this study, most complaints concerning advertising occurred after 1994, although some may have been based on the former prohibitions. The majority however alleged violations of the requirements that announcements (advertising) should accurately reflect the competencies of practitioners in a factual, non-comparative and professional way.

Competence: This concerns the obligation of psychologists to conduct only procedures in which they have been trained and formally supervised, and in which they are abreast of current practice developments. Competence complaints also reflect interventions not grounded in accepted theory or lacking empirical evidence. In earlier studies (cf. Slack & Wassenaar, 1999) some items included in this category were coded as “Questionable Intervention”. “Questionable Intervention” was not used in this study as it does not correspond with a known ethical principle.

Confidentiality: This concerns the psychologist’s obligation to work within the prescribed limits of confidentiality, with particular regard to written and verbal communications to parties other than the primary client.

Consent: This concerns the psychologist’s obligation to recognise client autonomy in formulating professional decisions - “informing clients about goals, techniques, rules and limitations” of services rendered (Neukrug et al., 2001, p. 62). It should be noted that in a sense most confidentiality issues are secondary to consent issues (Peterson, 1996), but are coded separately internationally and in this study.

Ethnicity: This category exists in international studies to reflect tensions arising out of intercultural work - ranging from naivete to discrimination, cultural insensitivity, disrespect, etc. (Hansen, Pepitone-Arreola-Rockwell & Greene, 2000).

Fees: This concerns all aspects of billing for professional services, including initial negotiation for services, payment arrangements, medical aid claims, billing practices and contracts. In South Africa, there is no statutorily prescribed fee. However, the Psychological Society of South Africa publishes recommended fees for services annually, as does the Board of Health Care Providers. Although these publications are only guidelines, the Board refers to them in determining parameters of overcharging.

Inappropriate practice: This category was developed specifically for the current study and contains items previously coded internationally as "Questionable Intervention", some of which in this study were coded under Competence. Those items that could not be regarded as Competence items seemed best categorised as "Inappropriate practice". Items coded as such were items that were not frank ethical code violations but were examples of poor professional conduct, poor 'customer care', poor practice management, and breaches of etiquette and courtesy - e.g., taking non-urgent telephone calls during consultations; missed and late appointments; failure to apologise for administrative, scheduling or other errors; rudeness; hostile responses to requests or questions; impolite or insensitive language; gossiping; inattentiveness (including falling asleep); tardiness in producing reports; failure to respond to clients' requests or those of other professionals; failure to monitor services rendered by administrative staff; rendering of services in unsuitable premises or facilities, etc. In this regard it is possible that the public has fewer clear expectations of what to expect from psychologists compared with longer-established professions such as medicine or dentistry. An alternate title for this category might have been 'poor practice management'. The category is believed to be distinct from 'practitioner impairment' - a category that has not been cited in studies of dilemmas to date and did not arise naturally out of the Complaints or Dilemmas data in the present work (Barnett & Hillard, 2001; O'Connor, 2001; Sherman & Thelen, 1998).

Interprofessional Issues: This category concerns complaints and dilemmas arising out of exchanges between professionals and commonly includes issues of interprofessional etiquette, courtesy, disrespect, power struggles, public criticism, supersession and control

of clients, especially concerning alternate treatments and hospital admission and discharge disputes. This category is distinct from the category “colleagues’ conduct” used in earlier studies of psychologists’ dilemmas, which was a separate category of concerns about colleagues’ behaviour (Pope & Vetter, 1992).

Non-sexual Dual relationships: This concerns multiple non-sexual role relationships that most ethical codes urge psychologists to avoid if possible. This category is distinct from sexual dual relationship, which was coded separately as such violations are generally regarded as more serious than non-sexual dual relationships. Dual relationships may involve two or more professional roles (e.g., therapist and expert witness for the same case; academic supervisor and psychotherapist for a student), or may involve dual professional and nonprofessional roles (e.g., psychotherapist and family friend; psychotherapist and estate agent client, etc., cf. Anderson & Kitchener, 1998).

Records: This category concerns psychologists’ obligation to make and retain adequate records of their professional work for each unit of service (e.g., assessment, counselling or psychotherapy, etc.) rendered to a client (APA, 1993a; Wiger, 1997).

Registration Fees: This is a technical category arising from unpaid annual registration fees to the Board. This technically results in unlicensed professional practice which is a legal offence rather than an ethical issue (HPCSA, 2001c; INMDCSA, 1997). The category was nevertheless retained for this study as it occurred relatively frequently, as it does internationally (APA, 2001d; Neukrug et al., 2001).

Sexual issues: These complaints concerned dual relationships where a primary professional relationship developed into a sexual relationship between psychologist and client, or vice versa.

Other Issues: Several other categories were used in the initial coding but preliminary analysis of the results showed that the frequency of complaints in these categories did not justify their retention and were coded as Miscellaneous (cf. 6.2.2.2 below).

Although many Complaints typically involved more than a single ethical issue, a primary ethical issue was identified which seemed to characterise each complaint best. Analysis of multiple ethical issues generated too many data categories that compromised data analysis of an already large number of categories. The focus on primary issues does however sacrifice some complexity

that typifies this area. The category “inappropriate practice” contains many relatively petty violations that probably constitute a list of subcategories. Similarly, many other categories are sub-divisible into subcategories.

### 6.1.2.3 Practice Context

A unique feature of this study involved the identification and categorisation of a practice context associated with each complaint and each dilemma wherever possible. While earlier work identified some contexts, (Pope & Vetter, 1992; Slack & Wassenaar, 1999), the associations between ethical issues and practice contexts were not analysed.

For this study, it was felt that particular ethical issues might arise in particular practice contexts and that exploration of possible patterns of association might inform the practical teaching of ethical issues and their associated high risk contexts. The contexts were developed intuitively from re-reading the complaints and dilemmas and identifying the practice context in which the ethical dilemma or context arose (Holsti, 1969). Some categories reflect settings, while others reflect practice modalities and activities. The list of contexts below is thus not exhaustive as it was generated by the Complaints and Dilemmas databases themselves. Future studies might therefore generate additional contexts (e.g., group psychotherapy) as they arise and might also specifically explore differences associated with psychologists in private practice compared with psychologists in state or other employment contexts. Specific suggestions in this regard will be made in the sections that follow. In some cases, e.g., unpaid registration fees, no practice context was applicable. The Context categories are presented alphabetically below.

Academic setting: This category contains several smaller categories including lecturing, training and research supervision. See also supervision below.

Adult therapy: The conduct of a psychotherapeutic intervention with an adult client or patient.

Assessment: Formal evaluation of adults using interviews and/or psychometric testing.

Child abuse interventions: This concerns actions taken by psychologists intervening in suspected or confirmed child abuse, in keeping with the Child Care Act (Government Gazette, 1983).

Child custody work: Refers to interventions and activities associated with all aspects of child custody work - from contracting, assessment, report writing, liaison with other parties and legal professionals to presentation of findings in court.

Child custody and abuse settings: This category was created to accommodate specific situations where claims of child abuse arose in the context of child custody disputes.

Couples and family work: This combined category reflects work where more than one client is simultaneously the focus of interventions, and includes parent counselling.

Follow-up: This concerns a variety of issues surrounding termination of interventions and abandonment of clients through failure to terminate or follow-up professionally. This applies to a variety of services and settings.

Forensic: This category accommodates all court work by psychologists other than child custody or child abuse work, and typically involves all aspects of criminal forensic work and psychological reports for civil liability claims.

Hospital: Work undertaken in private or public sector hospital settings was coded in this category.

Industrial: This category includes organisational and industrial contexts of psychological work. The term should more correctly be organisational, but was retained as Industrial to correspond with the current South African category system of registration.

Minors: In some analyses that follow, this category contains assessment and intervention with legal minors, *excluding* custody and child abuse work.

Miscellaneous: This category was used to accommodate several smaller contexts that were originally separate but involved such small numbers as to not warrant separate categories - such as NGOs, schools, prisons and other government departments.

Religious: This category reflects work done in the context of a church or other religious organisation.

Research: This category refers to settings in which research activities were primary.

Supervision: This category was retained as distinct from academic in that it refers to the practical training of professional psychologists specifically, other than academic training. It excludes thesis supervision and largely refers to supervision of diagnostic, therapeutic or organisational interventions.

As with the ethical issues listed above, these categories were not always mutually exclusive or exhaustive. Some categories reflect settings while others reflect practice modalities. Coding of a single primary context was necessary for data analysis but compromised richness and complexity. As with ethical issues, the coding of ambiguous cases ( $n=14$ ) was referred to a second skilled reader and coded by consensus, consistent with procedures reported for coding ethical issues in other studies (Lindsay & Clarkson, 1999; Lindsay & Colley, 1995; Slack & Wassenaar, 1999). Reliability of coding is discussed further when the coding of Dilemmas is discussed in section 6.2.2 below. It is hoped that this study will provide an empirical basis for further rational classification of categories of the professional contexts in which most psychologists work.

## 6.2 Dilemmas

### 6.2.1 Procedure

To generate a representative mailing list, a computer-generated electronic list of 1000 names of psychologists was requested from the appropriate office of the Board. The researcher requested a random selection of 1000 names and addresses of psychologists, independent of category, but excluding interns, psychometrists and psychotechnicians. This represented just less than 25% of the more than 4000 psychologists registered with the Professional Board at the time of the data collection, comparable with other professional surveys in psychology (Pingitore, Scheffler, Haley, Sentell & Schwalm, 2001).

The questionnaire used to elicit ethical Dilemmas in this study was based on that used in a series of international studies of ethical dilemmas (cf. Slack & Wassenaar, 1999; also Appendix A). This, in turn, was based on an original study by Pope and Vetter (1992). The questionnaire was mailed to 1000 psychologists with a covering letter and a reply-paid self-addressed envelope. The questionnaire assured respondents of their individual anonymity and did not require the names or addresses of respondents but requested demographic details, some ratings of ethics training, malpractice insurance details, and the essential research request:

“Describe, in a few words or in more detail, an incident that you or a colleague have faced in the

past year or two that was ethically challenging or troubling to you” (cf. Appendix A).

Three examples of typical replies and primary coding follow:

“Medico-legal scenario: I was instructed by defence attorneys to examine a patient and comment on two issues raised by the psychologists for the plaintiff (brain damage sequelae). I found many more problems than the plaintiff’s psychologist had identified, yet I was instructed to comment only on the issues. My dilemma was that the patient’s problems were greater than the plaintiff’s team realised (and therefore I think he deserved more in terms of compensation), but I also had a duty to my defence attorney” (Coded as a dual relationship issue, forensic context).

“Taking on a case when my own level of experience in the relevant area is quite low - whether to take on a case and when to refer elsewhere” (Coded as a competence issue, adult psychotherapy context).

“Adolescent revealed that he used to take heavy drugs (LSD, Ecstasy) until a few months ago. In therapy for agitation/depression which may have something to do with withdrawal. Refuses to tell parents, begs me not to do so. Issue of confidentiality” (Coded as a confidentiality issue, minors context).

Demographic details requested by the questionnaire were Highest degree; Category of registration; University of training; Year of first registration with the Board; Age; Gender; Primary work setting; and ranked listing of main professional activities (see Appendix A).

The questionnaires were numbered to enable a reminder to be sent to non-respondents if necessary.

## 6.2.2 Coding of Dilemmas

### 6.2.2.1 Primary Ethical Issue

The responses were initially coded according to the primary categories generated by Pope and Vetter (1992). The coding system was modified, as discussed in 6.1.2 above, following discussions at two international symposia (Pettifor, 1997, 1999) at which several problems were recognised. These included the absence of a category for the coding of 'competence' (as opposed to 'questionable intervention'), and recognition that the Pope and Vetter (1992) system inadequately distinguished ethical issues from the practice contexts in which they arose. Early attempts to explore the data involved coding the Complaints and Dilemmas into primary and secondary ethical issues. This was done because many of the Complaints and Dilemmas contained more than a single ethical issue. This coded data comprised a vast matrix which was then explored using a hierarchical cluster analysis (Tredoux & Pretorius, 1999). However, the resultant dendrogram produced too many clusters to be useful and was abandoned. It was consequently decided to reduce the number of variables and focus only on a primary ethical issue for each Complaint and Dilemma, as listed in section 6.1.2.2 above. The results are shown in section 8.1.2 below.

To increase reliability of the coding, the Dilemmas were independently re-coded by a colleague who had conducted a similar study (Slack, 1997) and collaborated on another (Slack & Wassenaar, 1999; Wassenaar & Slack, 1997). Differences were noted in 46 (12.2%) protocols. Of these, 21 concerned the coding of the ethical issue, and of these, four added a coding score where none had been. The remainder added secondary codes to an existing code. However, in the statistical analysis only primary codes were used. This means that in effect only four (1.06%) changes were made to the coding of the ethical issue. The remaining 25 differences concerned the coding of the context. Of these, 15 (3.9%) added contexts where none had been coded before, with the remainder adding secondary contexts, which were not used in the statistical analysis of the data. This means that 15 (3.9%) changes were made to the coding of contexts. The combined number of changes to the entire Dilemmas data set was thus 19, (5.03%), suggesting concordance of 94.07% by the raters on the original scoring of the Dilemmas data set. Reliability of coding was not provided by other studies using this methodology (Antikainen, 1997; Colnerud, 1997a;

Lindsay & Clarkson, 1999; Lindsay & Colley, 1995; Odland, 1997; Orme & Doerman, 2001; Pope & Vetter, 1992; Sinclair, 1997; Slack & Wassenaar, 1999).

While no similar reliability data was available for the coding of Complaints, it is hoped that the Complaints reliability compared favourably with the above, particularly since the Complaints cases involved much more information than the Dilemmas vignettes, leading to redundancy of information and ease of coding, despite the length of the records. Related studies of Complaints provided no data on reliability of coding (Scherrer et al., 2002).

The eventual set of ethical categories was narrowed down as described for the Complaints data in section 6.1.2 above, since in this study an overriding concern was to code the Complaints and Dilemmas data using similar categories so that these two data sets could be meaningfully compared, as shown in section 8.1.3 below.

#### 6.2.2.2 Primary Context

As with the Complaints data, the Dilemmas data were also coded into a primary practice context as logical categories became apparent from the vignettes (Holsti, 1969; Terre Blanche & Kelly, 1999). The linking of Complaints and Dilemmas data to practice contexts was thought to be a novel aspect of this study. The initial categories that emerged were: academic teaching; forensic work; research; adult assessment; professional committees; school; publishing; assisting the impoverished; supervision; industrial settings; medical; termination and follow-up; political settings; university settings; couples; families; custody work; religious settings; work with minors; HIV/AIDS; miscellaneous; child abuse interventions; adult therapy; no dilemmas and custody and child abuse combinations. It is clear from these listings that there were too many categories to make the data meaningful. In the early stages of coding the data, descriptive statistics were generated and several categories were rationally collapsed where relevant, and small categories were collapsed or excluded. The final listing was outlined in section 6.1.2.3 above and the results are shown in chapter 9.

### 6.2.2.3 Ratings of Ethics Training

The questionnaire also asked respondents to rate the quality, relevance and duration of their ethics training; whether they had sought subsequent ethics training, and whether they would seek further ethics training if it were available (cf. chapter 10). Respondents were also asked whether they had purchased malpractice insurance (cf. section 7.9.2.3).

### 6.2.2.4 Professional Activities

The questionnaire also explicitly asked respondents to identify their primary professional activities and the primary settings in which they work. The categories that emerged are presented early in the results (section 7.9) and are not listed separately here<sup>1</sup> as they do not apply to the Complaints data and do not form part of the comparison of Complaints and Dilemmas data sets. The aim was to identify the professional activities in which this sample of psychologists was primarily engaged, and to explore whether such activities were associated with particular ethical issues and practice contexts. Some attempt is made to compare this data with other South African data on practice patterns of psychologists to establish the extent to which the present data was a reliable reflection of professional psychological activity in South Africa.

## 6.3 Survey of University Training in Professional Ethics

To obtain information on ethics training, a survey questionnaire was constructed and posted to all South African Universities that train psychologists eligible for registration with the Board (cf. Appendix B). A self-addressed reply-paid envelope was included with the questionnaire. A similar method was used by van der Westhuizen and Plug (1987) to identify training patterns in South African psychology. Respondents were asked to answer questions on ethics training, including the teaching format, time allocated, and primary resource references as reported in section 10.2 below. Confidentiality was not promised to respondents, and the covering letter expressed the hope that the results would be made available to all South African universities at

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<sup>1</sup>E.g.: adult assessment, child assessment, adult therapy, child therapy, parent guidance, counselling, marital therapy, family therapy, organisational work, management, supervision, lecturing, etc.

a future date.

These questionnaires were coded and analysed to determine features of ethics teaching at training universities, and to explore whether any ethics training variables, if any, were associated with rates of complaints against practitioners trained at particular universities, as shown in section 8.4.1 below. Despite problems with reliability and validity of self-report surveys of this type, similar methods remain in use in studies of university training patterns (Samuel & Gorton, 1998; Wiederman & Sansone, 1999).

#### 6.4 Registered Psychologists by Category and University of Training

A further document contributed to this study. The Board was asked to generate a listing of psychologists by category and university of training (cf. Appendix C). This listing was generated for the years 1995 and 1999 and was used to determine whether psychologists from particular categories, years of experience and universities were proportionally over- or under-represented in the Complaints data set (cf. section 7.4). Psychologists with more than one registration category were sorted into a primary category by the Board. It is not known to what extent these documents were accurate and reliable as indices of psychologists by university of origin, years of experience and category. However, they were derived from the statutory Register which is assumed to be a reliable official source of such information used in other studies of South African psychologists (Bassa & Schlebusch, 1984; Richter & Griesel, 1999). The use of these figures as the basis for such calculations may have caused some inaccuracy in calculations spanning the period covered by the present study (1990 to 1998). However, the purpose of this research was to detect trends in Complaint patterns, rather than exact annual statistics. Furthermore, it was assumed that variance in the Register by category and university of origin remained proportionally stable during this study. Use of Register data was likely to be more reliable than data based on membership lists from voluntary psychological associations (PASA and PsySSA) as used by Manganyi and Louw (1986). As discussed below (cf. section 6.6), the identities of universities in the Complaints data will remain coded.

## 6.5 Data Analysis

The data from all the components of the study were initially coded and entered on four separate (Quattro Pro) databases (Complaints, Dilemmas, University Training Survey, Register) and then converted to SPSS for Windows (SPSS, 1990).

The databases were cleaned before data analysis by eliminating coding of secondary and tertiary categories, and checking for missing data. Random cross checks of data entries for all data sets were done, but no record was kept of the number of entries checked or corrected. In any event, these were relatively few and certainly less than 5% of the Complaints and Dilemmas entries and none of the University survey entries.

Each database was initially analysed independently, followed by an investigation of selected interrelationships between components of the data. The descriptive and exploratory design of this study and the largely categorical nature of the data, was best suited to analysis through descriptive statistics and simple tests of significance (e.g., chi-squares, *t*-tests) where appropriate (Durrheim, 1999; Dyer 1995).

## 6.6 Ethical Issues

Following the framework of Emanuel, Wendler and Grady (2000) for determining whether research is ethical, the following applied to this research:

The study was thought to have value in that it would hopefully impact on future ethical training and conduct of psychologists, which in turn might be of benefit to the public at large. Benefits might accrue to the participants indirectly through long term contributions of this data to CPD which will be mandatory in South Africa from April 2002 (Professional Board, 2002). The risks of this study were relatively low in that the identity of individual respondents is protected. Harm could however accrue to the reputation of individuals and universities seen to be associated with disproportionately high Complaints ratios. Harm could also possibly accrue to those categories of psychologists found to have high Complaint ratios. However, this would hopefully be offset

by explanation of the limitations of the data and, if indicated, the opportunity to identify and remedy such trends through improvements to initial ethics training and ongoing CPD. The potential harm to psychologists associated with particular practice contexts could hopefully also be offset by highlighting the risks inherent in these areas so that corrective and preventive ethical precautions can be applied. In summary it was felt that if data concerning individuals remained confidential, the balance of potential harms to potential benefits was favourable.

Furthermore, this was a low risk study in the sense that it was exploratory and not experimental (Kelman, 1982). The design of this study merely shows associations between selected variables and does not prove any causal linkages. The analysis which follows thus highlights areas which might warrant further study in order to demonstrate any cause-effect relationships. The potential harm to those universities shown to have higher Complaints ratios could be offset by revision of ethics training. As an exploratory study, the results hopefully, and at best, might suggest potentially key variables for future research into the relationship between ethics training and Complaint patterns. It is emphasised throughout this study that Complaint patterns are not *de facto* indices of unethical conduct. As will be shown in the discussion, more complaints could simply accrue to practitioners and graduates of certain training universities because they see more difficult clients, see more clients, or see clients who are more ethically vigilant or litigious than those who attract lower rates of complaints. Indeed, Scherrer et al. (2002) reported that more than 50% of complaints do not lead to formal disciplinary inquiries. In contrast, data on actual convictions after formal disciplinary inquiries against psychologists are a matter of public record and the university of training of psychologists found guilty of professional misconduct can easily be obtained from the Register, which is a public document. In the present study, however, Complaints do not represent adjudications and cannot be taken as indications of *de facto* unethical conduct, as stated earlier. It could thus be argued that the present data, being unadjudicated, is less controversial and potentially damaging to institutional reputations than university examination pass and failure rates, which are also a matter of public record, and can impact on a university's standing and enrolments. It was hoped that universities shown to have high Complaints ratios would scrutinise their records and ethics training in an ongoing effort to deliver professional psychologists with high standards of technical and ethical competence. Universities with low Complaints ratios would similarly not be able to rest on their laurels and

should identify the strengths and weaknesses of their ethics training and Complaints record of their professional graduates.

The above arguments notwithstanding, the consent received from the Professional Board and PASA to examine their records was conditional upon the identities of individuals remaining confidential. The status of public institutions (universities) referred to in the Complaints data set was not made clear in the correspondence. Further consent from The Board and PASA/PsySSA would be required to clarify this. This might take care of the 'indemnity' aspect of the consent to disclose institutional identities from the Complaints database. However, it would be most ethical to seek the informed consent of each named university to disclose data on their relative Complaints ratio, rather than to rely on the 'proxy' consent of the Board (Capron, 1982; Macklin, 1982). For pragmatic reasons, it was decided to avoid the possibly long delays in seeking these consents from the Board and each training university, and for this reason the identities of training institutions in the complaints data will remain anonymous and will be coded (e.g., UniA, UniB, etc.) following the example of Scherrer et al. (2002). For South African readers, this will regrettably lead to some disappointment as it will render the results and discussion somewhat sterile and unavoidably cryptic. The identities of universities in the Dilemmas and Training survey data are less controversial and will be disclosed where unlinked to Complaints data.

The identity and training ratings of universities obtained from Dilemmas respondents were not subject to this restriction, nor was the feedback received from training universities themselves subject to any assurance of confidentiality. Data pertinent to specific universities obtained in the Dilemmas and Training survey data sets will be identifiable where the data is unlinked to the Complaints data.

This ethical decision reveals a compromise typical of ethical decision making. Although it is hoped that the disclosure of this data could be helpful to institutions in examining the complaints ratios of their own graduates, this is different from the public disclosure of such data, even though the raw data was accessed with the consent of a different source (the Board). Thus, the possible beneficence argument (disclose the data so that problems can be identified and remedied) is outweighed by the autonomy argument (don't disclose the data without further

detailed informed consent from the named parties about what is to be revealed). It was hoped that no harm will accrue through the non-publication of identifiable university complaints patterns. This last point represents a (weak) argument for nonmaleficence.

Finally, as a way forward, should the results of this study be deemed potentially publishable, the full consent processes outlined above will be activated. A number of options are possible: Furnish each university with its own Complaints ratio, along with its ranking in the list of Complaints ratios. The identities of all the other universities would remain coded. Thus, no comparator universities would be identifiable but each university's own Complaints ratio would be made available confidentially, so that each university could privately assess their own position. This disclosure could be accompanied by a request for permission to publish the data in an uncoded form. After a prescribed period of time the data could be published disclosing the identities of those universities who had consented to this. The non-consenting or non-responding universities would remain coded. These are more likely to be those with unfavourable Complaints ratios. The risk remains that in a relatively small country like South Africa the members of the non-consenting coded group could probably be identified, but could not be linked to specific Complaints ratios.

## Chapter 7: Sample Characteristics

Characteristics of the samples are described first. In the sections that follow, the results and discussion of these results are integrated. This was done because this study covered many areas, rather than a narrow area in depth. The wide range of issues covered in this study lend themselves to integrated presentation of results and discussion, rather than a formal separation of these as is more usually the case in research reports. Separate presentation would have required repetition of the main results in the discussion section, adding length but relatively little value.

### 7.1 Complaints

Between May 1993 and September 1998, 242 complaints were submitted to the Board by the public and were included in this sample. The complaints rate average was 37 complaints per annum (242/6.5), reflecting complaints against 0.88% of registered psychologists per annum (37/4200x100). This is lower than the 1.2% annual rate of complaints reported by Scherrer et al. (2002) in 461 South African complaints lodged with the Board between 1990 and 1999. The present data falls within this period and many cases thus overlap with the present study. There was no comparable international figure for the annual rate of complaints to statutory bodies against psychologists. Woody (1994, cited in Reaves, 1995a) reported that the rate of complaints in Florida (USA) averaged 5.5% per year between 1990 and 1993. Koene (1997) reported an average complaints rate of 0.3 percent in a survey of complaints in 14 European countries. The reported South African complaints rate was higher than the average rate of 10 complaints per annum for the period 1974-1990 described by Louw (1997b), which represented an average rate of complaints against 0.6% (10/1769x100) of registered psychologists annually. These rates take annually increasing registrations into account (Professional Board for Psychology, 1999b). Compared with Louw's (1997b) data, these results suggest an increase in the annual rate of complaints from the public against psychologists, even when increasing numbers of psychologists was controlled for. A rising annual rate of complaints would also account for the present study's lower rate than reported by Scherrer et al. (2002) whose data extends to 1999. A possible variable accounting for this might be the increasing sophistication of the public, or a simple increase in the incidence of unethical professional conduct. It should also be noted that a

complaint, as used in this study is not a conviction. The focus on complaints in the present study was thus used as an index of public dissatisfaction, and was not necessarily a *de facto* index of unethical conduct. This study did not consider the adjudication outcomes of these complaints. It should also be noted that although consecutive Complaints cases were included in the sample for the period sampled, a small number ( $n=9$ ) of individual psychologists attracted more than one complaint. The highest number of complaints against a single psychologist was six, followed by five, three and two ( $n=6$ ), with the remaining 216 complaints being against psychologists who attracted only a single complaint each. Scherrer et al. (2002) report that a single psychologist in their sample attracted eight complaints, while 69 individuals attracted more than one complaint. Each complaint, in practice, is treated as an independent legal entity, independently of any previous or concurrent complaints against a particular practitioner. The mean number of Complaints per practitioner in the Complaints data set was 1.04 and will not be a further focus of this study. The characteristics of psychologists attracting multiple complaints would be a separate study beyond the scope of the present work. While the fact that complaints and individual psychologists were not fully independent categories in theory compromises the independence of some variables and suitability for chi-square testing, these statistics were used illustratively rather than to prove or disprove hypotheses, consistent with the descriptive aims of this study. Treating them as independent was also consistent with the way Complaints are adjudicated by the Board. The impact of overlaps between multiple Complaints and individual psychologists are specifically mentioned where relevant in the sections that follow.

In addition, and as described in the previous chapter, 56 complaints submitted to the Psychological Association of South Africa (PASA) ethics committee between September 1990 and April 1995 were coded. This yields a complaints rate of 12.4 per annum, compared with Louw's (1997a) report of two per annum between 1955 and 1976. The rate of complaints to the voluntary psychological association for the present study reflected an annual rate of complaints against 0.31% of psychologists (as opposed to PASA members) per annum. This rate is marginally lower than the average annual ratio of 0.49% for complaints<sup>1</sup> received against APA members during the same period (APA, 1991b,

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<sup>1</sup>It should be noted that unadjudicated complaints, the focus of the present study, are called 'inquiries' in the APA reports and 'enquiries' by the BPS. In contrast, South African complaints which proceed to formal adjudication are called inquiries, illustrating some of the difficulties in making international comparisons. The South African terminology is used throughout this study to facilitate comparison.

1993b, 1994b, 1995, 1996a, 1997). More recent APA reports show a decreasing rate of complaints to 0.34%, 0.34% and 0.28% for 1998-2000 respectively (APA, 1999, 2000, 2001d). American data suggests that 11% of all psychologists receive a complaint over the course of their professional careers (Schoenfeld, et al., 2001). No comparable figures are published by the Canadian Psychological Association (Pettifor, personal communication). While the British Psychological Society has only recently begun to publish complaints and disciplinary data (BPS, 1999b), BPS data does not follow the APA reporting format and is not expressed as a ratio of total membership numbers. However, taking the 77 complaints reported to the BPS in 1997-1998 (BPS, 1999b) against their membership of 21239 at the end of 1996 (BPS 1997, excluding foreign affiliates) - yields a complaints ratio against 0.3% of BPS membership for 1997-1998, comparable with the present study. The 79 complaints resolved in 2000 represented a complaints ratio of 0.23% for the BPS for 2000 (MacKay, 2000). In summary, the average annual rate of complaints against South African psychologists to the non-statutory body (PASA) for the period under study was 0.31% compared with a rate of 0.49% for the APA for the same period and a rate of 0.2% to 0.3% for British psychologists in 1999 and 2000. The lower British rates coincide with a lowering of APA rates for these years. The present study data does not extend to 1999-2000 so it remains unknown whether South African complaint patterns to PsySSA dropped after 1998. The data from Scherrer et al. (2002) on Board complaints did however extend to 1999 and suggests a rising rather than falling annual rate of complaints when compared with the present data. No comparable data was available from PsySSA at the time of writing.

It must be pointed out that these comparisons with APA, and to a lesser extent BPS data are problematic in that the APA is not a statutory body, - the BPS is partially so (only for Chartered Psychologists, who comprise a minority (less than 10%) of British psychologists. However no comparable data was available for statutory licensing bodies comparable with the Board - limited data from cases against American State and Provincial Psychology Boards (ASPPB) are discussed where relevant in some following sections. The annual APA Ethics Committee reports cited above remain the most comprehensive sources of complaint and disciplinary data against psychologists, and despite the limitations expressed above, were used as a primary source of comparison. This

points to the need for international standardisation of reporting categories, terminology and statistical procedures in reporting complaints data against psychologists, if international comparisons are to be made in facilitating better ethics education and development of empirically informed practice guidelines and ethical codes.

This 'Complaints' data set thus comprised a total of 298 complaints received from the public between January 1990 and September 1998. This data set thus comprised 242 (82%) complaints submitted to the Board and 56 (18%) complaints submitted to PASA. All complaints were recorded consecutively for the time mentioned and no complaints were omitted. No cases were common to both the Board and PASA. The entire Complaints data set comprised more than 10,000 pages of written material documenting these Complaints and the responses of the psychologists.

In summary, combined complaints to the Board plus complaints to the non-statutory body, suggests that the mean annual rate of complaints against South African psychologists during this study was 0.7%, similar to previous South African data and comparable international rates. Further research would have to establish the relationship of this complaints rate to rates of adjudicated findings of *prima facie* professional misconduct, based on comparative a study of adjudication outcomes. Such a study would be complicated by the lack of internationally standardised adjudicative procedures, but would provide the basis for further exploratory research. The effects of different international rates of consumer assertiveness regarding unsatisfactory experiences with psychologists, as a variable affecting on complaints ratios, is unknown. At face value, however, it could be hypothesised that American clients would be more assertive, more legally sophisticated and thus more likely to complain than those in South Africa, but this remains to be verified (Lockhat, 2001; Scherrer et al., 2002). This point serves to emphasise that the present study merely serves to establish complaint patterns, but not the causes of these patterns. Consumer assertiveness could however be an important contributing variable affecting such patterns but was beyond the scope of the present work. Other variables not considered here were professional psychologist/client contact hours, with high contact hours and a high workload possibly associated with higher likelihood of complaints, in addition to psychiatric diagnosis and severity of the problem for which psychological services were being

sought.

## 7.2 Dilemmas

The mailing of 1000 reply-paid questionnaires yielded a total of 377 replies (37% response rate). This compares adequately to six international studies using similar methodology where the mean response rate was 38%, ranging from 19% to 61% (cited in Slack & Wassenaar, 1999). Pope and Vetter (1992), whose work was the basis of this study, attained a response rate of 52% after refining their survey to improve on a rate of 15% attained by an earlier APA survey. The present rate was comparable to rates for other mail surveys of South African psychologists; 37% (Bassa & Schlebusch, 1984), 38.6% (Manganyi & Louw, 1986), 30.8% (Pillay & Peterson, 1996), but is lower than the 45% attained by Richter and Griesel (1999). Yammarino, Skinner and Childers (1991) report that response rates for commercial survey research are typically around 46%. Kerlinger (1986) states that response rates of 40% are common for mail surveys, and while he cautions that data obtained from such surveys should be treated with circumspection he adds that survey data can nevertheless be used with care (p. 387), particularly where the data can be compared with other data. In this study the characteristics of this data set are compared with the Register in section 3.2. The response rate represented about 8% of South African psychologists who responded. Respondents reported 'no dilemmas', with occasional comments such as: "No dilemmas" and "As I act in an ethical manner I prevent having ethical dilemmas". One respondent returned 'address unknown' or 'emigrated' and one completed questionnaire had been coded and computed.

A total of 375 dilemmas was produced by the remaining 255 respondents who submitted dilemmas - see Fig. 1. The 'no dilemmas' respondents were excluded from the data analysis. A previous South African study (Slack & Wassenaar, 1999) using this methodology found that the demographic characteristics of 'no dilemmas' respondents were no different from those who submitted dilemmas. This analysis was therefore not repeated here. No reminders were sent to non-respondents as the incremental gain of attempts to increase response rate is reported to be only a further 6.5%

(Yammarino et al., 1991). Since three of the five methods likely to maximise return rates (excluding financial incentives cf. Fox, Crask & Kim, 1988; Groves & Olsson, 2000; Yammarino et al., 1991) were used in this study, viz. a reply-paid self-addressed return envelope, university affiliation and a short questionnaire of less than four pages had already been used, the cost benefit of posting 600 reply-paid reminders for a further 24 replies could not be sustained by the research budget. A further factor possibly accounting for the response rate was the mailing only of questionnaires in English, although an apology was extended for this and respondents were encouraged to reply in Afrikaans if they so chose, which 14 respondents did. A similar study by Orme and Doerman (2001) generated a 17% usable response rate that yielded 69 vignettes for analysis.

### 7.3 University Ethics Training Survey

Of the 19 universities to which questionnaires were sent to the heads of professional training, a total of 15 responded with 19 completed questionnaires. Some returned more than one questionnaire and completed separate questionnaires for different categories in training, while others sent one questionnaire for combined courses (e.g., in clinical/counselling/educational psychology). Two universities stated that they did not conduct professional training. Thus, a total of 19 usable questionnaires was received, reflecting a usable return rate of 73%. This return rate was similar to a training survey by van der Westhuizen and Plug (1987) who received 13 replies from 21 universities, reflecting 41 Masters programmes, and equals the 73% return obtained by Pettifor and Pitcher (1982) in a similar Canadian survey.

Table 1 shows the categories of professional training represented by the survey and the number of courses for each category. Data from van der Westhuizen and Plug (1987) was included for comparison.

