A STUDY OF INFORMAL BREACHES OF CONFIDENTIALITY AMONG A SAMPLE OF SOUTH AFRICAN CLINICAL, COUNSELLING, AND EDUCATIONAL PSYCHOLOGISTS, IN THE LIGHT OF ASPECTS OF ETHICAL EDUCATION AND OF COUNTERTRANSFERENCE PHENOMENA

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Unless specifically indicated to the contrary in the text, this thesis represents my own original work;

Signature

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ABSTRACT

The informal breach of client confidentiality by psychologists was discussed in relation to various issues in professionalism and professional ethics, both in general and in the South African context. Informal breaches of client confidentiality were identified as a common by under researched form of ethical malpractice, and nominated as the dependent variable in this study. Different emphases in ethical education were discussed in relation to various theories of moral thinking and moral action (particularly the 'levels' theory of moral thinking of R.M. Hare), and identified as an independent variable for the empirical portion of the study. A second independent variable, of countertransference responses by psychologists to clients, was also identified and discussed. A purpose-developed postal questionnaire was administered to a sample of South African clinical, counselling, and educational psychologists to assess the incidence of informal breaches of confidentiality in a South African sample, as well as the relationship between the variables. Although a high incidence of informal breaches of confidentiality was reported by the sample, and indirect support for Hare's levels theory of moral thinking found, the results did not demonstrate a significant relationship between the independent and dependent variables.

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CHAPTER 1:
INTRODUCTION AND OVERVIEW

The most common defining criteria for a specifically *professional* occupational group are that its members both have a specialised training to perform some task valued by society, and that they undertake to comply with an ethical code established and administered by their peers (Steere, 1984). Such codes ideally represent a relatively objective crystallisation of implied contracts between both individual professionals and their peers, and between the professional group as a whole and the rest of society (Abbott, 1983; Frankel, 1989; Larson, 1977). These contracts, in turn, respectively guarantee individual members of the profession a degree of autonomy from state control in their day-to-day practice, and members of the public with the assurance that members of the profession are accountable for how they exercise this autonomy *(ibid.)*.

In these terms, Applied Psychology emerged as a profession in Europe and the United States during the first half of this century (Benjamin, 1986; Phares, 1984), and in South Africa after World War II (Kruger, 1987; Langenhoven, 1978; Louw, 1987a; 1987b). Since 1974, the *Medical, Dental, and Supplementary Health Professions Act* (Act 56 of 1974) has delegated the regulation of the activities of psychologists to the Professional Board for Psychology. The Board executes its functions in accordance with the provisions of the Act, of its own regulations, and of the rules of professional psychological associations. The most influential codification of professional ethics by a professional psychological association in South Africa has been the *Ethical Principles of Clinical Psychologists (Provisional Draft)* (Steere & Wassenaar, 1985). This document was originally adopted by the (now defunct) Institute for Clinical Psychology of the Psychological Association of South Africa in 1985, but has subsequently been endorsed by a succession of South African professional associations of clinical, educational, and counselling psychologists (Wassenaar, 1994).

Like other professional ethical codes (*eg.*, APA 1992), the 1985 *Ethical Principles of Clinical Psychologists* (Steere & Wassenaar, 1985) provides guidelines regarding many areas of professional practice, including relationships with professional bodies and other professions, the practical administration of professional practice, and the acceptable parameters of relationships between professionals and their clients. Not least among the latter are imperatives for psychologists to hold information about clients in confidence.

Traditions of not divulging secrets entrusted to one are shared by other professional codes, both in Psychology (Phares, 1984) and in other professions (Lindethal & Thomas, 1992; Luban, 1992; Oosthuizen, Shapiro & Strauss, 1983, *various contributions*). Luban (1992, p.1132, emphasis added) attributes this common ethic of confidentiality across professions to the fact that the effective exercise of their duties often requires professionals to "dig out information which will *only* be tendered in confidence". Although most professions recognise that there are exceptional conditions under which clients' rights to privacy are overridden by other considerations, the general principle of confidentiality remains highly prized - in professional Psychology (Keith-Spiegel & Koocher, 1985) at least as much as in other professions (Haysom, 1987; Joseph & Onek, 1991; Luban, 1992).

Both empirical and theoretical research on the actual compliance of psychologists with professional regulations on confidentiality (and that of members of closely related professions, such as psychiatry) has tended to concentrate on formal breaches of this principle under extreme circumstances, such as when maintaining confidentiality exposes the client or a third party to danger, and preventive measures have to be taken (Joseph & Onek, 1991; Keith-Spiegel & Koocher, 1985). More informal - or gossipy - breaches of confidentiality by professionals under routine circumstances, where there is less obvious danger of potential harm to anyone, have been relatively unexplored in the literature. Although Olinick (1980) and Caruth (1985) discussed such behaviour in the psychoanalytic forum, the first empirical indications of the actual incidence of such behaviour emerged unexpectedly from a study by Pope, Tabachnik, and Keith-Spiegel (1987). This study set out to survey the behaviours and beliefs of American psychologists regarding 83 ethically questionable behaviours, of which six involved aspects of confidentiality. In only four of the total of 83 behaviours was psychologists' practice less ethical than their beliefs, and of these four, three involved informal breaches of confidentiality. Furthermore, psychologists reported engaging in these behaviours with disturbing frequency: nearly three-quarters, for instance, admitted to discussing their clients with friends.

The high incidence of such clearly unethical behaviour is clearly disturbing, and forms the focus of this thesis. Informal breaches of confidentiality thus form the dependent variable in the empirical portion of this study (which also aims simply to survey the incidence of such behaviours among a sample of South African clinical, educational, and counselling psychologists). Two hypotheses tested in the empirical portion of this study concern the incidence of informal breaches of confidentiality among South African

clinical, counselling, and educational psychologists, and the relationship between such behaviours and the psychologists' ethical beliefs. Chapter 2 contextualises informal breaches of confidentiality in relation to issues of professionalism and ethical codes in general, in Psychology, and in South Africa.

The fact that the high incidence of informal breaches of confidentiality among the psychologists in the Pope *et al.* (1987) study appeared to occur for reasons other than mere ignorance of, or dissent with, professional ethical codes, is almost as disturbing as the incidence of behaviour itself. The empirical portion of this study therefore attempts to investigate the possible contribution of two independent variables to this gap between psychologists' ethical beliefs and their behaviour.

The first of these independent variables is the nature of the education in professional ethics which psychologists have received. Chapter 3 discusses various approaches to moral and ethical education, and argues that the theories of the moral philosopher Hare (1977; 1981; 1991) provide a more useful basis than others both to tailoring professional ethical education to maximise later ethical conduct, and for explaining (and preventing) gaps between ethical belief and ethical behaviour. Two hypotheses based on this argument are tested in the empirical portion of the study.

The second independent variable is the presence of countertransference reactions in the psychologist to the client material which is later inappropriately disclosed. The concept of countertransference is the focus of increasing interest in both the psychoanalytic and the general psychological literature. Although alternative interpretations of the concept are fairly common in this literature, countertransference in this thesis is taken (after Brenner [1985] and Arlow [1985]) to mean the negative effects of the psychologist's own needs or conflicts on their ability to understand and/or appropriately respond to a client's disclosures or behaviour. The identification of countertransference (so defined) as a possible factor contributing to informal breaches of confidentiality by psychologists is derived from a non-empirical argument to this effect by Caruth (1985). Chapter 4 expands the discussion of the current paragraph, and provides the foundation for three hypotheses tested in the empirical portion of this thesis.

Chapter 5 clarifies the research questions and states the formal hypotheses for the empirical portion of this thesis, and Chapter 6 reports the methodology and results of the research. The results of the research are discussed in Chapter 7, as are the conclusions drawn from these results about both the subjects investigated and the limitations of this study in Chapter 8.

CHAPTER 2:
PROFESSIONALISM AND CODES OF ETHICS

This chapter will explore the literature relating to the dependent variable of this study, namely compliance of South African psychologists with the confidentiality clauses of their professional ethical code. First, in Section 2.1 the development and nature of modern professionalism in general will be exlored, followed (in Section 2.2) by the specific history and nature of Psychology as a profession. Section 2.3 deals with the role and nature of codes of professional ethics, with an emphasis on Psychology. Section 2.4 deals with confidentiality in professional psychology, and with empirical studies of psychologists' actual compliance with ethical codes.

2.1 MODERN PROFESSIONALISM: DEVELOPMENT AND CRITIQUES

As Elliott (1972, pp.2-3) notes, "the name 'profession' is widely and imprecisely applied to a variety of occupations...(and) the adjective 'professional' is even more overworked, extending, for example to cover the opposite of amateur and the opposite of a botched job, two concepts which need not be synonymous". This situation persists, despite (or perhaps *because of*) the fact that the terms have been frequently used, and defined, both by members of a wide variety of occupational groups who wish to so classify themselves, and by sociologists from diverse theoretical backgrounds (Atkinson, 1983; Freidson, 1983; Louw, 1990; Wilensky, 1964). In addition, the usage and connotations of terms relating to professionalism have changed over time, and are (inevitably) influenced by prevailing trends of thought on broader social issues (*ibid.*).

More specifically, current conceptions of - and controversies about - the meaning of professionalism are rooted in two aspects of European society between the Renaissance and the Industrial Revolution. The first is the social role and organisation of the three traditional professions (the clergy, medicine, and law), and the second the guild system under which craftsmen were organised (Elliott, 1972; Freidson, 1983). These two historical approaches to occupational organisation coalesced in the nineteenth century, with the rise in Britain and the U.S.A. of professionalism in its modern form, and their origins and conflicts underlie many current debates in the field (*ibid.*).

2.1.1 The Nineteenth Century Emergence of Occupational Professionalism

The major social change wrought in Europe by the industrial revolution was the dramatic increase in population numbers, particularly in the cities and the rise of the middle class (Elliott, 1972; Larson, 1977). These social changes were reflected in the broadening of parliamentary democracy in England and France, and with a shift from a feudal agricultural economy to industrial capitalism (Larson, 1977). This led to a gradual reversal of the relationship between social status and work with a market-place value: the latter (rather than birth station) became the predominant marker of the former (*ibid.*; Elliott, 1972).

2.1.1.1 Competition Between Guild and Status Professionals: These broad social developments underlie the transition from "status" to "occupational" professionalism in Britain in the late eighteenth and early nineteenth centuries (Elliott, 1972, p.32, and *ff.*). The decline in the relative economic significance of aristocratic sinecure and patronage meant that practicing status professionals now had to compete with parallel guild-affiliated occupational groups in the lucrative new urban and middle-class market for skilled services, while young aristocrats experienced increasing and unaccustomed competition with members of the middle class for entry to the universities and professions (Elliott, *op cit.*). In addition, the emergence of practically useful (particularly scientific and medical) knowledge and technologies compelled members of the traditional three professions to defend their status and privileges on grounds other than birthright and gentlemanly cultivation (Louw, 1992).

These changes were reflected in the College of Physicians in the struggle by *medically* superiorly trained Scottish and Continental medical graduates for equal status with the Oxbridge oligarchy who dominated the College's affairs (Elliott, 1972). Simultaneously, however, physicians as a whole were losing their pre-eminent status among medical practitioners. Surgeons (less than a century after disaffiliating their guild from that of the barbers) obtained a Royal Charter and Royal College of their own in 1800 (*ibid.*).

2.1.1.2 Education as a Criterion of Professional Status: Similarly, an 1815 parliamentary act differentiated between shop-keeping chemists and apothecaries, granting the latter the right to charge fees for prescribing medicines, and their Society the mandate to impose minimum requirements of *relevant* education and clinical experience as conditions of membership (*ibid.*). The rigorousness of the Society of Apothecaries' licencing requirements led to their qualification rapidly gaining wide respect both within the

medical fraternity and with the public, and jointly qualified surgeon-apothecaries (known as "general practitioners") became the most numerous medical men (*ibid.*; Larson, 1977, p.88).

In the legal sphere, formerly guild-associated groups (rather than the status professionals) were simultaneously introducing competency criteria for accreditation: solicitors and attornies had by this stage had a statutory system of articled training and a succession of professional associations for almost a century, but they introduced written qualifying examinations for the first time in the 1820's (Elliott, 1972). In both medicine and law, these developments appear to have originated in the two-fronted battle for credibility and market-share waged by the guild-affiliated groups - against the established elites of the status professionals on one hand, and against untrained charlatans on the other (*ibid.*; Larson, 1977).

Although the status-professional groupings only introduced competency-based admission-criteria very much later in the nineteenth century *(ibid.)*, competence in a specialised field of useful knowledge, as certified by acknowledged authorities in that field, remains one of the currently accepted defining criteria of a profession (Elliott, 1972; Freidson, 1983).

2.1.1.3 The British Medical Act and Modern Professionalism: During the first half of the nineteenth century, the rivalry between the various certifying agencies within the broad fields of law and medicine remained intense, and it was only with the creation of the *General Medical Council (GMC)* by the *British Medical Act* of 1858 that the first - and still archetypal - modern occupational profession was born (Elliott, 1972).

What was distinctive about the GMC was that it was an overarching controlling body for a profession, composed of representatives of the state, of all the pre-existing training and accrediting bodies, and (later) of the profession at large, and delegated by the state to regulate the relationship between the public and the profession on objective grounds (Elliott, 1972). Despite critical challenges from both within and without their ranks, most established and aspirant professions still endorse the dimensions of 'professionalism' which were embodied in the 1858 act:

> "The cognitive dimension is centered on the body of knowledge and techniques which the professionals apply in their work, and on the training necessary to master such knowledge and skills; the normative dimension covers the service orientation of professionals, and their distinctive ethics, which justify the privilege of self-regulation granted them by society; the evaluative dimension implicitly compares professionals to other occupations, underscoring the professions' singular characteristics of autonomy and prestige" (Larson, 1977, p.[x]).

Attornies and solicitors never achieved the same degree of unity with barristers as did the various branches of medicine, but other occupations which developed rapidly in numbers and specialised competence in the wake of the Industrial Revolution, such as architecture, engineering, and other technical and service disciplines, modelled their struggles for recognition and economic protection on those of the 'lower' branches of medicine (Elliott, 1972). Fully ten of the thirteen occupations classified by sociologists in the *1960's* as professions in these classical terms formed national associations in Britain between 1825 and 1880 (Larson, 1977), while over the same period "examinations and qualification for professional membership organised by the professional association itself" gradually replaced more informal guild apprenticeships, and nepotistic recruitment from within the ranks of established elites (Elliott, 1972, p.42).

A similar process occurred in the United States, trailing that in Britain by approximately a decade, but only to a much more limited extent in other countries (apart from those falling under British imperial influence) (Larson, 1977). The fact that professionalism in this form is an almost wholly Anglo-American phenomenon (Freidson, 1983) has been variously explained as being due to the strongly capitalist nature of Britain and North America over the last two centuries (Larson, 1977), and as a manifestation of the strong value placed on autonomy in these two societies, particularly by the emergent middle class (Elliott, 1972).

In that they provide a public and apparently objective basis upon which professional bodies can base their regulating functions, codes of professional ethics form the interface between this desire of the individual professional for autonomy, and the possibly conflicting public desire for accountability (Frankel, 1989). Alternatively, Larson (1977) has described professional ethical codes as a compromise between the gentlemanly honour-codes of the pre-industrial, only incidentally remunerative status professions, and the economic protectionism and quality-assuring rationales of the craft guilds.

2.1.2 Critiques of the Classic Professional Model

Although many of the currently powerful professions had established themselves to some degree by the end of the nineteenth century *(see above)*, the current century has seen a mushrooming of other occupational groups clamouring for recognition as professions, on purportedly similar grounds and by similar means to those demonstrated by the archetypal profession of medicine (*ibid.*; Elliott, 1972; Freidson, 1983; Wilensky, 1964). Theoretical

writers prior to the 1960's tended to accept the rationales of the established professions, as outlined above, at face value; however, these have been challenged on a number of grounds, which reflect both the heterogenous factors which contributed to the development of occupational professionalism in the nineteenth century, and subsequent social changes (Freidson, 1983; Rueschemeyer, 1983). Some of these debates will be addressed in Section 2.2.4, with specific reference to Psychology.

2.2 PSYCHOLOGY AS A PROFESSION

2.2.1 Professional Development of Psychology in the U.S.A.

The professionalisation of Psychology first came to maturity in the U.S.A., rather than in Britain, and almost a century after the passing of the 1858 British Medical Act. However, similar factors were operative to those already discussed with regard to the 'classic' professions, namely, the growth of a field of useful scientific knowledge, social change, and individualistic values.

2.2.1.1 Early Roots: Psychology as Abstract Science: Although psychiatry remains to this day a separate discipline, and was not to strongly influence Psychology until World War I, the earliest modern roots of contemporary applied Psychology are to be found in reforms of the treatment of the mentally ill in the early nineteenth century (Phares, 1984). Pinel (in France), Tuke (in England), and Todd and Dix (in the U.S.A.) had at this time attempted to replace the cruelty and prejudice of earlier treatment of mental patients with humane care and scientific enquiry into the origins of their problems (*ibid.*; Sundberg, Tyler & Taplin, 1973). The tradition of rational enquiry into the origins and treatment of mental disturbance was continued through the latter part of the century by (mostly continental European) figures such as Kraeplin, Charcot, and Freud and his associates (*ibid.*).

During the late nineteenth century, however, Psychology *per se* was identified with the somewhat different tradition of (largely Anglo-American) scientists like Galton, James, and Cattell, who investigated non-pathological mental processes such as memory, learning, and reaction times on a strictly empirical basis, in the tradition of earlier German pioneers such as Wundt (*ibid.*; Steere, 1984). Although Galton and Cattell, in particular, had high hopes that the results of this research would eventually be usefully applied in selection and diagnostic procedures, the primary focus of the *American Psychological Association (APA)*

when it was founded in 1892 was on the advancement of Psychology as a *science*, rather than as an applied profession (Phares, 1984).

2.2.1.2 **Psychology Emerges as an Applied Discipline:** Nevertheless, the first psychological clinic (for assessing problematic school pupils) was founded by Witmer at the University of Pennsylvania in 1896, and it was followed by several others over the next few years (*ibid.)* Some of these clinics came under the influence of the European psychoanalytic tradition as they broadened their focus from learning to behavioural problems in pupils *(ibid.)*. Meanwhile, in 1908 Binet and Simon released in France the first standardised intelligence test for children *(ibid.)*. In 1916, the release by Terman and his colleagues at Stanford University of an American version of Binet and Simon's test came on the eve of the U.S.A.'s entry into World War I in 1917, and so provided American psychologists with a scientific basis upon which to develop the *Army Alpha* and *Beta* intelligence tests which were used to screen and classify vast numbers of army conscripts according to their ability levels (*ibid.*; Huysamen, 1983; Steere, 1984; Sundberg *et al.*, 1973). Towards the end of the war, some group-administered psychometric measures of personality functioning and psychopathology were also introduced (*ibid.)*.

Although the first training internships in applied psychology had already been instituted in 1908, it was on the basis of the demonstrated usefulness of their psychometric services during and after the war that psychologists began to stake a claim to professional (as opposed to scientific) recognition (Phares, 1984). Accordingly, a division of Clinical Psychology (which at this stage implied *any* applied psychology) was created within the *APA* in 1919, and in 1935 a committee on training standards was formed (*ibid.*). The societal events which expedited the emergence of Psychology as a profession (*i.e.*, World War I) were therefore more time-concentrated than the corresponding social facilitators for medicine's professionalisation (*i.e.*, the Industrial Revolution and urbanisation) (Louw, 1990).

The pre-occupations of the A.P.A. remained primarily scientific, however, and Psychology's professional development lay relatively fallow during the economically straitened 1930's, despite the efforts of the *American Association of Applied Psychology* (founded in the late 1930's) to address the specifically professional issues largely ignored by the A.P.A. (Benjamin, 1986; Louw, 1990; Phares, 1984; Sundberg *et al.*, 1973). Employment opportunities in all aspects of the discipline were limited, and its contribution (of research) to addressing the social problems of the Great Depression was less visible and of less immediately tangible benefit than that of other professions (*ibid.*). During this period

psychologists did consolidate and expand their psychometric expertise from intellectual tests to include various vocational batteries, and projective and other personality tests (Sundberg *et al.*, 1973; Phares, 1984). Although psychologists' applied role thus remained primarily diagnostic, some educational remedial work and parent counselling, and some adult and psychiatric group-work was done *(ibid.)*.