Table 1

Training Courses Surveyed by University and Registration Category

Category	No:	vdW&p <sup>2</sup>	Universities
Clinical	14	9	Unizul,Stell,UDW,Wits,RAU,Pret,UWC,UNP, UNISA,OFS,MEDUNSA,Potch,Rho,UCT,
Counselling	8	8	UDW,Stell,UWC,UNP,Pret, UND,UNISA,OFS
Educational	3	4	UWC,UNP,UND,
Research	1	13	Pret
Industrial	0	7	

Universities training in research and industrial psychology were under-represented by the survey response. With hindsight, it was recognised that some South African industrial psychology training programmes are in Commerce and Business faculties. The questionnaire may thus not have reached such training heads as the questionnaire was only sent to heads of professional psychology programmes. The low response from research psychology, however, may be because many universities in South Africa did not have formal training programmes leading to professional registration as a research psychologist at the time of this study.

#### 7.4 Registration Category of Psychologists

An attempt was made to compare the Complaints and Dilemmas samples with each other and with the representation of each professional category in the Register (INMDCSA, 1998). This was done to examine (contrast and compare) the composition of the data sets and to determine whether these represent the distribution of psychologists by category on the Register. Deviations from the distribution of categories on the Register are thus of interest, especially in the Complaints data set. The distribution of categories of subjects by data set is presented in Fig. 1. Note that the percentages

<sup>2</sup> v.d. Westhuizen & Plug (1987)

in the figure total 100% for each data set (each colour) and not for each stacked bar. (Specific types of complaints attracted by specific categories of psychologist are examined in section 8.2.1 below).

Fig. 1 shows that clinical psychologists comprised the largest single group against which complaints were lodged, exceeding their representation on the Register. They attracted 52% of Complaints but comprised only 36% of the Register. In contrast, complaints against educational psychologists were exactly proportional to their representation on the Register (20% in both). As can be seen in Fig. 1, complaints against counselling, research and industrial psychologists were all lower than their representation on the Register. (Although psychometrists and psychotechnicians were not a focus of this study, their data is shown here but will not be considered further). Scherrer et al. (2002) found that clinical psychologists attracted 45% of complaints, but did not present data for other categories, stating only that clinical psychologists were numerically over-represented in proportion to the Register (35%). The over-representation of clinical psychologists in the present Complaints was thus higher than that reported by Scherrer et al. (2002) but is nevertheless consistent with their findings.

The only other comparison available was a BPS (2001a, p. 17) report that listed clinical psychology as the main “area of psychology” against whom complaints were filed (47%), but no proportional data were given. As proportional representation of complaints per category is more meaningful than the absolute number of complaints, Table 2 shows the ratio of complaints for each category of psychologist on the Register in descending order.

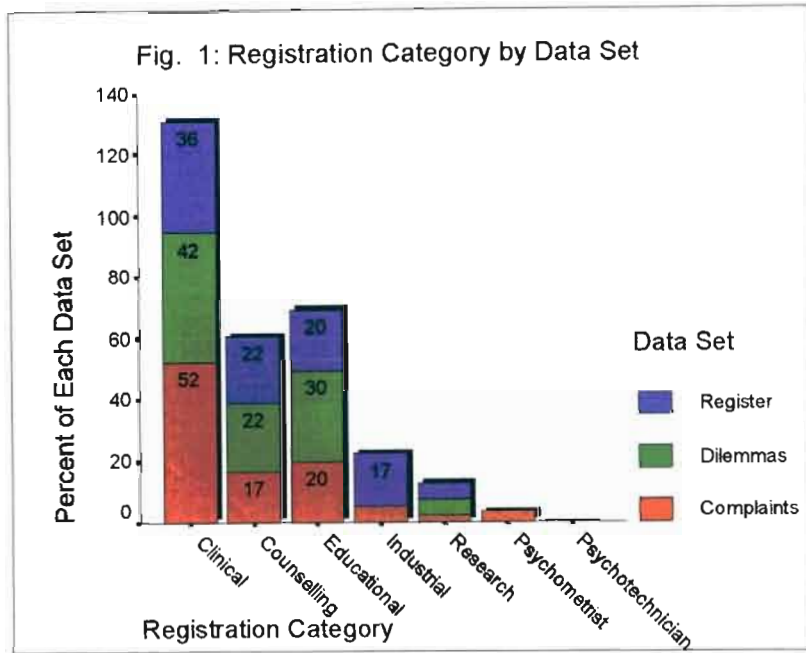


Table 2  
Ratio of Rate of Complaints by Registration Category

Category	Complaints	Register	Ratio of Complaints/Register
Clinical	154	1677	0.092
Educational	58	922	0.062
Counselling	49	1000	0.049
Research	6	238	0.025
Industrial	16	794	0.020
Psychomet.	12	2417	0.004
Psychotech.	3	284	0.010

From Table 2 in which the complaints ratios by category of psychologist were ranked, it can be seen that clinical psychologists had the highest complaints ratio - i.e., the number of complaints divided by the number of clinical psychologists on the Register, followed by educational psychologists,

counselling psychologists, research psychologists and industrial psychologists. Fig. 1 also shows the distribution by category of the 253 respondents who submitted the 375 dilemmas in the Dilemmas data set. Proportionally more clinical psychologists (42%) responded to the questionnaire than their representation on the Register (36%). This also applied to educational psychologists (30%) who represented only 20% of the Register, while counselling psychologists were proportionally represented.

A chi-square test was significant ( $\chi^2=52.31$ ,  $df=4$ ,  $p<0.0001$ , Cramer's  $V=.103$ ) showing that clinical psychologists were disproportionately over-represented in the Complaints data set (std. residual 4.7). Industrial psychologists were proportionally under-represented in Complaints (std. residual -4.5), as were research psychologists (std. residual -2.1). Counselling and educational psychologists attracted Complaints proportional to their numbers on the Register. Scherrer et al. (2002, cf. their Fig. 6) did not test statistically for significant over- or under-representation, but their data appears congruent with these findings. A study of Board complaints in one American state was also dominated by clinical psychologists, followed by counselling psychologists, but no proportional data were given (Schoenfeld et al., 2001).

There were also significant disproportions in the categories of psychologists who provided scorable dilemmas for the Dilemmas data set ( $\chi^2=54.29$ ,  $df=4$ ,  $p<0.0001$ , Cramer's  $V=.105$ ). Educational psychologists were over-represented (std. residual 2.7) while industrial psychologists were under-represented (std. residual -8.4). This was because although 25 (9.8% of respondents) industrial psychologists returned their questionnaires, all of them reported that they had "no dilemmas" and were thus excluded from further analysis. The other categories (clinical, counselling and research) responded proportionally to their numbers on the Register. The Dilemmas data set was thus fairly representative of the distribution of psychologists on the register for clinical, counselling and research psychologists, but was over-represented by educational psychologists and under-representative of industrial psychologists.

In summary, complaints against clinical psychologists were over represented, while educational,

counselling, research and industrial psychologists attracted a lower rate of complaints in proportion to their representation on the Register. This finding can be accounted for by hypothesising that clinical psychologists engage in work with more acutely distressed and psychologically unstable populations, generating more ethical complexity, a conclusion supported by Scherrer et al. (2002). On the other hand it would be unwise to dismiss the higher complaints rates against clinical psychologists as being based on compromised client judgement. Studies of complaint adjudication outcomes based on registration category could assist in testing this hypothesis.

The Dilemmas respondents were representative of clinical, counselling and research psychologists, while educational psychologists were over-represented and industrial psychologists under-represented. The under-representation of industrial psychologists in the Dilemmas data set is congruent with their under-representation in the Complaints data set. At face value, this suggests that industrial psychologists have few ethical dilemmas and similarly attract few Complaints. The literature, similarly, reflects far fewer publications in the industrial/organisational sphere compared with the voluminous literature addressing ethical issues in psychotherapy. The relative 'silence' of ethics applied to industrial/organisational psychology is thus noteworthy and an area probably worthy of further inquiry.

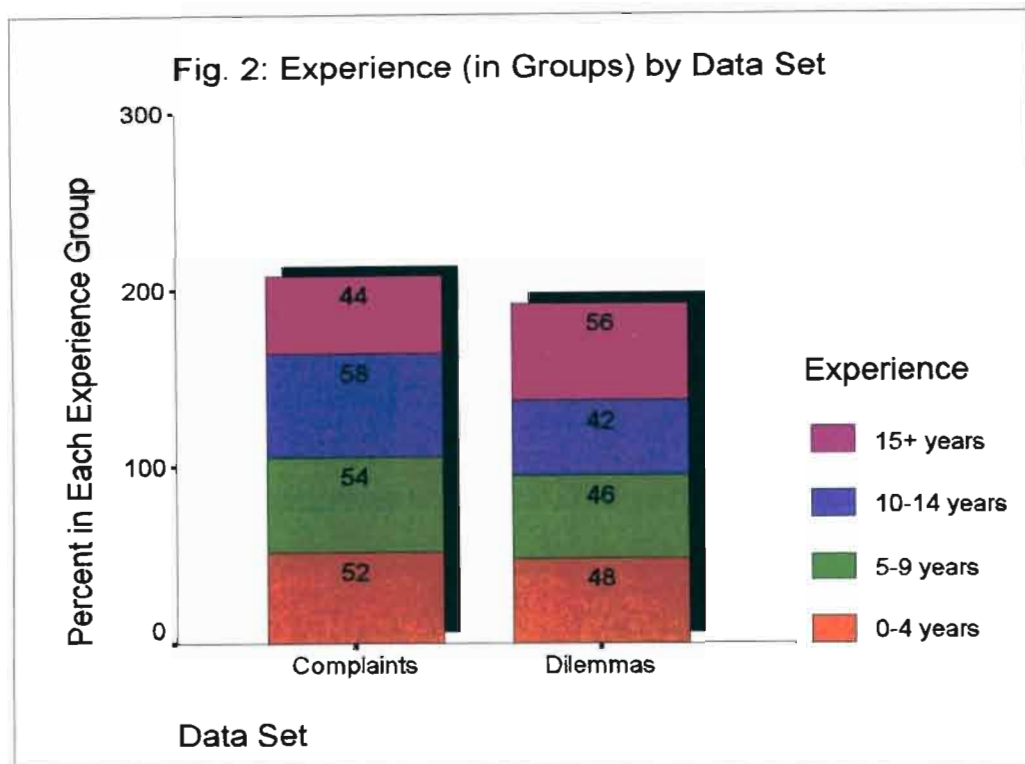
### 7.5 Years of Experience of Psychologists

The Complaints and Dilemmas samples were compared regarding their years of experience to determine whether they were comparable and to determine whether there was a relationship between years of experience and the likelihood of attracting Complaints. The experience of psychologists in both the Complaints and the Dilemmas data sets was divided into four groups for ease of analysis. Each group represents a 5-year period, with group 1 representing 0-4 years, group 2 representing 5-9 years, group 3 representing 10-14 years and group 4 representing 15 and more years of experience.

Fig. 2 shows a comparison of the years of experience of subjects in the Complaints and Dilemmas data sets. An independent samples *t*-test was conducted to determine whether the mean years of

experience of the Complaints sample ( $M=9.86$ ,  $SD=6.72$ ) differed significantly from the Dilemmas sample ( $M=10.76$ ,  $SD=8.36$ ). The  $t$ -statistic was not significant ( $t= 1.55$ ,  $df=673$ ,  $p=.122$ ). It is possible that this  $t$ -test was compromised by a lack of independence between the Complaints and Dilemmas samples - i.e. that some individual psychologists were represented in both Complaints and Dilemmas data sets. However, since Dilemmas respondents were anonymous, there was no way of verifying this. Therefore the  $t$ -test was used for illustrative purposes only, suggesting that psychologists in the Complaints and Dilemmas sample showed no significant differences in years of experience, with an average of 10 years, which was less than the average of 15 years found in an American study (Sentell, Pingitore, Scheffler, Schwalm & Haley, 2001). Scherrer et al. (2002) did not examine years of experience in their Complaints sample, but reported that the average age of Complaints respondents was between 30 and 39 years, which is compatible with the average of 10 years experience cited above. With greater production of psychologists, the national average in years of experience will tend to decline.

Although Fig. 2 shows that psychologists in the second and third groups in the Complaints data were somewhat over represented, suggesting that psychologists in the middle years (5 to 15) of practice attract the most complaints against them, the  $t$ -test shows that these differences were not significant. The average years of experience was higher than reported by Bassa and Schlebusch (1984) where most respondents had five years or less experience. The present data is consistent with the present study being conducted more than ten years later.



## 7.6 Sex of Psychologists

The sex distribution of registered psychologists in 1996, the median year of the period studied, was reported as equal by Richter and Griesel (1999). The years before 1996 were characterised by male dominance of the Register, signalling a trend towards female dominance after 1996, as paralleled by reports from the USA (Pingitore, Scheffler, Haley, Sentell & Schwalm, 2001). On average, the proportion of males to females on the Register for the period covered by this study was equal. There were 164 Complaints against females, and 134 against males. A chi-square test narrowly missed significance ( $\chi^2=2.88$ ,  $df=1$ ,  $p=0.068$ ) suggesting a slight tendency for females to be over-represented in Complaints. Scherrer et al. (2002) similarly found that males and females did not differ in the number of complaints lodged against them, although they did not compute this in proportion to the distribution of sex on the Register.

The Dilemmas data set also reflects the equality of gender on the Register, with 110 dilemmas from males and 106 from females. A chi-square on the Dilemmas data to check whether either sex was over- or under-represented in the Dilemmas data was not significant, suggesting that the sexes were proportionally represented in the Dilemmas data. The present study did not examine differences in practice contexts, preferred practice activities and ethical issue by gender, but an American study reported no differences between males and females regarding “patient demographics, caseloads, practice profiles, and payment sources” (Sentell et al., 2001, p. 607), although women earned significantly less than men.

Table 3  
Sex of Psychologists

Sex	Register*	Complaints	Dilemmas
Male	2130	134	110
Female	2125	164	106

(\*Richter & Griesel, 1998)

Specific ethical issues in complaints against males and females are examined in more detail in section 8.5.1 below.

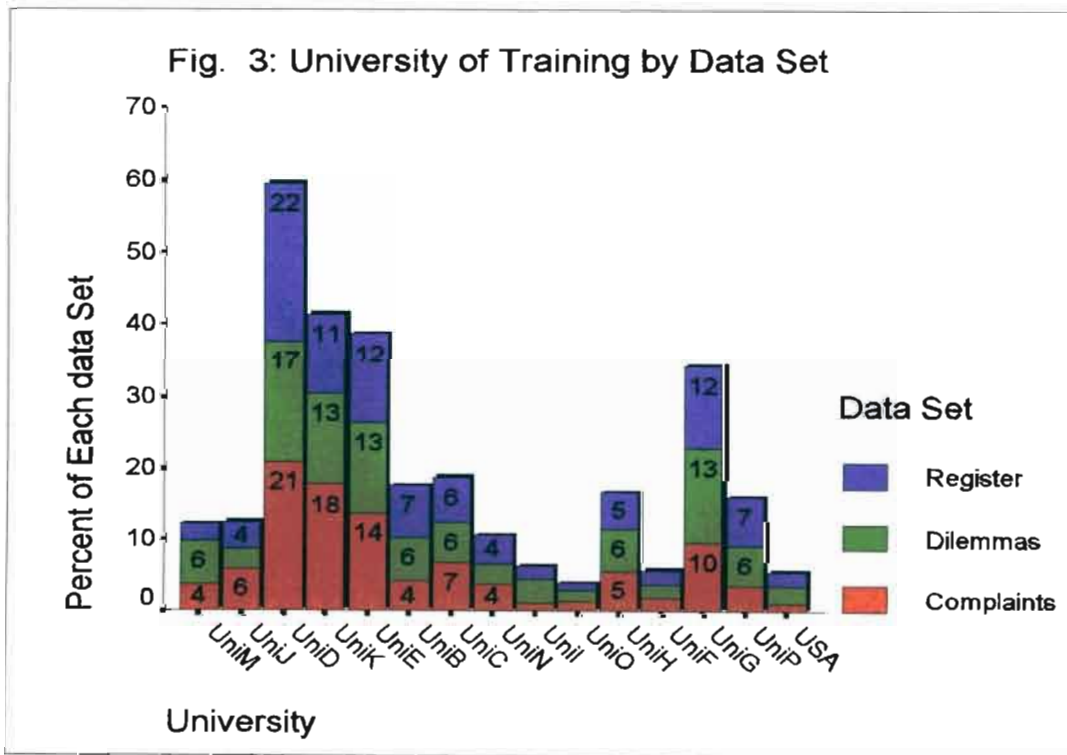
### 7.7 Highest Degree Attained

Dilemmas respondents were asked to indicate their highest degree attained. In South Africa the statutory requirement for registration as a psychologist is an approved Masters degree and an approved one-year internship. Of the 377 Dilemmas respondents, 61 indicated that they had attained a PhD, which was 16% of the sample, with the remainder (84%) having obtained a Masters degree. As highest degree attained was not one of the variables considered in relation to this study, this variable was not considered further. No similar data was available for the Complaints data set. In a future study it would be of interest to determine whether psychologists with the higher degree (PhD or DPsych) attract disproportionately more or less complaints.

7.8 University of Training

An analysis of the representation of graduates from the country's training universities was done to determine the representation of each university in each data set. This was also done to establish the extent to which the Complaints and Dilemmas data sets represented the Register were comparable with each other. As mentioned in section 6.6, universities in the Complaints data will not be named.

Fig. 3 shows the relative contribution of university of training to each data set, independent of registration categories. As found by similar studies (Bassa & Schlebusch, 1984; Richter & Griesel, 1999), more psychologists were trained at certain universities than at others. The distribution of contributions to the Dilemmas data set as shown in Fig. 3 was also roughly proportional to the contribution of each university to the Register, lending further support to the earlier contention that the Dilemmas respondents appeared to be fairly representative of South African psychologists by university of training.



The slight over-representation of UniM respondents in the Dilemmas data set was possibly due to this study's being based at UniM, with UniM<sup>3</sup> graduates possibly wishing to support a study from their university of training. Data for all other universities suggests that universities are evenly represented in the Dilemmas data. It is theoretically possible that universities whose graduates generated more Dilemmas show higher levels of ethical awareness, but this could not be verified by the present study.

As an index of the relative representation of each university in the Complaints data, the relative proportion of Complaints in relation to each university's contribution to the Register is ranked in Table 4 as a complaints ratio. The complaints ratio is an index of Complaints proportionate to each university's contribution to the Register and was calculated by dividing the number of complaints per university by the number of professional graduates on the Register from each university.

The results show that universities with the highest complaints ratios were UniJ, UniK, UniO, UniM, UniC and UniE, while the lowest complaints ratios for South African Universities were UniP, UniL, UniB, and UniF.

A chi-square test was conducted on this data despite the large number of cells resulting from cross tabulating University by data set and category, resulting in a high proportion of cells with expected values of less than 5. The chi-square was significant ( $\chi^2=65.8$ ,  $df=42$ ,  $p=0.01$ , Cramer's  $V=.08$ ). The standardized residuals suggest that UniK (3.3) and UniJ (1.8) were over-represented in the Complaints data, while UniP (-2.1) and UniB (-1.8) were disproportionately under-represented. UniM (3.4) was disproportionately over-represented in the Dilemmas data, as mentioned above.

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<sup>3</sup>This indirect disclosure of the identity of UniM is intentional.

Table 4

Complaints Ratio (Complaints/Graduates) for Universities of Training

Rank	University	Graduates	Complaints	Complaints Ratio
1	UniJ	119	17	.142
2	UniK	495	52	.105
3	UniO	46	4	.086
4	UniM	150	11	.073
5	UniC	278	20	.071
6	UniE	553	39	.070
7	UniH	227	15	.066
8	UniD	972	60	.061
9	UniN	182	11	.060
10	UniG	516	28	.054
11	UniF	93	5	.053
12	Oth. Afr.	23	1	.043
13	UniB	328	12	.036
14	Unil	87	3	.034
15	UniP	310	10	.032
16	USA	93	3	.032
17	All Other	165	5	.002*
	ALL	4631	298	$\bar{x}=0.063$

\*Outlier excluded from calculation of mean Complaints ratio

These results, while suggestive, should be treated with some caution. Reasons for caution include the following: the number of complaints did not reflect the number of individual graduates complained against but merely reflects the number of complaints or allegations. Multiple complaints against single individuals were not controlled for in this study as discussed in section 7.1 above. This means that the complaints ratio of universities with a relatively smaller graduate output were vulnerable to inflation by more than one complaint against a particular individual. It should also be

noted that a complaint is not a conviction. As mentioned earlier, the focus on complaints in the present study was used only as an index of public dissatisfaction, and was not a *de facto* index of unethical conduct. It is also reasonable to assume that busier practitioners were proportionally more likely to attract more complaints. This study did not control for the relative 'busy-ness' of psychologists. Finally, there is the possibility that the Register from which the training university of Complaints subjects was obtained, contains some inaccuracies, particularly where psychologists are registered in more than one category or have obtained additional degrees after their formal masters training.

Furthermore, the significant over-representation of clinical psychologists in the Complaints data, as shown earlier, also contributed to a higher complaints ratio for universities that train clinical psychologists than those not training clinical psychologists. This means that universities producing relatively higher numbers of research and industrial psychologists (e.g., UniH, UniD, UniK, UniE and UniP) had their complaints ratio moderated by the low complaints rate for these categories. Similarly, universities producing mainly clinical (and counselling) psychologists (e.g., UniM, UniN, UniI and UniO) had higher complaints ratios. This is congruent with the data presented in section 7.4 above.

Also, universities with long established programmes were more likely to have graduates who attracted complaints - this is supported by a tendency for psychologists who have between 11 and 15 years of experience to attract more complaints (cf. section 7.5). Universities with long-established training programmes would thus have graduates represented in more groups of Fig. 2 than those with a shorter training history.

Comparisons with the findings of Scherrer et al. (2002) could not be made as they also elected not to disclose the identity of training universities associated with higher complaints rates. The data presented above shows that there were significantly disproportional rates of Complaints against psychologists from particular universities of training. This would warrant closer study of the training programmes of those universities to determine whether training patterns might account for this

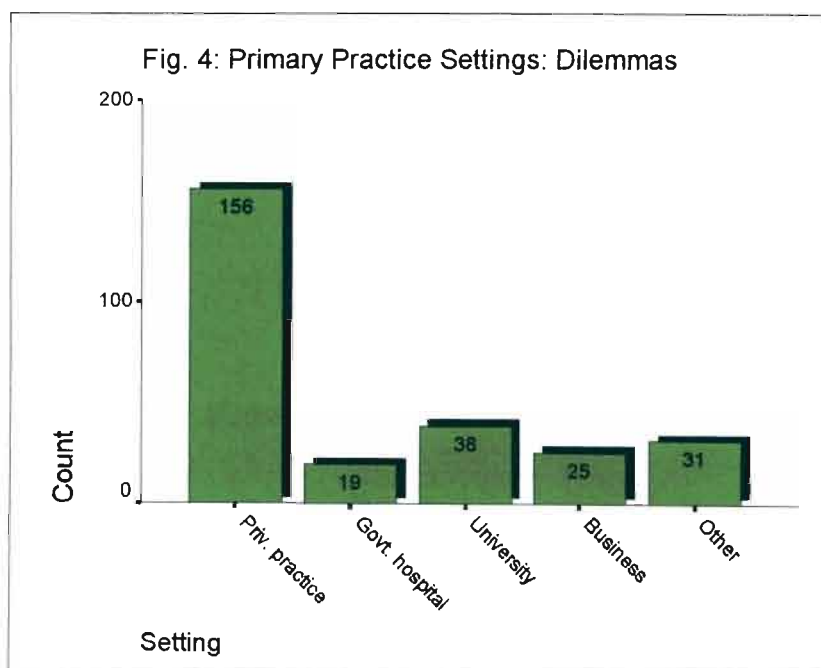
variance.

Sections 8.4, 10.1.6, and 10.2 also have a bearing on this section as they show the relationship of particular ethical issues to university of training as will be shown.

Geographical regions and Complaint patterns were not a focus of the present study. However, Scherrer et al. (2002) found that Complaints were distributed roughly proportionally to the regional distribution of psychologists in South Africa.

### 7.9 Primary Practice Settings, Professional Activities, and Malpractice Insurance

To help with interpretation of the results of this study, Dilemmas respondents were asked to indicate their primary practice settings, primary activities and whether or not they subscribed to a malpractice



insurance scheme. Ethical codes increasingly urge psychologists to consider malpractice insurance (e.g., BPS, 1995b) as it is designed to compensate clients for harm caused by malpractice. It was hoped that this data would provide useful background on the types of professional settings, professional activities and registration categories of psychologists in the Dilemmas sample, which might represent South African psychologists in general. Dilemmas respondents were asked to provide information on these contextual dimensions in the hope that the Complaints and Dilemmas could be interpreted against this background data. Where relevant these findings were compared with available literature (Bassa & Schlebusch, 1984; Manganyi & Louw, 1986; Pillay & Petersen, 1996; Richter & Griesel, 1999; Seedat, 1998; Wilson et al., 1999).

#### 7.9.1 Primary Practice settings

Fig. 4 shows that the overwhelming majority of psychologists who replied to the Dilemmas questionnaire were primarily involved in private practice (58%), followed by university settings (14%); 'other' settings (includes government departments other than Health, includes NGO's) (12%); business settings (9%), government hospital settings (7%). The low number of hospital settings was comparable with American data (Pingitore et al., 2001). The present data is possibly a useful representation of major employment settings of South African psychologists (cf. Viljoen et al., 1999; Wilson, et al., 1999). No published studies on employment settings of all categories of South African psychologists could be found. However, several studies have reported data on settings of South African clinical psychologists (Bassa & Schlebusch, 1984; Manganyi & Louw, 1986; Slack & Wassenaar, 1999) and one study on settings of clinical and counselling psychologists (Pillay & Peterson, 1996). These report a temporally increasing trend for clinical psychologists to be in private practice, ranging from 16% in 1984 (Bassa & Schlebusch, 1984) to 84% in 1999 (Slack & Wassenaar, 1999), consistent with the findings of Richter and Griesel (1999), Viljoen et al. (1999) and American reports (Phares, 1984; Pingitore et al., 2001). Academic settings also showed a temporal increase (to 38%) compared with the studies cited, which averaged 13%. As mentioned earlier, these studies did not include all registration categories so that comparisons with the present study must be interpreted with caution. Furthermore, all of the studies cited had smaller samples and

settings other than private and academic were not comparably defined. Trends in the present study would however seem compatible with these findings which show a progressive increase in the number of psychologists working in private and academic settings relative to employment in the state and NGO sectors.

### 7.9.2 Primary Professional Activities

Fig. 5 provides an indication of the primary professional activities of the psychologists who replied to the Dilemmas questionnaire. Respondents were asked to list their major professional activities in descending order (cf. Appendix A, item 1.9). As with most of the other categories in this study, the categories were developed from the protocols and were linked to the author's impressions of common practice settings (cf. Holsti, 1969). This hopefully provides a guide to the primary professional activities of South African psychologists overall. It is well known that psychologists typically engage in multiple professional activities, but for convenience only primary activities (i.e., from item 1.9.1) are listed in Table 5 in descending order.

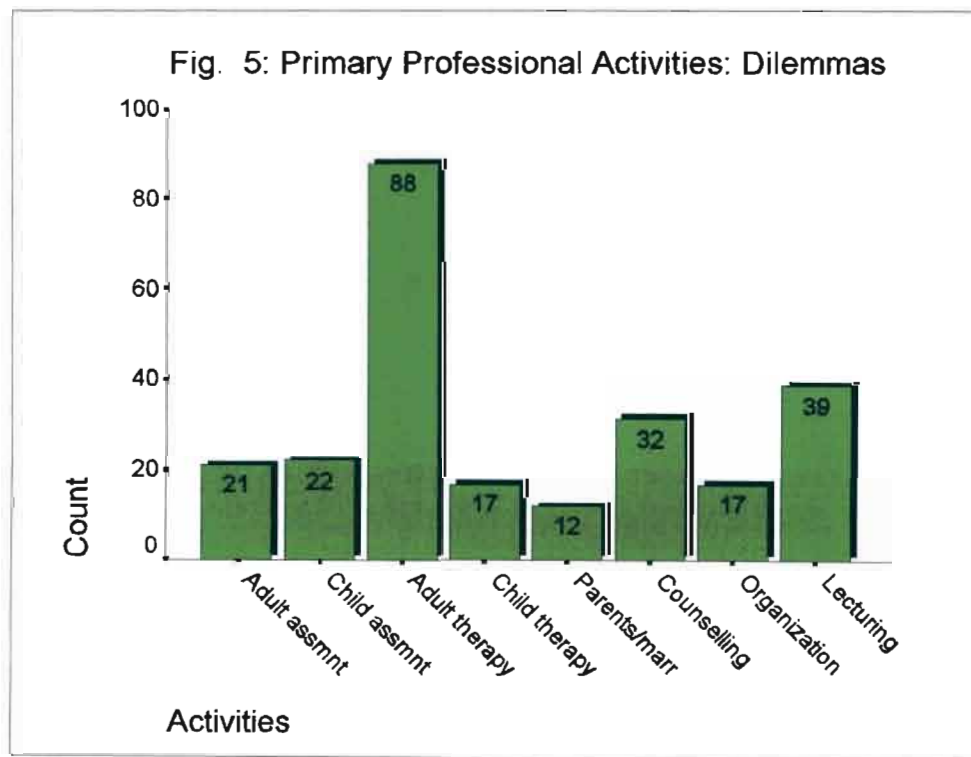


Table 5

## Primary Professional Activities (Descending)

Professional Activity	%
Adult psychotherapy	34
Lecturing	15
Counselling	13
Child assessment	9
Adult assessment	8
Child therapy	7
Organisational work	7
Parent counselling & marital	5
Other*	2

\*Other\* represents activities reported as primary by less than 2% of respondents, including supervision, research consulting, forensic work, custody work, materials development, group work, management, and retired.

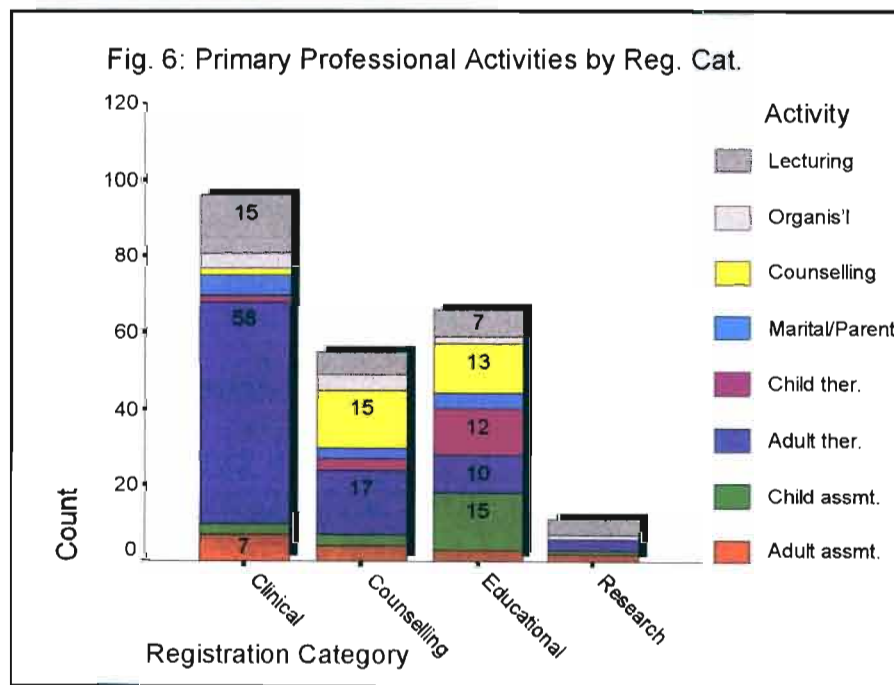
No South African studies provided directly comparable data. As mentioned in section 7.9.1 above, published South African studies focus mainly on clinical psychologists. However, individual psychotherapy was the dominant activity in all studies reviewed ranging from 85% (Viljoen et al., 1999), 84% (Slack & Wassenaar, 1999) to 44% (Bassa & Schlebusch, 1984) to 37% (Manganyi & Louw, 1986). Considering that the present sample included all registration categories, and combining individual and child psychotherapy with counselling, it would appear that 'therapeutic services' to individuals comprised 54% of the work of South African psychologists. This concurs with the prediction made by Bassa and Schlebusch (1984) that individual psychotherapy would become the major activity of South African clinical psychologists and parallels patterns described in the USA (Phares, 1984; Pingitore et al., 2001). This reflects the low priority given to research activity by South African psychologists, a theme mentioned by several South African publications (Manganyi & Louw, 1986; Raubenheimer, 1981; Richter & Griesel, 1999; Seedat, 1998), despite a relatively high demand from employers for research skills (Wilson et al., 1999). A study by Radeke and

Mahoney (2000) found that psychologists primarily engaged in research were less emotionally stressed than those conducting psychotherapy, who nevertheless reported higher life satisfaction. In contrast, clinical psychologists in academic settings were reported by Himelein and Putnam (2001) as spending most of their time teaching (37%), followed by research activities (26%) and then professional activities (12%, including practical supervision). Most said that they would prefer to spend more time on research.

### 7.9.2.1 Primary Professional Activities by Registration Category

Following the above section, a breakdown of primary professional activities by registration category also provided some background to the results that follow. Results are shown in Fig. 6.

The professional activities shown in Fig. 6 are listed below by registration category in descending frequency. Industrial psychologists ( $n=25$ ) were omitted due to their uniformly reporting ‘no dilemmas’ on the questionnaire.



Clinical psychologists were primarily engaged in adult psychotherapy, followed by lecturing, adult assessment, parent counselling and marital therapy, organisational work and child assessment. Relatively few clinical psychologists were engaged in child therapy and counselling. The rank ordering of this data was similar to findings of other South African studies of clinical psychologists (Bassa & Schlebusch, 1984; Manganyi & Louw, 1986; Slack & Wassenaar, 1999).

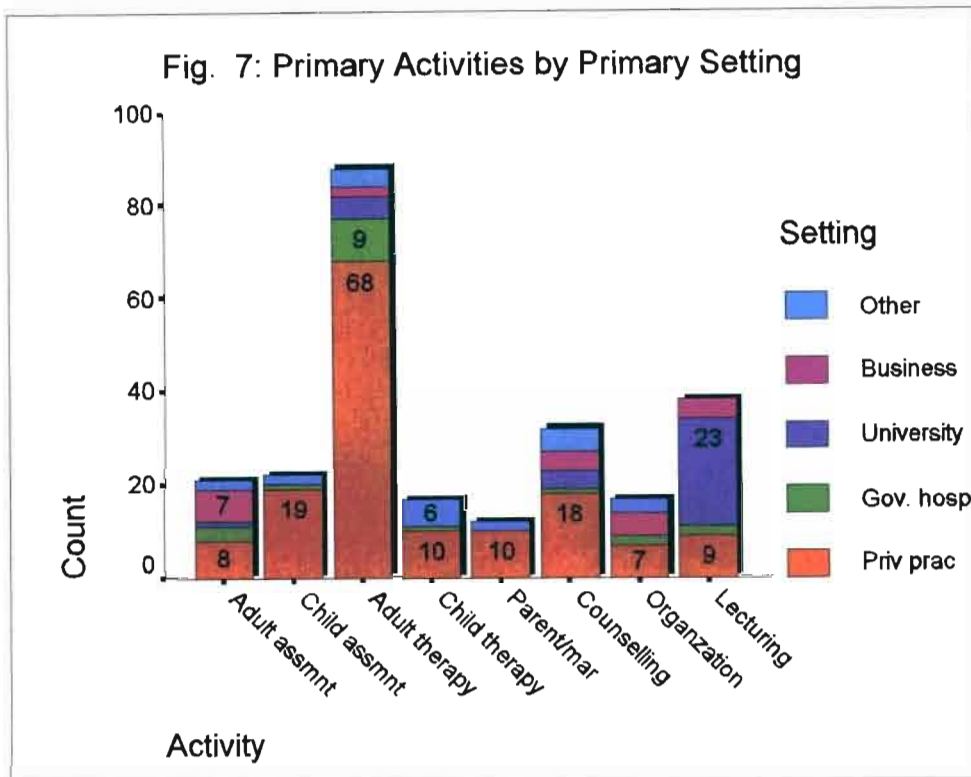
Counselling psychologists were primarily engaged in adult psychotherapy, followed by counselling, lecturing, organisational work, adult assessment, and roughly equal amounts of parent counselling and marital therapy, child therapy and child assessment.

Educational psychologists were primarily engaged in child assessment, closely followed by counselling, child therapy, adult therapy and lecturing. Relatively few educational psychologists engaged in parent counselling and marital work, adult assessment and organisational work.

Research psychologists were mostly involved in lecturing, followed, somewhat surprisingly by adult therapy, adult assessment, organisational work and child assessment. The presence of adult therapy in this section will be referred to further when Complaints data for research psychologists are presented in section 8.2 below, and can be seen against a background of growing opposition by this (and other) categories of psychologists to the restrictive scope of practice imposed on each category by the Professional Board for Psychology, warranting the following comment by Richter et al. (1998): “The recent efforts by the Professional Board for Psychologists to act against Research psychologists in an effort to protect the practice domain of Clinical and Counselling psychologists illustrates this preoccupation” (p. 6).

#### 7.9.2.2 Primary Professional Activities by Primary Setting.

The relationship between primary professional activities and the primary settings in which they occurred is also relevant contextual background for the data that follows. While Fig. 7 is fairly self



explanatory, major trends are mentioned briefly in descending order of frequency.

Adult psychotherapy was primarily conducted in private practice settings, followed by government hospital and university settings.

Lecturing was predictably carried out in university settings, followed by private practitioners and psychologists in business settings.

Counselling was primarily carried out in private practice settings, followed by ‘other’, business and university settings.

Child assessment was also primarily carried out in private practice settings.

Adult assessment was primarily conducted in private practice settings, followed by business settings and government hospitals.

Child therapy was mainly carried out in private practice settings, followed by 'other' and government hospital settings.

Organisational work was primarily carried out by private practitioners, followed by 'other' settings - but the under-representation of industrial psychologists in reporting dilemmas for the present sample must be borne in mind here.

Parent counselling and marital therapy were primarily carried out in private practice settings, followed by 'other' settings.

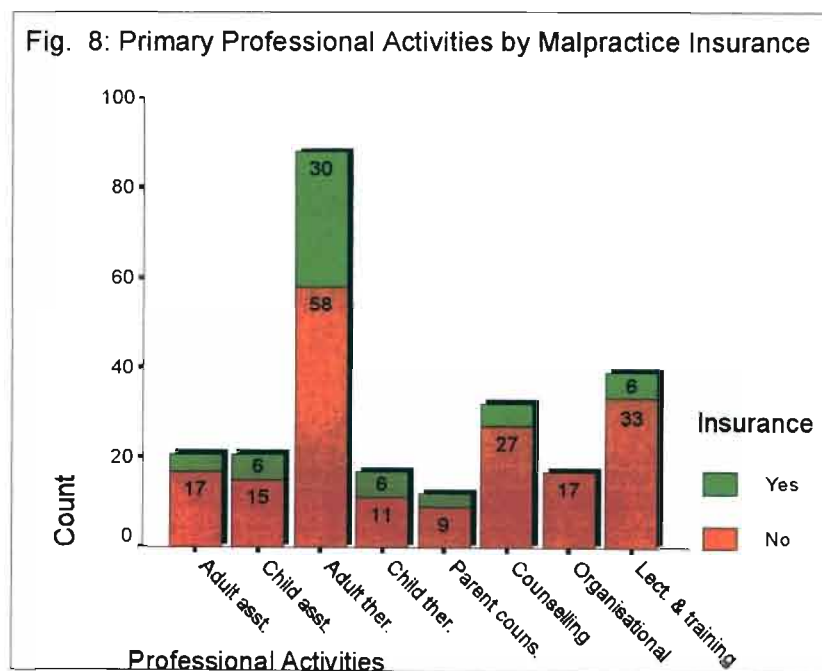
#### 7.9.2.3 Primary Professional Activities and Malpractice Insurance

As further background to contextualising the Complaints and Dilemmas data which follow, it was decided to analyse the relationship between the type of professional activities conducted by psychologists and whether or not they are covered by professional indemnity insurance. Since an aim of this study was to determine the profile of psychologists who attract complaints, it was of interest to determine whether 'high risk' professional activities or settings are also associated with malpractice insurance cover.

It has been said that "the best protection from liability is no insurance at all" (Reaves & Ogloff, 1996b, p. 135). Malpractice insurance has been available to South African psychologists for several years. Unlike American insurance schemes, the primary scheme (MPS) available to South African psychologists covers Board complaints plus civil liability, and was thus relevant to this study. It is difficult to determine its impact on psychologists' ethical practice and public complaint patterns (Hedges, 2000). The BPS practice guideline for clinical psychologists strongly recommends malpractice insurance to protect the interests of psychologists and clients (BPS, 1995b). It was felt

that considering presence or absence of malpractice insurance as a contextual background to the present study might be useful and that some baseline information on a sample of South African psychologists would be relevant. Furthermore, this survey attempted to identify whether psychologists who conducted particular professional activities were more likely to have malpractice insurance.

Fig. 8 shows the relationship between the professional activities conducted by psychologists and the extent to which psychologists engaged in these professional activities were covered by malpractice insurance.



It is clear from Fig. 8 that adult psychotherapy was the professional activity most associated with malpractice insurance cover. In spite of this, most practitioners of adult psychotherapy had no malpractice insurance. Psychologists engaged in all other professional activities had lower rates of insurance cover and most of these psychologists had no malpractice insurance. It appears that South African psychologists are at risk of incurring legal costs and possible damage claims in the event of

a complaint or civil suit. Practitioners of adult psychotherapy were more likely to have insurance cover than psychologists who practised other activities. Although the number of psychologists engaged in child custody work was too small to be shown here, section 9.1.1 below shows that child custody work was disproportionately likely to attract a complaint. Based on this finding, for example, psychologists doing child custody work would be well advised to purchase malpractice insurance cover. This argument will be more fully developed in the analysis of Complaints and Dilemmas to be presented in the following sections.

In summary, this chapter has described the essential features of the samples in this study. The data suggests that clinical psychologists attracted disproportionately more Complaints than psychologists in other categories. There were also significant differences between universities in their over- and under-representation in the Complaints data. Specific ethical issues arising in the data are explored in the following chapter.

## Chapter 8: Results 1: Primary Ethical Issues

The previous chapter outlined the major characteristics of the three data sets - Complaints, Dilemmas and the training survey. In this chapter, more detailed results from the Complaints and Dilemmas data sets are presented, compared and discussed. The first sections focus on primary ethical issues, followed by ethical issues and the registration category of psychologists in the Complaints and Dilemmas data sets. Within each following subsection, Complaints are presented first, followed by Dilemmas and a comparison of Complaints and Dilemmas.

Presentation of these results is combined with discussion due to the large number of separate research findings presented. A separate 'discussion' chapter would have warranted lengthy representation of each result before discussion. Therefore presentation and discussion of results are integrated in the sections that follow. As in the previous chapter, figures referring to the Complaints data set are shown in red, and the Dilemmas data set in green throughout.

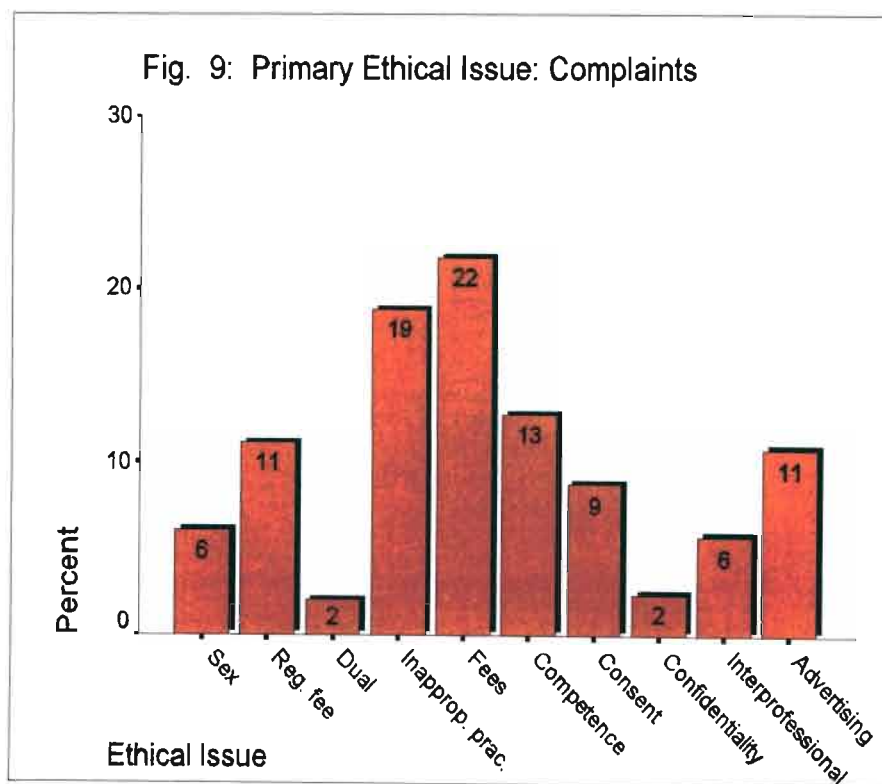
### 8.1 Primary Ethical Issues

This section presents the primary ethical issues which arose in the Complaints and Dilemmas samples. Definitions of categories of ethical issue were presented in sections 6.1.1.2 and 6.2.2.1. While there were no internationally comparable data from statutory licensing Boards (e.g., ASPPB) with which to compare these data, the Complaints data will be compared with local and international data where available. These comparisons were included in this section as to provide some perspective on the present data, but caution needs to be exercised because categories may not be equivalent. Furthermore, Reaves' (1995d) data was based on convictions rather than on complaints; Peterson's (1996) data is not rank ordered and was compiled from both APA and American statutory Board publications (which may not be comparable). The APA (1999, 2000) data reflected complaints to a non-statutory body. Koene's (1997) data was based on a study of 26 European non-statutory psychological associations, of which only 14 responded to his survey. Comparable BPS data (MacKay, 2000) is referred to where possible while Canadian data were not available at the time of

writing (Pettifor, personal communication). Data from Neukrug et al. (2001) was based on credentialed counsellors rather than licensed psychologists, warranting further caution in comparing results. Results were compared with South African data reported by Scherrer et al. (2002) which covers a period (1990-1999) incorporating the present Board data (1993-1998). The present data can thus be viewed as a subset of the Scherrer et al. (2002) data. As mentioned above, some variations may be due to the lack of an internationally standardised framework for categorising ethics complaints.

In the sections which follow, data from the Complaints data set will be presented first, followed by data from the Dilemmas data set, followed by a comparison of the two data sets.

### 8.1.1 Primary Ethical Issue: Complaints



The relative percentage of ethical issues as they appeared in the Complaints data is shown in Fig.

9. Complaints about fees were clearly the largest single (22%) source of complaints against psychologists in this sample. Fee issues were also found to rank first (40%) in an earlier study of complaints to the Board between 1974 and 1990 by Louw (1997b). Scherrer et al. (2002) ranked fees first (16%) amongst public complaints in their study. Fees were ranked second (15%) in complaints to the APA (1999) and third (13%) in a report on American disciplinary actions between 1983 and 1985 (Reaves, 1995d), and fifth (4%) by Koene (1997) in Europe. Peterson (1996) reports that 11% of American Board complaints concerned fees as did 15% of complaints reported to the APA up to 1993. Fees were not listed among the nine “areas of complaint” ranked by MacKay (2000) in a report on ethics investigations by the BPS - possibly because most British psychologists are in the National health Service and not in private practice (Slack & Wassenaar, 1999). Fees were ranked sixth (4%) in a review of complaints against credentialed counsellors in the USA (Neukrug et al., 2001). A recent study of South African medical practitioners’ business practices (Landman, 2001) found widespread evidence of financial irregularities. These included over servicing, perverse incentives and a variety of other business malpractices, resulting in an editorial request by the HPCSA (2001a, p.1) for an emphasis “on ethical behaviour on all fronts” warning of a “zero tolerance approach” and more stringent disciplinary steps against such practices (HPCSA, 2001b, p. 1). Reporting on complaint trends among South African psychologists, Lockhat (2001) noted an escalating number of complaints about fees, leading to professional complaints, criminal and civil charges against psychologists. The findings of the present study suggest that research and training attention needs to be paid to the financial practices of South African psychologists who may be struggling to reconcile the business and professional ethical obligations of professional practice, like the doctors in Landman’s (2001) study. Psychologists should probably also be made aware of the complex meanings that fees may embody, for clients and psychologists alike, in psychotherapeutic work (Birnbach, 1999; Kovacs, 2001; Lanza, 2001; Parvin & Anderson, 1999; Valentine, 1999). A comparative study of ethical codes from 23 countries found 79% agreement on the importance of fee issues in ethical practice (Leach & Harbin, 1997).

The second largest category was inappropriate practice (19%). This category accommodated a variety of types of poor practice management and poor client service, rather than frank violations

of ethical codes (cf. section 6.1.1.2). This category was not used by Louw (1997b) but Scherrer et al (2002) ranked “problems regarding reports” (p. 59) second (13.1%) amongst their complaints, although they also had a further category “unacceptable rendering of services” (p. 59) which accounted for 1.5% of complaints. Together these categories seem compatible with, but somewhat lower than the inappropriate practice category used in the present study. The present study would have coded some complaints about the content of reports as competence issues, and complaints about late or missing reports as inappropriate practice, highlighting problems arising from the lack of standardised coding categories for domains of professional and unprofessional conduct. Reaves (1995d) ranked this category as the second (24%) source of convictions against American psychologists, as did Koene (1997) who ranked it second (25%) in a survey of disciplinary actions in Europe. MacKay (2000) ranked “conduct” issues first (42%) in a report on BPS complaints, but the definition of this term is not specified. Items in this category could be regarded as ‘consumer disputes’ rather than frank ethical violations (cf. Koocher & Norcross, 1998).

Ranked third were competence issues (13%), which were ranked fourth (9%) by Louw (1997b) and third (12.9%) by Scherrer et al. (2002). Competence problems were ranked first (30%) by Koene (1997), sixth (5%) by the APA (1999) and third by the BPS (9%) (MacKay, 2000). Neukrug et al. (2001) ranked unprofessional conduct as the second (17%) most frequent complaint against credentialed counsellors. Peterson (1996) reported that competence issues accounted for 47% of actions by American Boards. This high rating corresponds roughly with Reaves’ (1995d) ranking of “Unprofessional/unethical/negligent practice” as second (24%). The reports by Peterson and Reaves also illustrate divergent categorisation of ethical issues in complaints. International ethical codes for 23 countries showed 89% agreement on the importance of competence for psychologists (Leach & Harbin, 1997).

Complaints about advertisements and unpaid registration fees (both 11%) ranked fourth in the present study. Louw (1997b) ranked advertising second (19%) while the APA (1999) ranked it eighth (2%). Advertising was legalised by the Board in 1994, although broad guidelines still have to be observed in advertising psychological services and in descriptions of training and

competencies. In the early 1990's there was a campaign by masters-level psychologists to use the title 'doctor' (cf. G. Louw, 1993), which led to several complaints about misleading use of titles in advertising, and which were included in this category. Scherrer et al. (2002) ranked advertising complaints sixth (4%), agreeing with the present author that the relaxation of legal advertising regulations after 1994 would lead to a reduction in such Complaints, which is borne out by the lower rate reflected their slightly more recent data. The lower percentage of cases in their data may be partially explained by their having an additional category called "recruitment" (p. 59) which accounted for a further 0.2% of cases and which in the present study would have been included in advertising complaints. Unpaid registration fees comprised 21% of complaints reported by Scherrer et al. (2002), but they point out that this technical legal offence cannot be regarded as a public complaint, so was not ranked first in their listing of public complaints against South African psychologists.

Consent issues accounted for 9% of Complaints, ranked fifth, compared with Koene's (1997) ranking third (19%). Consent (concerning services to minors only) was ranked 14<sup>th</sup> (0.4%) by Scherrer et al. (2002). Including minors only in this category would account for their lower ranking and rate. Consent was ranked last (6%) by a BPS report (MacKay, 2000), while Louw (1997b), Reaves (1995d) and the APA (1999) did not use this category.

Sexual misconduct ranked sixth at 6%, compared with fourth (7%) by Louw (1997b), first (38%) for Reaves (1995d), first (44%) for APA (1999), and fifth (3%) by Koene (1997) for psychologists in Europe. Scherrer et al. (2002) subsume sexual misconduct in a general category of "Improper conduct" (p. 59) which ranked fourth (11.5%) in their study, of which 4.8% were described as sexual misconduct. The remaining behaviours in their "Improper conduct" category included behaviours which the present study would have coded as consent issues, accounting for their higher ranking of this issue. Sexual misconduct was not specifically listed in a BPS report (MacKay, 2000, p. 17), but may have been subsumed in the high ranking of an undefined category called "conduct". Sexual misconduct was ranked fourth (7%) in complaints against credentialed counsellors (Neukrug et al., 2001). As discussed below, the relatively low ranking of sexual misconduct among incoming

complaints contrasts with the relatively high ranking of sexual misconduct convictions in adjudicated cases professional misconduct. The APA (2000, 2001d) ranked it first among convictions. The present data did not determine specific patterns of sexual misconduct, but the APA (2001d) reported that male psychologist-female client was the most common pattern, followed by female-male patterns, homosexual patterns and adult-child patterns less often. Similar patterns were noted in a commentary on South African complaints (Lockhat, 2001). Although based on unadjudicated cases, the South African data suggests lower rates of sexual misconduct complaints than available international reports on guilty adjudications.

Interprofessional issues ranked eighth at 6%, compared with eighth (3%) by Louw (1997b), eighth (2.5%) by Scherrer et al. (2002), and ranked eighth (2%) by the APA (1999).

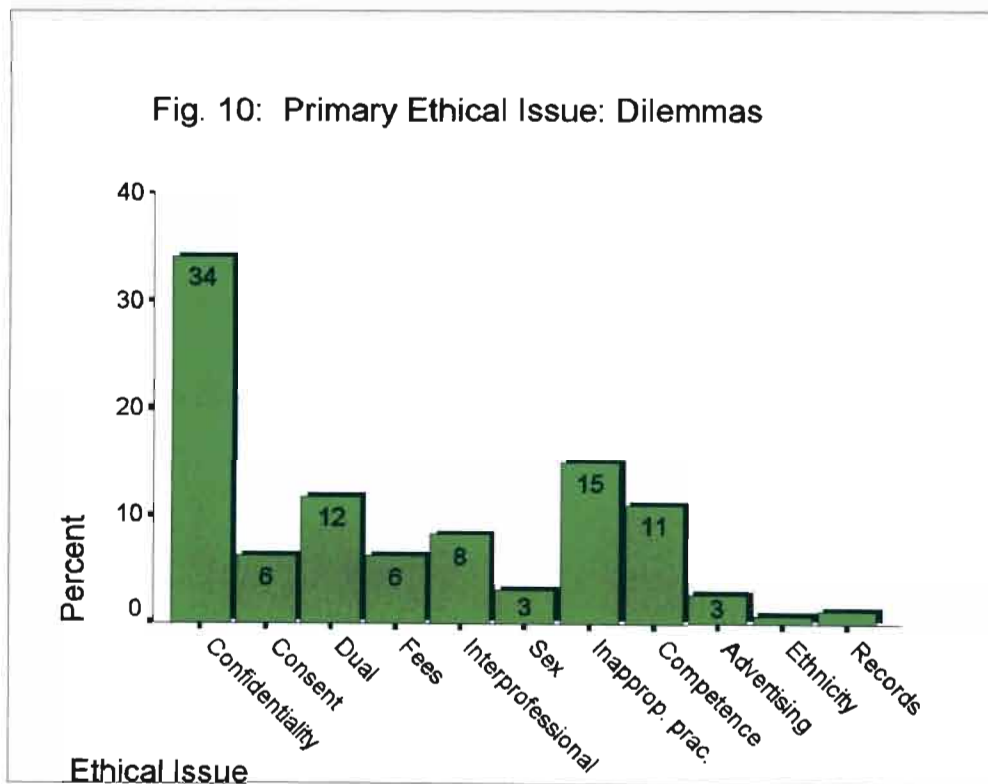
Non-sexual dual relationships and confidentiality issues both ranked ninth at 2%. Non-sexual dual relationships were ranked third (13%) by the APA (1999) and sixth (3%) by Koene (1997). Scherrer et al. (2002) did not use the category of non-sexual dual relationships, but they ranked confidentiality issues fifth (6%). Confidentiality was ranked fifth (6.5%) by the APA (1999), seventh (3%) by Reaves (1995d) and fourth (14%) by Koene (1997). BPS complaints ranked dual relationships joint fifth (3%). Peterson (1996) combined consent and confidentiality issues and reports that they accounted for 2% of American Board complaints and 10% of complaints to the APA up to 1993. Dual relationships ranked first, (24%) however, in complaints against credentialed counsellors (Neukrug et al., 2001).

Smaller categories (<2%) were excluded from consideration to reduce the number of variables for discussion in this section. Complaints about record-keeping (Soisson, VandeCreek & Knapp, 1987) and management of ethnic differences (Brown, 1999) were absent.

### 8.1.2 Primary Ethical Issue: Dilemmas

The relative frequency of various ethical issues in the Dilemmas data set is illustrated in Fig. 10.

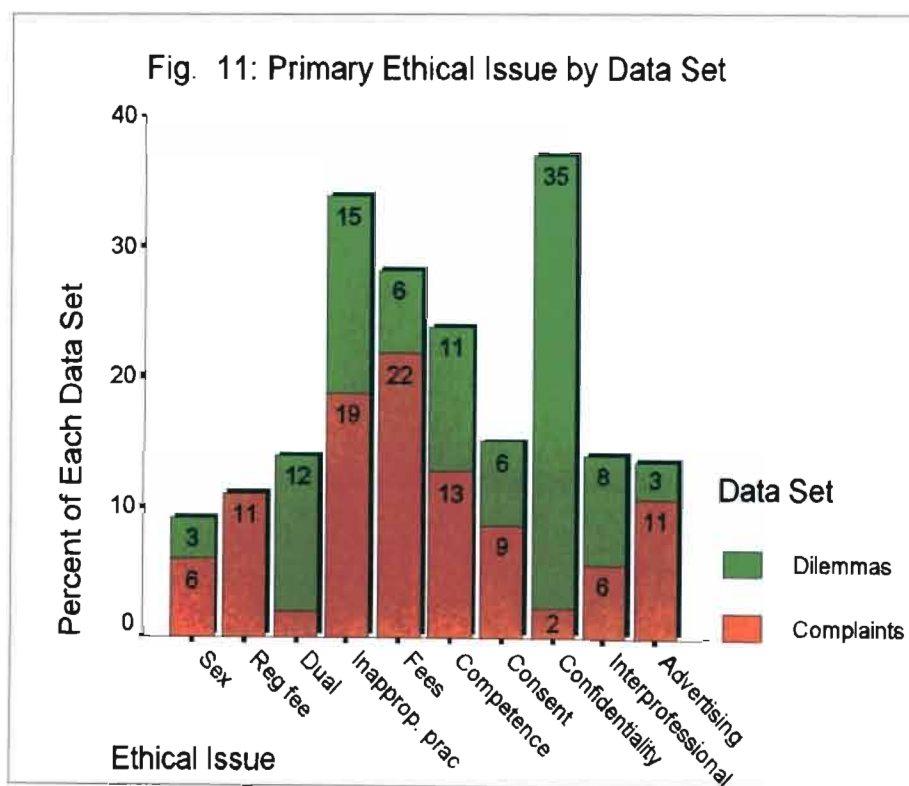
Confidentiality issues emerge as the primary concern of psychologists (34%), followed by lower frequencies of concerns about inappropriate practice (15%), non-sexual dual relationships (12%), competence (11%), interprofessional issues (8%), consent and fee issues (both 6%), sexual issues and advertising (both 3%), followed by record-keeping and issues around ethnic differences (both less than 2%). This data is similar to the results of a variety of studies using similar methodology compared by Slack and Wassenaar (1999) which showed that in seven countries surveyed, confidentiality was the primary source of dilemmas, non sexual dual relationships second (five of seven countries), fees third (four of seven countries), with no clear patterns emerging for ethical issues ranked less frequently.



### 8.1.3 Primary Ethical Issue: Comparison of Complaints and Dilemmas

A comparison of the relative frequencies of ethical issues in the Complaints and Dilemmas data sets is shown in Fig. 11. It is clear from the figure and from sections 8.1.1 and 8.1.2 that there were discernable differences between the prominent ethical issues in the two data sets. These differences

could not however be subjected to chi-square testing as the observations in the data sets were not independent as some Dilemmas respondents provided more than one dilemma. These overlaps conflicted with the assumptions of chi-square testing for significant differences. Nevertheless, it is graphically and descriptively evident that there were clear differences between some ethical issues which concern the consumer public (Complaints) and issues which concerned psychologists themselves (Dilemmas). For this reason Fig. 11 illustrates a comparison of the ethical issues as reflected in the two data sets. It is important to note that the percentage values for the Dilemmas data set reflected in Fig. 11 are marginally different from those shown in Fig. 10 above. This is because the ‘no dilemmas’ respondents and smaller categories of ethical issue were removed for the comparative Fig. 11. Ethical issues that affected only a minority of both data sets were also omitted for the sake of clarity and to highlight the major comparative issues. The relative ranking of the ethical issues remained unaffected, however.



A comparison of the frequency of ethical issues in each data set, as shown in Fig. 11, is presented in detail below, according to descending points of discrepancy between Complaints and Dilemmas. Comparisons with other studies were limited by that fact that no prior comparative studies of public complaints and psychologists' ethical issues could be identified.

1. Confidentiality: It is clear from Fig. 11 that there was a dramatic difference between the extent to which confidentiality issues generated Complaints and the extent to which psychologists reported confidentiality Dilemmas. The discrepancy of 33% was the largest in the comparison of ethical issues in the two data sets. The number of Complaints concerning confidentiality (2%, ranked 10<sup>th</sup>) was far lower than the extent to which psychologists expressed Dilemmas about confidentiality (35%, ranked 1<sup>st</sup>). The Dilemmas results showed psychologists to be acutely aware of confidentiality issues. It is possible that this accounts for, or is in some way associated with the very low rate of Complaints against psychologists for confidentiality issues. Recognition of this ethical problem is an essential strategy in avoiding unethical practice (Anderson et al., 1998; CPA, 2000). This recognition may be reflected in the correspondingly low rate of Complaints in this area, confirmed by the other studies cited in section 8.1.1. above. It could, however, also be argued that a preoccupation with confidentiality as a dominant ethical issue may make psychologists inattentive or 'blind' to other issues that attracted Complaints, such as management of fees, inappropriate practice and competence issues as reflected in the Complaints data. It is counterintuitive to argue that the low rate of Complaints about confidentiality may be due to public unawareness of this issue, as it has been argued that confidentiality is the single most important ethical variable expected by the public of psychologists (Hillerbrand & Claiborn, 1988; McGuire, Toal & Blau, 1985; Rubanowitz, 1987; Slovenko, 1998; Taube & Elwork, 1990). Comparative studies of international ethical codes for psychologists also reveal that there was almost 100% consensus on the importance of confidentiality across 23 countries (Leach & Harbin, 1997; Leach, Wassenaar & Gray, 2002). The high ranking of confidentiality issues is compatible with the data reported earlier (cf. section 7.9.2) showing that psychotherapy was the most frequent professional activity conducted by South African psychologists.

2. Fees and Payment issues: There was a marked difference (18%) between the prominence of Complaints concerning fees (22%, ranked 1<sup>st</sup>) and psychologists' low concerns about fee matters (6%, ranked 6<sup>th</sup>). The discrepancy between Complaints (high) and Dilemmas (low) suggests that psychologists were insufficiently concerned about ethical issues in billing matters and that this may represent a neglected area of training. It is also theoretically possible that complainants misunderstand the billing process in the context of psychological services, and that the prominence of fee issues in the Complaints data reflects the psychological complexities of fee issues in the client's experience of the therapeutic relationship (Birnbach, 1999; Lasky, 1999; Valentine, 1999). Further analysis of the nature of billing problems is however required to determine whether the majority were *bona fide* errors or intentional fraudulent practices. Adjudication outcome data on fee issues would also provide useful data on whether the psychologist or the client is at fault in fee complaints. However, Landman's (2001) report on South African medical practitioners suggests that these concerns may not be mere accidental errors, to the extent that his data is generalisable to psychologists. This contrasts with Koocher and Keith-Spiegel's (1998, p. 234) view that fee complaints "often...arise from miscommunications, procedural ignorance, or naivete, rather than greed or malice", arguing that in the USA professional training before 1990 and managed care were never discussed in training. There is a need to determine the extent of financial management training in South African professional psychology programmes.

3. Non-sexual Dual Relationships: Such dual relationships were a source of Complaints (2%, ranked 9<sup>th</sup>) much less frequently than Dilemmas about non-sexual dual relationships (12%, ranked 3<sup>rd</sup>). Psychologists showed greater concern about non-sexual dual relationships than the rate of public complaints about this area. Recognition of ethical problems is the first step in avoiding misconduct and although the design of this study cannot show any causal link between the two data sets, it is possible that this over concern may be protective against complaints in this area. Conversely, the low rate of Complaints may mean that the public were not aware of this area of possible misconduct, did not construe it as problematic or detrimental, or were simply not being exposed to it because of relatively high levels of psychologist awareness of its potential problems. There is a growing literature on the prevalence and management of non-sexual dual relationships (Anderson &

Kitchener, 1998; Evans & Hearn, 1997; Gottlieb, 1993; Gottlieb et al., 1988, 1995; Kitchener, 2000b; Phillips & Lee, 1986; Rubin, 2000; Sonne, 1994) - and in a host of specific contexts e.g., in supervisory relationships (Biaggio et al., 1997; Burian & Slimp, 2000; Koocher & Keith-Spiegel, 1998; Lamb & Catanzaro, 1998); in forensic work (Gerson & Fox, 1999; Greenberg & Shuman, 1997; Iverson, 2000), research (Hart & Crawford-Wright, 1999), in rural communities (Brownlee, 1996; Schank & Skovholt, 1997); in military settings (Jeffrey, Rankin & Jeffrey, 1992; Johnson, 1995; Orme & Doerman, 2001); in sport psychology (Andersen, van Raalte & Brewer, 2001), and pastoral work (Smith & Smith, 2001) to list but a few.

4 Advertising: Advertising matters were more frequently a basis of Complaints (11%, ranked 4.5<sup>th</sup>) than cited as Dilemmas (3%, ranked 9<sup>th</sup>). This area does not warrant much discussion as the data sets cross a period during which relatively prohibitive regulations concerning advertising were considerably relaxed by the Professional Board in 1994 (INMDCSA, 1996a). It is possible that some of these complaints were based on violations of the relaxed standards set for advertising after 1994, whereas before 1994 most forms of advertising were *de facto* violations. Recent APA reports (APA 1999, 2000, 2001d) list no complaints in this area, although Koocher and Keith-Spiegel (1998) still devote a chapter to the ethics of advertising and public statements.

5. Inappropriate Practice: Fig. 11 shows that Complaints about inappropriate practice (19%, ranked 2<sup>nd</sup>) exceeded Dilemmas about inappropriate practice (15%, ranked 2<sup>nd</sup>) by 4%. Psychologists were less concerned about inappropriate practice than was warranted by the frequency of complaints concerning this issue. It is interesting, however, that this issue was ranked second on both data sets. As with fees, this could be construed as a 'consumer dispute' arena in which psychologists may be insufficiently attentive to some peripheral and nonprofessional aspects of service delivery and practice management (cf. sections 6.1.1.2 & 6.2.2.1). Again, it is possible that psychologists receive insufficient training in 'customer care' aspects of their practice management and in the training of their nonprofessional staff. On the other hand, the peculiar intensities of psychological practice might also lead to unrealistic client expectations, which, when unmet, might lead to complaints (Clarkson, 2000; Hedges, Hilton, Hilton & Caudill, 1997; Sussman, 1995). However, a training evaluation

report on graduates from one South African university (Viljoen et al., 1999) found that graduates were most dissatisfied with the “management aspects” (p. 202) of their training for professional practice. As mentioned earlier, this category is not a formal ethical violation but more a ‘practice management and customer care issue’ created by the researcher to accommodate items emerging from the data sets (Holsti, 1969). The relative prominence of this issue in both data sets suggests that these issues require further research and more careful attention in training and practice (Koocher & Norcross, 1998).

6. Consent: Consent issues were more frequently a basis for Complaints (9%, ranked 6<sup>th</sup>) than a source of psychologists’ Dilemmas (6%, ranked 6.5<sup>th</sup>). There was a discrepancy of 3%, although consent ranked equally in both data sets. As mentioned earlier, the coding of consent issues in this study referred to consent issues other than issues that relate to confidentiality issues. Confidentiality issues, which relate to information exchange, usually embody consent issues (coded as one category by Peterson, 1996). The consent issues coded in this study thus refer to consent issues mostly related to consent for particular procedures or professional acts by psychologists (cf. sections 6.1.1.2 & 6.2.2.1). Psychologists seemed less concerned about obtaining informed consent to conduct certain procedures than was warranted by the relative frequency of Complaints concerning this issue.

7. Sexual Issues: Sexual issues were a source of Complaints against psychologists (6%, ranked 7<sup>th</sup>) only marginally more than Dilemmas about sexual issues (3%, ranked 7<sup>th</sup>). This apparently low frequency of concerns about unethical sexual relationships in both data sets was somewhat counterintuitive and contrary to popular notions of misconduct by psychologists. Louw (1997b) also expressed the view that sexual issues were “quite low” (p. 191), ranked fourth in his ranking of complaints to the Board up to 1990. This may be because, as mentioned earlier, the Complaints data set reflects unadjudicated incoming complaints, as opposed to legally confirmed violations following formal disciplinary proceedings. The present study was concerned with complaint patterns, rather than confirmed violations (convictions). Many other studies on violations report confirmed violations (e.g., APA, 1999, 2000, 2001d), where sexual violations were often in the majority. Furthermore, these are brought to prominence by the press as their sensational news value is greater

than violations concerning consent or fee issues. It is thus possible that while sexual issues ranked relatively low among Complaints, they may rank much higher proportionately in adjudicated outcomes of professional misconduct. When international data (APA, 1999, 2000; Peterson, 1996; Pope, 1994; Reaves, 1995d) are taken into account, the prominence of sexual misconduct in disciplinary outcomes against psychologists warrants greater awareness of and training in sexual issue ethics for all categories of psychologist (Housman & Stake, 1999). This is not however an argument for more rigid ethical rules against sexual dual relationships; it should be noted, for example, that in the Netherlands there appears to be no simple proscription against sexual dual relationships. Psychologists there are however obliged to consider the potentially harmful nature of these relationships and are required to show consideration of this when contemplating entering into them (NIP, 1998). Disciplinary actions under such rules would be required to show that a dual sexual relationship was exploitative or harmful to the client, rather than be regarded as intrinsically and *a priori* and *de facto* unethical. This discussion also raises the issue discussed by some authors (Cohen & Cohen, 1999; Dyck, 1993; Lazarus, 1994) who argue that a particular type of slavish rule following for self protective motives by a psychologist might, in theory at least, be more unethical than a rule violation for ethically virtuous motives.

8. Competence: There was only a relatively small difference (2%) between Complaints and Dilemmas concerning competence. Complaints concerning competence were ranked more prominently (13%, ranked 3<sup>rd</sup>) while psychologists themselves were less concerned about their Competence (11%, ranked 5<sup>th</sup>). The discrepant ranking suggests that the public complained about issues related to competence more often than was justified by psychologists' own relatively low expression of concern about this area. The inception of CPD in South Africa from 2002 (Professional Board, 2002) may raise psychologists' awareness of the need to practice within areas of competence and the need to stay current in established fields of practice.