2.2.1.3 World War II: The Emergence of Psychology as a Profession: As had been the case with World War I, it was the U.S.A.'s involvement in World War II which catalysed further rapid professional development in Psychology, rather than the discipline's modest expansions of expertise during the preceding peace (Louw, 1990). Psychologists who served in the American army during the war not only applied their expanded psychometric skills, but - more significantly - began increasingly to work therapeutically with the war's psychiatric casualties, who were so numerous that the psychiatrists were overloaded (*ibid.;* Phares, 1984; Steere, 1984; Sundberg *et al.*, 1973). Some diversification and specialisation of functions occurred, with so-called clinical psychologists beginning to work as much with psychiatric and adult clients as with children, while educational psychologists continued to work primarily in school settings (Phares, 1984; Sundberg *et al.*, 1973).

After the war, the expanded role of clinical psychologists was carried over from military to civilian life as the Veterans' Administration and the National Institute of Mental Health funded hospital posts and internships, and various American states began legislating licencing regulations and bodies for psychologists (*ibid.*). In response to these developments, the APA began from 1944 to address the professional development of Psychology as energetically as it had hitherto the scientific (Sundberg *et al.*, 1973), although this split of focus remains controversial (Phares, 1984).

These developments had a significant landmark in 1949, when an APA-initiated conference at Boulder, Colorado, proposed a "scientist-practitioner" model of doctoral-level university training for clinical and counselling psychologists, which was endorsed by the U.S. Public Health Service (*ibid.*, p.56). The Boulder-model specifications of academic grounding in Psychology and research methods as well as applied training in applied professional skills, as prerequisites for professional registration in Psychology, remains dominant, despite subsequent challenges, discussed in Section 2.2.3 (*ibid.*).

Invigorated by widening recognition as professionals in their own right, American psychologists increased greatly in numbers from the 1940's onwards, as did the number of professional publications and training programmes (*ibid.*; Sundberg *et al.*, 1973). Although psychodiagnostics lost ground to psychotherapy in psychologists' concerns, the theoretical

influence of psychoanalysis which had dominated the field since the late 1930's began to wane in the 1950's, and behavioural, social-learning, cognitive, and existential approaches acquired more prominence (*ibid.).* A growing proportion of psychologists worked in private practice settings (rather than in institutions), and a number of legal battles were successfully fought with the medical profession over the rights of psychologists to treat clients without medical supervision, and to claim reimbursement from medical insurance companies for their services (*ibid.*). The *APA* has played an important role in this professional development, not least through its promotion of professional ethics (as discussed in Section 2.3).

2.2.2 The Development of Professional Psychology in South Africa

2.2.2.1 Early Years: Psychological Testing: In South Africa, as in America, psychology first expressed itself as an applied discipline through psychological testing - as early as 1915, attempts were made to test Zulu children with modified versions of the Binet-Simon scale, and shortly after World War I a number of university-based psychologists began developing intelligence tests for use in South African schools (Huysamen, 1983). Prominent among these was Prof. E.G. Malherbe, who also provided psychological input on the Carnegie Commission of Enquiry (O'Meara, 1983). Adaptations of the Stanford-Binet tests for use with white South Africans were published by Eybers in 1925 and Fick in 1927, and the *South Afican Group Test of Intelligence* was published in 1930 by a Department of Mines committee chaired by Wilcocks (Huysamen, 1983).

Since 1929, the *National Bureau of Educational Research* of the national Education department (and from 1969, its successor, the *South African Institute for Psychological and Edumetric Research* of the *Human Sciences Research Council [HSRC])* has co-ordinated the adaptation and/or development of a range of intellectual, interest, and personality psychometric tests for South African use (*ibid.*; Louw & Edwards, 1993). Critical discussion of the HSRC's contribution to South African Psychology is to be found in Sections 2.2.3 and 2.2.4.

2.2.2.2 World War II and Expanded Applications of Psychology: The development of original and adapted psychometric tests for adults in South Africa is primarily undertaken by the *National Institute of Personnel Research (NIPR)* (of the *Council for Scientific and Industrial Research,* or *CSIR)* (Huysamen, 1983). This body was founded in 1945 under Simon Biesheuvel, as a peace-time successor to the *South African Air Force Aptitude Testing*

Section he had headed during the war, and concentrates on the psychometric requirements of industry, particularly the mines (*ibid.*; Louw, 1987a; O'Meara, 1983).

As can be seen from the origins of the NIPR, South African psychologists serving in the armed forces during World War II had (like their American counterparts in both World Wars) contributed considerably to the recognition of the discipline as a field of specialised knowledge which could be usefully applied outside of academia - an important milestone in professionalisation (Louw, 1987a). Although there were insufficient psychologists available to provide services to branches of the South African armed forces other than the air force, the stress which the war had placed on South African industry had reinforced these developments, since it had led to the founding of the *Personnel Research Section of the Leather Industries Research Institute* - the first significant application of psychology in the civilian world of work in this country (*ibid.*). Also, as was the case on a larger scale in the USA, a number of psychoanalytically trained refugees from Nazism (including Fritz Perls) were domiciled in South Africa from the mid-1930's until the end of the war, and introduced this perspective to local psychologists and psychiatrists (O'Meara, 1983).

During the war air-force psychologists had expanded their roles from testing to include therapeutic work (again, like their American counterparts) (Louw, 1987b), and it would appear that it was this development, as much as the more prominent testing applications in industry and education, which stimulated the development of more formal professional (as opposed to applied/ task-oriented) structures (Huysamen, 1983; Kruger, 1987; Langenhoven, 1978). Although a psychologist had been appointed in the Department of Home Affairs (which at that stage subsumed the health portfolio) as early as 1923 (Louw & Edwards, 1993), it was only in 1947 that Tara Hospital became the first to appoint a full-time clinical psychologist (Louw, 1987a). It is surely no co-incidence that the following year the South African Medical and Dental Council (SAMDC) proposed that what it called "medical psychologists" should be registered on the roll of its Committee of Supplementary Services (Langenhoven, 1978, p.1.).

2.2.2.3 Professional Development and Controversy Between 1948 and 1974: In 1948, the *South African Psychological Association (SAPA)* was formed in response to this development, and argued for the creation of a separate register and of a controlling statutory body for Psychology independent of the SAMDC, as well as for registration to recognise distinctions between psychometrists and psychologists, and between different specialities of psychologists (*ibid.*). However, the SAMDC was reluctant to recognise these distinctions, and in 1950 SAPA were taken by surprise by the gazetting of provision for the registration

of a single category of "psychometrists" on the Register of Medical Supplementary Services (Langenhoven, 1978, p.1).

During 1951, two protests were made by SAPA to the SAMDC and the Minister of Health: the first requested the recognition of three apparently hierarchical categories, of Psychometric -, Team Worker -, and Consulting Clinical Psychologists; the second and more comprehensive protest requested the creation of an independent statutory council for psychologists, and for registration to differentiate between (apparently equally-ranked) categories of Clinical, Personnel, Industrial, and Educational Psychologists (Langenhoven, 1978). (The nature of the distinction between Personnel and Industrial psychologists is not clear.) The Minister of Health (a doctor) rejected these requests, possibly because the Medical Council had argued that "in the medical field, the term *clinical* conveyed a special meaning and the standard of training in clinical psychology was not at that stage recognised as satisfactory" (*ibid.*, p.2).

Nevertheless, SAPA persisted in its efforts, and in 1955 the SAMDC agreed to distinguish between psychometrists and psychologists in its (voluntary) Register of Medical Supplementary Services (Langenhoven, 1978). Furthermore, SAPA was granted the authority to screen all applications for such registration (*ibid.*). Although some official recognition of the professional status of Psychology had been gained, the discipline remained in a subservient position to the older profession of medicine, with registration being both voluntary, and administered by medicine's statutory council. SAPA had in 1951 been prepared to accept the regulation by the SAMDC of clinical psychologists (but not of other categories), strictly as an interim measure (*ibid.*). The SAMDC's insistence on registering psychologists from all categories (or none at all) was thus interpreted by many psychologists as indicating either bureaucratic imperialism on the part of the SAMDC, or a protectionist attitude among doctors who felt threatened by the growth of a profession which partly overlapped their own (Kruger, 1987).

In 1956 a specifically South African controversy erupted within SAPA, when for the first time an application for membership was received from a person who was not 'white', one J. Naidoo (Louw, 1987b). The issue aroused emotional and deeply divided responses among the membership of SAPA, and fears of its leading to a split in the organisation led to evasive procrastinations in facing it head-on (such as the passing of ambiguous congress resolutions, and the formation of several policy-investigative committees), which lasted several years (*ibid.*). Eventually, at the 1961 SAPA conference, after failing to get racial exclusivity entrenched in the organisation's constitution, a significant minority of SAPA's

membership broke away to form the exclusively white (and largely Afrikaans-speaking) *Psychological Institute of the Republic of South Africa (PIRSA)* (*ibid.*).

Despite direct antagonism from several government ministers (including the then-prime minister H.F. Verwoerd), SAPA continued to exist as a *de jure* non-discriminatory (but *de facto* largely white, and English-speaking) professional body (*ibid.*), and applications by psychologists for registration by the SAMDC were now vetted by an SAMDC-chaired committee composed of equal numbers of SAPA and PIRSA representatives (Langenhoven, 1978). Both organisations continued to attempt to advance the professional status and recognition of Psychology beyond the minimalist standards implied by (non-compulsory) SAMDC registration, but did so independently and sometimes competitively - for instance by maintaining separate registers of qualified psychologists (*ibid.*; Louw, 1987b; 1990).