9. Interprofessional Issues: There were relatively small differences (2%) between these issues in Complaints (6%, ranked 8<sup>th</sup>) and Dilemmas (8%, ranked 5<sup>th</sup>). The discrepant ranking suggests that psychologists need to be more attentive to their conduct in dealing with other professionals in order

to practice ethically and avoid attracting complaints.

## 10    Isolated Issues

As can be seen from Figs. 9 and 10, some ethical issues appear unique to each database and are thus not compared. These are discussed briefly below.

- 10.1    Registration fees: Nonpayment of annual registration fees (cf. Fig. 9) by psychologists to the Board constitutes a technical offence rather than an ethical violation, in that it leads to psychologists practising while not legally registered, rendering such practice illegal rather than unethical. As can be seen from Figs. 9 and 11, and confirmed by Scherrer et al. (2002), this was a frequent (11%, ranked 4th) cause of Complaints against psychologists, albeit emanating from the statutory authority itself. There was no comparable ethical dilemma reported by psychologists themselves. However, at face value the frequency of this item may be linked to the inappropriate practice category, and thus be seen as a further example of poor professional practice management. The only other related data on this was from Neukrug et al. (2001) who found that practicing unlicensed ranked third (8%) in complaints against credentialed counsellors.
- 10.2    Record keeping (cf. Fig. 10): A few psychologists reported Dilemmas about record-keeping (ranked 10<sup>th</sup>), while no Complaints concerning records were documented in the period of this study or by Scherrer et al. (2002). This is a relatively 'private' aspect of practice management that would only come to public attention where records were subpoenaed or otherwise brought to public attention. Reaves (1995d) reported that less than 2% of convictions in American Board hearings concerned failure to keep records. A study of complaints, such as the present one, is probably an unreliable index of record keeping practices and research in this area would probably have to involve direct auditing of psychologists' record-keeping practices to determine if these were adequate and ethical. Record keeping practices were

discussed by Fulero and Wilbert (1988), McMinn, Buchanan, Ellens and Ryan (1999), Moline, Williams and Austin (1998), and documentary guidelines were provided by Wiger (1997) and the APA (1993a).

- 10.3 Ethnicity: Concerns about ethnicity were reported by a few Dilemmas respondents (ranked 11<sup>th</sup>). These concerns were limited to cautions about sensitivity to cultural issues in practice and were not a source of Complaints during the period under study. This area is a rich potential source of complaints, given the history of institutionalised racism in South Africa and the possible practice of covert or “subtle” racism (Duncan et al., 2001; Ibrahim & Arredondo, 1986; Jones, 1998, p. 285; Slabbert, 2001) by psychologists. The low rate of Complaints focussed on ethnicity may reflect the fact that most consumers of psychological services were members of the white minority population (Bakker, 1999; Peltzer, 2000), as were most psychologists themselves, resulting in relatively low rates of interracial or inter cultural service delivery. Alternately, clients may have sought practitioners of their ‘own’ cultural or racial groups, leading to low complaints in this area. It could furthermore be argued that the absence of a culture of human rights in the period before 1994 may also have contributed to a low rate of Complaints against professionals from members of the historically oppressed majority black population. Psychologists would thus be well advised to attend to developing inter cultural sensitivity and skills to provide ethical services to the broad cultural spectrum of races and cultures in South Africa, as advocated by a burgeoning literature on inter cultural practice (Hansen et al., 2000; Kometsi, 2001; Madu, Baguma & Pritz, 2000; Peltzer, 2000). In any event, a study of patterns of racial and cultural matching between psychologists and clients in the private and state sectors would cast more light on this finding.

## 8.2 Ethical Issues and Registration Category

The main purpose of this section of the analysis was to identify registration categories that were

over- or under-represented on particular ethical issues in each data set. In each section, the Complaints data set is described first, then the Dilemmas data followed by a comparison of findings from each data set. There is little available local or international data with which to compare these findings as the South African system of registration categories (soon to be phased out) is unique. Scherrer et al. (2002) did not analyse the type of ethical issue by registration category.

### 8.2.1 Ethical Issue by Registration Category: Complaints

The distribution of psychologists by category and ethical issues is depicted in Fig. 12.

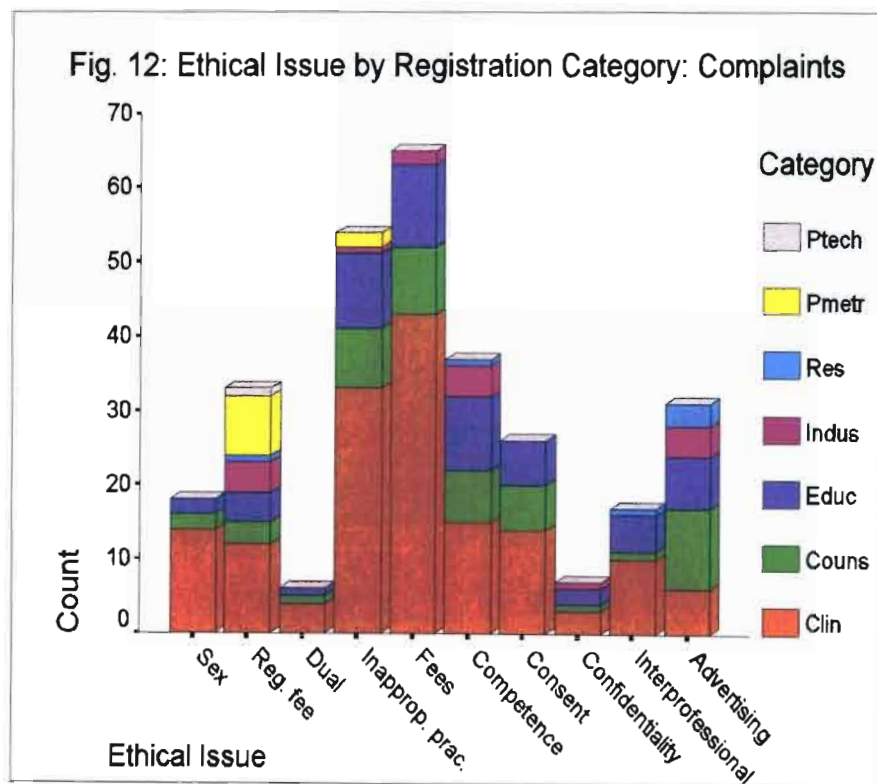


Fig. 12 depicts the Complaints data discussed in section 8.1 above, but in more detail regarding registration categories to determine whether there are any disproportional patterns of ethical issues by registration category. Although Fig. 12 includes data for psychometrists and psychotechnicians,

they were not included in the analysis and discussion below. It is however noteworthy from Fig. 12 that the ethical issue most commonly associated with complaints against psychometrists was unpaid registration fees. The most common ethical issues by registration category in Fig. 12 are tabulated as shown in Table 6.

Table 6

Most Frequent Ethical Issue by Registration Category: Complaints

Reg. Category	First	Second	Third	Fourth
Clinical	Fees	Inapprop. prac.	Competence	Consent
Counselling	Advertising*	Fees	Inapp. prac.	Competence
Educational	Fees	Inapp. prac. & Competence	Advertising	
Industrial	Advertising*, Competence & Reg. Fees*	-	-	-
Research	Advertising*	Competence	Interprof.	-

\*Statistically significant

The ethical issues that occurred least frequently for each registration category are listed in Table 7 below:

Table 7

Least Frequent Ethical Issue by Registration Category: Complaints

Reg. Category	Least Frequent Ethical Issue
Clinical	Confidentiality
Counselling	Confidentiality*, non sexual Dual*, Interprofessional*
Educational	non sexual Dual
Industrial	-
Research	-

\* In this row these ethical issues occurred equally frequently.

A chi-square analysis was performed to determine whether particular ethical issues were disproportionately spread across the five registration categories and the results are shown in Table 8. The analysis was done although 66% of the cells had expected values less than 5, because the main purpose of this analysis was not to test any hypothesis about independence, but to enable a qualitative interpretation of patterns and trends within the data. The chi-square statistic was significant ( $\chi^2=55.57$ ,  $df=36$ ,  $p=.019$ , Cramer's  $V=.44$ ). The standardized residuals<sup>1</sup> in Table 8 indicate that in comparison with the other categories, research psychologists attracted disproportionately more complaints about advertising (std. residual 2.9), followed by counselling psychologists (2.4) and industrial psychologists (1.7). Disproportionately few clinical psychologists attracted advertising complaints (-2.6) (cf. also section 8.2.3). Disproportionately many industrial psychologists had problems with unpaid registration fees (2.3), which may reflect ambivalence by industrial psychologists about mandatory professional registration with the medically-orientated statutory council (HPCSA).

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<sup>1</sup> A standardised residual of greater than 1.67 or less than -1.67 suggests disproportionately high or low representations within particular categories.

Table 8

## Ethical Issue by Registration Category: Complaints

Ethical Issue		Registration Category					Row Total
		Clin	Couns	Educ	Ind.	Res	
Sex	Count	14	2	2	-	-	18
	Std. Residual	1.3	-0.6	-0.09	-1	-0.6	6.4%
Reg. Fee	Count	12	3	4	4	1	24
	Std. Residual	-0.3	-0.6	-0.4	2.3	0.7	8.5%
Dual	Count	4	1	1	-	-	6
	Std. Residual	0.4	-	-0.2	-0.6	-0.4	2.1%
Inappr.	Count	33	8	10	1	-	52
	Std. Residual	0.9	-0.3	-0.2	-1.1	-1	18.4%
Fee	Count	43	9	11	2	-	65
	Std. Residual	1.3	-0.7	-0.6	-0.9	-1.2	23.0%
Compet.	Count	15	7	10	4	1	37
	Std. Residual	-1.1	0.2	0.9	1.3	0.2	13.1%
Consent	Count	14	6	6	-	-	26
	Std. Residual	0	0.7	0.3	-1.2	-0.7	9.2%
Confid.	Count	3	1	2	1	0	7
	Std. Residual	-0.4	-0.2	0.5	1	-0.4	2.5%
Interprof.	Count	10	1	5	-	1	17
	Std. Residual	0.2	-1.1	0.8	-1	1.1	6.0%
Advert.	Count	6	11	7	4	3	31
	Std. Residual	-2.6	2.4	0.3	1.7	2.9	11.0%
Column	Count	154	49	58	16	6	283
Total		54.4%	17.3%	20.5%	5.7%	2.1%	100.0%

## 8.2.2 Ethical Issue by Registration Category: Dilemmas

Figure 13 shows the ethical issues of concern to each registration category for the Dilemmas

respondents. A simple frequency ranking method was employed to investigate patterns of differences in ethical issues across the different registration categories for the Dilemmas data set. Cross-tabulations and chi-square analysis could not be employed because of a lack of independence between observations. The data set included 375 dilemmas from 255 respondents. Many respondents provided more than one vignette, and thus the properties of the vignettes (e.g., ethical issue) were not independent of the subject variable (e.g., registration category). To make the two comparable, the proportion of psychologists from each registration category citing each ethical issue was calculated. These were then converted into percentages, allowing one to determine whether a single ethical issue was located at a similar rank in the different registration categories. Note that as no industrial psychologists submitted dilemmas as mentioned earlier, this category does not appear in the analysis. The results are shown in Table 9.

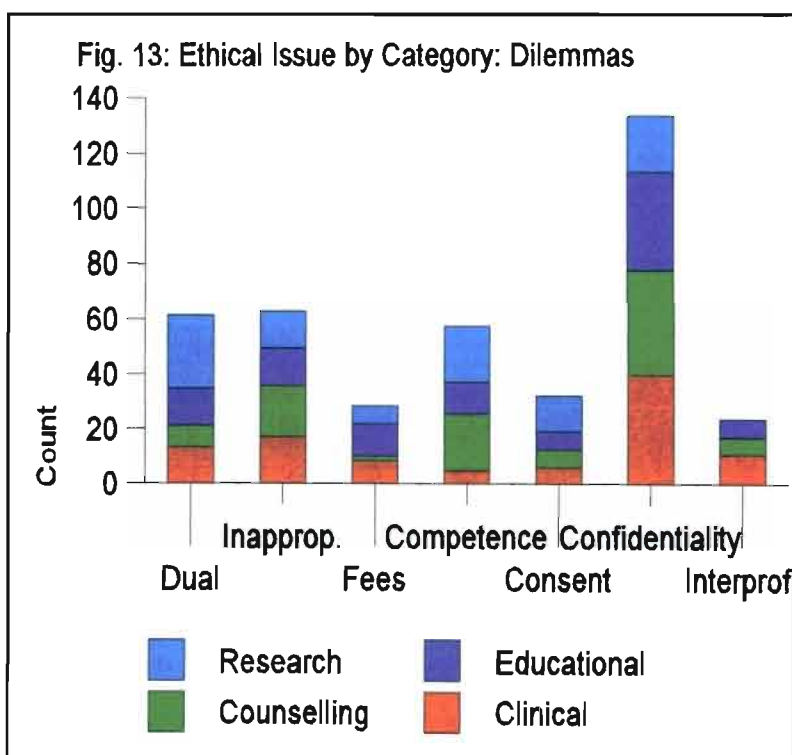


Table 9

Ethical Issue by Registration Category: Dilemmas

Ethical Issue	Clinical	Counselling	Educational	Research
Dual	13.3	7.9	13.6	26.7
Inappr. prac.	16.9	19.0	13.6	13.3
Fees	8.4	1.6	11.9	6.7
Competence	4.8	20.6	11.9	20.0
Consent	6.0	6.3	6.8	13.3
Confid.	39.8	38.1	35.6	20.0
Interprof.	10.8	6.3	6.8	0
Total	100.0%	100.0%	100.0%	100.0%

Table 10 below shows the main ethical issues (Dilemmas) experienced by members of each registration category, and Table 11 shows the least frequent ethical issue for each registration category.

Table 10

Most Frequent Ethical Issue by Registration Category: Dilemmas

Reg. Category	First	Second	Third	Fourth
Clinical	Confidentiality	Inappr. prac.	Dual	Interprof.
Counselling	Confidentiality	Competence	Inappr. prac.	Dual
Educational	Confidentiality	Inappr. prac. & Dual*	Fees & Competence*	Consent & Interprof.
Research	Dual	Confidentiality & Competence*	Consent & Inappr. prac.*	Fees

\* In this row these ethical issues occurred equally frequently.

Table 11

Least Frequent Ethical Issue by Registration Category: Dilemmas

Reg. Category	Least Frequent Ethical Issue
Clinical	Competence
Counselling	Fees
Educational	Consent & Interprofessional*
Research	Fees

\* In this row these ethical issues occurred equally frequently.

### 8.2.3 Ethical Issues by Registration Category: Comparison of Complaints and Dilemmas

This section compares the ethical dilemmas in the Complaints and Dilemmas data by Registration category. The discussion is based on a comparison of Tables 6, 7, 10 and 11 and considers only the most and least frequently occurring ethical issues in the Complaints and Dilemmas data sets. Some ethical issues will be omitted from discussion as space limitations dictate that only the most marked discrepancies between Complaints and Dilemmas are presented below.

I. Fee and Payment Issues: Fee and payment issues ranked first among Complaints against clinical and educational psychologists. Clinical psychologists did not, however, rank fee issues amongst the top four concerns in the Dilemmas data set, suggesting that this is possibly a neglected area of practice management or training deficit. Educational psychologists rated concerns about fees third (equal to competence) in the Dilemmas data set. Fees ranked second in Complaints against counselling psychologists, who did not rank fee issues in their top four Dilemmas. Fees ranked third in Complaints against industrial psychologists, who did not submit any Dilemmas for comparison. Combined with data in the previous chapter, this large discrepancy between the high ranking of fees in the Complaints data and its low ranking in Dilemmas suggests that fee issues warrant further attention in basic training and continuing education programmes for clinical, educational and counselling psychologists in particular.

2. Advertising: Complaints about advertising comprised the primary ethical issue against counselling, industrial and research psychologists, suggesting that they campaigned more actively for clientele by advertising. Advertising was not reflected as an ethical dilemma by any of the categories of psychologist in the Dilemmas data. In contrast, clinical psychologists were significantly under-represented in Complaints concerning advertising, suggesting that this registration category attracted clientele without resorting to problematic advertising. Although the present study did not examine the source of complaints, Louw (1997b) found that most complaints about advertising were submitted by other professionals rather than by the public or consumers of psychological services. He argued that this reflected inter-professional competition rather than an ethical concern about client well-being. It could, however be argued that some professionals submit such complaints about advertising because the registration category of the advertising psychologists, especially research psychologists, was discrepant with the services being advertised, thus reflecting a concern about competence, which is squarely a public interest (nonmaleficence, beneficence) issue. This could also be applied to industrial psychologists who were the second most frequent recipients of complaints concerning advertising. Further research examining the contexts of the advertisements concerned would be required to show this, but it can be hypothesised that advertisements by research and Industrial psychologists concerned therapeutic services, which are not traditionally within the training and scope of practice of these categories. This was also suggested by the finding that interprofessional disputes were the third most frequent source of complaints against research psychologists (cf. Table 6), which was the only category of psychologist to have this ethical issue among its top four complaints.

3. Inappropriate practice: Inappropriate practice was the second source of Complaints against Clinical and educational psychologists, and the third source of Complaints against counselling psychologists. Clinical and educational psychologists also ranked inappropriate practice as their second highest ethical concern in the Dilemmas data set, while counselling psychologists ranked inappropriate practice third. Inappropriate practice did not appear in the top four sources of Complaints against industrial and research psychologists, where this ethical issue was outranked by Complaints about competence, which will be discussed below. The comparison of Complaints and

Dilemmas concerning inappropriate practice suggests that while clinical, educational and counselling psychologists showed high levels of awareness and concern about this area, their concern was not effective in reducing the number of complaints in this area. Viljoen et al. (1999) reported that graduates from one South African university were most dissatisfied with the practice management aspects of their training. As mentioned earlier, this area appears to warrant further research and analysis so that specific problematic behaviours and practices can be identified to inform training and continuing education programmes, particularly for clinical, educational and counselling psychologists.

4. Competence: Competence was the second most frequent Complaint against industrial and research psychologists, while it ranked third for clinical and educational psychologists and fourth for counselling psychologists. Counselling psychologists ranked competence issues second in their Dilemmas, while research psychologists also showed concerns about competence, ranking it second in their Dilemmas, along with confidentiality. Clinical psychologists did not rank competence as highly while educational psychologists ranked it fourth, along with fees. This data suggests that research and Industrial psychologists attracted disproportionately more complaints about competence, possibly those who are practising in 'therapeutic' modes beyond their scope of training. Clinical psychologists, however, showed low concerns about competence in relation to the ranking of competence complaints against them, suggesting that they may also be practising beyond their scope of training or that they underestimated the challenges of their more 'psychiatric' client population. These hypotheses would have to be verified by further research that examines the exact nature of competence Complaints and takes the outcomes of the legal inquiries into account to establish whether inadequate training or another factor is at fault.

5. Non-sexual Dual relationships: These issues did not rank among the top four sources of Complaints for any of the categories of psychologist, but ranked first among the Dilemmas of research psychologists, second for educational psychologists, third for clinical psychologists and fourth for counselling psychologists. This suggests that non sexual dual relationships concern psychologists more than they do the public consumers of services. Again the level of concern may

be protective in raising standards of practice, thus preventing Complaints. On the other hand, consumers may not be aware of what the boundaries of acceptable dual relationships are, especially in the non-sexual realm. The high level of concern shown by research psychologists may reflect their historical lack of formal training in interpersonal dynamics, whether in therapeutic or standard research settings or the increasing trend towards contractual formalisation of student research supervision (Goodyear et al., 1992).

6. Sexual Issues Sexual issues did not rank in the top four categories of Complaints against any particular category of psychologist, nor did they rank highly in each category's self-reported Dilemmas. Since no data unique to any registration category was found, no discussion further than that outlined in section 8.1.3 is considered here.

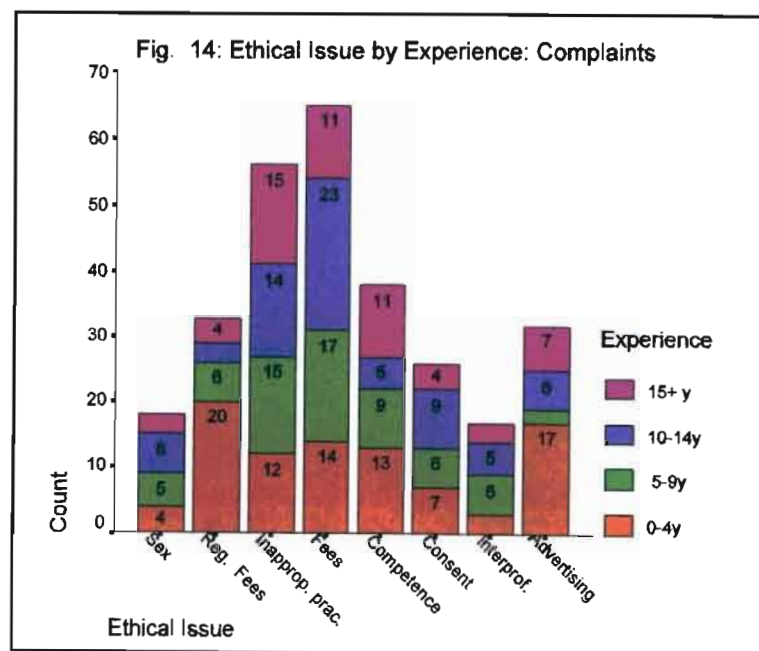
In summary, this section has shown that there are significant differences in the types of ethical issue arising in the Complaints and Dilemmas data sets. Furthermore, different registration categories of psychologist attract Complaints concerning particular ethical issues more than others. Although this data cannot prove that any particular variable is responsible for these differences, it does suggest fruitful avenues for further research and for specific ethics training tailored to meet these patterns and expressed concerns. Further patterns are explored in the following section.

### 8.3 Ethical Issue by Experience

This section examines the association between ethical issues and the years of experience of the practitioner. The experience of the practitioner is referred to here rather than the age of the practitioner, as the professional development of the practitioner is of interest, rather than his or her age - although these may be related. Furthermore, the age of practitioners was not available from the Complaints data. This discussion will therefore be confined to years of professional experience. As in the previous sections, the Complaints data will be presented first, followed by the Dilemmas and then a comparison of Complaints and Dilemmas.

#### 8.3.1 Ethical Issue by Experience: Complaints

As reported in section 7.5 above, psychologists who attracted complaints had a mean of 9.8 years of experience ( $SD=6.7y$ ) with a range of one to twenty-nine years of post-qualification experience. This was consistent with the report by Scherrer et al. (2002) who found that psychologists attracting complaints were between 30 and 39 years of age. The analysis which follows attempts to identify whether specific ethical issues in Complaints were associated with psychologists in particular age



groups. Ethical issues by grouped years of experience are shown in Fig. 14.

As shown in Fig. 14, experience was divided into four groups. Each group represents a five-year period, with group 1 representing 0-4 years, group 2 representing 5-9 years, group 3 representing 10-14 years and group 4 representing 15 and more years of experience. A chi-square analysis was performed to determine whether ethical issues were associated with experience and the results are shown in Table 12. All expected frequencies were greater than five, and the chi-square statistic was significant ( $\chi^2=40.27$ ,  $df=21$ ,  $p=.007$ , Cramer's  $V=.21$ ). The standardized residuals in Table 12 show the following in relation to each group of experience: in the first group (0-4y), psychologists disproportionately attracted complaints about unpaid registration fees and advertising. However, in the second group (5-9y) complaints about advertising were disproportionately under-represented, suggesting that the urgency to advertise new services in a problematic way had dissipated significantly. In the third group (10-14y) fee issues were disproportionately over-represented and unpaid registration fees were disproportionately under-represented. No particular issues were over-or under-represented in the fourth group of experience (15+ y). Although not statistically significant, Fig. 14 shows that psychologists in the fourth group of experience were the only group not to attract fee complaints as the primary ethical issue, while inappropriate practice was the most frequent, though non significant, issue in this group. A survey by Lamb and Catanzaro (1998) found that sexual boundary violations in their sample occurred most amongst psychologists with a mean of 20 years of experience.

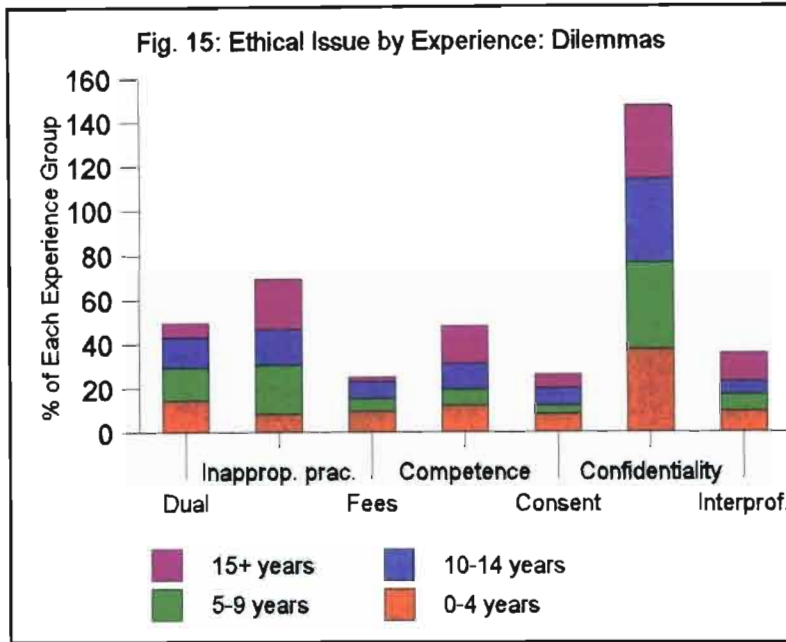
Table 12

## Ethical Issue by Experience: Complaints

Ethical Issue		Experience(Groups)				Total
		Group 1: 0-4y	Group 2: 5-9y	Group 3: 10-14y	Group 4: 15+y	
Sex	Count	4	5	6	3	18
	Std. Residual	-.7	.4	.7	-.3	
Reg. Fees	Count	20	6	3	4	33
	Std. Residual	3.0	-.6	-1.8	-1.0	
Inapprop.	Count	12	15	14	15	56
	Std. Residual	-1.4	.6	.0	1.1	
Fees	Count	14	17	23	11	65
	Std. Residual	-1.4	.5	1.7	-.6	
Comp.	Count	13	9	5	11	38
	Std. Residual	.3	.1	-1.5	1.2	
Consent	Count	7	6	9	4	26
	Std. Residual	-.4	.0	1.0	-.6	
Interprof.	Count	3	6	5	3	17
	Std. Residual	-1.0	1.0	.4	-.2	
Advertis.	Count	17	2	6	7	32
	Std. Residual	2.2	-2.0	-.7	.2	
Total	Count	90	66	71	58	285

## 8.3.2 Ethical Issue by Experience: Dilemmas

The ethical issues for each group of experience are shown in Fig. 15, which shows that confidentiality was the most frequent Dilemma. A simple frequency ranking method was employed to investigate patterns of differences in ethical issues across the different groups of experience. Cross tabulations and chi-square analysis could not be employed because of a lack of independence between observations. The data set included 375 dilemmas from 255 respondents. Many respondents provided more than one vignette, and thus the properties of the vignettes (e.g., dual relationships) were not independent of the subject variables (e.g., years of experience).



To compare these variables, the proportion of respondents within each category was calculated, in percentages, separately for each of the four groups of experience. These were then ranked, allowing one to determine whether a single ethical issue was located as a similar rank in the different groups. Table 13 shows the ranking of ethical issue by experience in groups. The rows are ranked in descending order of rank totals for each ethical issue.

Table 13 (and Fig. 15) show that confidentiality was the most frequent ethical issue for all groups of experience for Dilemmas respondents. After this, psychologists with less than five years of experience reported dilemmas about non-sexual dual relationships, followed by competence concerns. In group two, psychologists with less than ten years of experience reported concerns about inappropriate practice, followed by non-sexual dual relationships. In group three, psychologists with less than fifteen years of experience showed concerns about inappropriate practice, followed by non-sexual dual relationships. In group four, psychologists with more than fifteen years of experience showed concerns about inappropriate practice, followed by concerns about competence.

Table 13

## Ethical Issue by Experience: Dilemmas

Ethical Issue	Years of Experience in Groups			
	0-4	5-9	10-14	Over 15
	Rank (%)	Rank (%)	Rank (%)	Rank (%)
Confidentiality	1 (37.3)	1 (38.9)	1 (37.3)	1 (33.3)
Inapp. prac.	5 (8.4)	2 (22.2)	2 (15.7)	2 (22.9)
Non-sex dual	2 (14.5)	3 (14.8)	3 (13.7)	5 (6.3)
Competence	3 (12.0)	4 (7.4)	4 (11.8)	3 (16.7)
Interprofessional	4 (9.6)	4 (7.4)	6 (5.9)	4 (12.5)
Consent	5 (8.4)	5 (3.7)	5 (7.8)	5 (6.3)
Fees	4 (9.6)	6 (5.6)	5 (7.8)	6 (2.1)
<i>n</i> (%)	83(100%)	54(100%)	51(100%)	48(100%)

Regarding least expressed concerns per group, psychologists in the first group were least concerned about inappropriate practice and consent issues; psychologists in the second group were least concerned about consent and fee issues; psychologists in the third group were least concerned about interprofessional issues, followed by equal concerns about fee and consent issues. The most experienced group were least concerned about fees, followed by equal concerns about non-sexual dual relationships and consent.

While confidentiality concerns ranked first across all groups of experience, other ethical concerns appeared to wax and wane across the career path. For example, concerns about non-sexual dual relationships diminished with experience, while concerns about inappropriate practice appeared to increase with experience. Concerns about fees appeared to decrease somewhat with experience. Concerns about competence were of greater concern to psychologists in the first and fourth groups of experience, as expected. Psychologists in the middle years of experience expressed least concern

about competence. Concerns about consent were fairly constant across years of experience, as were concerns about interprofessional relationships.

### 8.3.3 Ethical Issue by Experience: Comparison of Complaints and Dilemmas

Inspection of the data in the above two sections suggests that there were differences between the nature of the Complaints psychologists attracted across their career span and issues that psychologists themselves were concerned about. Psychologists were concerned about differing ethical issues depending on their years of experience. This discussion must be seen as speculative, as psychologists in different groups of experience may also have received different quantity and quality of training in ethical issues, as shall be discussed in section 10.1.5. This may have influenced their vulnerability to particular types of complaints and their ethical vigilance for particular types of Dilemmas. Further, it should also be borne in mind that although the Register was predominantly male before 1998, by 1998 males and females were evenly represented on the register, with more new registrations being female, resulting in the register becoming predominantly female after 1998 (Richter & Griesel, 1999). This suggests that more psychologists in the first group are likely to be female, with those in the remaining groups likely to be predominantly male. No similar trend was predicted for race, with whites remaining disproportionately over-represented on the Register, according to Suffla et al., (2001), with no significant growth in new registrations by black psychologists.

For ease of discussion, each group of experience is considered regarding the two most prominent ethical issues.

In the 0-4 year group of experience, advertising was disproportionately over-represented in Complaints against psychologists, while it was absent from Dilemmas for psychologists in this group. This is a rather difficult comparison to discuss as advertising regulations have been relaxed in recent years (INMDCSA, 1996a) and may feature less in complaints against psychologists in future, as discussed earlier. Unpaid registration fees was the most disproportionately over-

represented issue in Complaints, and had no parallel in Dilemmas. Confidentiality and non-sexual dual relationships ranked highest in Dilemmas, however. Taken together, these findings suggest that psychologists in the first years of practice may have advertised inappropriately and did not pay their registration fees on time while they were primarily concerned about maintaining confidentiality and attaining appropriate boundary management skills with their clients.

Complaints against practitioners in the 5-9 years of experience range revealed no over-represented ethical issue, although advertising was disproportionately under-represented, in contrast to the experience group mentioned above. Confidentiality and inappropriate practice remained ranked first and second for Dilemmas respondents. Inappropriate practice remained ranked second in the Dilemmas data set for the third and fourth groups of experience.

Regarding the 10-14 year group of experience, fee issues were disproportionately over-represented in Complaints while psychologists themselves at this level of experience did not rank fee concerns highly, to the extent that fee concerns dropped to the lowest area of concern in this experience group in the Dilemmas data. This discrepancy between high Complaints and an inappropriately low level of concern by psychologists themselves may warrant concern in training and in continuing professional education around fee management. This experience group was disproportionately under-represented in Complaints about nonpayment of registration fees, however.

There were no significantly over-or under-represented issues in Complaints against the 15-and-over years of experience group. Numerically, however, inappropriate practice Complaints were the most frequent for this group, possibly suggesting that practitioners in this experience group did not keep up with current standards of practice. Inappropriate practice ranked second in Dilemmas, suggesting that practitioners in this group were concerned about remaining current. The Complaints data suggest that a proportion do not do so effectively.

## 8.4 Ethical Issue by University of Training

### 8.4.1 Ethical Issue by University of Training: Complaints

In this section only data relating to the 10 universities producing the most psychologists are presented, for ease of discussion. To determine trends of association between ethical issues arising in Complaints and university of origin, a chi-square analysis was performed. Due to the large number of categories in both university and ethical issues, 70% of the cells had expected values less than five. The analysis was used, again, to facilitate interpretation of trends, rather than to test the hypothesis of independence. The chi-square statistic was not significant ( $\chi^2=74.54$ ,  $df=63$ ,  $p=.15$ ). No further interpretation was undertaken, and it was concluded that there was no meaningful difference in the distribution of specific ethical issues by university of training for the Complaints data set. Thus, although section 7.8 showed that some universities were significantly over-represented in the Complaints data set, particular ethical issues were not disproportionately associated with universities in the Complaints data.

### 8.4.2 Ethical Issue by University of Training: Dilemmas

The frequency of ethical issues by university of training for Dilemmas respondents is shown in Fig. 16. The figure shows that while confidentiality was the ethical issue most prominent for graduates of most universities, there was some variation among other ethical issues of concern to graduates of different training universities. A simple frequency ranking method was employed to investigate patterns of differences in ethical issues reported by Dilemmas respondents for their universities of training. Cross tabulations and chi-square analysis could not be employed because of a lack of independence between observations. The data set included 375 dilemmas from 255 respondents. Many provided more than one vignette, and thus the properties of the vignettes (e.g., ethical issue) was not independent of the subject variable (e.g., university). To compare the two, the proportion of subjects within each of the ethical issues categories was calculated separately for each university.

These were then ranked, allowing one to determine whether particular ethical issues were ranked similarly across universities. Universities with relatively small contributions to the Dilemmas data set were excluded. Fig. 16 and Table 14 show the ten universities most reflected in the Dilemmas data. For ease of comparison, Dilemmas from each university are presented as 100% to emphasise differences in types of Dilemmas for each university.