It was only after SAPA and PIRSA began co-operating more closely on matters affecting the profession as a whole, at the very end of the 1960's, that further progress occurred (*ibid.*). In 1972, the Minister of Health agreed to register practitioners in separate categories of Clinical, Vocational, Industrial, and Research Psychology (with Educational Psychology being added at a later date) (Langenhoven, 1978). Attempts to gain an independent statutory regulatory body for Psychology, on the other hand, had had to be abandoned the previous year as logistically impracticable (because of the small size of the profession) (*ibid.*). In 1973, there was another setback to the recognition of Psychology as a profession autonomous of medicine: the Minister of Health refused to incorporate in the new *Mental Health Act* of that year the recommendations of the Van Wyk Commission of Enquiry that the opinion of a psychologist could be accepted in lieu of one of the two medical opinions required to certify someone mentally ill (Kruger, 1980).

2.2.2.4 Act 56 of 1974: Psychology as a Registrable Profession: The goal of professional autonomy came substantially closer to being realised the next year, with what was theretofore (and remains) the most significant event in the professional development of Psychology in South Africa: this was the passage by parliament of *The Medical, Dental and Supplementary Health Professions Act* (Act 56 of 1974). This act restricts the title of 'psychologist', and the performance of specified psychological activities, to individuals registered as psychologists with a new body created by the act, the *Professional Board for Psychology (PBP) (ibid.)*. The PBP reports to the SAMDC, and is composed of representatives of the SAMDC, the professional psychological associations (*ibid.*), and, more recently, of the training institutions, with direct representation of the lay public

contemplated for the near future (Wassenaar, 1994). However, any decisions the PBP takes regarding Psychology must be in accordance with principles previously approved by the SAMDC, and may not embody principles not yet endorsed by the SAMDC (Becker, 1994).

Like that of the General Medical Council created by the British Medical Act of 1858, the function of the PBP is to protect the public interest (on the delegated authority of the state), by supervising the registration, registration requirements, and disciplining of members of the profession; this is done in terms of the provisions of the act, and of regulations drawn up by the Board and approved by the Minister of Health (Langenhoven, 1978). Many psychologists were - and remain - disappointed that the PBP was created as a subsidiary body of the SAMDC, rather than a completely autonomous statutory body; nevertheless, the passage of the *Medical, Dental, and Supplementary Health Professions Act* was and still is regarded as marking Psychology's coming of age as a profession in South Africa (*ibid.*; Kruger, 1987; Nell, 1992).

2.2.2.5 Non-Statutory Professional Organisations After 1974: However, the function of the PBP is the protection of the interests of the general public, and SAPA and PIRSA continued to provide a means through which psychologists could lobby for their own interests in matters such as fee reimbursements from medical aid societies and public service post and salary structures (Langenhoven, 1978; Louw, 1987b; Wassenaar, 1994). In 1977, clinical psychologists, dissatisfied with the capacity and/or willingness of SAPA and PIRSA to promote the development and standing of their sub-discipline, founded the *Society for Clinical Psychology* (Louw & Edwards, 1993). Similar societies were subsequently formed by counselling and industrial psychologists to attend to their specific concerns (*ibid.*).

Despite SAPA and PIRSA's closer co-operation from the late 1960's (they had even held joint congresses in the late 1970's) (Langenhoven, 1978), both these organisations continued to separately lobby the PBP regarding professional matters, as did the various sub-discipline-specific societies (Wassenaar, 1994). It became increasingly difficult for the PBP to accommodate these various, sometimes contradictory, representations *(ibid.)*; organisational fragmentation of what was still a relatively small profession limited its effectiveness in representing its interests (Louw, 1987b). In addition, changes in Nationalist government rhetoric, from rigid apartheid towards tentative racial reconciliation, had undercut the *raison dtre* for PIRSA's continued 'principled' separation from SAPA (*ibid.*).

Consequently, at a conference held in Bloemfontein in 1982, SAPA and PIRSA united to form the racially non-discriminatory *Psychological Association of South Africa (PASA)*, into which the then Societies of Clinical, Industrial, and Counselling Psychology were incorporated as subsidiary 'institutes'; Institutes of Research and of Educational Psychology were also created (Wassenaar, 1994; Louw & Edwards, 1993). On occasion, conflicts between the Clinical and Industrial Institutes, on the one hand, and the Educational and Counselling Institutes, on the other, seemed to echo the old rivalry and ideological differences between SAPA and PIRSA respectively (Louw, 1987b). Nevertheless, PASA survived these stresses intact, and South African psychologists had a single unified voice to represent their guild interests, for the first time in more than two decades. The organisation was active in this regard on several fronts, co-ordinated the publication of a number of professional journals, and also promoted the development of professional ethics (as will be discussed in Section 2.3.3).

Starting in 1985, the Institute of Clinical Psychology made a series of public statements (*reprinted in* SAICP, 1985a; 1986; 1987), critical of the inhumane consequences of government policy. After embarrassingly arduous debate, a similar statement was eventually endorsed by PASA as a whole, and published by the British Psychological Society in 1988 (Wassenaar, 1994). Possibly in consequence of this tentativeness on the part of PASA, psychologists' responsibilities to society, and in particular to South Africa's specific social problems in the apartheid years, were more vigorously expressed through other organisations. (In its apparent preoccupation with guild issues rather than service ones, PASA is by no means unique among professional organisations, either in South Africa or internationally [Abbott, 1983].) In 1981, the activist *Psychology and Apartheid Committee* was formed in the Western Cape, but a more significant development was the formation of the *Organisation for Appropriate Social Services in South Africa (OASSSA)* in 1983 (Louw & Edwards, 1993).

OASSSA was explicitly aligned with anti-apartheid political movements, and aimed to encourage the development of social service and mental health policies, services, and training more appropriate to the needs of South Africa's politically and economically disadvantaged majority population than those provided under apartheid (Dawes, 1986; de Beer, 1986; Hayes, 1986; Vogelman, 1986). To this end, a journal *(Psychology in Society)* was published, regular conferences and policy working groups were organised, and such psychological services as the organisation's meagre resources permitted were provided to victims of apartheid (*see* Eagle *et al.*, 1989, various contributions). After several years of

financial problems and falling membership, in 1992 OASSSA amalgamated with a number of other (some much larger) left-wing health and social service organisations to form the *South African Health and Social Services Organisation (SAHSSO)*, in which the discipline-specific interests of psychologists are not pre-eminent (Louw & Edwards, 1993).

Although an increasing number of people who were not white had been entering the psychological profession from the 1960's onwards, PASA (to its increasing disquiet, and despite its non-racial constitution) failed to attract these psychologists to its ranks in significant numbers. In order to address this problem, the constitution of PASA was substantially revised in 1990, and in January 1994, three months before the country's first democratic election, the organisation again re-constituted itself, this time under the new name of *The Psychological Society of Southern Africa (PsySSA)* (Wassenaar, 1994).

South African psychologists had achieved a fairly secure professional position by the mid 1990's, but, as the various re-groupings of organisations discussed above imply, the appropriate role of the profession during and after current dramatic social changes remain contentious issues. Some of these arguments will be developed below.

2.2.3 Re-Evaluations of Psychology as 'Applied Science'

2.2.3.1 Scientific Status, Usefulness, and Accountability: Although some professions (*eg.*, Law) are rooted in specialised non-scientific knowledge (Louw, 1990), psychologists from most schools have from the beginning generally hitched the wagon of their professional standing to the star of science, even before this coalition was formalised by the Boulder Conference in 1949 (Benjamin, 1986; Bevan, 1976; Louw, 1990; Riebel, 1982; Wood, Jones & Benjamin, 1986). However, despite a steady cumulative increase in the volume and integration of psychological knowledge since the last century, the public standing of the applied profession has waxed and waned inconsistently: the relationship between scientific substrate and professional status is mitigated by other variables (*ibid.*).

The era since World War II has seen a shift in the public attitude toward science and technological advancement: in the light of issues such as the nuclear threat and increasingly obvious environmental despoilation, uncritical adulation has gradually lost ground to *fin de siecle* cynicism about the hidden costs of science and technology, and demands by legislators that publicly-funded research and services should yield immediately tangible benefits (*ibid.;* Bevan, 1976; Capra, 1982; Kates, 1994; Walsh, 1982).

2.2.3.2 Psychology's Perceived Scientific Shortcomings: Psychology has been especially disadvantaged relative to other disciplines by these developments - for instance, by reductions in state-funding for training, and by a temporary removal of Psychology from the (American) National Science Foundation's list of funded disciplines (Benjamin, 1986). In South Africa in late 1994, the HSRC mooted the blocking of further research grants for masters students in applied Psychology (Wassenaar, 1994).

More importantly, however, despite the above-mentioned increasingly qualified nature of public admiration for science, the scientific paradigm (of coherent, reliable, and useful analysis of events, and intervention in them) remains an important yardstick in determining the public prestige of a discipline (Benjamin, 1986; Walsh, 1982; Weinberg, 1994). At least some of both research and applied Psychology's disipline-specific current credibility problems derive from alleged deviations from this ideal - although some of these allegations are well-founded (Keith-Spiegel & Koocher, 1985; Strupp, 1976), others stem from misunderstandings of the nature of science.

The mushrooming of the discipline's knowledge-base and number of applied practitioners and practices since the 1940's has led to a proliferation of theoretical approaches (and consequently, also of theoretical disputes) exceeding those of the 1930's, with many of the newer approaches in applied Psychology having shallow roots (if any) in the tradition of empirical verifiability (Corsini, 1984).

Psychology may sometimes lose credibility in the public eye relative to other disciplines no more scientific, but whose subject matter is less apparently accessible to, or of less inherent interest to, non-specialists. For instance, face-value contradictions inherent in the dual particle- and wave-nature of light may trouble the man in the street less than complementary approaches to psychopathology, child-rearing, or criminal responsibility.