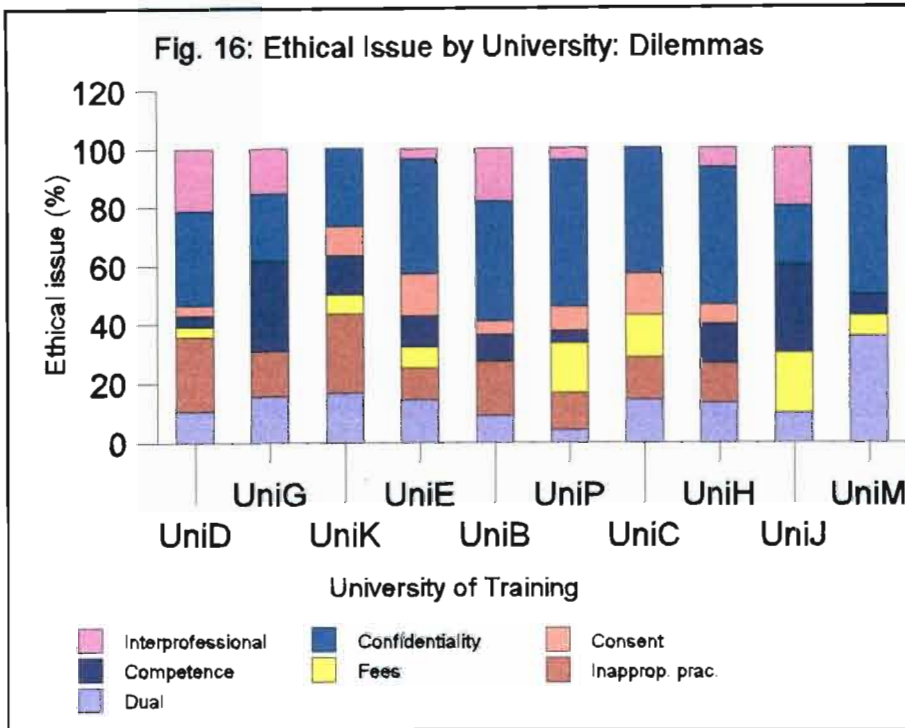


Table 14 shows that graduates from most universities rated confidentiality as their primary ethical concern, except graduates from UniG and UniJ who rated Competence as their primary ethical concern. However, section 7.8 showed that UniG had a favourably low Complaints ratio while UniJ had a high Complaints ratio, suggesting that the above differences in primary ethical issue reported by graduates from each university might be unrelated, or arise for different reasons. A higher concern with competence could thus be because the importance of remaining current is emphasised in training. Conversely, concerns about competence could arise because trainees feel inadequately skilled to commence practice. The data did not allow a clear differentiation of these possibilities.

There was no clear trend for least frequent ethical issue by university of training among Dilemmas respondents.

Table 14

Most and Least Frequent Ethical Issue by University of Training: Dilemmas

University	Most Frequent	Least Frequent
UniD	Confidentiality (32.1%)	Fees, Competence, Consent (all 3.6%)
UniG	Competence (30.8%)	Dual, Inappropriate Practice, Interprofessional (all 15.4%)
UniK	Confidentiality and Inapprop. prac. (both 26.7%)	Fees (6.7%)
UniE	Confidentiality (39.3)	Interprofessional (3.6%)
UniB	Confidentiality (40.9%)	Consent (4.5%)
UniP	Confidentiality (50%)	Dual, Competence, Interprofessional (all 4.2%)
UniC	Confidentiality (49.2%)	All others equal (at 14.3%)
UniH	Confidentiality (46.7%)	Consent, Interprofessional (both 6.7%)
UniJ	Competence (30%)	Dual (10%)
UniM	Confidentiality (50.1%)	Fees, Competence (both 7.1%)

#### 8.4.3 Ethical Issue by University of Training: Comparison of Complaints and Dilemmas

The comparison of Complaints and Dilemmas with regard to the relationship between ethical issue and university of training is difficult since no particular ethical issues in the Complaints data were significantly associated with a particular University of training, despite the fact that some universities

appear to be over-represented in the Complaints data set (cf. section 7.8). However, the Dilemmas data suggest that graduates from most universities rated confidentiality as their primary ethical concern, while graduates from only two universities rated competence as their primary ethical concern. The lack of significance in the Complaints data suggests that psychologists' concerns about confidentiality and competence were not linked to a similar pattern of ethical issues by university of training in the Complaints data.

## 8.5 Ethical Issue by Sex

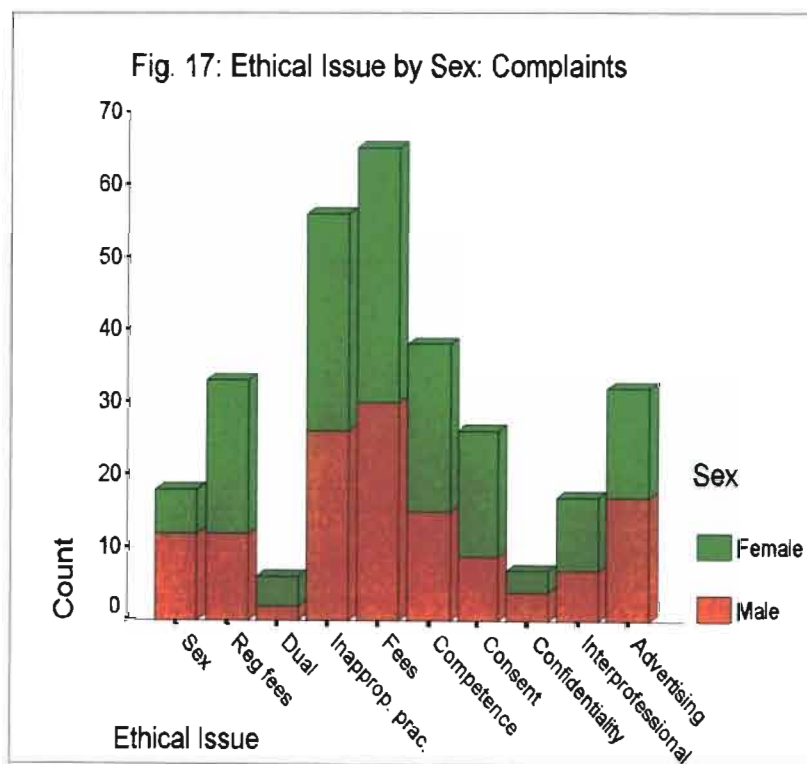
For the years covered by this study, the proportion of psychologists on the register can be regarded as equal, as a rising trend in female registrations resulted in equal numbers of male and female psychologists on the Register in 1996 (Richter & Griesel, 1999). Although section 7.6 showed that marginally more women attracted Complaints than men, this was not significantly disproportionate to the Register. This section attempts to establish if particular ethical issues were associated with Complaints by sex of the psychologist. Particular ethical issues may be more associated with particular sexes than others. For example, Haspel, Jorgenson, Wincze and Parsons (1997) suggested that complaints about sexual misconduct were significantly more likely to be directed against male psychologists than against female psychologists. This section examines the distributions of complaints against psychologists by sex in the Complaints and Dilemmas data sets.

### 8.5.1 Ethical Issue by Sex: Complaints

Fig. 17 shows the distribution of sex in the Complaints data set. Male psychologists attracted more complaints about sexual relationships and confidentiality, while female psychologists attracted more complaints about non-sexual dual relationships, competence, consent issues, interprofessional issues and registration fees. The sexes were roughly equally distributed in Complaints concerning inappropriate practice and fee issues.

A chi-square analysis was performed to determine whether ethical issues were associated with sex.

The chi-square statistic was not significant ( $\chi^2=7.79, df=9, p=.56$ ). The data does however suggest some trends that might be useful in pointing out some high risk areas for male and female practitioners, some of which are consistent with the literature (e.g., male psychologists and sexual misconduct). It is also possible that female psychologists attracted more complaints about competence due to bias by complainants holding stereotyped views seeing men as more competent and females less so. This would be a worthwhile area of further study. That female psychologists also attracted more complaints about consent issues is also worth further exploration, which might warrant particular study and possible educational focus regarding the different ethical management of consent by men and women, with women perhaps having a more relational than legalistic concept of consent issues (Brabeck & Ting, 2000).



### 8.5.2 Ethical Issue by Sex: Dilemmas

The distribution of Ethical issues by Sex for the Dilemmas data is shown in Fig. 18. A simple

frequency ranking method was employed to investigate patterns of differences in Ethical Issues by sex of respondent. Cross tabulations and chi-square analysis could not be employed because of a lack of independence between observations. The data set included 375 dilemmas from 255 respondents. Many subjects provided more than one vignette, and thus the properties of the vignettes (e.g., ethical issue) were not independent of the subject variables (e.g., sex). To compare the two, the proportion of subjects within each of the ethical issues categories was calculated separately for each sex. These were then converted into percentages. The results are shown in Table 15.

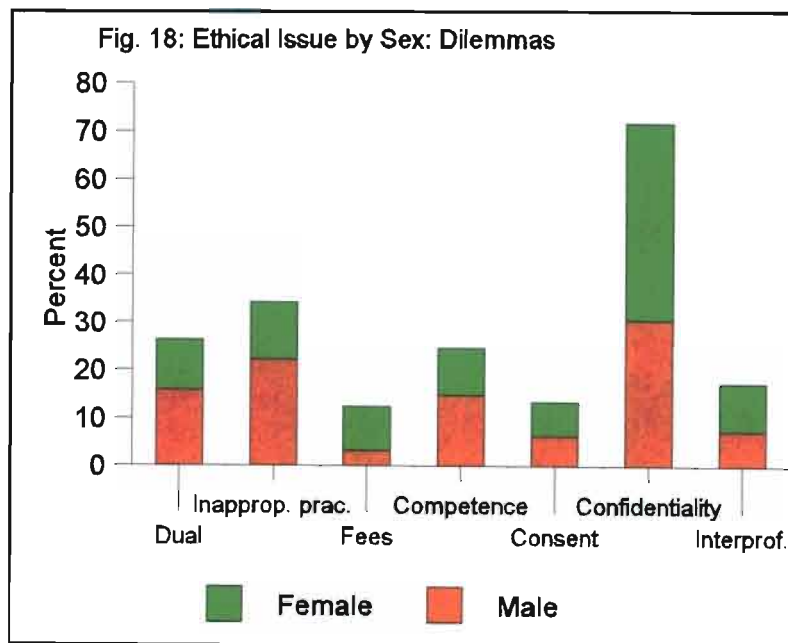


Table 15

Ethical Issue by Sex: Dilemmas

Ethical Issue	Sex of Psychologist		
	Male%	Female%	$\bar{x}$ %
Dual non sexual	15.8	10.6	12.7
Inappropriate prac.	22.1	12.1	16.1
Fees	3.2	9.2	6.8
Competence	14.7	9.9	11.9
Consent	6.3	7.1	6.8
Confidentiality	30.5	41.1	36.9
Interprofessional	7.4	9.9	8.9
Total	100	100	100

The following were the most and least frequent ethical issues or dilemmas reported by psychologists of each sex, tabulated in Table 16.

Table 16

Most and Least Reported Ethical Issues by Sex: Dilemmas

Sex	Most Frequent	Least Frequent
Males	Confidentiality (30.5%); Inapprop. prac. (22.1%)	Fees (3.2%)
Females	Confidentiality (41.1%) Inapprop. prac. (12.1%)	Consent (7.1)

This indicates that both male and female psychologists regarded confidentiality issues as their highest ethical concern, with inappropriate practice ranked second for each sex. There were differences in their least rated ethical concerns, however, with males least concerned about fees and females least

concerned about consent.

### 8.5.3 Ethical Issues by Sex: Comparison of Complaints and Dilemmas

Bearing in mind that ethical issues were not statistically significantly different by sex in the Complaints data (cf. section 8.5.2) and that no statistical analysis of the Dilemmas data could be conducted, some descriptive patterns emerged.

Males attracted more Complaints for sexual misconduct than females. While sexual misconduct was the most evident gender difference in Complaints, it must be borne in mind that Complaints about sexual misconduct ranked only seventh in the Complaints data. In contrast, sexual misconduct did not rank in the top seven ethical issues among Dilemmas respondents and thus did not appear in Table 15.

The second most common ethical Complaint against males that occurred more frequently than against females was advertising, which did not emerge as a self-reported Dilemma for male psychologists. As this is no longer a strictly regulated area, it will not be discussed much further here. Males attracted slightly more complaints concerning confidentiality than females, while both male and female psychologists rated confidentiality their most frequent ethical Dilemma.

Both males and females rated inappropriate practice as their second most frequent ethical concern, which matched this issue's high prevalence in the Complaints data as can be seen in Fig. 18. This suggests that the many 'customer care', practice management and etiquette issues coded in this category warrant attention in CPD and basic ethics training, as inappropriate practice was ranked highly in both Complaints and Dilemmas data sets. This is supported by a report documenting dissatisfaction with practice management training at one South African university (Viljoen et al., 1999).

Females attracted more Complaints than men where the ethical issues involved consent, non-sexual

dual relationships, and competence. In contrast, female psychologists rated confidentiality and inappropriate practice as their most frequent source of ethical Dilemmas, and, in marked contrast with their Complaints data, rated consent as the least frequent of their top seven ethical concerns.

These patterns suggest that males need to attend more to sexual issues in their professional conduct, and that females need to be more attentive to consent and competence issues. Both males and females need to be more attentive to fee issues (which men ranked lowest out of seven ethical Dilemmas). The fact that psychologists of both sexes received equally high numbers of Complaints about inappropriate practice, while showing a high level of expressed concern about this area, suggests the need for detailed basic and CPD training in this area of practice management (Koocher & Norcross, 1998).

## **Chapter 9: Results 2: Contexts and Ethical Issues**

### 9.1 Contexts of Complaints and Dilemmas

This section examines the association of ethical issues with particular practice contexts. The application of professional ethics is typically context dependant. Ethical judgements are often made in relation to particular practice contexts and circumstances. Ethical codes, therefore, are often described as guidelines (e.g., BPS, 1995a; CPA, 2000) rather than as coercive rules, which must be carefully interpreted depending on current conditions and circumstances. For this reason, this study attempted to explore relationships between practice contexts and ethical issues in the Complaints and Dilemmas data sets. It was hoped that identification of ethical issues associated with particular practice contexts might inform ethics training and the revision and development of ethical guidelines. This chapter comprises several subsections described briefly below.

The chapter begins with an examination of the particular ethical issues associated with particular contexts for the Complaints data set (9.1.1). This analysis will show the particular contexts in which complaints arise, and particular ethical issues associated with these contexts. In this section child therapy and child assessment were collapsed into a single category called 'minors' - on the basis that the minority age of the clients was of more ethical relevance than the service provided. However, child custody and child abuse settings remained separately coded because of the special ethical tensions they generated.

A subsequent section (9.1.2) repeats the above process for the Dilemmas data in which the contexts most commonly associated with Dilemmas are presented, followed by an examination of the ethical issues associated with particular contexts. The section concludes with a comparison of the most problematic contexts for Complaints and Dilemmas, and a comparison of the most common ethical issues associated with each context and data set (9.1.3).

9.1.1 Contexts Associated with Complaints

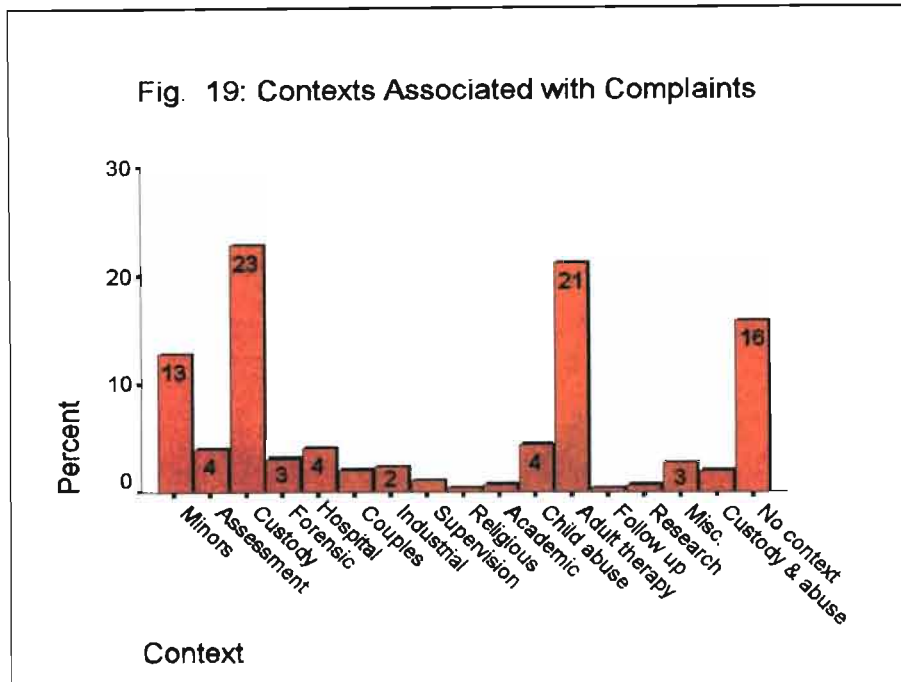


Fig. 19 shows that Complaints against psychologists most frequently arose in the following contexts, rank ordered in Table 17 below:

Table 17  
Rank Ordered Contexts of Complaints

Rank	Context	Frequency (%)
1	Child custody work	23
2	Adult psychotherapy	21
3	Work with minors	13
4	Psychological assessment	4
4	Hospital settings	4
4	Child abuse interventions	4
5	Forensic work	3

In Table 18 the data shown in Table 17 is compared with contexts associated with Dilemmas and with the most common practice contexts of psychologists.

It should be noted that the context of some Complaints could not be coded due to the information being unavailable from the complaint documentation. However, most of the Complaints that lacked context reflected in Fig. 19 as 'No context' were Complaints involving unpaid registration fees. It is relevant to note that in section 8.2 above dealing with ethical issues by registration category for Complaints, it was found that industrial psychologists were disproportionately over-represented among psychologists who did not pay their registration fees, while the proportional representation of other categories of psychologists who did not pay their registration fees was normal. It is thus possible that the context most often associated with the 'no context' category was organisational settings, based on the above inference, and that the most common associated ethical issue was unpaid registration fees.

The dominance of child custody work as a context in which Complaints occurred was noteworthy considering that data in section 7.9.2 and shown in the right-hand column of Table 18 suggested that fewer than 4% of Dilemmas respondents said that they chose to engage in custody work. Nevertheless, over 23% of complaints occurred in the context of child custody work, compared with rates of 7-10% in complaints to the APA (Glassman, 1998). In a larger South African sample, Scherrer et al. (2002) also found that custody work accounted for 23% of the contexts associated with complaints. Child custody work has been identified as a context fraught with ethical dilemmas that combine the particular problems of working with children with the legal pressures typical of forensic work (Bailey, 1998; Hagen & Castagna, 2001; Kirkland & Kirkland, 2001; Krock & Zibbell, 1998; Lee, Beauregard, & Hunsley, 1998; Montgomery et al., 1999; Schetky, 1998; Stahl, 1996). "Perhaps there is nothing that transforms ordinary citizens into rabid litigants as quickly as a divorce-related child custody dispute" (Williams, 2000, p. 78). It should also be noted that in section 7.9.2 the Dilemmas respondents could check child therapy assessment and therapy separately from child custody work, so that this possible overlap would not account for the strong association noted above. This data suggests that ethical issues in child custody work warrant CPD input, in view of custody

work being the most disproportionately over-represented context of Complaints and its relatively low occurrence as a practice preference. The APA guidelines on custody work (APA, 1994a) have been shown to be an effective tool in ensuring better technical and ethical standards in custody work (Bow & Quinnell, 2001; Glassman, 1998).

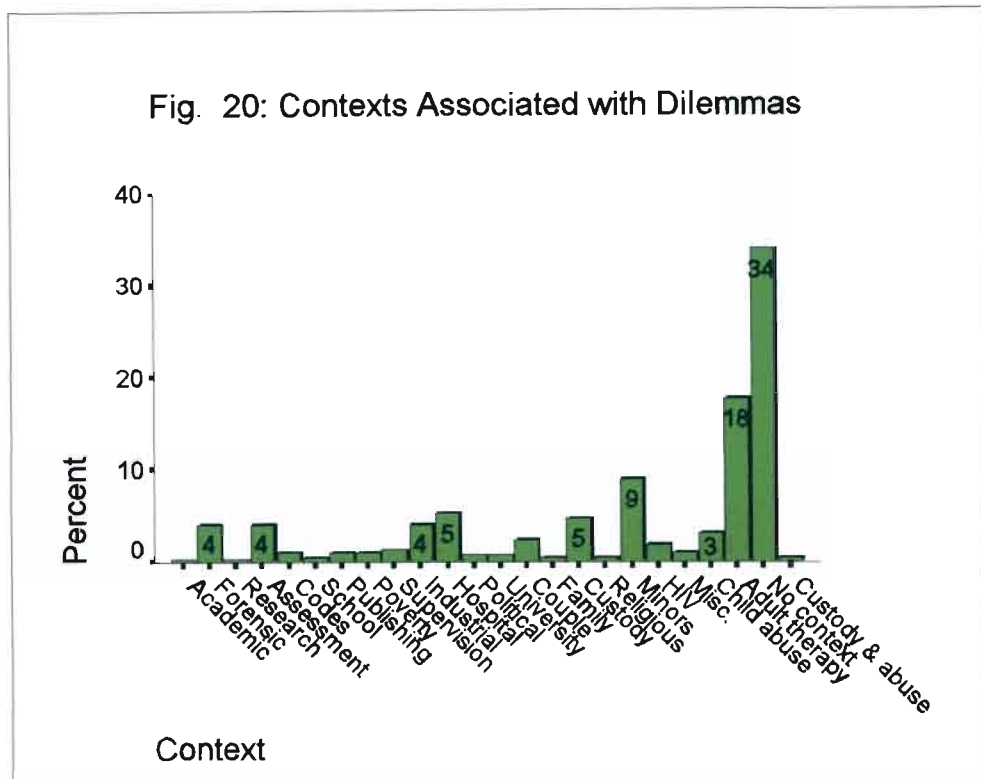
The second most frequent context in which Complaints occurred was adult therapy. This finding was less surprising than the association with child custody matters reported above, as most respondents in section 7.9.2 above, as shown in the right-hand column of Table 18, ranked adult therapy as the most prominent activity in which they engage. That the second highest number of complaints originates in this arena is consistent with the high number of adult therapeutic hours conducted by psychologists nationally (Bassa & Schlebusch, 1984; Peltzer, 2000; Slack & Wassenaar, 1999; Viljoen et al., 1999). This was followed by work with minors as the third most frequent context in which complaints arose and is roughly consistent with the combined frequency of child therapy and child assessment activities reported by respondents in section 7.9.2 and shown in the right-hand column of Table 18.

Ranked equally low as contexts producing Complaints were adult assessment, hospital work, and child abuse interventions. Assessment work was associated with 15% of complaints reported by Scherrer et al. (2002), but they did not separate child from adult work as was done in the present study. This may account for their higher frequency, again highlighting some of the problems with coding and comparisons in the study of ethics complaints. Lower still and ranked equally were forensic work, miscellaneous settings, industrial work, couple counselling and supervision. The low ranking of couple work as a context for complaints is consistent with its relatively low standing as a reported primary area of practice in section 7.9.2 and as shown in the right-hand column of Table 18. Work with couples is nevertheless also described in the literature as a context in which complex ethical issues arise (Marsh & Magee, 1997; Rubin, 2000), due to the complexities of servicing multiple clients simultaneously. As can be seen in Table 18, contexts which ranked relatively highly as areas of professional activity in section 7.9.2 and almost absent as contexts for Complaints were lecturing/academic work. It is possible that complaints arising in this context were dealt with by the

host institution rather than by the Board. Nevertheless, few formal complaints arose in this context, in contrast with a survey by Montgomery et al. (1999) that ethical complaints arising out of supervision affected 22% of their respondents.

### 9.1.2 Contexts Associated with Dilemmas

The contexts in which psychologists themselves reported most ethical Dilemmas are shown in Fig. 20.



More context categories emerged here than in the Complaints database, reflecting the contexts reported by Dilemmas respondents. No context could be identified in 34% of the vignettes. In future these categories should be refined so that Complaints and Dilemmas contexts resemble each other more closely (cf. sections 6.1.2 and 6.2.2). The context in which most Dilemmas arose was adult therapy - which, as stated above, is unsurprising as it was the activity listed as primary by most psychologists. (Specific ethical issues which arose in the context of adult psychotherapy are presented

further in section 9.2.1 below). The contexts that gave rise to the most ethical concern in the Dilemmas data set are presented in rank order in the centre column of Table 18.

Table 18  
Comparison of Context of Complaints, Dilemmas and Most Common Professional Activities

Rank	Context of Complaints	Context of Dilemmas	Most Common Activities
1	Custody Work (23%)	Adult Psychotherapy (18%)	Adult Psychotherapy (23%)
2	Adult Psychotherapy (21%)	Minors (9%)	Lecturing (14%)
3	Minors (13%)	Custody Work (5%)	Counselling (12%)
4	Assessments (4%)	Hospital Settings (5%)	Child Assessment (8%)
5	Hospital Settings (4%)	Forensic Work (4%)	Adult Assessment (8%)
6	Child Abuse (4%)	Assessments (4%)	Child Therapy (6%)
7	Forensic (3%)	Industrial Settings (4%)	Organisational Work (6%)
8	Misc. (3%)	Child Abuse Int. (3%)	Parent Couns. & Marit. (4%)

For ease of comparison, a ranked ordered list of most common practice activities of psychologists appears in the right-hand column of Table 18 - extracted from section 7.9.2 above. The purpose of Table 18 was to determine whether the contexts in which Complaints and Dilemmas arose were similar to the most common practice contexts reported by the Dilemmas sample. Table 18 shows that adult psychotherapy was the most frequent context in which psychologists experienced ethical Dilemmas, and this was ranked equally to adult psychotherapy's status as the most common practice activity. Apart from industrial/organisational work, this was the only Dilemmas context that ranked equally with practice activities. Work with minors ranked second as a context of Dilemmas, but was ranked only fourth and sixth as a common practice area. Child custody work ranked third as a source of dilemmas but was not listed in the top eight areas of practice by psychologists, suggesting that this work generated ethical dilemmas disproportionate to how few psychologists reported this as a practice area. This finding was also consistent with reports by Kirkland and Kirkland (2001) and its high ranking as a context associated with formal Complaints against psychologists (Glassman, 1998).

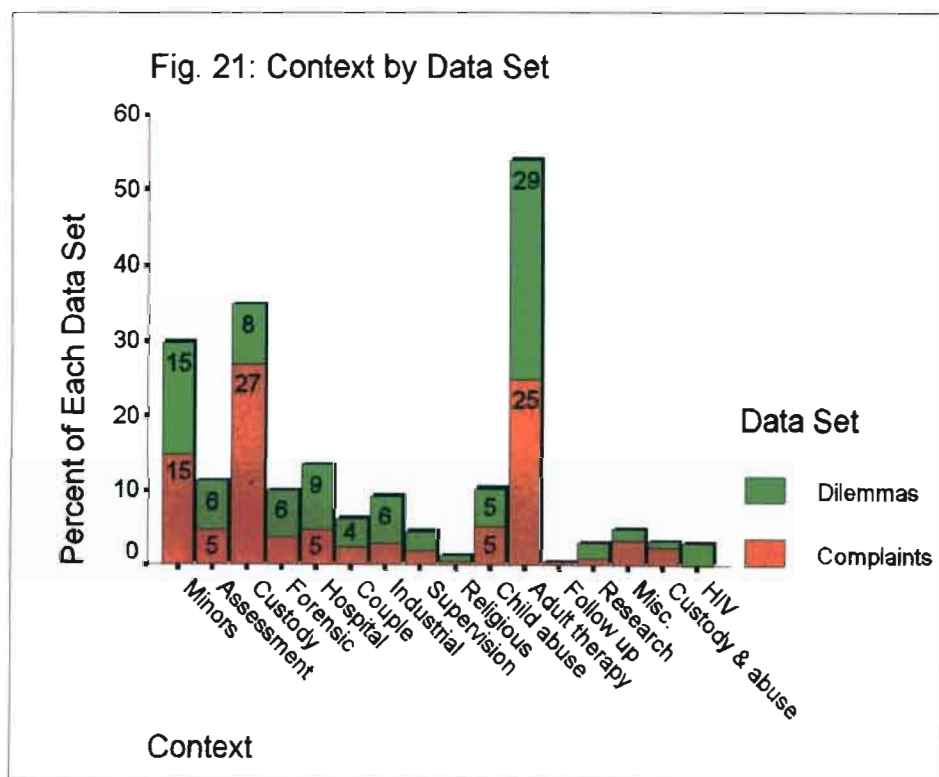
Hospital settings similarly ranked fourth as a source of Dilemmas for psychologists, despite not being ranked in the top eight practice areas. Forensic work, similarly, ranked fifth as a source of ethical Dilemmas but did not appear in the top eight fields of practice, suggesting that these two contexts generated Dilemmas disproportionate to the number of practice hours spent in such settings. Assessment work, as a context, ranked lower as a source of Dilemmas than its ranking as a common field of practice, suggesting that assessment is experienced as a relatively uncomplicated practice context in relation to its fairly high ranking (4<sup>th</sup> and 5<sup>th</sup>) as a common practice activity. Industrial work ranked equally to its status (7<sup>th</sup>) as a common field of practice activity. Finally, child abuse interventions ranked eighth as a context for Dilemmas but was not listed as one of the top eight practice activities, again suggesting that its ranking as a source of ethical dilemmas was disproportionate to its relatively low level of activity in practice. This is consistent with what is known about child abuse interventions, which are emotionally, legally, and ethically complex activities (Behnke & Kinscherff, 2002; Kalichman & Craig, 1991; MacDonald, Hill & Li, 1993; Mikkelsen, Gutheil & Emens, 1992; Nicolai & Scott, 1994; Renninger et al., 2002; Small et al., 2002; Thelen, Rodriguez & Spengelmeyer, 1994), leading to its being ranked sixth as a context associated with Complaints.

Viewing Table 18 from the right to the left, it is interesting that while lecturing was rated as the second most popular practice activity by respondents, it does not appear in the top eight contexts associated with ethical Dilemmas nor does it rank highly as a context associated with Complaints (cf. Fig. 19). This was despite several American studies that cite that up to 17% of postgraduate students reported sexual involvements with their teachers and supervisors (Bartell & Rubin, 1990; Lamb & Catanzaro, 1998; Needels, 1998). Such issues were relatively infrequent in the present data as sources of Complaints or Dilemmas, which is consistent with APA ethics committee reports (APA 1999, 2000). Counselling, while ranked third as a field of practice, did not appear in the top eight contexts of Dilemmas, and thus was experienced by psychologists as a relatively low source of dilemmas. Finally, parent and marital counselling, while ranked eighth as common practice activities, did not appear in the top eight contexts associated with dilemmas, and ranked fairly low as contexts associated with Complaints.

### 9.1.3 Comparison of Contexts: Complaints and Dilemmas

This section compares contexts associated with Complaints and Dilemmas in more detail. There were several differences between contexts from which Complaints arise and the contexts which psychologists themselves experience as ethically problematic, as shown in Fig. 21. The number of contexts reflected in Fig. 21 differs from the number of contexts depicted in Fig. 20 as smaller categories were excluded to facilitate comparison. In addition, only those categories that appeared in both data sets were compared.

The differences between the contexts for the two data sets are discussed below in descending order of size of difference. It should be noted that in Fig. 21 the actual percentages given differ from those in the two above graphs as the “no contexts” categories were excluded from the comparison. The rank ordering of the issues for each data set remained unchanged, however.



Child custody work: The largest discrepancy in context concerned child custody work, which was frequently (27%) associated with Complaints but was relatively infrequently (8%) a source of concern to psychologists themselves. Furthermore, in section 7.9.2 this activity was rated as a relatively uncommon practice activity, as shown in Table 18.

Other differences were smaller, with smaller (4% or less) discrepancies between data sets - these concerned adult psychotherapy (Complaints 25%, Dilemmas 29%), hospital settings (Complaints 5%, Dilemmas 9%) and combined child abuse and custody interventions. Research, working with HIV, and issues in industrial/organisational settings were all more prominent concerns in the Dilemmas data set than they were in the Complaints.

There was relative accord between the two data sets regarding the following settings or contexts: work with minors (15% each) adult psychological assessment (Complaints 5%, Dilemmas 6%); child abuse interventions (Complaints and Dilemmas 5% each).

A chi-square analysis was performed to investigate a possible association between Context and data set. This analysis was possible because, unlike the Dilemmas data set, the observations are independent. The results showed that the two variables were not independent ( $\chi^2=49.095$ ;  $df=15$ ;  $p<.0001$ ). Although 31 percent of the cells had expected counts less than five, the measure of association was strong (Cramer's  $V=.319$ ), suggesting that the hypothesis of independence should be rejected.

Table 19  
Comparison of Contexts in Complaints and Dilemmas

Context		Complaints	Dilemmas	Total
Minor	Count	38	34	72
	Std. Residual	-0.1	-0.1	
Assmt	Count	12	15	27
	Std. Residual	-0.5	0.6	
Cust.	Count	68	18	86
	Std. Residual	3.5	-3.6	
Forens.	Count	9	15	24
	Std. Residual	-1.0	1.0	
Hosp.	Count	12	20	32
	Std. Residual	-1.1	1.2	
Coup.	Count	6	9	15
	Std. Residual	-0.6	7	
Indust.	Count	7	15	22
	Std. Residual	-1.3	1.4	
Superv.	Count	5	6	11
	Std. Residual	-0.3	.3	
Relig.	Count	1	2	3
	Std. Residual	-0.4	0.5	
Chd.Ab	Count	13	12	25
	Std. Residual	0.0	0.0	
Adult Th	Count	63	67	130
	Std. Residual	-0.6	0.6	
Follow	Count	1	0	1
	Std. Residual	0.7	-0.7	
Res.	Count	2	5	7
	Std. Residual	-0.9	0.9	
Misc.	Count	8	4	12
	Std. Residual	0.7	-0.7	
Cust. Ab.	Count	6	2	8
	Std. Residual	0.9	-0.9	
HIV	Count	0	7	7
	Std. Residual	-1.9	2.0	
Total	Count	251	231	482
	% within	52.1%	47.9%	100.0%

Examination of the standardised residuals in Table 19 showed that custody work was disproportionately over-represented in Complaints and disproportionately under-represented in Dilemmas, despite the relatively low numbers of psychologists who report being active in custody work (cf. section 7.9.2). Complaints concerning HIV related issues were disproportionately under-represented in Complaints but were correspondingly over-represented in Dilemmas. This suggests that psychologists were concerned about issues in the management of HIV positive clients (Anderson & Barrett, 2001; Chenneville, 2000; McGuire, Nieri, Abbott, Sheridan & Fisher, 1995; Stanard & Hazler, 1995), but that such issues were not (yet) presenting themselves in Complaints.

It would be of interest in future studies to control for the number of hours worked in particular contexts, which could possibly generate an index of the most hazardous contexts per hour worked. The present study relied only on psychologists' indication of most and least frequent practices (cf. section 7.9.2) without reference to the actual number of hours involved. The type of caseload would also be of interest, as more difficult, pathological clients may generate more ethical dilemmas and risk of complaints.

## 9.2 Ethical Issue by Context

### 9.2.1 Ethical Issue by Context: Complaints

This section will elaborate on the previous section and outline in detail the specific Ethical issues associated with specific contexts in the Complaints data. While the previous section has shown which contexts were more likely to be associated with Complaints and Dilemmas, this section now goes further to examine specific ethical issues associated with particular contexts. Elaborating on the above findings, (cf. Fig. 21 and Table 19) this section presents the ethical issues that occurred in the most prominent contexts. Fig. 22 shows the ethical issues associated with particular contexts in the Complaints data set.

A chi-square analysis was performed to determine whether ethical issues in the Complaints database were disproportionately associated with particular practice contexts or settings. In an attempt to reduce the number of cells with small expected frequencies, those categories of ethical issue and context with small frequencies were deleted before the chi-square analysis was computed. Despite these attempts, 66.7% of the cells still had expected values less than five. The analysis was nevertheless undertaken to assist with interpretation of the data and should only be regarded as suggestive. The chi-square statistic was significant ( $\chi^2=109.46$ ,  $df=30$ ,  $p<.0001$ , Cramer's  $V=.32$ ). The extremely small probability level suggests that the hypothesis of independence can be rejected despite the high proportion of cells with small expected frequencies.

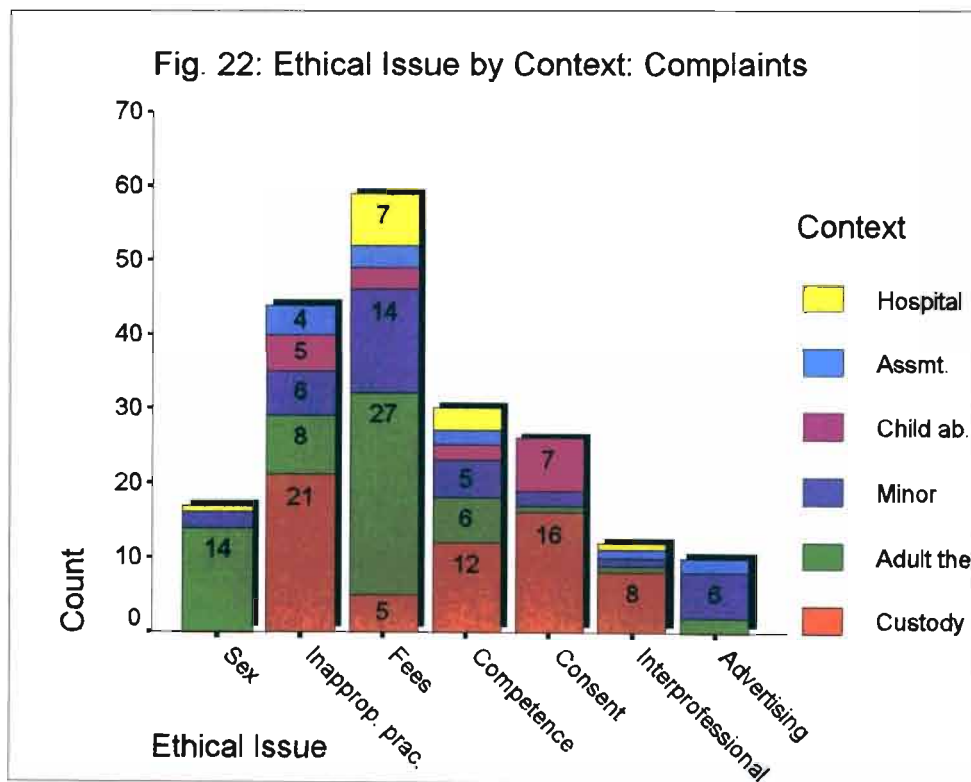


Table 20  
Ethical Issues by Context for Complaints

Ethical Issue		Context					Total	
		Ad.	Minor	Child ab.	Assmt.	Hosp.		
Sex	Count	0	14	2	0	0	1	17
	Std. Residual	-2.3	4.0	-.7	-1.2	-1.0	.0	
Inapprop.	Count	21	8	8	6	4	0	47
	Std. Residual	1.7	-1.6	-.3	.9	.7	-1.7	
Fees	Count	5	27	14	3	3	7	59
	Std. Residual	-3.1	2.3	.9	-1.0	-.3	1.9	
Compet.	Count	13	6	5	2	2	3	31
	Std. Residual	1.1	-1.0	-.3	-.5	.1	.9	
Consent	Count	16	1	2	7	0	0	26
	Std. Residual	2.8	-2.4	-1.3	3.1	-1.2	-1.2	
Interprof.	Count	8	1	1	0	1	1	12
	Std. Residual	2.2	-1.4	-.8	-1.0	.3	.3	
Advert.	Count	0	3	6	0	2	0	11
	Std. Residual	-1.8	-.1	2.7	-1.0	1.7	-.8	
Total	Count	63	60	38	18	12	12	203

The standardized residuals in table 20 show that the following contexts were disproportionately over-represented, shown in descending order in Table 21.

Table 21  
Over-represented Contexts and Ethical Issues: Complaints (Ranked)

Rank	Context and Ethical Issue	Std. residual
1	Adult therapy & Sexual issues	4
2	Child abuse & Consent issues	3.1
3	Custody & Consent issues	2.8
4	Minors & Advertising	2.7
5	Adult therapy & Fees	2.3
6	Custody work & Interprofessional	2.2
7	Hospital & Fees	1.9
8	Custody & Inapprop. prac.	1.7
8	Assessment & Fees	1.7

These patterns of over-representation are discussed in descending order below.

Complaints concerning sexual issues were most likely to arise in the context of adult therapy, which was consistent with international complaints data (APA, 2001a). Presumably the intimacy associated with adult psychotherapy is more conducive to sexual issues than any other professional context (Evans & Hearn, 1997; Gabbard, 1995; Gottlieb et al., 1995; Gutheil, 1989, 1991, 1992; Hedges et al., 1997; Lamb & Catanzaro, 1998; Pope, 1994; Sussman, 1995). Non-significant numbers of sexual Complaints arose in work with minors and hospital settings.

The significant over-representation of consent issues in child abuse contexts was consistent with the interventionist requirements of work in such settings, where psychologists are legally obliged to disclose suspected child abuse in terms of the Child Care Act (Government Gazette, 1983), leading to complaints about such disclosure from rightly or wrongly accused parties. The data suggests that one of the parties in child abuse settings was likely to complain that the evaluation, removal of the child, and/or reporting was done without their consent - (as permitted by current laws) suggesting that psychologists should take particular care to be aware of the legal provisions governing such settings and that they be familiar with appropriate guidelines (Berman, 1997; Denton, 1987; Nicolai & Scott, 1994; Renninger et al., 2002; Small et al., 2002). It is worth noting that a recent South African civil action was settled in favour of the psychologist (Natal Mercury, 1999) who reported suspected child abuse in good faith and according to the law. It is likely that in this area psychologists might attract complaints that would not be sustained as violations, and that the complaints merely reflect the distress of the parent from whom the child was removed without consent - as the law allows. This finding is especially significant in view of the relatively low number of psychologists who reported working in child abuse contexts nationally (cf. section 7.9.2). Much of the above discussion also applies to the finding that Consent issues were also disproportionately frequently associated with custody work, where Complaints were brought against psychologists on the grounds that evaluations and interventions are conducted without the consent of both parents. The adversarial context of both of the above fields of work (Marsh & Magee, 1997) clearly attracted disproportionately more complaints than all other contexts except adult therapy.

Consent issues also occurred disproportionately frequently in custody settings. In this instance the most probable pattern of complaint was linked to allegations that the psychologist evaluated the child without the consent of both parents, and the 'excluded' parent lodged the complaint. In some cases, psychologists reported on the absent parent without consent and also without actual contact - evaluation by proxy, which is unethical (APA, 1992a, item 7.02). This over-represented combination of custody and consent issues reflects the complexities of this work that combines minors, adults and many professionals at the intersection of legal and emotional domains, leading to situations latent with material for a complaint (Bow & Quinnell, 2001; Kirkland & Kirkland, 2001; Lee et al., 1998; MPS, 2001b; Scherrer et al., 2002; Schetky, 1998).

The disproportionate over-representation of work with minors and advertising suggests that most advertising Complaints were aimed at services for minors - appeals to parents to have their children seen for assessment or therapeutic services. Psychologists working with minors were significantly more likely to attract advertising Complaints. Section 8.2.1 showed that counselling, industrial and research psychologists attracted disproportionately more advertising complaints. Integration of these findings suggests that a significant number of advertising complaints were directed at psychologists whose training, nominally at least, did not equip them to perform services with children (industrial and research psychologists). The Complaints might have been motivated by concerns about the competence of psychologists (other than counselling psychologists) advertising services for minors. This suggestion would have to be confirmed by a study of adjudicated outcomes, however.

Fee Complaints were disproportionately over-represented in adult therapy, although adult therapy was the most common practice context of South African psychologists. The emotional and interpersonal complexities of the intimacy of the therapeutic relationship has already been mentioned (cf. section 8.1.1) as a possible contributing factor here. However, the disproportional over-representation of fee issues, considered against the critical findings of Landman (2001) concerning the billing practices of South African medical practitioners, strongly suggests that fees and billing issues should enjoy more intensive training and supervisory attention at basic training and CPD levels (Birnbach, 1999; Faustman, 1982; Fay, 1995; Koocher, 1994; Koocher & Keith-Spiegel, 1998; Koocher & Norcross,

1998; Lasky, 1999; Scherrer et al., 2002; Stout, Levant, Reed, & Murphy, 2001; Viljoen et al., 1999). Fees were also disproportionately associated with services provided in hospital settings, warranting detailed training attention. Fee Complaints were also disproportionately frequently associated with assessment services, supporting the comments on financial management outlined here.

Interprofessional issues arose disproportionately frequently in custody settings, where psychologists interact and ‘share’ clients with a variety of other professionals, mainly medical, legal and social work. This finding warrants more detailed study to determine the nature of the disputes producing this finding. Interprofessional courtesies and etiquette, and respect for professional boundaries would nevertheless appear to warrant more training in such adversarial settings, and more attention in training to existing guidelines (Berman & Siegel, 1982; Bow & Quinnell, 2001; Burstein, 1980; Glassman, 1998; Pope, 1990). Complaints about inappropriate practice were also disproportionately associated with custody settings, highlighting the adversarial tensions of working in this context and its high potential for attracting complaints (Kirkland & Kirkland, 2001; Lee et al., 1998; MPS, 2001b).

In contrast, the following contexts and ethical issues were significantly proportionally under-represented in Complaints:

Table 22

Under-represented Contexts and Ethical Issues: Complaints (Ranked)

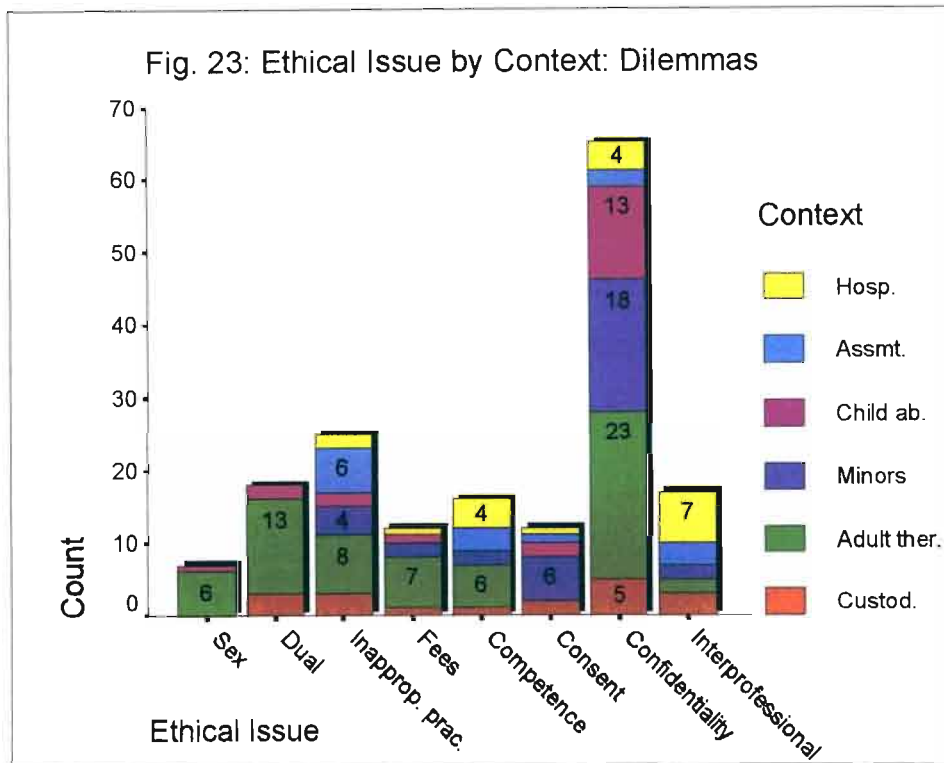
Rank	Context and Ethical Issue	Std. residual
1	Custody work & Fee issues	-3.1
2	Adult therapy & Consent issues	-2.4
3	Custody work & Sexual issues	-2.3
4	Custody work & Advertising	-1.8
5	Hospital settings & Inappropriate prac.	-1.7

The combinations shown in Table 22 were statistically infrequent, reflecting unlikely combinations of particular ethical issues with contexts. The only noteworthy under-representation was custody issues and fee issues, where anecdotal evidence suggests that fee issues arose when one of the parties in a custody dispute refused to pay the fee if the custody report was not in their favour. This clearly happened extremely infrequently, with complainants focussing primarily on consent and interprofessional issues in this context. The remaining combinations listed in Table 22 were unlikely to occur in Complaints and will not be discussed further. The same issues will, however be considered when psychologists' self-reported ethical dilemmas are reviewed by context and ethical issue, below.

In summary custody work, whether or not associated with child abuse allegations, is the context that attracted a disproportionately large number of complaints about consent, in relation to other more popular areas of practice. Furthermore, it is clear from Fig. 22 that custody work attracted Complaints concerning a greater variety of ethical issues than most other fields of practice. Custody work attracted complaints concerning consent, inappropriate practice and interprofessional issues in descending order of occurrence. This area clearly warrants fuller attention in basic and ongoing training, with a focus on the technical, legal, ethical and practice management issues involved (Bow & Quinnell, 2001; Kirkland & Kirkland, 2001; Louw & Allan, 1997).

### 9.2.2 Ethical Issue by Context: Dilemmas

As in the above section, this section presents data concerning the relationship between particular contexts and particular ethical issues, as reported by the Dilemmas respondents. The relationship of particular ethical issues to specific contexts for the Dilemmas sample is shown in Fig. 23.



A chi-square analysis was performed to determine whether Ethical Issues were associated with context. In an attempt to reduce the number of cells with small expected frequencies those categories of ethical issue and context with small frequencies were deleted before the chi-square analysis was computed. Despite these attempts, 79% of the cells still had expected values less than five. The analysis was nevertheless undertaken to assist with interpretation of the data. All conclusions should only be regarded as suggestive and extremely tentative. The chi-square statistic was significant ( $\chi^2=81.48$ ,  $df=35$ ,  $p=.00001$ , Cramer's  $V=.31$ ).

Table 23

Ethical Issue by Context: Dilemmas

		CONTEXT						
Ethical Issue		Custody	AdTher	Minors	ChAb	Assm t	Hosp	Row Total
Sex	Count	0	6	0	1	0	0	7
	Std. Residual	-0.9	2.1	-1.2	0.2	-0.8	-0.9	4.1%
Dual	Count	3	13	0	2	0	0	18
	Std. Residual	0.8	2.4	-1.9	-0.1	-1.3	-1.4	10.5%
Inapp	Count	3	8	4	2	6	2	25
	Std. Residual	0.2	-0.5	-0.4	-0.6	2.6	-0.5	14.5%
Fees	Count	1	7	2	1	0	1	12
	Std. Residual	-0.2	1.2	-0.2	-0.4	-1.0	-0.3	7.0%
Compet	Count	1	6	2	0	3	4	16
	Std. Residual	-0.5	0.0	-0.7	-1.4	1.4	1.7	9.3%
Cons	Count	2	0	6	2	1	1	12
	Std. Residual	0.7	-2.1	2.4	0.4	0.0	-0.3	7.0%
Confid	Count	5	23	18	13	2	4	65
	Std. Residual	-0.7	-0.3	1.4	1.8	-1.5	-1.2	37.8%
Inter	Count	3	2	2	0	3	7	17
	Std. Residual	0.9	-1.7	-0.7	-1.4	1.2	3.7	9.9%
Column		18	65	34	21	15	19	172
Total	Count	10.5%	37.8%	19.8%	12.2%	8.7%	11.0%	100.0%

From Table 23 it can be seen that the following ethical issues and contexts were disproportionately frequently associated. These are presented in rank order below:

Table 24

Over-represented Contexts and Ethical Issues: Complaints (Ranked)

Rank	Context and Ethical Issue	Std. residual
1	Interprofessional issues & Hospital settings	3.7
2	Inappropriate practice & Assessment	2.6
3	Consent issues & Minors	2.4
3	Dual & Adult therapy	2.4
4	Sexual issues & Adult therapy	2.1
5	Confidentiality & Child abuse	1.8
6	Competence & Hospital settings	1.7

The over-representation of interprofessional issues in hospital settings probably reflects the complexity of interdisciplinary work, which led to ethical concerns in the experience of Dilemmas respondents. Such settings probably involved situations where diverse opinions were exchanged about common clients, in addition to power and hierarchical disputes concerning authority over patient care and professional services (Berman & Siegel, 1982; Burstein, 1980; Pope, 1990). It is thus interesting to note that this was the most disproportionately over-represented combination of context and ethical issue. Specific useful recommendations for improving interprofessional relationships have been made by Kainz (2002) and Koocher and Norcross (1998).

The next most disproportionate combination was inappropriate practice with psychological assessment. This somewhat surprising finding as psychological assessment was reported as one of the least ethically problematic contexts by Dilemmas respondents in section 9.1.2. Nevertheless, a significant number of respondents expressed concern about inappropriate practice in this context. A qualitative review of the protocols suggested a concern with outdated test norms and wording in the South African context, and the use of unstandardised assessment materials, particularly in personnel

selection, all of which have been the subject of local (Huysamen, 2002; Taylor & Radford, 1986) and international academic reports and recent changes to employment legislation (Berndt, 1983; Government Gazette, 1998; Weiner, 1989). Some respondents were also concerned about the use of untrained and unregistered personnel in assessment practice.

Consent issues with minors followed, which is an unsurprising and well-documented area of ethical concern (Allan, 1997b; Bailey, 1998; Beeman & Scott, 1991; Gustafson, McNamara & Jensen, 1994; Jensen, McNamara & Gustafson, 1991; Mannheim, Sancilio, Phipps-Yonas, Brunnquell, Somers, Farseth & Ninonuevo, 2002; Milton, Koocher & Saks, 1983; Rau, 1997).

Concern about non-sexual dual relationships was disproportionately frequently associated with adult therapy, a concern not reflected in the Complaints data presented in section 9.1.1 earlier. Non-sexual dual relationships attract considerable research interest (Anderson & Kitchener, 1998; Evans & Hearn, 1997; Gottlieb, 1993; Gutheil & Gabbard, 1993; Hedges et al., 1997; Lamb & Catanzaro, 1998; Pipes, 1997; Sonne, 1994; Strasburger, Jorgenson & Sutherland, 1992), reflecting their complexity.

Also disproportionately frequently associated were sexual issues and adult therapy, also an active area of concern and publication (Hamilton & Spruill, 1999; Koocher & Keith-Spiegel, 1998; Lamb & Catanzaro, 1998; Layman & MacNamara, 1997; Pope, 1994; Samuel & Gorton, 1998; Somer & Saadon, 1999; Wiederman & Sansone, 1999).

Confidentiality issues were disproportionately frequently associated with child custody contexts, probably reflecting concerns about reporting disclosure of client material in the legal settings associated with custody disputes, and concerns about the limits of confidentiality as determined by the best interests of the child. It is clear that psychologists experience Dilemmas in such contexts (Mannarino, 1997; Mannheim et al., 2002).

Competence concerns were disproportionately associated with hospital contexts. This may be because hospital settings, as illustrated above, involve intense interprofessional work, where each professional

has concerns about locus of control in a setting where competence issues are more frankly exposed to other professionals in comparison with the relative privacy and isolation of private practice (Berman & Siegel, 1982; Burstein, 1980; Pope, 1990).

In contrast, consent and adult therapy (-2.1), non-sexual dual relationships and minors (-1.9) and interprofessional and adult therapy (-1.7) were significantly infrequently associated, as indicated by the standard residuals shown in brackets. These statistically significant patterns are discussed below in descending order of magnitude.

The disproportionately low association of consent issues with adult therapy suggests that adult therapy was the context in which psychologists experienced least concerns about consent, as such work is mostly concentrated on a single consenting adult in the relative privacy of a private practice setting.

Similarly, disproportionately low concerns about non-sexual dual relationships were associated with working with minors. This suggests that psychologists have few concerns about boundary violations of a non-sexual nature with minor clients. This is not to say that such boundary violations have not occurred (APA, 2001d). The data merely suggests that psychologists infrequently regarded this association as ethically problematic - either because they did not occur or because they were not seen as problematic when they occurred. At face value, however, it could be argued that there was relatively little concern by psychologists about boundary-blurring non sexual dual relationships with minors.

Finally, there was disproportionately low concern about interprofessional issues in the context of adult therapy, probably for the reasons given in discussion of the relationship between consent issues and adult therapy above. Adult therapy may be protected from such issues because of the relatively simple, dyadic and isolated context of private practice with a single adult client. However, taking the high ranking of confidentiality Dilemmas into account, this suggests that confidentiality dilemmas are not the primary ethical issue in the interprofessional domain. It thus seems more likely that most confidentiality dilemmas arise in the context of communications with non-professionals with whom

psychologists interact. Research cited by Baker and Patterson (1990) suggests that psychologists have strong needs to discuss their work with their own family and friends. An unpublished South African study (Peel, 1998) found that 64% of respondents actually did so, many of them mentioning clients by name. Baker and Patterson suggest that while the client’s right to privacy is primary, it may not be realistic to iterate ethical principles given the persistently high frequency of breaches reported by psychologists themselves. They go on to suggest that at the very least, psychologists should take care, when discussing their work, to protect the anonymity and dignity of their clients. In conjunction with the present data, this indicates that psychologists need to pay particular attention to confidentiality and disclosure about their clients amongst their own families and acquaintances, which warrants further research and training attention, even though this issue did not rank highly in Complaints against psychologists in the present study and internationally.

### 9.2.3 Ethical Issues by Context: Comparison of Complaints and Dilemmas

For ease of discussion, only the four most significant relationships between ethical issues and contexts from each data set will be compared and discussed. Table 25 shows the most disproportionately over-represented associations between ethical issues and contexts, ranked in descending order for each data set.

Table 25  
Over-represented Contexts and Ethical Issues: Complaints and Dilemmas (Ranked)

Rank	Complaints: Ethical Issue and Context	Dilemmas: Ethical Issues and Context
1	Sexual & Adult therapy	Interprofessional & Hospital
2	Consent & Child Abuse	Inappropriate practice & Assessment
3	Consent & Custody	Consent & Minors
4	Advertising & Minors	Non-sexual Dual & Adult therapy
5	Fees & Adult therapy	Sexual & Adult therapy
6	Interprofessional & Custody	Confidentiality & Child Abuse
7	Fees & Hospital	Competence & Hospital

Table 25 presents a stark contrast of the ethical issues and contexts over-represented in Complaints, in comparison with the ethical issues and contexts over-represented in the Dilemmas data set. It is clear from this table that the combinations of ethical issues and contexts that led to Complaints were markedly different from the combination of ethical issues and contexts that practitioners themselves experienced as Dilemmas.

Table 25 could be discussed in a variety of ways. First, the combinations that appear in both data sets are mentioned.

Sexual issues with adult therapy was a combination in both data sets, ranked first in Complaints and fifth in the Dilemmas. This combination was disproportionately over-represented in Complaints and was also over-represented in Dilemmas among practitioners themselves. This supports international data showing that most sexual violations occur with adult clients (APA, 2001d; Gutheil, 1989; Hamilton & Spruill, 1999; Lamb & Catanzaro, 1998; Pope, 1994). Psychologists themselves showed concern about non-sexual dual relationships, while this was an insignificant ethical issue in the Complaints data set. This suggests that complainants only report dual relationships as problematic when they have a sexual nature, while some authors (Strasburger et al., 1992) argue that non-sexual dual relationships usually provide the 'slippery slope' into sexual misconduct. Although the present data proves no causal links between Dilemmas and Complaints, the contrasting data sets suggest that although psychologists' concerns about non-sexual dual relationships might protect them from complaints of this nature, these concerns do not protect them from sexual misconduct *per se*, as suggested by the significant over-representation of sexual issues associated with adult therapy in Complaints.

No other combination of ethical issues and context appeared in both data bases. Working from the Complaints list (centre column of Table 25), the second most frequently associated combination was consent with child abuse. Child abuse led to concerns about confidentiality in the Dilemmas data, however, showing that Dilemmas respondents regarded the child abuse area as a context of concern. The Complaints data suggests that psychologists should be concerned about consent issues in this area

to supplement their reported concerns about confidentiality. The absence of this combination in the Dilemmas listing suggests that psychologists themselves must pay careful attention to this combination if they are to avoid attracting complaints, which also suggests that this issue warrants a training focus. Similarly, management of fee issues (in adult therapy) was also present as a combination in Complaints but absent in the Dilemmas data set. Finally, consent and custody also appeared as a combination in the Complaints data base but this combination was absent from the Dilemmas database.

The list of combinations in the Complaints column of Table 25 can be seen as a warning list of combinations that are significantly over-represented in Complaint patterns. Similarly, the list of ethical issues and contexts combined in the Dilemmas column shows the reported concerns of practitioners themselves.

This data cannot argue for a causal link between the columns of Table 25. In some cases it might be argued that a high ranking on the Dilemmas list may be protective against Complaints, suggesting that practitioners were aware of the high-risk combination and therefore addressed such issues prudently. On the other hand it could also be argued that awareness of the issue might be because such issues were seen to be associated with Complaints rather than a reflection of ethical awareness. It is suggested that all of the combinations reflect areas that psychologists should focus on in basic and ongoing professional training. The Complaints list because these combinations caused dissatisfaction to clients (and other professionals); the Dilemmas list because psychologists clearly regarded these combinations of ethical issue and context as ethically problematic.

This analysis of the ethical issues arising in Complaints, Dilemmas and contexts will be supplemented with an examination of the results of the data on training in professional ethics in the following chapter.

## Chapter 10: Results 3: Training Issues

One of the characteristics of most professions is specialised intensive training. Professional ethics was described as an important component of professional psychology training internationally in chapter 4. It will be a compulsory component of CPD for South African psychologists (Professional Board, 2002). For this reason, an examination of training issues in professional ethics in South African psychology would be relevant to the Complaints and Dilemmas data discussed in the previous chapters. Firstly, it seemed relevant to determine how psychologists rated their ethics training, and to establish whether this had any relationship to elements of the Complaint and Dilemma patterns reviewed in the previous sections. Secondly, such patterns may also be relevant to reports of ethics training offered by universities themselves.

It was hoped that an analysis of this training data might inform future ethics training in two ways. Firstly, knowing the major patterns of public complaints against psychologists might allow ethics training in professional psychology to be more focussed on patterns of actual public complaints and empirically reported dilemmas of psychologists themselves. Secondly, particular 'high risk' practitioner demographics and vulnerabilities might be highlighted in a preventative manner. Such information might also be useful in the focussed design of mandatory CPD courses in professional ethics, in the hope that more focussed basic and CPD ethics training might contribute to better ethical standards, more ethical service to consumers of psychological services, and hopefully fewer public complaints against psychologists.

This final major section of the data reflects the results obtained on two data sets. Firstly, as described in section 7.3, a questionnaire was sent to all South African training universities requesting information on ethics training in professional psychology masters and internship training (cf. Appendix B). The return rate was 73%. The data represented fourteen clinical, eight counselling, three educational, and one research masters programme. No questionnaires on ethics training in industrial psychology training were received, with hindsight probably due to the inadvertent mailing of questionnaires only to Psychology departments and not to Business or Commerce faculties where

some industrial psychology programmes are offered

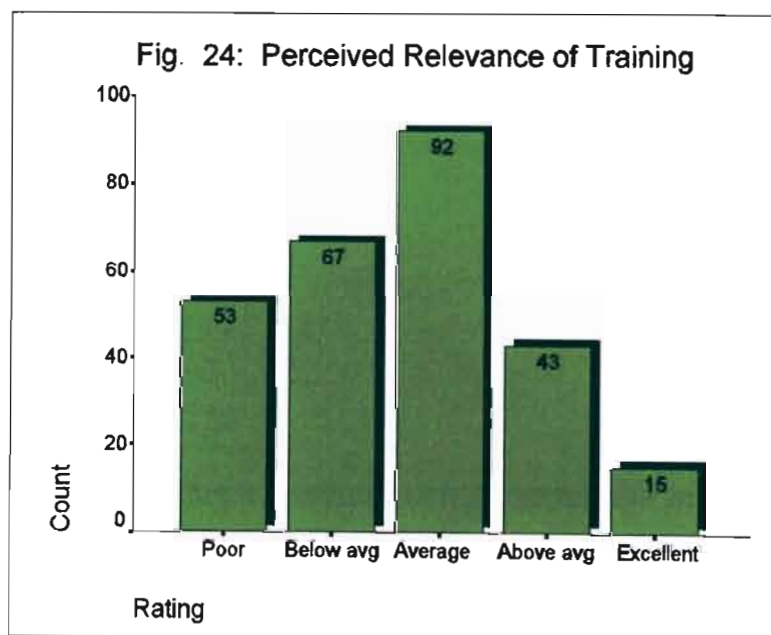
Secondly, Dilemmas respondents were asked to rate the quality and quantity of their ethics training in section 2 (Appendix A, items 2.1-2.6) of the questionnaire sent to registered psychologists.

### 10.1 Ratings of Ethics Training by Dilemmas Respondents

This section details ratings by Dilemmas respondents of various aspects of their ethics training.

#### 10.1.1 Perceived Quality and Relevance of Ethics Training

The perceived quality and relevance of ethics training was measured on two 5-point Likert-type questions. The scores on these scales covaried strongly ( $r=.87$ ), and the scores on the two scales were summed to form a reliable measure of training quality (Cronbach  $\alpha=.93$ ), which had a range from 0 (poor quality) to 10 (high quality). The mean rating of ethics training on this 10 point scale was 3.04 which suggests that the mean quality of ethics training at South African universities was perceived as below average.



Perceptions of quantity of time spent on ethics training during formal university training was measured by a single item that required the respondents to indicate whether or not they thought sufficient time was allocated to ethics training. 74.1 % of respondents reported that not enough time was spent on ethics training, while 25.9 % felt that it was sufficient. The university survey showed that an average of 9.8 hours was spent on ethics training, which most respondents thus regarded as insufficient.

Respondents were asked to rate the perceived practical relevance of their ethics training. More respondents rated the relevance of their ethics training as poor or below average than above average or excellent (cf. Fig. 24). This suggests that efforts must be made to link ethics training more directly to the experiences which practitioners are likely to face in their professional lives after training. It is hoped that data such as that derived from the earlier chapters (8 & 9) of the present study might improve the perceived relevance of ethics training in psychology to actual professional practice by basing training on actual Complaint patterns and psychologists' own Dilemmas.

Respondents were also asked to indicate whether they had sought subsequent ethical training since qualifying. The category subsequent training was scored positively if respondents indicated that they had undertaken any form of ethics training after completion of their training and registering, other than merely reading. Some form of subsequent ethics training was reportedly sought by 30.6% of respondents. This is unsurprising, given the absence of formal CPD requirements at the time of this study. It is possible that the vagueness of the definition of subsequent training in the questionnaire may account for this result, in addition to the fact that this question may have been answered in a socially desirable direction by respondents, inflating this figure to an unknown extent.

Respondents were also asked to indicate whether they would enrol for further ethics training in the future if it was convenient for them. 68.2% indicated they would seek further ethics training, while 31.8% indicated they would not enrol for further ethics training if it became available to them. Although it is possible that most respondents indicated they would seek future training because they also indicated that they had not already sought subsequent training, a chi-square test showed no

association between subsequent training and future training, as discussed further below. It should be noted that this survey was conducted before the introduction of mandatory CPD (Professional Board, 2002) - which would certainly increase those seeking future training.

### 10.1.2 Ethics Training Quality and Other Measures of Ethics Training

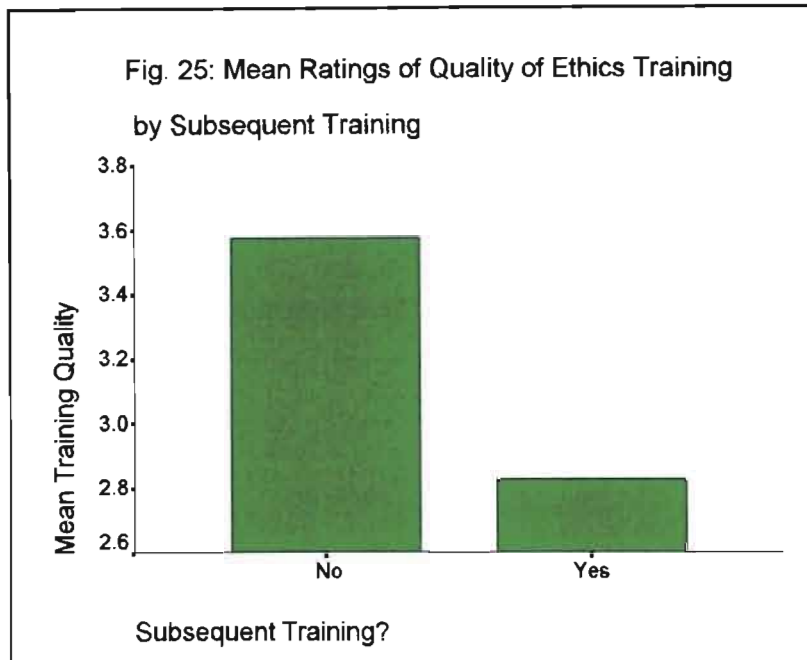
Some interrelationships between measures of ethics training are explored below.

A series of independent samples *t*-tests were conducted to determine whether perceptions of training quality were related to training quantity, subsequent training, and further training. All three results were significant.

Respondents who indicated that enough time (training quantity) was allocated to ethics training during formal training ( $n=66$ ,  $M=5.5$ ) evaluated their training to be of higher quality than respondents who indicated that not enough time was spent on ethics training ( $n=192$ ,  $M=2.3$ ) ( $t=-12.20$ ,  $df=256$ ,  $p<.0001$ ).

Respondents who had sought subsequent training ( $n=183$ ,  $M=2.99$ ) evaluated their formal ethics training to be of poor quality in comparison with respondents who had not sought subsequent training ( $n=81$ ,  $M=3.74$ ) ( $t=-2.52$ ,  $df=262$ ,  $p<.012$ ). This is illustrated in Fig. 25.

Similarly, respondents who indicated that they would enrol for further ethics training ( $n=81$ ,  $M=2.51$ ) evaluated their quality of initial ethics training less positively than respondents who indicated that they would not enrol for further training ( $n=178$ ,  $M=3.61$ ) ( $t=3.78$ ,  $df=258$ ,  $p<.0001$ ). These results, taken together, suggest that post-basic training in ethics was sought mainly by those who rated their initial ethics training as low in quantity and relevance.



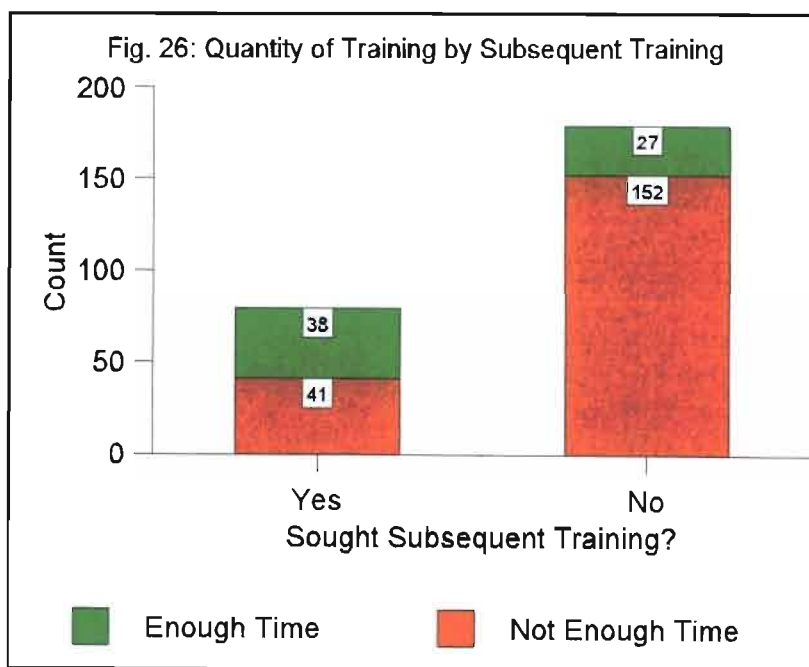
Chi-square tests were performed to determine whether the variables Subsequent Training and Further Training were associated. There was no association between Subsequent Training and Further Training. Respondents' indications of whether not they had sought subsequent training were unrelated to their intentions to enrol for further training.