Nevertheless, even when qualified as above, the scientific paradigm still remains influential, and it demands the closest approximation of empirical objectivity possible under any given circumstances - and obfuscating interactions between scientific observer and his/her subject are *indeed* much more difficult to control for when the subject matter is human behaviour and experience than when it is physical phenomena (Bevan, 1976; Doherty, 1986). Applied interventions in the psychological sphere are similarly less reliably predictable and measurable in their effects than are manipulations of purely physical phenomena. For instance, Marxists, the anti-psychiatry movement, and other critics have forcefully argued that the purportedly objective scientific criteria according to which psychological knowledge is acquired and evaluated are deeply dependent upon

western philosophical assumptions emphasising individual and conservative values over community or progressive ones (Holzkamp-Osterkamp, 1991; Maiers, 1991; Masson, 1988; Szaz, 1974; Tolman, 1991; Vogelman, 1986). More disputably, it has also been argued that this approach *inevitably* reinforces existing social inequalities *(ibid.)*.

2.2.3.3 **Psychology as Science in South Africa:** In South Africa, it is true, the use of simulatedly 'scientific' psychological research as a Trojan horse for sectarian political objectives has sometimes been shamelessly explicit - for instance, in exhortations (*eg.*, in 1967 and 1972) by PIRSA to its members to bolster apartheid's moral authority by researching and documenting psychological differences between races (Dawes, 1985). At the other end of the political spectrum, so-called progressive psychologists are unapologetically blunt about the socio-political motives underlying much of their work (OASSSA, 1986, & Eagle *et al.*, 1989, *various contributions)*. More subtly and more commonly, value-bias has expressed itself in the selection of research topics and subjects: white school children formed the overwhelming majority of experimental subjects in published South African psychological research prior to 1939 (Louw *et al.*, 1993).

Comparable criticisms of selective focus have been compellingly levelled against South African psychological research and teaching right up to the present time, even in liberal university settings (Daniels, 1994; Dawes, 1985; 1986a; 1986b; de Beer, 1986; Liddell & Kvalsig, 1990; Mauer, 1987; Mauer, Marais & Prinsloo, 1991; Raubenheimer, 1981; Vogelman, 1986). Some attempts to redress these imbalances also come in for criticism from the same quarters, as being nave or counterproductive in the uncritical manner in which they have taught and applied western, first-world research and assessment paradigms in a country whose population mostly have different backgrounds and life contexts (*ibid.*).

While there is general acknowledgement of the shortcomings of South African Psychology as regards the white-biassed target of its research, the appropriateness of western scientific paradigms for research on the country's heterogeneous population is more contentious. A number of authors (*eg.*, Biesheuvel, 1987; Gilbert, 1989; [G.] Louw, 1992; Nell, 1990; Retief, 1989) have balked at the apparent rejection of the applicability of orthodox psychological research methodology to the South African context by authors such as Dawes (1985; 1986a; 1986b), de Beer (1986), Foster (1986) and Vogelman (1986; 1989). The former group see empiricism and a focus on individual behaviour as defining characteristics of Psychology, and the undercutting of these as emasculating the discipline's distinctive (if necessarily circumscribed) potential contribution to the welfare of the population. The latter, in common with overseas authors from the critical tradition

(Holzkamp-Osterkamp, 1991; Maiers, 1991; Tolman, 1991), see this focus as culpably ignoring broader (socio-political-economic) influences on behaviour and experience.

While this debate has roots in deeply differing philosophical world-views and assumptions, and extends beyond the South African context, the controversy nevertheless has a particular local twist. In the shadow of apartheid and of resistance to it, and of the apartheid-justifying research rationale of PIRSA, advocating research into the differences between disadvantaged social groups and those upon whom the bulk of psychological research has been conducted has divisive connotations in South Africa, whereas this approach is normative in overseas critical Psychology (Dawes, 1985; Kottler, 1988; 1990).

2.2.4 Re-evaluations of Psychology as a Profession

While acknowledging the various qualifications raised above, this thesis will assume that Psychology, like any aspirantly scientific discipline (Weinberg, 1994), remains *more or less* a value-neutral set of tools for interpreting and intervening in events (Bevan, 1976). Any such tool-set based on an expanding knowledge-base is perforce circumscribed and provisional, pending further advances *(ibid.*; Capra, 1982; 1983; Weinberg, 1994). Nevertheless, it is the conduct of the agents wielding it that determines whether the two-edged blade of any existing body of knowledge (and related technology for expanding or applying such knowledge) is used as a ploughshare (to till whose field?), or as a sword (in whose service?). This section is concerned with debates in around these questions.

2.2.4.1 Racial Inequalities in Psychological Services in South Africa: As is the case with psychological research, South African psychologists have tended in their service provision to till the fields of advantaged whites, at the expense of those of other population groups (Daniels, 1994; Dawes, 1986b; de Beer, 1986; Hayes, 1986; Vogelman, 1986). For instance, until very recently the primary target group of the psychological tests developed by the HSRC has been white school pupils (Huysamen, 1983; Louw, 1987b).

Furthermore, even with regard to the tests developed for other groups, the reservations expressed in a recent HSRC re-evaluation of its own published tests is worth noting: "The dearth of cross cultural validity and bias studies pertaining to these tests is little short of alarming, but has only recently come to be viewed as such" (England, 1991, p.60).

Similar complaints have also been levelled against NIPR-developed tests; further, some tests developed and standardised by the NIPR have been criticised as serving the interests of (white-aligned) employers, rather than those of the (largely black) worker populations to

whom they are applied (de Beer, 1986; Louw, 1988; Dawes, 1986a; 1986b; Vogelman, 1986).

As regards the provision of direct psychological services to the South African public, virtually the only psychologists employed outside of universities prior to 1939 worked in (white) provincial education departments (Louw, 1987a). Similarly, when psychologists began to be employed in the government health sector following World War II, they were initially exclusively drawn from, and as restrictedly served, the white population group (*ibid.;* Daniels, 1994; de Beer, 1986). State psychological services rendered to the black population in health and education (and more markedly those available to Indian and so-called Coloured groups) improved slightly from the 1960's onwards, but gross imbalances remained entrenched in these services right up until South Africa's transition to democracy in 1994, and will take years to redress (Daniels, 1994; de Beer, 1986; Floyd, 1986; Vogelman, 1986; 1989). Psychologists in private practice in South Africa have also tended to be mostly white, and they have inevitably served the needs only of those able to afford their services, *viz.* predominantly affluent whites *(ibid.)*.

2.2.4.2 **Controversies About Values in Applied Psychology:** But it is not only the *extent* of psychological service provision to South African disadvantaged communities which has come under fire: conventional techniques of paternalistically applying, to individual clients, individualistic western concepts of optimal personality functioning, its aberrations in psychopathology, and the individual resolution of these aimed at by most psychotherapies have also been criticised as inappropriate to the South African context.

Firstly, as was mentioned above with regard to psychological research, this approach is seen as culpably ignoring socio-political-economic determinants of behaviour and experience (Dawes, 1985; 1986a; 1986b; de Beer, 1986; Prinsloo, 1989; Swartz, 1988; Vogelman, 1986; 1989). Western-trained psychologists have been criticised for - at best - aiding their clients to better accommodate themselves to pathogenic injustices, rather than empowering them to confront these *(ibid.)*. Even interventions sensitive to this issue can be complicated by the ambivalent compromises with the political *status quo* which both psychologists and disadvantaged clients are often circumstantially forced to make (Seedat & Nell, 1992). These problems are by no means unique to South African psychology; their manifestation in American Psychology is described in detail by Simon (1983).

On the other hand, it has been contested whether attempting to *directly* confront broad socio-political-economic causes of individual and community distress is the primary responsibility of psychologists *qua psychologists,* as opposed to, say, as citizens (Biesheuvel,

1987; Nell, 1990). In fact, the *International Union of Psychological Science* in 1976 passed a resolution implying that "psychologists should not use their professional position and methods to promote social issues or movements that they may endorse as private citizens" (Pedersen & Marsella, 1982). Although the glaring nature of local social injustices intensifies this debate in South Africa, it has parallels in the international literature (Holzkamp-Osterkamp, 1991; Maiers, 1991; Tolman, 1991).

Secondly, untempered applications of individual-focussed Western psychology in the South African context are sometimes seen as incompatible with more communitarian traditional African concepts of being human, of illness, and of appropriate healing strategies (Bodibe, 1993; Mjoli, 1987; Nzimande, 1989). Psychological applications which do not take account of such cultural differences can be interpreted as simply an expression of cultural repression or imperialism (*ibid.;* Dawes, 1986a; 1986b; Prinsloo, 1989; Vogelman, 1986; 1989). These problems have likewise been encountered in applications of Psychology, deeply rooted in Western philosophy and science, in other (*e.g.*, Eastern) cultural contexts with flourishing alternative world-views and intellectual traditions (Nixon, 1991).

Similar disputes can arise even within Western societies and culture. In 1973, the APA declared that "counseling of persons of culturally diverse backgrounds by persons who are not trained or competent to work with such groups should be regarded as unethical" (Pedersen & Marsella, 1982, p.492). Given the unavailability of such appropriate training, this decision may in fact *limit* psychologists' capacity to render services to disadvantaged groups, since "minority populations... constitute a resounding majority of the client population to be served" (*ibid.*, p.497).

A number of authors have also argued that many professional applications of Psychology (particularly psychotherapy), in their focus on individual behaviour and experience, may encourage in the individual client narcissistically mean-spirited values, to the detriment of other individuals and of the broader community (Cushman, 1990; Lasch, 1980). There are, of course, counter arguments (and even research findings) indicating that increased self-knowledge and -actualisation leads to a *less* selfish approach to others (Perloff, 1987; Waterman, 1980), and applied Psychology has even been criticised for *failures* to adequately address clients' individual rights (Hare-Mustin *et al.*, 1979). The full extent of this ancient philosophical debate is beyond the scope of this dissertation.

Thirdly, South Africa's resources simply can not accommodate an extension to formerly disadvantaged groups of the same expensively high psychologist-client ratio currently normative in individual-based services to whites (Daniels, 1994; Dawes, 1986a; 1986b;

Prinsloo, 1989; Vogelman, 1989). There are consequently increasingly strident calls for South African psychologists to move from individualistic towards group- and community-oriented interventions *(ibid.)*.