### 10.1.3 Quantity of Ethics Training and Subsequent Ethics Training

Respondents were asked to indicate 'yes' or 'no' to a single question asking whether enough time had been allocated to ethics training in their basic training. Fig. 26 shows that most respondents who had not sought subsequent training nevertheless felt that insufficient time had been spent on their basic ethics training.

The association between perceived training quantity and subsequent training was significant ( $\chi^2=31.7$ ,  $df=1$ ,  $p<.00001$ , Cramer's  $V=.35$ ). The standardized residuals reported in the cross tabulation between

training quantity and subsequent training in Table 26 indicate that proportionally more respondents who felt that they had enough ethics training had sought subsequent ethics training. Disproportionately few respondents who indicated that enough time was spent on ethics training indicated that they had not sought subsequent training. Similarly, significantly few respondents who thought that not enough time was spent on ethics training indicated that they had sought subsequent training. The question thus arises as to why those who rated the quantity of their initial training as inadequate did not seek subsequent training. This cannot be answered by the present data, but some speculation is possible.



Additional training in ethics may have been financially or geographically inaccessible to these respondents, as there was no clear culture of CPD before its formal inception (Professional Board, 2002). Further, the earlier finding that respondents who were dissatisfied with their training quantity

also rated training quality poorly may suggest that those dissatisfied with training quality and quantity had also become sceptical about the value and relevance of future ethics training, and did thus not seek it. This is supported by data reported earlier (cf. section 10.1.2) that respondents who rated their basic ethics training quality as poor were more likely also to have sought subsequent training.

Table 26

Relationship between Quantity of Ethics Training and Subsequent Ethics Training

Training Quantity		Subsequent Training?		
		Yes	No	Row Total
Not Enough	Count	41	152	193
	Std. Residual	-2.4	1.6	74.8%
Enough	Count	38	27	65
	Std. Residual	4.1	-2.7	25.2%
Column		79	179	258
Total	Count	30.6%	69.4%	100.0%

#### 10.1.4 Quantity of Ethics Training and Future Ethics Training

Fig. 27 shows that of those who would seek future ethics training if it were available, proportionally more felt that insufficient time had been allocated to their basic ethics training. This is not a satisfactory result however, as it implies that ethics training is seen as a 'once-off' learning, rather than an evolving domain requiring updating, as would be the case in other spheres of professional practice. It is unfortunate that the present data provides no comparison with ratings of other aspects of professional training (e.g., psychodiagnostics, psychotherapy or psychopathology) to determine whether these patterns are unique to ethics or generic to professional training and practice generally. The figure shows that most respondents would seek future ethics training. Of those who would,

however, the majority reported that not enough time was spent on basic training, as supported by the standardised residuals in Table 27.

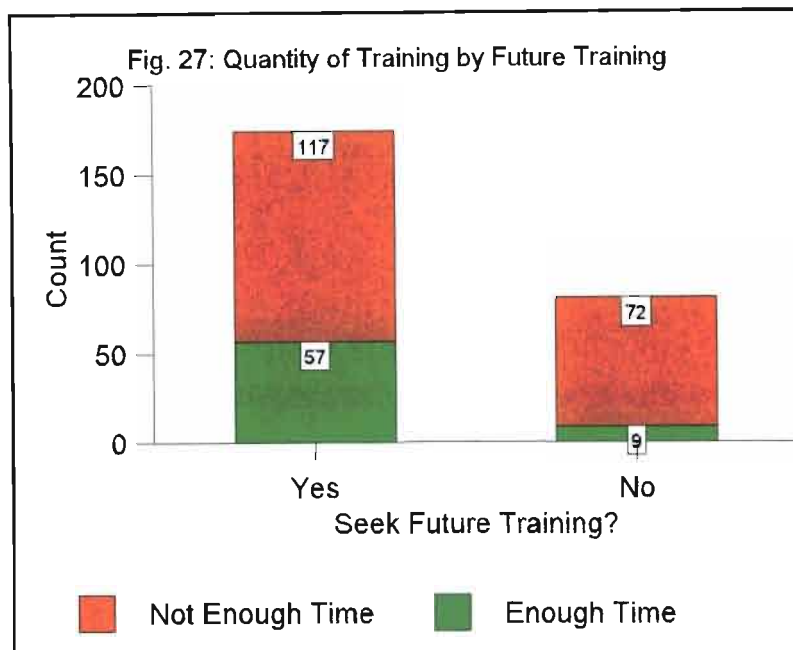


Table 27 shows that the association between perceived training quantity and further training was also significant ( $\chi^2=13.5$ ,  $df=1$ ,  $p<.00024$ , Cramer's  $V=.23$ ). The standardized residuals reported in the cross tabulation between training quantity and further training show that proportionally fewer respondents who indicated that enough time was spent on ethics training also indicated that they would not seek future training. Respondents who thought that enough time was spent on their initial ethics training were likely to seek future ethics training.

Table 27

## Perceived Quantity of Ethics Training and Future Training

Future Training		Training Quantity		Row Total
		Not Enough	Enough	
Yes	Count	117	57	174
	Std. Residual	-1.1	1.8	68.2%
No	Count	72	9	81
	Std. Residual	1.5	-2.6	31.8%
Column	Count	189	66	255
Total		74.1%	25.9%	100.0%

In summary, these analyses suggest that most psychologists had not sought additional post-basic training in professional ethics. Disproportionately many of those who had sought subsequent ethics training felt that sufficient time was allocated to ethics training in their basic training ( $\bar{X}$ =9.8 hours, according to universities), or perceived the quality of their original ethics training to be poor. An unpublished study by Mommsen (1990) found that on average 16 hours was spent on ethics training in South African psychology training, but this included legal and forensic issues. American data (Vanek, 1990) suggests that on average ethics training comprised 20 hours of work.

The disproportionate number of those who sought subsequent training and who also rated their initial training quality as high suggests that good basic ethics training might stimulate the need for, and interest in, additional training. Respondents nevertheless mainly sought ongoing or future ethics training as a function of unsatisfactory or insufficient basic training, rather than as a commitment to their ongoing professional development. Despite this, the data suggests that the majority of respondents would seek future ethics training. While social desirability might inflate this figure somewhat, this report is encouraging.

### 10.1.5 Relationships between Measures of Ethics Training and Age and Experience of Respondents

It seemed possible that ratings of ethics training and the age and years of experience of psychologists were correlated, and this possibility is explored below.

Correlation coefficients indicated that the overall rating of the perceived quality of ethics training at university was unrelated to both age ( $\alpha=-.003$ ) and experience ( $\alpha=-.067$ ). Independent samples *t*-tests were conducted to determine whether age and experience were related to training quantity, subsequent training and further training.

Subsequent training was related both to age ( $t=4.88$ ,  $df=119.13$ ,  $p<.0001$ )<sup>1</sup> and experience ( $t=4.96$ ,  $df=121.47$ ,  $p<.0001$ ). Respondents who indicated that they had not sought subsequent training were older ( $n=81$ ,  $M=49.81$ ) than those who had ( $n=184$ ,  $M=41.34$ ); and respondents who indicated that they had not sought subsequent training were more experienced ( $n=81$ ,  $M=14.89$ ) than those who had ( $n=184$ ,  $M=9.04$ ). Thus, older more experienced psychologists were less likely to have received subsequent training and were less likely to seek future training in professional ethics. Data presented earlier, (section 8.3) though not significant, suggested that psychologists with between 5 and 15 years of experience attracted slightly more Complaints than those with less than 5 or more than 15 years of experience. These are likely to be the busiest years of professional life. Complaints are thus possibly more likely to arise as a statistical probability rather than as a function of lower interest in ethics training. Nevertheless, the low expressed interest in seeking further ethics training in the 5-15 years of experience age range may have been a contributory factor. It would be of value to track complaint rates in this experience range after the introduction of CPD, which stipulates compulsory ethics updates (Professional Board, 2002).

The relationship between quantity of training and age was the only other test to reach significance. Older respondents ( $n=65$ ,  $M=49.92$ ) indicated that enough time was spent on ethics in their formal training, whereas younger ( $n=194$ ,  $M=42.85$ ) respondents did not think that enough time was

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<sup>1</sup>Fractional *df* calculated by SPSS to test for differences between means when samples have unequal variance.

allocated ( $t=-2.35$ ,  $df=257$ ,  $p<.02$ ). From this it would appear that older, more experienced psychologists were less likely to feel dissatisfied with their ethics training and were accordingly less likely to enrol for additional ethics training. It is difficult to interpret this finding. It is possible that younger psychologists are less confident about themselves generally and thus sought more training, while older psychologists were more confident, based on their experience and initial training. Younger psychologists might be more aware of consumer rights and fear litigation. No longitudinal data was available to suggest whether basic ethics training has increased or decreased in quantity or quality over the years to account for this difference. Nevertheless, older psychologists had no reason to be as reluctant to seek ethics training as reported, since data presented earlier in section 8.3 suggested that more years of experience were not protective against the likelihood of attracting a complaint.

#### 10.1.6 Relationship between Measures of Ethics Training and University of Training

##### 10.1.6.1 Ratings of Quality of Training by University of Training

A one-way ANOVA was conducted to determine whether respondents from different universities rated the quality of their ethics training differently. Although there was a wide range in mean ratings across the different universities, due to the presence of error variance, the  $F$ -statistic was not significant ( $F(16, 249)=1.64$ ,  $p<.059$ ), but the results are suggestive when presented in descending order as in Table 28 below<sup>2</sup>. The maximum possible score was 10.

Chi-square tests were employed to determine whether university of training was associated with training quantity, subsequent training and future training. University of training was not associated with either subsequent training ( $\chi^2=18.86$ ,  $df=16$ ,  $p<.28$ ) or future training ( $\chi^2=9.54$ ,  $df=16$ ,  $p<.89$ ). University of training did thus not predict whether graduates were likely or not to have sought subsequent training or would seek future ethics training.

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<sup>2</sup> This data was not from the Complaints data set and is thus shown uncoded.

Table 28

ANOVA: Rating of Quality of Training of Universities

Mean Rating of Training Quality	University
5.2000	UNP
5.0000	UK
4.0000	USA
3.8333	Rho
3.7857	Potch
3.5484	Stell
3.4524	UPRET
3.2500	UDW
3.0909	UNISA
3.0588	UCT
2.9091	UPE
2.7500	UND
2.7059	Wits
2.6500	OFS
2.5938	RAU
2.0000	Medun
1.0000	UWC

In an attempt to see if this rating of the quality of ethics training was related to the ratio of Complaints for each university, this ranking (Table 28) was correlated with the Complaints ratio for each university shown earlier in Table 4. A negative correlation was expected, as the university with the highest complaints ratio was predicted to correlate with the lowest quality of training. A

Spearman's Rho showed a weak negative correlation ( $r_s = -.291$ ). Because this was based on a small sample ( $N=16$ ) the  $p$ -value did not reach significance. Nevertheless, this suggests that there was a weak negative correlation between each university's Complaints ratio and quality of ethics training. This should be pursued in future research with more reliable and explicit measures of the quality of training.

### 10.1.6.2 Quantity of Ethics Training by University of Training

There was considerable variation in the rated adequacy of time spent on ethics training at various universities. Ratings of quantity of training did vary across the universities ( $\chi^2=30.96$ ,  $df=16$ ,  $p<.014$ , Cramer's  $V=.35$ ), as shown in Fig. 28 and Table 29.

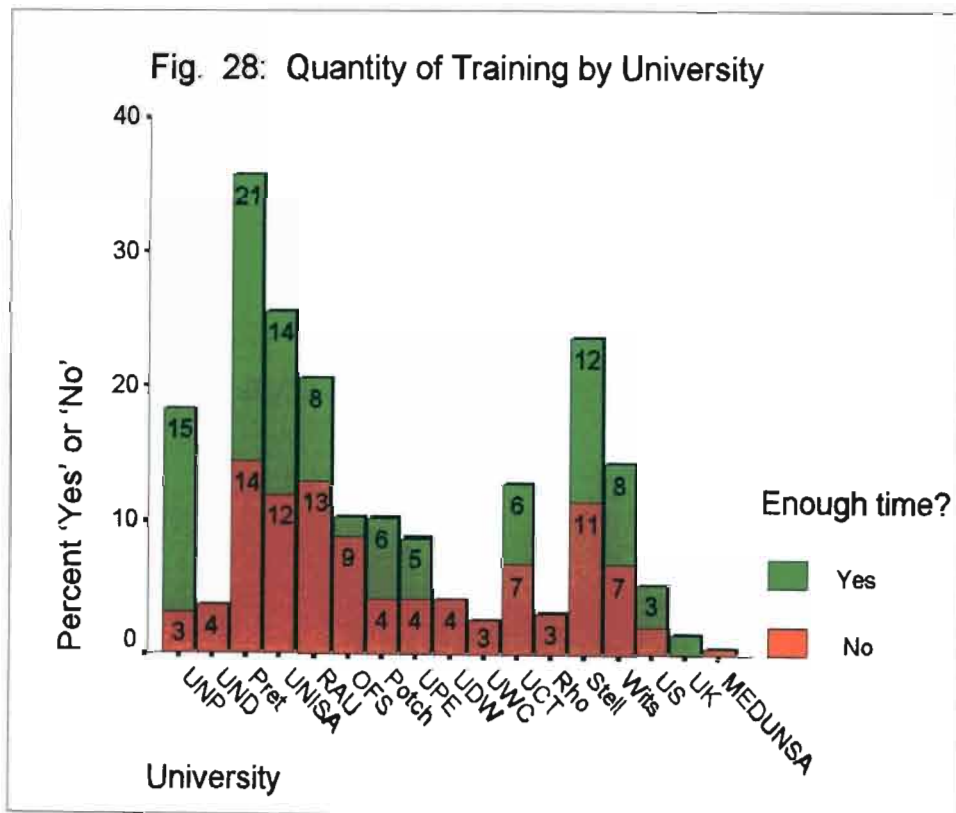


Table 29  
Quantity of Training by University of Training

University		Quantity of Training		Row Total
		Not Enough	Enough	
UNP	Count	6	10	16
	Std. Residual resrrer	-1.7	2.9	6.2%
J.P.D	Count	0.8	-1.3	2.7%
	Std. Residual	-0.6	1.0	16.2%
Pret	Count	23	9	32
	Std. Residual	-0.2	0.3	12.3%
UNISA	Count	25	5	30
	Std. Residual	0.6	-0.9	11.5%
OFS	Count	17	1	18
	Std. Residual	1.0	-1.7	6.9%
Potch	Count	8	4	12
	Std. Residual	-0.3	0.5	4.6%
UPE	Count	8	3	11
	Std. Residual	-0.1	0.1	4.2%
UDW	Count	8	0	8
	Std. Residual	0.8	-1.4	3.1%
UWC	Count	5	0	5
	Std. Residual	0.7	-1.1	1.9%
UCT	Count	13	4	17
	Std. Residual	0.1	-0.2	6.5%
Rho	Count	6	0	6
	Std. Residual	0.7	-1.2	2.3%
Stell	Count	22	8	30
	Std. Residual	-0.1	0.1	11.5%
Wits	Count	13	5	18
	Std. Residual	-0.1	0.2	6.9%
USA	Count	4	2	6
	Std. Residual	-0.2	0.4	2.3%
UK	Count	0	1	1
	Std. Residual	-0.9	1.5	4%
Medun	Count	1	0	1
	Std. Residual	0.3	-0.5	.4%
Column		194	66	260
Total		74.6%	25.4%	100.0%

Fig. 28 shows that there were large discrepancies between the rated adequacy of time spent on ethics training at different universities. Proportionally more graduates from Pretoria, UNP, UNISA and Stellenbosch reported that enough time had been spent on ethics training, which was not the case for all other universities, excluding graduates from the UK and the USA who also felt enough time had been allocated. In contrast, graduates at all the other universities felt that not enough time had been allocated to ethics training. From Fig. 28 it can also be seen that proportionally more respondents from specific universities felt that not enough time was allocated to ethics training than respondents who felt that enough time was spent on ethics training. The standardized residuals in Table 29 show that UNP graduates disproportionately reported that enough time had been allocated to ethics training and disproportionately few UNP graduates felt that not enough time had been allocated. A social desirability factor may account for this in that respondents were aware that the survey emanated from UNP. A significantly disproportionate number of graduates from OFS reported that not enough time had been allocated to ethics training, which may be consistent with independent findings that OFS graduates were dissatisfied with the practice management aspects of their professional training (Viljoen et al., 1999).

Dissatisfaction with time spent on ethics training cannot by itself be an index of quality of ethics training, however, and must for the present be noted only as dissatisfaction with time spent, independent of quality of ethics training. A poor quality course might attract a rating of 'enough' time spent simply because students resist further time spent on poor quality inputs.

#### 10.1.7 Ratings of Ethics Training and Registration Category

A comparison of means of ethics training ratings (Table 30) was conducted by means of a one-way ANOVA to determine whether respondents in different categories of registration rated the quality of their ethics training differently. Although the  $F$ -statistic was not significant ( $F(3, 241)=1.80, p<.15$ ), the differences between the means was as expected, and the results were thus suggestive. The table suggests that research psychologists rated their quality of ethics training lowest. Educational,

clinical and counselling psychologists showed ascending ratings of their quality of training. Counselling psychologists had the highest ratings of their quality of ethics training by a small margin. An early Canadian study (Pettifor & Pitcher, 1982) found that clinical psychologists were most likely to have received formal ethics training.

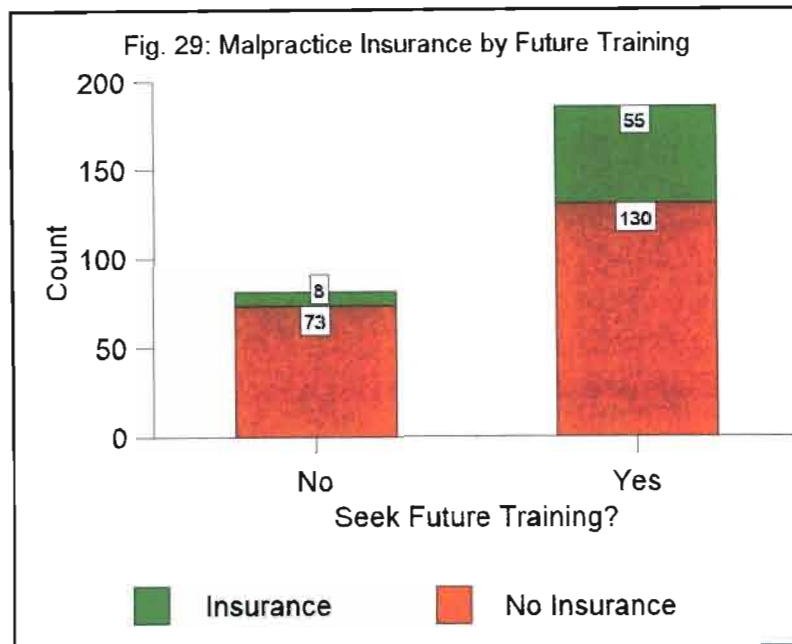
Table 30  
Mean Ratings of Quality of Ethics Training by Registration Category

Mean Quality	Registration Category
3.2623	Counselling
3.2200	Clinical
3.2029	Educational
1.8667	Research

In addition, chi-square tests were employed to determine whether registration category was associated with scores on training quantity, subsequent training and future training. None of the chi-square values reached significance. A study of graduates from OFS found that educational psychologists were less dissatisfied with their general professional preparation than clinical or counselling psychologists (Viljoen et al., 1999).

#### 10.1.8 Ratings of Ethics Training and Malpractice Insurance

Fig. 29 shows that the majority of respondents did not have malpractice insurance. The likelihood of malpractice insurance appeared to increase with subsequent training, as proportionally more psychologists who had sought subsequent training had malpractice insurance than those who had not sought subsequent training.



An independent samples *t*-test was conducted to determine whether there was a relationship between ratings of the quality of ethics training and whether or not respondents had malpractice insurance. It was hypothesised that good ethics training would also be associated with the need for malpractice insurance. This hypothesis was not supported as the test was not significant ( $t=1.54, df=264, p<.32$ ). A set of three chi-square tests was conducted to determine whether having malpractice insurance was associated with training quantity, subsequent training and future training. Only the chi-square statistic for the association between malpractice insurance and willingness to seek future training reached significance ( $\chi^2=12.28, df=1, p<.0005, \text{Cramer's } V=.21$ ) as shown in Table 31.

This suggests that those psychologists willing to seek future ethics training were disproportionately more likely to have malpractice insurance, as shown in Fig. 29 and Table 31, while disproportionately few respondents not interested in future training had malpractice insurance. This suggests that the perceived need for further ethics training and the need for malpractice insurance might have been linked by some common factor other than training quality and quantity. It is hypothesised that this factor might be the motivation to avoid the risks of malpractice litigation. The BPS (1995b) states clearly that all Chartered psychologists have a moral obligation to protect their

clients with malpractice insurance.

Table 31  
Malpractice Insurance and Future Ethics Training

Insurance		Future Training?		Row Total
		No	Yes	
No	Count	73	130	203
	Std. Residual	1.4	-.9	76.3
Yes	Count	8	55	63
	Std. Residual	-2.6	1.7	23.7%
Column		81	185	266
Total		30.5%	69.5%	100.0%

## 10.2 Survey of Ethics Training by University

While some data from the University training survey was integrated in the above sections, some data remains to be presented independently, as follows below.

### 10.2.1 Ethics Training as Integral

All the Universities who responded (15 of 16) indicated that they saw ethics training as integral to professional training in psychology in all of their professional courses ( $N=26$ ). An early Canadian survey found that 15% of professional training universities sampled did not believe ethics teaching was needed (Pettifor & Pitcher, 1982), while American data suggests that by 1979 only 67% of training programmes had some ethics content (Hall, 1987).

### 10.2.2 Hours Allocated to Ethics Training

An average of 9.84 hours ( $SD=6.21$ ) was spent teaching professional ethics, with a reported range

from 30 hours to 3 hours.

Qualitative comments on some of the questionnaires ( $n=6$ ) suggested that the figures for this section might have been confounded by the fact that the questionnaire did not adequately distinguish formal teaching from less formal teaching as might occur in case presentations, supervision, and clinical rounds. Future research should make this distinction more clearly.

A Canadian survey (Pettifor & Pitcher, 1982) showed that ethics training courses typically ran for two to three hours per week for one semester - estimated by the present author as 25-30 hours. An unpublished study by Mommsen (1990) found that on average 16 hours was spent on ethics in South African psychology training, but this included legal and forensic issues. American data from Vanek (1990) stated that on average ethics training comprised 20 hours of work.

### 10.2.3 Ethics Training Format

The majority of professional courses ( $n=20$ ) reported teaching ethics in a case supervision format. Case study methods (i.e. using published or local case examples) were used by 19 respondents. Combinations of readings with workshops was the next most commonly used ( $n=17$ ), followed by combinations of readings with lectures ( $n=14$ ). Most programmes ( $n=18$ ) used a combination of 3 or more teaching modalities. A Canadian study reported no consensus on the format of ethics training. Even departments who believed ethics should be taught did not necessarily believe that ethics should be taught formally and examined: "Forty-four percent of the programs provided only informal teaching or none at all" (Pettifor & Pitcher, 1982, p. 240).

### 10.2.4 Recommended Ethics Readings

The most widely used texts are rank ordered in Table 32 below:

Table 32  
Most Frequently Used Ethics References (Ranked descending)

Rank	Author	Date	No. of Users*
1	Steere & Wassenaar	1985	12
2	Steere	1984	9
3	SAMDC Regs.	1992	8
4	APA Code	Not provided	3
	PASA Code	1987	3
5	SAMDC Regs.	1994	2
	Spitzer	Not provided	2
6	APA Code	1981**	1
	Lakin	1988	1
	SAMDC Regs.	1974	1
	Snyder & Forsyth	Not provided	1
	Wolman	1963	1

\* Some respondents cited more than one text and one stated they were "looking for" a suitable text.

\*\*Incorrect date

Table 32 shows that there was little uniformity in the readings used for teaching professional ethics. While this may be seen as a desirable expression of academic freedom, it is argued here that this reflects the absence of any recognised text in South African professional ethics (Wassenaar, 1998a, 1988b). Furthermore, the data shows that many texts in use were more than ten years old at the time of the survey.

#### 10.2.5 Reference to SAMDC/HPCSA Regulations

The SAMDC (now HPCSA) regulations were used in ethics teaching by 23 (88%) respondents. While no respondents said that they did not refer to the SAMDC regulations, this poorly designed question was unlikely to be answered as such because of social desirability in the response set. When the SAMDC regulations appeared in a supplied reading list, however, the answer was coded as

affirmative. In future research, current students and recent graduates should be asked to cite the sources which were referred to in their ethics training, which could be correlated with university reports of sources used, which might reveal a social desirability bias in the present reports of training universities.

#### 10.2.6 Version of the SAMDC Regulations

Respondents were asked to indicate which version of the SAMDC regulations for psychologists their ethics training referred to. Although this is a statutory guide rather than an ethics code, knowing current statutes is arguably integral to ethics training and the currency of the reference would index currency of teaching materials. Fewer than 24% of universities referred in their training to the then most current SAMDC regulation. Nine respondents (34%) did not provide information on SAMDC regulations. This result was worse than data from a more recent American survey where it was found that only slightly more than half of their survey respondents referred to current statutes and regulations in their ethics training programmes (Samuel & Gorton, 1998), which raises serious questions about their graduates' ability to avoid misconduct. Given the earlier finding that a disproportionate number of Complaints arise at the interface of legal and ethical domains, this requires detailed attention in future training.

#### 10.2.7 Method of Exposure to SAMDC Regulations

Ten respondents (38%) used both a lecture and a handout to make students aware of the SAMDC regulations. Of those using only one modality, 7 (27%) used the lecture only while 7 (27%) used a handout only. Two respondents (8%) did not answer this question.

#### 10.2.8 Ratings of Importance of Ethics Training

Universities were asked to rate the importance of ethics training in the professional psychology curriculum. Again, poor questionnaire design allowed socially desirable answers to be given. No

universities rated ethics as less than ‘important’ (38%), while the remainder (62%) rated ethics training as ‘extremely important’.

### 10.2.9 Motives for Ethics Training

Respondents were given a list of seven possible reasons for ethics training, and were asked to rate these on a 7-point scale with 1 being the most important and 7 the least important reasons for ethics training. Responses are ranked in Table 33:

Table 33  
University Motives for Ethics Training (Rank ordered)

Rank	Motivation	Mean	SD	“Expert” rank
1	To protect the client	1.92	0.99	1
2	Safeguard human rights	2.61	1.77	2
3	Enhance ethics awareness	3.61	1.57	3
4	Protect the practitioner	3.65	1.29	5
5	Facilitate problem solving	4.50	1.64	4
6	Maintain professional image	5.15	1.40	6
7	Avoid prosecution	6.53	0.69	7

Table 33 makes it clear that universities ranked protection of the client as a primary motivation for teaching professional ethics, compatible with human rights, ranked second. Concerns for the protection of the practitioner appeared only fourth and lower on the list. The column marked “Experts” reflects the ranking given by a sample of ethics experts ( $N=4$ ) to these motives as a reason for ethics training. (“Experts” were persons other than the researcher who had either served on a professional ethics committee or Board, or who had conducted and published research on ethical dilemmas).

It was decided to explore whether a relationship existed between aspects of this university survey data and aspects of the Complaints data set. The data presented earlier in section 7.4 (Fig. 1, Table

2) showed that clinical psychologists were significantly over-represented in the Complaints database. As an exploratory exercise, information concerning clinical psychology training programmes was related to the Complaints data by registration category and by university. Such an analysis might determine whether any items on the training survey correlated with a high rate of Complaints for clinical psychologists from a particular university of origin. The aim of the analysis was to determine whether clinical psychology training universities were related to an objective index (cf. section 7.8 (Fig. 3, Table 4) of Complaint ratios for each training university. The index of ethical practice was computed as the proportion of clinical psychology graduates from a particular clinical training university who had attracted Complaints (number of Complaints per university/number of graduates per university). This procedure was similar to the Complaints ratios presented in Tables 2 and 4 earlier. This index of ethical practice was slightly positively skewed, and the indices ranged from .03 (low rate of Complaints) to .29 (higher rate of Complaints).

This index was related to the motives given for teaching ethics in clinical psychology programmes. Reliability analysis suggested that only 4 of the 7 motives for ethics training were intercorrelated. Items 1, 5, 6 and 7 were summed to form an index of motives. The Cronbach alpha coefficient for this index was 0.59, suggesting that universities who scored these as primary motives for teaching ethics also had lower rates of Complaints against their clinical psychology graduates. Thus, in contrast to the ranking of these motives for ethics teaching, the following motives, in rank order, were most associated with low rates of complaints against clinical psychologists:

- To protect the client (Item 1)
- To facilitate problem solving (Item 5)
- To maintain a professional image (Item 6)
- To avoid prosecution (Item 7)

While item 1 was also ranked first by most universities as a motive, the relatively high ranking of items 5,6, and 7 is surprising as items 5 and 6 were ranked by universities as the least important motives for teaching ethics. Item 5 suggests that ethics has a pragmatic value to practitioners in

problem solving - and is consistent with the slightly higher ranking given to this motive by the 'experts' than by universities themselves. Items 6 and 7 are more surprising as they ranked lowest in motives for ethics training by universities themselves and amongst the four 'experts'. However, it can be argued that despite this, a willingness to maintain a good professional image, and the 'risk-management' motive of wishing to avoid prosecution act as real incentives to psychologists to behave in an ethical manner. This data supports the view that ethical rules may often be obeyed for reasons that are not in themselves ethical! (Bernet, 1995; Dyck, 1993). The four items represent a balance between the best interests of the client (protect the client, ethical problem solving) and professional self interest (professional image, avoid prosecution) which may represent a pragmatic rationale for thorough ethics training. These results suggest that universities might consider explicitly adopting items 1,5,6,and 7 as primary motives for ethics teaching, as universities doing so produced clinical graduates who attracted significantly fewer Complaints.

Bivariate correlations were generated to determine whether the set of self-described ethics training variables from the survey were related to the index of ethical practice. None of the correlations were significant at the 0.1 level of significance.

The university training survey data did thus not predict the pattern of Complaints elicited by registration category and university described in section 7.8 above and illustrated in Fig. 3.

#### 10.2.10 Study Levels of Ethics Training

Only six (23%) of respondents said that professional ethics was taught at undergraduate level in their courses; of these, two said it was only indirectly mentioned.

Sixteen (61%) respondents said professional ethics was taught at Honours level, but of these, five stated that this was indirectly taught.

Professional ethics did thus not feature in undergraduate curricula and was only mentioned in about

half of the Honours courses reflected by the respondents.

Eighteen (69%) of the respondents replied that ethics was taught in both the masters (M1) and internship (M2) years.

Eight (30%) of the respondents replied that ethics was only taught in the masters (M1) year.

In summary, most respondents indicated that ethics was taught the masters (M1) and internship (M2) years, with the remainder focussing exclusively on the M1 year.

Qualitative comments on six (30%) of the questionnaires suggested that the teaching in M1 was more formal and theoretical, and in the M2 year ethics teaching took place during case supervision.

### 10.3 Summary

Overall, the survey of ethics training suggests that most respondents found their basic ethics training to be of below average standard, of insufficient duration and rated it as being of low relevance to their practice experience. Most respondents stated that they had not sought subsequent ethics training, but most would voluntarily seek further training in the future. Most respondents did not have malpractice insurance, while more psychologists willing to seek future ethics training had malpractice insurance than those who would not seek future ethics training.

Older, more experienced respondents seemed more satisfied with the duration and quality of their ethics training than younger respondents, even though data suggested that years of experience did not protect against Complaints. Counselling psychologists had the most positive ratings of their ethics training quality, and research psychologists the lowest.

An analysis of the relationship between the Complaints ratios of clinical training universities suggested a weak inverse correlation between Complaints ratios and psychologists' ratings of the

quality of ethics training they received. Universities that endorsed four particular motives for ethics training had significantly lower Complaints ratios.

The mean duration of ethics training was 9.8 hours, which most respondents regarded as insufficient. Most universities used a mixture of lectures, readings and workshop formats in their ethics training, and there was great variability in the recommended readings, although most referred at least to a version of the statutory regulations. Most did not teach ethics at undergraduate level, some did so at honours level while all did so at masters level. Masters ethics training was most often formal, followed by informal case-based training during the internship.

These patterns suggest that training in professional ethics requires careful revision if it is to be rated as sufficient, relevant to practice circumstances, and effective in providing ethical service and reducing complaint rates. Recommendations are made in the following chapter.

A weakness of the university training survey was its probable unreliability and vulnerability to social desirability bias. Future research should be based on audits of teaching materials, resources, scheduled course outlines and site visits. Comparisons of staff and student descriptions of courses should also be made. The survey did not elicit information about ethical decision-making models which might have been taught to students. Data on industrial psychologists was absent from this survey, and from the Dilemmas data.

## Chapter 11: Summary and Conclusions

This study attempted to describe patterns of Complaints against psychologists and compare them with the ethical Dilemmas that concerned psychologists themselves. These patterns were in turn related to ratings of ethics training and a survey of ethics training in South African professional psychology programmes. A total of 298 consecutive Complaints from the public was studied, and compared with 375 Dilemmas submitted by a sample of 253 psychologists. These data were also related to a university ethics training survey of 26 professional psychology Masters programmes. Industrial psychologists were under-represented in the Dilemmas data and university surveys.

The data generated by this study were thus 'wide and thin' rather than 'specific and deep', and represent a kind of epidemiology of ethical issues in South African professional psychology. The lens used was 'wide angled' rather than microscopic, covering almost the entire scope of practice of South African professional psychology. Because of the broad, descriptive design of this study, it is difficult to accommodate all the findings within an all-embracing theoretical framework. Such an approach was hopefully justified by the relative lack of such data internationally and in South Africa specifically. The findings might provide a focus for more specific research on the main results of the study, in the hope of improving ethics training, professional practice and guideline development.

Specific findings were discussed in relation to related studies and literature in the results sections above. Discussion will not be repeated in the summary which follows.

This section attempts to highlight the major significant findings and implications of the study. If the Complaints represent our mistakes (Hilfiker, 2000; Leape, 2000), it is hoped that this work might help us learn from them and use them in training future psychologists. "Considering ethical transgressions often harm those whom psychologists have promised to help, it is important for the profession to further investigate the frequency and causes of ethical transgressions in addition to helping students to avoid them" (Fly et al., 1997, p. 495).

## 11.1 Practitioner Variables: Complaints and Dilemmas

The overall rate of Complaints against South African psychologists determined by this study appeared to be comparable with American and British rates. Clinical psychologists were over-represented in Complaints against psychologists, and had the highest Complaints ratio. Disproportionately few research and industrial psychologists attracted Complaints. Psychologists who attracted Complaints had a mean of 9.8 years of experience (Dilemmas 10.7 years, n.s.). There was no significant difference in years of experience and number of Complaints. Complaints were thus evenly distributed across the whole experience range of psychologists, from inexperienced to those with more than 15 years of experience. Long experience or recency of training were thus not protective against attracting Complaints. Years of experience were, however, associated with significant differences in the type of Complaint which was made. Psychologists with less than five years of experience attracted disproportionately more Complaints about advertising and unpaid registration fees, while those with between 10-14 years of experience attracted more Complaints about fees. There were no disproportionate patterns for those with between five and nine years of experience or those with more than 15 years of experience, although increased years of experience showed a non-significant rise in Complaints concerning inappropriate practice and competence.

As in all the international studies cited earlier (section 3.4.5.1), confidentiality dominated the self-reported ethical Dilemmas of psychologists across all years of experience, with inappropriate practice ranked second for all years of experience except the 0-4 year group who reported non-sexual dual relationships as their second most frequent ethical concern.

Complaints were evenly distributed amongst both male and female psychologists, and there were no significant differences in the types of ethical issue in Complaints about males and females. Non significant differences showed that males attracted more Complaints about sexual misconduct and advertising, while females attracted more Complaints about consent, competence and unpaid registration fees. The greater frequency of sexual misconduct Complaints against males parallels American data (cf. sections 3.4.1 and 8.5.1). Males and females both reported confidentiality as their

primary ethical concern, while males self-reported more concerns about inappropriate practice and non sexual dual relationships than females, who reported more concerns about confidentiality and fees.

The results also showed that graduates from some universities were significantly more likely to attract Complaints than others, with Complaints ratios for universities ranging from 1.4% to 0.3%, with the national average being about 0.7%. Two universities were proportionately over-represented in the Complaints data, while two were under-represented. No causal relationship could be demonstrated between the universities' Complaints ratios and their training, but their rates may be linked to the higher Complaints rates for clinical psychologists and relatively low rates for research and industrial psychologists. Furthermore, universities which endorsed items favouring a balance of 'client welfare' and 'risk management' priorities in the university ethics training survey had lower Complaints ratios. Different universities were not significantly associated with particular types of ethics Complaints. Graduates from most universities reported confidentiality as their primary ethical concern, while graduates from the university with the least favourable Complaints ratio reported competence as their primary ethical concern. It should be noted that graduates from a university with a very favourable (i.e., low) Complaints ratio also reported competence as their primary ethical concern. This apparently contradictory outcome could be explained by considering that concerns about competence would be produced if students are poorly trained and lacking in professional confidence; however, well-trained students would also be expected to be vigilant about remaining competent after qualifying.

Most psychologists did not subscribe to malpractice insurance at the time of this study. Psychologists who did have malpractice insurance conducted adult therapy as their primary activity and were disproportionately more likely to have sought further ethics training after their basic professional training.

## 11.2 Ethical Issues in Complaints and Dilemmas

Complaints about fees dominated the Complaints data, followed by inappropriate practice and competence. In contrast, psychologists themselves reported confidentiality as their overriding ethical concern, followed by inappropriate practice and non-sexual dual relationships. Complaints concerning sexual misconduct ranked much lower in frequency for South African psychologists than for American psychologists, suggesting either that South African consumers were less likely to report such misconduct or that it occurred less frequently in South Africa.

Research, counselling and industrial psychologists attracted disproportionately more Complaints about advertising. No particular pattern applied to educational psychologists, while clinical psychologists attracted disproportionately few Complaints about advertising. Industrial psychologists attracted disproportionately more Complaints about unpaid registration fees. In contrast, clinical, counselling and educational psychologists themselves reported confidentiality as their primary ethical concern, while research psychologists were most concerned about non-sexual dual relationships. This last finding warrants further research and exploration.

## 11.3 Ethical Issues and Practice Contexts

Adult therapy, conducted mainly in private practice, emerged as the main practice activity of South African psychologists, followed by lecturing, individual counselling, and assessment.

Custody disputes attracted the most disproportionately high number of Complaints, followed by adult therapy. Custody work was not listed in the top eight practice activities of South African psychologists, exposing the ethical complexity and the 'high risk for Complaints' nature of this work. This highlights a conclusion that Complaints are much more likely to arise at the adversarial interface of ethical and legal domains of professional practice. Since adult therapy was the primary practice activity of psychologists, consistent with other studies, it is not surprising that it was the second highest activity associated with Complaints, followed by work with minors.

There were significant differences between the contexts associated with Complaints and contexts reported as being of ethical concern to psychologists themselves. Complaints were dominated by fee issues while psychologists themselves were overwhelmingly concerned about confidentiality issues. Concerns about HIV-positive clients were disproportionately over-represented in Dilemmas and were correspondingly under-represented in Complaints. Adult therapy was unsurprisingly also the activity most reported by psychologists themselves as the activity in which most ethical Dilemmas arose, followed by work with minors and less frequently by custody work and hospital settings. The over-representation of custody work in contexts associated with Complaints makes it clear that custody work warrants more attention in basic and CPD training. With regard to guideline development, specific attention should be paid to specific practice guidelines on fee issues, management of custody work and reduction of inappropriate practice (as defined in section 6.1.2.2 above). Such guidelines already exist in South Africa for forensic work (Louw & Allan, 1997), while specific guidelines in the USA have been shown to improve standards of practice in child custody evaluations (Bow & Quinnell, 2001). Efforts must be made to supplement the extant guidelines and link them to training programmes (Wassenaar, Slack & Leach, 2002; cf. CPA 2002).

A number of specific practice contexts were also significantly associated with Complaints about particular ethical issues. Adult therapy was disproportionately associated with sexual issues and fees, custody work with consent, interprofessional issues with inappropriate practice. Child abuse work was associated with consent issues. Hospital work and assessment were associated with fee issues. Non-payment of registration fees was disproportionately frequent amongst industrial psychologists working in organisational contexts, suggesting that there might be dissatisfaction with their mandatory registration with the medically-orientated HPCSA. This issue warrants further detailed study to establish whether industrial psychologists are best accommodated under health-orientated professional regulations. The low response rate of industrial psychologists to the Dilemmas questionnaire further supports the hypothesis that industrial psychologists possibly see themselves as a professional group different from the other four categories of psychologists, more oriented to the commercial sector than the health sector.

In contrast to the Complaints findings, the self-reported Dilemmas of psychologists reflected the following associations. Hospital settings were associated with interprofessional disputes and competence, assessment with inappropriate practice, minors with consent issues, adult therapy with non-sexual dual relationships and sexual issues, child abuse work with confidentiality. It can be seen that with the exception of adult therapy and sexual issues, there were significant differences between the ethical issues linked to practice contexts in Complaints against psychologists and the ethical issues which psychologists themselves associated with particular practice activities.

Essentially, comparison of the Complaints and Dilemmas data sets suggested that the public responded to ethical issues which were different from those which psychologists themselves were concerned about, although there were some similarities. Similarly, the practice contexts that were linked to a disproportionate number of Complaints were not the practice contexts that psychologists themselves were concerned about. The public and the profession concern themselves about different ethical issues in different practice contexts. This suggests that there is room to refine and focus ethics training so that it embraces both the views of the complaining public and the anxieties of practitioners themselves. This is supported by the finding that most psychologists did not rate their basic ethics training as relevant to their professional practice, and suggests a need for training to be informed by Complaints and Dilemmas data, as discussed further below. Ethics training needs to embrace both of these perspectives if 'relevant' ethics training is to be achieved.

#### 11.4 Training Issues and Recommendations

Most psychologists in this study rated their basic university ethics training as below average. Most psychologists rated the relevance of their ethics training as average to below average. There were no significant differences in the ratings of different categories of psychologists of training quality, although counselling psychologists reported the highest ratings of their ethics training quality, followed by clinical, educational and research psychologists.

Ratings by respondents of the quality of training at their universities of training ranged from a low

of one to a high of 5.2 on a ten-point scale, but these did not differ significantly. There was a weak correlation between these ratings and the Complaints ratios of these universities, suggesting a weak relationship between perceived quality of ethics training and Complaint patterns for each university. Furthermore, a subset of universities that trained clinical psychologists who reported that their ethics training prioritised the following cluster of principles had significantly lower Complaints ratios: client protection, problem solving, maintenance of professional image and prosecution avoidance. This suggests that ethics training which combined a focus on client protection and enhanced ethical decision-making along with motives to maintain a professional image and avoid prosecution were less likely to be associated with Complaints. Although this cannot be shown to be a causal relationship, it may be useful in informing ethics training. Furthermore, it is clear from this study that university training is only one variable amongst other variables (registration category, practice context) which probably contributed to Complaint patterns.

Less experienced (younger) psychologists in particular felt that insufficient time was allocated to ethics training. The university survey showed that an average of nine hours was spent in ethics training, mostly in the first Masters year, followed by case-based ethics work during the internship. Most universities used a combination of formal teaching and workshops in ethics training. A wide variety of primary literature sources were used. A weakness of this study was that ratings of the quality, relevance and quantity of ethics training were not compared with other aspects of training to determine whether these dissatisfactions were unique to ethics training in psychology.

Younger, less experienced psychologists were more likely to have sought subsequent training. A disproportionate number of older, more experienced psychologists reported that they had sufficient basic ethics training and had not sought subsequent training. This data suggests that more recently trained psychologists were less satisfied with their ethics training and were more likely to seek further ethics training. This might be a desirable finding suggesting greater ethical awareness in more recently trained graduates. This possibly positive finding was offset by signs of ethical complacency among more experienced practitioners. This should be considered against the finding that psychologists with more years of experience were as likely to attract complaints as more

inexperienced practitioners, although they attracted different types of complaints as shown in section 8.3.1 above.

Of those who would not seek future ethics training, a disproportionate number felt that not enough time had been spent in basic ethics training, while a disproportionate number of those who would seek future ethics training felt that enough time had been spent on ethics training. The mean reported time reported by universities (approx. 9h) was clearly regarded as insufficient by most respondents. There was little uniformity amongst universities with regard to recommended ethics readings, and the majority did not cite current legal regulations for psychologists. A weakness of the present study was the failure to ask for details of the specific ethics problem-solving strategies used by training universities.

There were no significant differences between registration categories and whether psychologists had sought subsequent training or their willingness to seek training in future. This is significant in view of the finding that clinical psychologists attracted a disproportionately high number of Complaints.

Literature was reviewed in chapter four above which suggested some models and practical approaches to ethics training. The common aspects of these models are presented briefly below, followed by recommendations linked to the main findings of the present study where relevant.

- Professional ethics training should comprise more than just rule learning alone or supervision alone;
- Professional ethics education should ideally be done using a combination of teaching approaches, including formal exposure to codes and rules, readings, workshops, case discussion, simulations and membership of departmental ethics committees;
- Professional ethics education should be more formal and theoretical in the academic years of training and be followed up and complemented by applied ethical problem solving in case supervision in the professional training and internship years;
- Professional ethics education should include practical strategies for resolving ethical dilemmas,

preferably through a system of value clarification;

- More time (more than 9 hours) needs to be devoted to ethics training.

An integrated model ethics curriculum for South African training is described below. The educational outcome of this proposed outline would be to improve the relevance, quality and quantity of ethics training in South African psychology, to reduce the incidence of the Complaints patterns described in earlier sections and particularly to improve ethics training in those universities and categories of psychologists found to have disproportionately high Complaints patterns.

#### 11.4.1 Undergraduate level:

The main aim of undergraduate ethics teaching would be to promote ethical sensitivity. Studies suggest that undergraduates generally respond more readily to such teaching (Myry & Helkama, 2002; Rest & Narváez, 1994; Strom & Tennyson, 1989). The course should outline basic ethical principles, such as the four basic principles of the CPA (2000) code. No detailed standards need be taught at this level. Data from other studies suggests that undergraduates require a focus on student misconduct such as plagiarism and cheating. There should be work on case vignettes requiring students to make their own judgements and apply the principles to specific case materials in discussions and assignments.

Although not arising directly out of the results of the present study, literature suggests that formal structures should be in place in teaching departments which are capable of taking remedial or disciplinary action in the event that academic dishonesty occurs. This would model response systems to deal with actual ethical misconduct amongst students and staff (Koocher & Keith-Spiegel, 1998). Ethical issues in teaching and research should be a focus of regular staff-student colloquia. Guidelines for appropriate informal and formal adjudication of Complaints should be in place. Academic departments or schools should invest in developing ethics teaching capacity in one or two staff members to drive this process with the consent and support of the whole school in an integrated and consensual manner.

#### 11.4.2 Junior Postgraduate Years

The focus here should be to emphasise and further develop ethical sensitivity to common issues in academic misconduct, especially plagiarism and cheating. Ethical principles and their application to various scenarios (e.g., Jones, Shillito-Clarke, Syme, Hill, Casemore & Murdin, 2000) should be applied in a context which itself supplies a response framework should actual ethical infringements be suspected or detected. This postgraduate level generally allows more class discussion and interactive learning than the undergraduate years.

#### 11.4.3 Professional Ethics Training

Most ethics training literature suggests that professional ethics training programmes should be built upon the ethical sensitivity and knowledge of ethical principles emphasised at the undergraduate and junior postgraduate levels as described above.

Frank discussion of ethical concerns, from students' personal experience, their training experiences, or in their interactions with or observations of their peers, teachers and supervisors should be encouraged.

Although the present data did not suggest significant problems in this area, clear guidelines should be provided for management of staff-student interactions, with an explicit focus on dual relationships, sexual attraction and sexual boundary violations (Biaggio et al., 1997; Fly et al., 1997). A climate of open recognition and discussion of such issues needs to be promoted (Callahan & Bok, 1980; Hamilton & Spruill, 1999; Housman & Stake, 1999; Samuel & Gorton, 1998).

Formal professional teaching should follow this creation of a climate of ethical sensitivity. A curriculum including national ethics and regulatory structures, local and international codes, should be followed by case statistics which outline the most frequent practice Dilemmas, Complaints and adjudicated violations. The data generated by the present study might be useful in making the case

discussions more immediately relevant to the prospective practice contexts of the students (e.g., management of fee issues, child custody work, child abuse reporting and inappropriate forms of practice all empirically appear to warrant careful attention in training).

Similarly, the Dilemmas data can be used to highlight the corresponding Dilemmas experienced by practitioners, (e.g., confidentiality concerns, inappropriate practice and non sexual dual relationships). This should be followed by an examination of the large differences and few similarities between Complaints and Dilemmas as sources of data.

In order to keep such information current and relevant, national bodies should be encouraged to publish annual reports on the numbers and types of Complaints received, modelled on the format used by the APA for almost two decades (APA, 2001d). International efforts should be made to standardise the categories used in such reports. This would generate powerful and useful data for relevant ethics training and research. Such reports should outline patterns and need not disclose the identities of the respondents. These can be linked to practice specialities if this information is available. Detailed ethical standards or specific speciality practice guidelines should supplement the basic principles covered in the earlier academic years, based on the current CPA (2000) or draft APA (2001a) ethical codes. Reports on practice contexts, specialities and their Complaints patterns would refine this process even more. Careful study of the legal contexts impacting on professional practice must also be included, as suggested by the significant number of Complaints in the present study which arose at the interface of legal and ethical injunctions (child custody settings, child abuse settings, unpaid registration fees). All of this information would help psychologists learn to interpret and apply ethical codes to the realities of psychological practice as reflected the present work.

Professional-level ethics training must be based on a clear decision-making framework, based on one or more of the models reviewed in chapter 4 (e.g., Cottone & Claus, 2000; Kitchener, 2000a, 2001; Pryzwansky & Wendt, 1999; Rest & Narváez, 1994; Treppa, 1998). The CPA (1992) framework for ethical decision making embodies most of the stages outlined by various authors, and strikes a balance between simplicity and impractical complexity. This framework can be applied to actual

case material and empirically derived teaching vignettes in a workshop format. Training for ethical decision-making should include identification of emotional and contextual factors which influence ethical judgements and their action outcomes (Cottone, 2001; Kitchener, 2000a). The present data has attempted to provide empirical data on the types of practice contexts associated with Complaints and those associated with psychologists' own Dilemmas. The emotional dimension was not a focus of the present study, but in the author's experience is easily generated in discussion of case-based scenarios and should explicitly be recognised and integrated in the decision-making process (Betan & Stanton, 1999). This is important in view of research cited earlier (Bernard & Jara, 1986) that emphasised the motivational rather than the cognitive dimension of ethical conduct. Knowledge of codes alone was insufficient training for ethical professional conduct (Betan & Stanton, 1999; Pettifor, 1996; Smith et al., 1991). The present empirical data might generate the arousal and motivation needed to identify the emotional dimension of ethical decision making and interpretation of ethical codes.

The literature suggests that the professional postgraduate component of ethics training should involve around 25 hours of study time, combining directed reading, formal didactic inputs, workshops and assignments on applied decision making. A regular group forum should be created in which students can discuss ethical issues arising in their training. Individual supervision should also create a safe and confidential space where trainees can discuss complex feelings and vulnerabilities towards clients in order to make ethically sensitive and appropriate professional decisions (Hámlton & Spruill, 1999).

Although very little literature exists on whether such a format and process will improve ethical problem-solving capacity and reduce ethical violations in qualified professionals, such a structured curriculum creates further research and outcome evaluation opportunities. Ethics training cannot be assumed to occur by "osmosis" during professional training (Handelsman, 1986b, p. 371). For this reason, structured baseline and outcome evaluations of students' knowledge, decision-making ability and self awareness should be conducted to evaluate outcomes of the training programme (Samuel & Gorton, 1998).

## 11.5 Limitations of This Study

This study has a number of limitations. The Dilemmas survey overlooked many industrial psychology training departments which fell outside schools of psychology and were probably placed in Commerce or Business faculties. The Dilemmas data thus under-represented ethical dilemmas of concern to industrial psychologists. It could be argued that despite the anonymity of individual respondents, the Dilemmas survey was subject to social desirability bias. The extent of this bias could not be reliably estimated by the present study design. The university training survey suffered from the problems of many self-report surveys, the most serious of which was social desirability bias, which possibly limited the validity of some of the university survey findings. Future studies should involve direct on-site audits of ethics training materials and interviews with staff, corroborated by interviews with students. Data should be compared with satisfaction or dissatisfaction with other aspects of professional training to determine whether results are generic or specific to professional ethics training. Future evaluations of ethics training should also examine the extent to which clear local structures are in place for responding actively to local or institutional ethical violations by trainees and staff. The training survey should also have asked about the presence or absence of explicit local structures or procedures for responding to ethical issues raised by or concerning students and training staff.

However, the training data showed that most respondents were dissatisfied with their ethics training, and that some patterns were distinguishable for specific categories of psychologists. This suggests some reliability of the data because meaningful patterns emerged for definite subgroups of respondents. Patterns were also evident in the data on whether respondents had sought further training - while most respondents said they had sought further ethics training, most also gave a socially undesirable response in saying they would not seek future ethics training.

No clear rationale has been given in any of the Dilemmas studies cited in section 3.4.5 for limiting the reporting of Dilemmas to “the past year” (cf. Appendix A). Although this has enabled comparison with other published work using this method, it might be worthwhile to extend the

period to “past five years” to generate more vignettes. Furthermore, none of the studies reviewed in section 3.4.5 clearly stated that only a single vignette per respondent was analysed. In most of the studies reviewed, more than one ethical Dilemma was generated by many respondents. In the present study, which sought to determine the statistical significance of some of these findings and compare Dilemmas to Complaints data, this led to problems with the statistical analysis of the data as some of the categories of data in the Dilemmas data set were not independent. Only descriptive data could be given in such cases. In future only one Dilemma per respondent should be analysed if practitioner variables are also being studied.

More rigorous reliability checks should have been conducted on the Complaints data. The coding of both the Complaints and Dilemmas data was complex, resulting in many categories. More systematic attempts could have been made to refine the number of categories through further explorations with hierarchical cluster analysis. Ethical problems often involve overlapping ethical issues. The design of this study necessitated a focus only on primary ethical issues for each Dilemma or Complaint. Although secondary issues were initially coded, they proved too complex to include in the analysis, resulting in too many categories for meaningful analysis and comparison. International efforts should be made to standardise the way in which Complaints and ethical dilemmas are categorised and coded, to facilitate international comparison of data. At present, for example, it is almost impossible to meaningfully compare South African, American and British Complaints data, as reviewed in sections 3.1 and 3.2 below. To exacerbate this situation, formal Complaints data is difficult to access nationally and internationally. These factors contributed to the difficulty of coding the data and making meaningful comparisons with other published sources. These issues limit the reliability and validity of the present findings. It is nevertheless hoped that some major patterns, deserving of further research and attention in training, have been identified and described.

The practice context categories could have been further separated into settings and professional acts. Settings would be institutions and physical contexts, while professional acts would be specific actions, such as psychotherapy, intelligence assessment, parent counselling, etc. Analysis of the data

could thus have related ethical issue, setting, and professional acts to each other in the search for high or low risk patterns for Complaints. This study nevertheless makes an attempt to distinguish ethical issues from the contexts in which they arise. This distinction has not been systematically reflected in comparable literature to date. It is hoped that future studies will refine this.

The scope of the study was over-broad because of its descriptive, exploratory nature. Very little local data was available at the design stage of this study to support a more focussed hypothesis-driven exploration. It is hoped that the present study might be a source of such hypotheses, supplemented by the recent work of Scherrer et al. (2002). A narrower more specific focus on specific ethical issues, settings, activities and practitioner variables would have allowed more in-depth exploration of some of the patterns which emerged as significant. It is hoped that subsequent designs will benefit from this 'bandwidth-fidelity' tension and be able to seek fidelity. Based on the present data, four clear areas appear to warrant further detailed study: child custody work, fee issues, inappropriate practice, and unpaid registration fees by psychologists in organisational settings. Detailed study should also be conducted to determine why the rates of Complaints for sexual misconduct are relatively low in South Africa. Are clients reluctant to report these problems, or is their incidence actually low? Efforts should be made to ensure that the rate remains low because practitioners identify sexual attraction as early as possible and take appropriate steps to avoid exploitation of clients (Kitchener, 2000a; Pope, 1994).

Difficulties in reviewing issues in professional ethics arise not only because of debates within the ethics field itself, but also because the discipline and profession of psychology are also constantly evolving and changing (Fuller et al., 1997). Practices which might have been acceptable to Freud are unacceptable today. Similarly, practices acceptable today might have been seen as unethical in Freud's time. Similarly, actions by research psychologists might be ethically acceptable while similar actions would be unacceptable in clinical practice. There is thus the interplay of history, values and social trends in a rapidly changing professional and technical landscape. This must complicate ethical decision making and moral judgements by psychologists and clients alike (Cottone, 2001). The present study has at best provided a limited and artificially static representation of some issues

in this dynamic matrix.

Several issues not reflected in the present study but which pose increasing ethical challenges are internet service provision (Griffiths, 2001; Humphreys, Winzelberg & Klaw, 2001), electronic data security (McMinn et al., 1999), recovered memories of childhood sexual abuse (Strand & Nash, 1997), prescribing of medications (Lindegger, 1999; Newman, Phelps, Sammons, Dunivin & Cullen, 2000; Scherrer et al., 2002), whistleblowing (Bentall, 1999; Masser & Rupert, 1996; Simon, 1978), euthanasia (assisted suicide) (Faberman, 1997), HIV and AIDS (Anderson & Barret, 2001; Chenneville, 2000; McGuire et al., 1995), student plagiarism (Carpenter, 2002), the use of touch in psychotherapy (Durana, 1998), and collaboration with traditional healers (Bakker, 1999; Kottler, 1988). Although such issues did not appear in the Complaints and Dilemmas data, training should include examples of these issues as they are undoubtedly going to face practitioners in the new millennium. Proactive teaching might prevent them from featuring prominently in future Complaints data.

Finally, due to the long period involved in the completion of this study, some of the data may be dated, especially the university training data which was collected in 1995. The dating process affects all empirical data to which psychologists refer, however, and it is hoped that the present data will nevertheless stimulate more focussed research on more recent data. The Complaints data covered the period 1993 to 1998 and is less dated. The data set captures an era in South African professional psychology preceding the introduction of compulsory CPD and the proposed changes in the South African professional training framework that is planned for introduction in 2003 or 2004. The introduction by the Board of a new ethical code in 1999 (Professional Board, 1999a) suggests that the present study would provide a useful baseline sample of Complaint patterns prior to the introduction of this new code. The new code contains specific ethical decision making guidelines, based on the APA and CPA codes, which will hopefully impact positively on ethics training, problem solving, Complaint rates and patterns, although codes alone are widely regarded as insufficient in improving ethical conduct (Cohen & Cohen, 1999; Cottone & Claus, 2000; Handelsman, 1986b; Neukrug, Lovell & Parker, 1996; Pettifor, 1996; Welfel & Kitchener, 1992).

Changing public sophistication with psychological services and growing awareness of human rights issues in South Africa may also impact on future Complaints patterns. Demographic variables amongst complainants might also influence Complaint patterns. Such forces and factors were beyond the scope of this study but are important contexts against which to assess future Complaints trends. The present data provide a baseline against which to compare changing Complaint and Dilemmas patterns. It would be interesting, for example, to see whether the campaigns to raise public awareness of the rights of women and children in the sexual domain lead to more Complaints in the future about sexual misconduct, which the present data showed to be lower in South Africa compared to APA data.

Similarly, demographic, diagnostic and contextual variables characteristic of complainants themselves were beyond the scope of the present study, but are clearly relevant to the patterns inherent in the Complaints data. Future work examining the experience of injury leading to the initiation of a Complaint would provide a valuable counterpoint to the profession-centered view of this study (cf. Claiborn, Berberoglou, Nerison & Somberg, 1994). Qualitative work would appear to be worthwhile in this potential area. Profiles of high-risk complainants and 'false-complainants' would also enrich risk-management training. Careful qualitative and quantitative studies could also be done of psychologists complained against. Although work has been done on the impact of the Complaints and adjudication process on psychologists (e.g., Montgomery et al., 1999; Schoenfeld et al., 2001, reviewed in section 3.4), the role of practitioner impairment (Barnett & Hilliard, 2001) in misconduct remains undetermined. Such information could be used to promote better self-care by psychologists of themselves in an effort to improve service delivery and occupational satisfaction without negative impact on clients. It is noteworthy that self-reported concerns about personal impairment did not feature in any of the Dilemmas, but might have been inherent in the 'inappropriate practice' and 'competence' categories. This warrants closer scrutiny. Support and humane rehabilitation services for disciplined psychologists should also be designed (Barnett & Hilliard, 2001; O'Connor, 2001; Sussman, 1995).

Complaint outcomes also require careful scrutiny. Is justice done? Do professional disciplinary

structures deliver justice to those injured by misconduct? Is the rate of prosecutions and convictions comparable to international data and to common criminal data? Are there systemic injustices which mitigate against complainants or practitioners? Such questions seem vital and again were beyond the scope of the present study.

Despite the limitations of the study it is hoped that some of the major patterns described may be useful in basing future ethics training programmes on empirical data about local Complaints patterns and practitioners' Dilemmas. Such data may also be of use in designing revisions to the code and in drafting specific speciality practice guidelines (e.g., for custody work). Training using such guidelines has been shown to be effective in improving standards of practice in the USA (Bow & Quinnell, 2001).

A final limitation of this study was the failure to anticipate the ethical problems associated with publishing Complaints rates for different training universities, which might have obviated the necessity of coding the identities of the universities' Complaints ratios. The present reporting format represents an ethical compromise, and a way forward has been proposed should publication be seen as worthwhile.

#### 11.6 Recommendations for Future Research

In addition to the recommendations made in the previous section, the author concurs with Scherrer et al. (2002) in recommending that the Board publish annual summaries of Complaints data to educate psychologists about Complaint trends. Such summaries should reflect patterns and trends only and should not reveal the identities of individuals. The APA reports (e.g., APA, 2001d) are examples of such reports, but their categories omit some ethical issues and blur contexts, activities and ethical issues. Categories similar to those used in the present study might be used, with further separation of contexts and activities. There is a need for greater international standardisation in Boards' reporting of Complaints. Many categories used are not comparable and this limits their utility in further training, research and guideline development. Efforts have been made to improve

international collaboration (Pettifor, 2002). The ‘inappropriate practice’ category, as described in section 6.1.2.2 above, contains a cluster of problematic behaviours which warrant further analysis and explication.

Future studies might be more manageable and useful if they narrowed their focus to particular ethical issues, settings, activities and practitioner variables. The present study was broad in scope and analysis was correspondingly superficial. Differences within particular patterns (e.g., types of confidentiality breaches, types of non-sexual dual relationship) could not be explored in sufficient detail. However, it is hoped that some groundwork for future studies can be found here. Three clear areas for further research were mentioned in an earlier section, viz.: child custody work, fee management and inappropriate practice require further detailed study.

Universities should evaluate their own ethics training and commission independent audits of their ethics training programmes and local ethics structures and procedures. This should be accompanied by tracking graduates and researching their reports on the relevance of their training to their fields of professional practice. This would create a feedback loop to training universities. For example, the present data suggests that there are significantly disproportionate rates of Complaints attracted by different training universities. Further research is needed to explain these findings. Training variables seem the most likely factors to study, although graduates’ practice contexts may also account for part of this variance.

Universities and CPD ethics trainers should focus their teaching on prevalent patterns of Complaints and Dilemmas, along with systematic decision-making skills which take guidelines, contexts and emotional factors into account. Comparative longitudinal studies of different ethics training systems and formats should be systematically compared, using trainee ratings and Complaint patterns as outcome variables. Similarly, training universities could monitor published Complaint patterns to identify whether their graduates attract disproportionate numbers of Complaints, and the types of Complaint.

A study similar to the present one should be conducted to coincide with the new practice framework which may be introduced in 2003, to track Complaint patterns of the various categories created by the new system (Professional Board, 1997c). This would indicate the need for remedial action should it be indicated by the data.

In the absence of any empirical or theoretical data which has unequivocally been shown to promote ethical professional conduct (Samuel & Gorton, 1998), the studies recommended above would hopefully further the basic ends of professional ethics and raise the ethical quality of services rendered to the many and varied populations which psychology strives to serve.

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9<sup>th</sup> July 1998

Dear Colleague,

### **ETHICAL DILEMMAS EXPERIENCED BY SOUTH AFRICAN PSYCHOLOGISTS**

As part of the process of transformation in South African psychology, ethical issues are also under discussion. There is an international trend towards basing ethical codes on the ethical dilemmas actually experienced by registered psychologists. It is hoped that this information will assist in the development of ethics codes and structures which are more closely tied to the actual practical experiences of psychologists and their clients.

As a component of a broader project, South African psychologists are invited to outline their own ethical dilemmas and submit these for analysis.

I would be most grateful if you would complete the attached brief questionnaire. The questionnaire should take no longer than 10 minutes to complete. A stamped and addressed return envelope is provided.

Your responses are anonymous and you are not required to put your name on the questionnaire. Data analysis will identify common themes and will not reflect individual submissions. The number which appears on the return questionnaire or envelope is solely for the posting of reminders and will not be used to identify respondents for any other purpose.

If you cannot complete part 3 of the questionnaire, I would however be most grateful if you would nevertheless return the questionnaire and mark it 'no dilemmas'.

Although this questionnaire has only been circulated in English, you are welcome to complete the questionnaire in Afrikaans or the language of your choice.

Your contribution is much appreciated.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'D R Wassenaar'.

D R WASSENAAR







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The Head  
Professional Training  
Department of Psychology

February 1995

Dear Professor

**SURVEY: TRAINING IN LEGAL AND ETHICAL ISSUES IN PROFESSIONAL PSYCHOLOGY.**

I am at present undertaking research into professional ethics in South African professional psychology training.

I would be most grateful if the head(s) of professional training, if offered at your Department, could complete the attached questionnaire. The questionnaire is very brief and should take less than five minutes to complete.

It would be appreciated if SEPARATE questionnaires could be completed for EACH of the training courses (categories) offered at your university. A self addressed stamped envelope is attached for the return of this information.

It is hoped that the results of this survey will be made available to South African training Universities in the near future.

Your cooperation and assistance are much appreciated. **Please return the questionnaire BEFORE June 30th 1995.**

Yours sincerely

**ETHICS TRAINING SURVEY**

1: University \_\_\_\_\_

2: Department \_\_\_\_\_ Phone: \_\_\_\_\_

3: This questionnaire reflects ethics teaching in the (indicate category) \_\_\_\_\_  
Psychology Masters Programme. (NB If professional courses are not taught in your  
department kindly mark the form "Not Taught" and return it to the writer).

4: Is professional ethics taught as an integral part of this course? Yes/No\*

\*: Delete which does not apply

4.1 Is Professional Ethics taught in M1 or M2 or both? \_\_\_\_\_

5: Approximately how many hours in total are spent teaching professional ethics in the  
masters course? \_\_\_\_\_ hours.

6: What format does this teaching take? Mark more than one if applicable):

6.1 Reading only

6.2 Lecture only

6.3 Reading and a lecture

6.4 Reading and a workshop

6.5 Seminar

6.6 Case studies

6.7 Practical supervision

6.8 Other


7: What are the main prescribed or recommended readings for the course?

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8: Are the S.A. Medical and Dental Council Regulations drawn to the students'  
attention? Yes/No\*

8.1 If so, in what way :

8.1.1 Lecture

8.1.2 Handout

8.1.3 Referred to only in passing 279


8.2 If so, what version of the Regulations is referred to? (ie. date of  
publication): \_\_\_\_\_

9: Rate the importance of training in professional ethics as part of professional training in psychology:

- 9.1 Extremely Important
- 9.2 Very Important
- 9.3 Important
- 9.4 Relevant but not important
- 9.5 Unimportant


10. Rank order, scoring 1 for the strongest factor and 7 for the weakest, the following as motivations for training in ethics in psychology:

- 10.1 To avoid prosecution
- 10.2 To safeguard human rights
- 10.3 To maintain the public image of the profession
- 10.4 To protect the client
- 10.5 To protect the practitioner
- 10.6 To enhance awareness of ethics and values
- 10.7 To facilitate ethics problem solving

RANK


11: Is professional ethics taught at Undergraduate level in your department? Yes/No\*

12: Is professional ethics taught at Honours level in your department? Yes/No\*

13: Please include any other comments or information you wish to include on a separate sheet.

14: If possible kindly enclose a copy of your Masters Syllabus or any other suitable materials used in ethics education at Masters level.

**THANK YOU FOR YOUR VALUED ASSISTANCE. KINDLY RETURN THIS QUESTIONNAIRE IN THE SELF ADDRESSED STAMPED ENVELOPE TO:**

**D.R. Wassenaar  
Psychology Department, University of Natal,  
Private Bag X01, SCOTTSVILLE, 3209.**

## Appendix C

### Register of Psychologists by category and University of Training Supplied by the Professional Board for Psychology

<u>UniD</u>		<u>UniE</u>	
180	Industrial	106	Industrial
256	Clinical	133	Clinical
61	Research	16	Research
299	Educational	144	Educational
176	Counselling	154	Counselling
<u>UniA</u>		<u>UniP</u>	
7	Clinical	48	Industrial
		153	Clinical
		18	Research
5	Educational	87	Educational
		10	Counselling
<u>UniO</u>		<u>UniN</u>	
3	Industrial	13	Industrial
34	Clinical	95	Clinical
		16	Research
1	Educational	24	Educational
8	Counselling	34	Counselling
<u>UniL</u>		<u>UniB</u>	
1	Industrial	50	Industrial
39	Clinical	106	Clinical
		5	Research
		43	Educational
2	Counselling	124	Counselling
<u>UniM</u>		<u>UniK</u>	
5	Industrial	111	Industrial
100	Clinical	148	Clinical
6	Research	33	Research
59	Educational	116	Educational
50	Counselling	87	Counselling

UniJ

35 Industrial  
 41 Clinical  
 9 Research  
 50 Educational  
 66 Counselling

UniG

75 Industrial  
 147 Clinical  
 20 Research  
 71 Educational  
 203 Counselling

UniF

11 Industrial  
 65 Clinical  
 6 Research  
 1 Educational  
 10 Counselling

USA

5 Industrial  
 25 Clinical  
 5 Research  
 15 Educational  
 43 Counselling

Other Foreign

6 Industrial  
 50 Clinical  
 8 Research  
 5 Educational  
 8 Counselling

UniI

6 Industrial  
 52 Clinical  
 1 Research  
 4 Educational  
 24 Counselling

UniC

83 Industrial  
 96 Clinical  
 9 Research  
 25 Educational  
 65 Counselling

UniH

49 Industrial  
 120 Clinical  
 28 Research  
 24 Educational  
 6 Counselling

UK

2 Industrial  
 6 Clinical  
 2 Research  
 6 Educational  
 5 Counselling

Other African

14 Industrial  
 3 Clinical  
 1 Research  
 2 Educational  
 3 Counselling