This trend is supported by calls to move from a conception of professional psychologists as a freemasonry (allegedly avariciously restricting to fellow guild-members the opportunity to profit from the application of their esoteric techniques), towards a model of practice which has psychologists disseminate their skills and provide a consultancy service to other (less expensively trained) service providers, rather than directly attend clients themselves *(ibid.*; Louw, 1988). In the USA, the APA spends more on ethical enforcement than does any other American professional organisation (Keith-Spiegel & Koocher, 1985), but Psychology's capacity to regulate itself in the public interest, rather than that of the guild, has still been seriously questioned from both within and without the profession (*ibid.;* Sinnett & Linford, 1982) - as has Psychiatry's (Taylor & Torrey, 1972; Zitrin & Klein, 1976).

Similarly, and finally, in line with the general international tendency to expect greater democratic accountability of professionals to their clients (Benatar, 1987b; Hare-Mustin, 1979; Jacobs, 1983; Strauss, 1987a; 1987b) *(see Section 2.1.4)*, a more consultative (as opposed to paternalistic) approach to rendering psychological services in South Africa is being widely advocated (Daniels, 1994; Dawes, 1986a; 1986b; [G.] Louw, 1988; 1992; [J.] Louw, 1988; 1990; 1992; Prinsloo, 1989; Villa-Vicenio, 1987; Vogelman, 1989). On the organisational level, this trend is demonstrated by the recent inclusion of members of the lay public on the South African Professional Board for Psychology (Wassenaar, 1994).

2.2.5 The Relevance of Ethical Codes to Current Professional Trends

2.2.5.1 Codes as an Interface Between Profession and Society: Taken together, these various critiques and emerging trends in professional Psychology reflect both an interesting juggling of values inherited from the guilds and status professions, as well as the introduction of new elements. To start with (Hare-Mustin *et al.*, 1979), the air of entitlement and feudally paternalistic attitude to clients, inherited from status professionals, are no longer acceptable to clients in view of the permeation of democratic enpowerment to all levels of Western and (belatedly) South African society. Similarly, the approaches of selling services only to those able to afford them, and of unapologetically

forming economic cabals dedicated more to the interests of the service-providers than of their clients, inherited from the craft-guilds, have also come under fire.

However, collective action in pursual of their interests by other occupational groups (*eg.*, trades union) is accepted with equanimity in the quarters critical of the self-interest demonstrated by professional groupings. Similarly, the increasingly consumerist attitude of clients (to which the guild functions of professional organisations are intimately related in both origin and function) has been as potent a force as any other in increasing both the accountability and the quality of professional services (Jacobs, 1983). While it is true that psychologists enjoy a privileged position in society, still more powerful groups exist in the workplace (Medicine springs immediately to mind), and sauce for the goose is, surely, sauce for the gander. Nell (1992) and [J.] Louw (1992) argue forcefully that the creation for South African Psychology of a controlling statutory body independent of the SAMDC (such as has been achieved by Nursing and Pharmacy) would be as much in the interests of clients as of the psychologists serving them.

As is the case with the values originating in the craft guilds, not all the values inherited from the status professions are currently either lost or under attack. The increasing guild-like emphasis on technical prowess in professional self-definition and corporate advocacy, at the expense of values (*e.g.*, disinterested service) derived from the status professions, has been lamented as depersonalising the quality of client service (Dyer, 1991). There is also an ironic echo the concept of *noblesse oblige* in its original sense in contemporary re-emphasis on professionals' accountability both to particular clients and to wider society, on whose mandate professional privileges now democratically depend.

Consequently, by specifying mutually acceptable conditions upon which professional privileges are permitted by the rest of society, most written codes of ethics attempt to regulate (and hence indirectly preserve) the traditional autonomy of the professional in dealing with clients, and that of the profession as a whole in relation to society (Abbott, 1983). Psychology has also been analysed in these terms (Hare-Mustin *et al.*, 1979).

2.2.5.2 Difficulties Inherent in Code Development and Application: However, this is more easily said than done: any attempt to operationalise philosophical concepts or values is fraught with inherent difficulties and limitations, and the development and administration of professional ethical codes is no exception (Bedau, 1992; Gewirth, 1985; Goldman, 1992).

In addition to serving an enabling function for professional self-regulation, codes may contain both obligatory rules and merely aspirational values, and further difficulties may arise because of failure to distinguish between these various functions (Frankel, 1989), or when the profession's values conflict with those of broader society (Goldman, 1992). South Africa's complex and rapidly changing society seems to make professional value development generically difficult in this country, as has been described (with varying degrees of critical awareness) for Accountancy (Gardner, 1990), Work Study (de Beer, 1990), Librarianship (Merrett, 1988), Social Work (O'Neil, 1993), Medicine (Benatar, 1987a; 1987b), Veterinary Science (van der Made, 1987), and Educational Administration (Gounden 1991). The following section discusses the difficulties experienced by (South African) Psychology in developing and implementing a practical set of professional values which is widely acceptable both among the members of the profession and among their constituency.

2.3 ETHICAL CODES IN PSYCHOLOGY

2.3.1 Professional Ethics in American Psychology

2.3.1.1 Professional Controls Before the First Code: In 1938, the APA formed a special committee to consider drafting an ethical code for Psychology (Golann, 1970). This committee instead to form a standing committee to consider complaints of unethical conduct concerning relations between psychologists and various other parties *(ibid.)*.

Largely as a result of their war work, psychologists more than tripled in number over the next seven years, and they also began increasingly to work in applied fields, thus increasing the range and scope of possible ethical malpractices *(see Section 2.2.1)* (*ibid.*; Koocher, 1983). From 1945 American states consequently began legislating requirements for the certification of psychologists (which restrict the use of the title *psychologist* to those so registered in law), and, later, licencing requirements (which afford the public the added protection of legally restricting the performance of specified psychological functions to certified psychologists) (Stigall, 1983).

2.3.1.2 The Development of Formal Ethical Codes in American Psychology: In response to these developments, the APA again formed a committee in 1947, to develop a written ethical code for the profession - both because the statutory regulations provided little guidance for professional practice after certification and/or licencing, and in order to maximise the acceptability to psychologists of regulations controlling their practice

(Koocher, 1983). The original ethics committee continued in the meanwhile to adjudicate on complaints as before, while the new committee involved the general APA membership in an exhaustively consultative process of code development *(ibid.*; Golann, 1970). Although the completed code of ethics was formally adopted by the association only in 1953, six years after its development had begun, Golann (1970, p.400) speculates whether "the process by which this document was developed was not as significant a means of encouraging high standards as the product itself". The APA publishes reports of its activities on an approximately annual basis (*e.g.*, APA Ethics Committee, 1990; 1991; 1993; 1994), and regularly reviews its codes in consultation with its membership.

2.3.2 Alternative forms of Professional Regulation in the USA

Although the professional regulation of Psychology in the USA therefore appears fairly simple, it is unfortunately complicated by a number of other factors. In the first place, the conduct of any particular psychologist often falls under several overlapping jurisdictions (*eg.*, the APA, a state licencing board, and a state psychological association), and disciplinary procedures can thus become complex and protracted - even though these bodies usually use the same (or very similar) ethical codes (Keith-Spiegel & Koocher, 1985). More to the point, however, a number of other professional and statutory bodies to regulate the practice of psychology have also arisen over the years, but it is unfortunately beyond the scope of this thesis to review these.

2.3.3 The Development of Professional Ethics in South African Psychology

As was the case with the introduction of enabling legislation in the United States, the passage in South Africa of the *Medical, Dental and Supplementary Health Professions Act* of 1974 situated the profession within a legal framework *(see Section 2.2.2)*. However, the provisions of the Act deal only with fairly coarse instances of malpractice, and fall far short of providing clear and practically useful guidelines regarding more subtle ethical complications which arise in daily practice (Wassenaar, 1994).

Prior to 1974, SAPA had circulated an ethical code (undated, *cited in:* PASA, 1987) which was apparently based on an early version of the APA code, but no formal structures seem to have existed to ensure that members conducted themselves in accordance with its provisions (Wassenaar, 1994). It is unclear what ethical codes or structures were in effect in PIRSA subsequent to this group's secession from SAPA, but by the time PASA was

formed in 1982 *(see Section 2.2.2)*, there was increasing general anxiety on the part of practitioners for more detailed ethical guidelines. Enquiries about the quality of psychological services were also being received in increasing numbers from the general public *(ibid.)*.

2.3.3.1 The 1985 SAICP Ethical Code: Consequently, in 1984, the (PASA-subsidiary) *South African Institute of Clinical Psychology (SAICP)* prioritised the formulation of a more comprehensive ethical code. D.R. Wassenaar was deputised to lead this project, assisted by J. Steere (a modified version of whose Masters thesis on professional ethics in Psychology was published in the same year [Steere, 1984]) *(ibid.)*. These two authors adopted the relatively expedient approach of condensing into a single document the provisions of the South African *Medical, Dental, and Supplementary Health Professions Act (Act 56 of 1974)*, the PBP *Rules for Psychologists* (SAMDC, 1977, *cited in* Steere & Wassenaar, 1985), the British Association of Behavioural Psychotherapy *Ethical Guidelines (undated, cited ibid.)*, the Ontario Board of Examiners in Psychology *Standards of Professional Conduct* (1985, *cited ibid.*), and the APA *Ethical Principles* (1981); other available ethical codes for psychologists were found to be largely based upon the APA principles (Wassenaar, 1994).

After publication of the resulting document, as *Ethical Principles of Clinical Psychologists (Provisional Draft)* (Steere & Wassenaar, 1985), Steere ran workshops in major South African centres, introducing psychologists to the principles and their application (Wassenaar, 1994). In 1985, the SAICP established its own ethics committee (chaired by Wassenaar) to assist clinical psychologists and their clients (SAICP, 1985b), which published details of its activities in subsequent SAICP Chairman's Annual Reports. Shortly afterwards, the Institutes of Counselling and Educational Psychology also established ethics committees, which both formally adopted the Steere and Wassenaar (1985) ethical code for their members (Wassenaar, 1994).

In one of the very few published commentaries on the SAICP document, the code has been criticised along the same lines as the general critiques of the profession discussed in Section 2.2.4. Swartz (1988) berates the *Ethical Principles* for sufficiently addressing neither socio-political-economic influences on behaviour and experience, nor psychologists' obligations in response to such factors in South Africa. A number of other authors, although not directly referring to the Steere and Wassenaar (1985) code, have also written on the particular ethical problems confronting psychologists and related professionals working in South Africa during the period of conflict preceding the transition to

democracy (*eg.*, Eagle *et al.*, 1989 *[various contributions]*; Jenkins, 1987; Manganyi, 1987; OASSSA, 1986 *[various contributions]*; Seedat & Nell, 1992). Steere and Dowdall (1990) argue that the complexity of the South African situation:

> "...demonstrates, firstly, that it may be a mistake to assume that... consensus exists (among members of the profession, about appropriate responses to these problems), and, secondly, that where consensus cannot be assumed ethical codes are *unable* to provide a standard for conduct.." (*ibid.*, p. 14, emphasis and parenthesised comment added).

2.3.3.2 Applications and Committees in Professional Ethics: Also in 1985, the PASA executive independently initiated the development of an ethical code for psychologists. Although the resultant document (PASA, 1987) showed some reference to Steere and Wassenaar (1985), it was more similar to the old APA code. Moreover, although the 1987 PASA code contained some sketchy guidelines for resolving ethical dilemmas, it was generally perceived as being inadequate for applied practitioners (Wassenaar, 1994). Since most PASA members were already using the SAICP code, some confusion inevitably resulted, and the 1987 code was never formally endorsed by PASA's subsidiary institutes of applied Psychology *(ibid.)*. The 1987 PASA code was thus used - if at all - only by research psychologists and unregistered psychology graduates in academic settings *(ibid.)*. Notwithstanding the above-mentioned difficulties, therefore, the Steere and Wassenaar (1985) code has continued to serve as the primary practical ethics reference for South African clinical, educational and counselling psychologists (Wassenaar, 1994).

To complement publication of the 1987 PASA code, in 1988 the PASA executive formed an overarching ethics committee for the association. The resultant *Council Committee on Malpractice and Offences (CCMO)* was initially chaired by Dr R.Prinsloo, and from 1993 by D.R. Wassenaar *(ibid.)*. At its inception, this committee was intended to deal only with ethical matters affecting the psychological profession as a whole, and with matters referred to it by the ethics committees of PASA's subsidiary Institutes. However, after a year it became clear that the duplication of committees was unnecessary, and the category-specific ethics committees were disbanded *(ibid.)*.

2.3.3.3 Problems in Ethical Enforcement: Verschoor and Alberts (1990) list a number of respects in which the enforcement by the SAMDC of ethical regulations for all the professions falling under its jurisdiction has at times lacked the consistency and transparency of even South Africa's less-than-perfect courts. For instance, not all the bases upon which the SAMDC or its subsidiary boards may take action for malpractice are specified in the regulations available to the rank and file of the relevant professions. This

is confusing - even if some reference to extra-textual norms is inevitable in the administration of *any* written code of conduct (Sunstein, 1990), and if some professions (such as British accountants) have disciplinary structures but no written codes (Abbott, 1983). The outcome of SAMDC or PBP disciplinary investigations are public domain, but they are not always made widely known - and even where they are, the possible mitigating or extenuating circumstances responsible for discrepancies in the punishments meted out for different instances of the same offence are discussed *in camera*, and not usually specified in the verdict, as they are in the criminal courts (Verschoor & Alberts, 1990).

More worryingly (*ibid.*; Strauss, 1987b), SAMDC disciplinary committees are not bound by the rules of precedent or admissability of evidence which are operative in the criminal courts, nor are the (medical or related) professionals composing them trained in legal procedure, nor (yet again) is frequent use made by the Council of its facility to consult expert legal opinion in determining a verdict or sentence (the accused is also entitled to legal representation). Verschoor and Alberts (1990, pp.xx-xxi) state that the SAMDC disciplinary structures have under the circumstances nevertheless apparently maintained a fairly consistent level of "natural justice" - but argue that this is not *stucturally* guaranteed, and there have on occasion been alarming inconsistencies in the outcomes of ethical enquiries. Although the disciplinary decisions of statutory bodies may be appealed in the Supreme Court, this may only be done on grounds of procedural irregularity (Strauss, 1987b). A similar situation pertains in the United States (Jacobs, 1983).

These difficulties in the statutory disciplinary system notwithstanding, numerous cases were investigated by PASA's CCMO annually, a smooth working relationship with the PBP was maintained, and policy and liaison issues were addressed (Wassenaar, 1994). Although separate reports were not published, as they are by the APA Ethics Committee (*eg.*, APA Ethics Committee, 1990; 1991; 1993; 1994; *see also* Keith-Speigel & Koocher, 1985), the activities of the CCMO were reported annually as an item in the Presidential address at the PASA congress (Wassenaar, 1994).

Although the ethical issues, difficulties, and common complaints in South African Psychology appeared from these addresses to parallel those encountered by the APA, to date no systematic analysis of the frequency, type, source, or outcome of such complaints has been published in South Africa *(ibid.)*. Such an analysis is currently being done by D.R. Wassenaar, and will hopefully be helpful in future revisions of legislation and ethical guidelines, and in initial and continuing ethical education.

2.3.3.4 The Drafting of New Professional Regulations, 1992-1994: In 1992 the CCMO became aware that the PBP was revising its regulations for psychologists (similar projects were underway for all professions falling under the jurisdiction of the SAMDC), and made representations to the PBP that this revision should be democratically undertaken, rather than simply imposed by the statutory body *(ibid.)*. The PBP consequently mandated the CCMO to construct a provisional draft of the amended regulations, and (by postal survey) to afford every registered psychologist and psychometrician the opportunity to submit evaluative comments and suggestions on these for consideration in the compilation of a final draft *(ibid.)*. This was done, the provisional new code (SAMDC:PBP, 1992) being basically an updated integration of the SAICP code and the provisions of Act 56 of 1974. Affording individual professionals the opportunity to contribute a code before its adoption was a unique procedure in the history of any South African medically-related profession (Wassenaar, 1994). Although a disappointing overall response to the survey was received, many constructive suggestions were received, and a second, accordingly amended draft (PASA, 1993) was submitted to the board for consideration in August 1993 (Wassenaar, 1994).

At this point, political developments in South Africa as a whole overtook this process - firstly because they had in the interim already indirectly precipitated PASA into passing a resolution to disband and re-constitute itself as PsySSA in January 1994 *(see Section 2.2.2)*. This meant, *inter alia*, that a new ethics committee should be formed, and the consultative process of developing and adopting an ethical code begun afresh *(ibid.)*. The political negotiation process was at this stage placing additional stress on the civil service, and the PBP thus felt under pressure from a number of quarters; further delays were considered too impractical and costly under the circumstances, and the PBP proceeded alone with the revision of the regulations. The amended professional regulations were published by the PBP late in 1993, with the only major revision being some relaxation of the prohibitions on advertising to the general public by professionals (Wassenaar, 1994).

2.3.4 Overview of Ethical Codes for Psychologists

2.3.4.1 The 1981 APA Ethical Principles: The APA *Ethical Principles of Psychologists* (APA, 1981) influenced the development of the first code for South African psychologists, and was in force at the time of the surveys discussed in Section 2.4.2. The *Preamble* of this document makes its provisions binding on APA members, and summarises the values it

embodies overall. The body of the code consists of ten generally-worded principles, and elaborations of the implications of each of these in various practical contexts. Each of the ten principles focuses either on a particular aspect of practice, or on a required value-commitment for psychologists:

Principle 1, Responsibility, urges the pursuit of high standards, and forbids the misuse of psychological findings and techniques;

Principle 2, Competence, limits each psychologist's practice to areas and populations for which they personally have training and experience, and in relation to which they do not have counter-productive problems or conflicts;

Principle 3, Moral and Legal Standards, obliges psychologists to comply with state law and APA standards, and alerts them to the possibly deleterious effects which discrepancies between their personal values and those of their clients might have on their own practice and on the standing of the profession;

Principle 4, Public Statements, restricts the public statements which psychologists may make about the discipline to established facts, and those about their own practice to factual details addressed to other professionals;

Principle 5, Confidentiality, will be discussed in Section 2.4.1;

Principle 6, Welfare of the Consumer, requires psychologists to not abuse their influence over their clients, and to protect clients from negative consequences of interventions arising from the involvement of third-parties;

Principle 7, Professional Relationships, promotes harmonious relationships between psychologists and members of their own and related professions;

Principle 8, Assessment Techniques, insists on scientific rigour and cognizance of client-welfare in the development and use of assessment techniques; finally,

Principle 9, Research with Human Participants,, and *Principle 10, Care and Use of Animals,* stipulate minimum standards for the humane treatment of subjects in psychological research.

In 1989, some of the restrictions on advertising in Principle 4 (Public Statements) were repealed after discussions between the APA and the Federal Trade Commission (AAAS, 1994). These discussions were an undesired consequence of a lawsuit brought by psychologists against the American Psychoanalytic Association in 1988, in which the restriction of psychoanalytic training to medical doctors was successfully challenged under anti-trust laws; "...in many ways it was a Pyrrhic victory, for in achieving its goals by the anti-trust route, many of the ethical tenets psychology had cherished as a profession had to

be forfeited to the market mentality" (Dyer, 1991, p.72). The amended *Ethical Principles* were published by the APA (APA, 1990).

2.3.4.2 The 1992 APA Ethical Principles: The next revision of the APA *Ethical Principles* (APA, 1992) was much more thoroughgoing, and appears to have influenced the draft revision of the South African code (SAMDC:PBP, 1992) published in the same year. Although rewritten, the *Preamble* is least substantively altered, and serves much the same function as in the 1981 code. However, the Preamble is now prefaced by an *Introduction*, which distinguishes between *aspirational* values, embodied in the Preamble and the General Principles which now immediately follow it, and *enforceable* Ethical Standards which comprise the remainder - and bulk - of the code. The Introduction elaborates that: "the fact that a given conduct is not specifically addressed by the Ethics Code does not mean that it is necessarily either ethical or unethical", implicitly because: "although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action, and may be considered by ethics bodies in interpreting the Ethical Standards" (APA, 1992, p.1598). The distinction between aspirational and enforceable ethical principles is significant, and will be returned to in subsequent chapters.

The six (aspirational) *General Principles* in the 1992 APA code systematically set out broad value-commitments for psychologists, which are essentially similar to those which are interspersed with practical directives in the 1981 code. Thus *Competence* (Principle A) and *Professional and Scientific Responsibility* (Principle C) in the 1992 code correspond respectively to Principles 2 and 1 in the 1981 code as described above, while the 1992 *Respect for People's Rights and Dignity* (Principle D) and *Concern for Others' Welfare* (Principle E) embody self-explanatory values from the old Principles 3, 6, 9 and 10. Principles B *(Integrity)* and C *(Social Responsibility)* similarly make explicit values discernible but less emphasised in the 1981 code.

The (enforceable) *Ethical Standards* of the 1992 APA code translate the values of the General Principles into empirical regulations, which include but extend the equivalent provisions of the (amended) 1981 code. Two sections of this code are relevant to this thesis: *Privacy and Confidentiality* (discussed below), and the last section, which specifies procedures for *Resolving Ethical Issues*.

2.3.4.3 The 1985 SAICP Code: The first enforceable code of ethics for South African psycholgists drew heavily on the 1981 APA code, but embodies several improvements over it, which anticipate similar changes in the 1992 APA code. Thus, the 1985 SAICP code

(Steere & Wassenaar, 1985) opens with a *Preamble* directly derived from the 1981 APA code, stating the commitment of psychologists to extend and use their knowledge and skills to the betterment of the human condition.

Similarly, seven of the ten broadly-worded *Practical Principles and Regulations for Professional Conduct* (each followed by more specific applications to practical issues), which comprise the main body of the SAICP code, correspond closely to equivalent sections in the 1981 APA code. These are Principle 1: *Professional Responsibility;* Principle 4: *Confidentiality;* Principle 5: *Competence;* Principle 6: *Welfare of the Client;* Principle 7: *Welfare of Research Participants;* Principle 8: *Professional Relationships;* and Principle 9: *Public Statements and Advertising.* Some of these seven Practical Principles (notably Principle 1) considerably expand or supplement the APA code, mostly from PBP regulations or the provisions of the *Medical, Dental, and Supplementary Health Professions Act.* However, Principle 10 *(Management of Practice)* draws almost exclusively on the latter sources, while Principles 2 and 3 *(Social Responsibility* and *Informed Consent,* respectively) give emphasis to values more fleetingly endorsed in the 1981 APA code.

Where the 1985 SAICP code differs from - and improves - the 1981 APA code is in its specification of three *Fundamental Ethical Principles,* which underlie the more empirically-preoccupied regulations. These are *Autonomy* ("Clinical psychologists respect the right of all individuals to exercise free choice regarding their personal actions and beliefs, providing that no person act in such a way as to impede the exercise of free choice by other individuals"); *Nonmaleficence* ("In all circumstances, clinical psychologists avoid inflicting harm on the individuals under their care and, in a broader sense, on society"); and *Beneficence* ("Clinical psychologists are committed to benefitting the individuals under their care and society as a whole by preventing or removing harmful circumstances and by conferring positive benefits on their clients") (Steere & Wassenaar, 1985, p.27). A paragraph following the Preamble explains that:

> "...clinical psychologists are guided in their day to day professional functioning by adherence to and application of fundamental ethical principles out of which may be derived practical principles which are expressed in terms of specific regulations for conduct" (*ibid.*, p.25).

A further paragraph gives directions for resolving ethical problems arising either from situations not covered by the Practical Regulations, or from those where "two or more of the regulations laid out in an ethical code are equally applicable and dictate opposing

courses of action" *(ibid.)*. In these circumstances, psychologists are directed to decide on a course of action:

> "... by referring back to the fundamental ethical principles on which the code is based. The ethical course of action would be that which best fulfills the dictates of the basic principles of autonomy, nonmaleficence and beneficence. Where no resolution is possible, in that the ethical principles themselves are in conflict the clinical psychologist is required to make a careful assessment of each conflicting course of action on all people who may be affected by them and to choose the course of action which produces the least overall harm. In such difficult situations it is strongly advised that the clinical psychologist seek the advice of professional colleagues or the governing professional body" *(ibid.)*.

Neither a similar reference to either underlying values, or appropriate ethical decision-making procedures is referred to in the 1981 APA code, and only the former is found in the 1992 APA code (the section on resolving ethical issues in the 1992 document concerns the procedural aspects of dealing *ex post facto* with code infringements). In this the SAICP *Ethical Principles* was thus well ahead of its time, as will become clearer in the next chapter.

2.3.5.4 The 1987 PASA Ethical Code: The 1987 PASA *Ethical Code* (PASA, 1987) was never endorsed by any of PASA's subsidiary institutes, and will therefore be dealt with only in passing. After some introductory comments dealing with the difficulties in compiling and applying a professional code, various *Basic Assumptions* are listed, including the politically (mis-?) interpretable:

> "Psychologists accept three basic premises: (a) that in some respects all people are alike, thus recognising their common humanity; (b) that in some respects certain people are alike, thus recognising differences between groups, such as age, sex, ethnic groups; (c) that in some respects each individual is unique" (*ibid.*, pages unnumbered).

Also (incongruously) included under the Basic Assumptions are *directives* to psychologists facing ethical dilemmas to consider the consequences of alternative courses of action, and accept responsibility for their actions. The bases on which psychologists might decide between such alternatives form the focus of the last of the eleven *Ethical Principles* which comprise the body of the code. This section is a rather garbled reduction of various values and procedures found in the SAICP and APA codes, and lacks the clarity of the former in informing conduct for applied practitioners. The other ten principles of the 1987 PASA code are similarly (sometimes confusing) abbreviated derivatives of sections from the 1981 APA and the 1985 SAICP codes.

2.3.4.5 The 1992 PBP Draft Regulations: The 1993 draft revision of the regulations governing South African psychologists (PASA, 1993), prepared by PASA on behalf of the PBP, shows (in decreasing order of significance) the influence of the 1985 SAICP code (Steere & Wassenaar, 1985), previous PBP regulations for psychologists (*e.g.*, SAMDC, 1990), and the 1992 APA code (APA, 1992). However, it differs from the 1985 SAICP and the 1992 APA codes in not having a preamble overviewing the appropriate objectives of Psychology, and in not clearly and separately specifying the underlying values which express themselves in the practical regulations. Many of the statements of value from the 1985 SAICP code are retained in the 1993 PASA draft code, but they are interspersed with more specific practical rules (as there are in the 1981 APA code).

This empirical bias may be because the 1993 draft is intended to serve the minimalist, consumer-protective regulatory functions of a statutory-body, rather than including also the broader aspirational functions of professional ethical self-regulation. Value commitments would obviously inform PBP disciplinary deliberations in cases where more practical regulations were inadequate for deciding the ethicality (or otherwise) of conduct (Sunstein, 1990). Nevertheless, the failure to identify these as such lends an air of arbitrary authoritarianism to the statement, in the 1993 draft code, that it "...does not profess to be a complete code of professional ethics or to specify all forms of professional misconduct which may lead to disciplinary action" (PASA, 1993, p.1).

The 1993 PASA draft code consists of eleven sections, of which the last is *Rules Specific to Psychometrists and Psychotechnicians*, and the first ten (labelled *Principles*) are directly derived from the ten Practical Ethical Principles of the 1985 SAICP code. (In view of the above-mentioned overwhelmingly empirical slant of the document, the first ten rubrics might more accurately also be labeled as rules pertaining to the relevant aspects of practice.) Although some clauses have been abbreviated, combined, or altogether dropped, the content of most of the sections in the 1993 PASA draft bears a close resemblance to that of equivalent sections in the 1985 SAICP code.

2.4 CONFIDENTIALITY AND ETHICAL COMPLIANCE IN PSYCHOLOGY

2.4.1 Confidentiality in Professional Psychology

Traditions of not disseminating secrets entrusted to one are not restricted to the context of professional-client relationships. They have a long history in most moral and

religious traditions, including Hinduism (Naidoo, 1983), Buddhism (van Loon, 1983), Judaism (Usdin, 1983), Christianity (Oosthuizen, 1983), and Islam (Nadvi, 1983). While some ethics of secrecy have the goal of protecting sacred beliefs or rites from the unprepared or the unworthy (*ibid.;* Naidoo, 1983; van Loon, 1983), most are motivated by a need to balance the conflicting "fundamental human needs to maintain a sphere of privacy, on the one hand, and to share information with others, on the other" (Luban, 1992, p.1132).

2.4.1.1 Confidentiality Clauses in Professional Ethical Codes: The ethics of professional Psychology require that personal matters learned in the course of one's professional duties be treated with an even higher level of confidentiality than is normative in private life. This tradition is derived from (and remains closely linked to) the analogous ancient tradition in Medicine, where conventions of confidentiality among Indian, Egyptian, and Greek healers were reported from earliest times (Lindethal & Thomas, 1992; Oosthuizen, 1983). Confidentiality acquired its modern prominence for professionals in the fourth century B.C., through its incorporation in Hippocrates' famous *oath* for medical men: "Whatsoever I shall see or hear in the course of my profession... if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets" (*cited in:* Joseph & Onek, 1991, p.313).

The spirit of this part of the Hippocratic oath has been preserved in more modern oaths taken by doctors, and can be discerned also in the PBP regulations for psychologists which were operative at the time of the empirical investigation discussed later in this thesis. Under the heading "Professional Secrecy", these regulations specify that disciplinary steps may be taken against psychologists for:

> "Divulging verbally or in writing any information which ought not to be divulged regarding the ailments, condition or problems of a patient or client, except with the express consent of the patient or client or, in the case of a minor or a person certified in terms of the Mental Health Act, 1973, with the consent of his parent or guardian or curator, as the case may be, or in the case of a deceased patient or client, with the written consent of his next-of-kin or the executor of his estate" (SAMDC, 1990, p.733).

More practical indications of quite what 'ought not to be divulged' follow the analogous paragraph in the old SAICP *Ethical Principles*:

> "Information obtained in clinical or consulting relationships, or evaluative data concerning children, students, employees and others, is discussed only for professional purposes and only with persons clearly concerned with the case. Such information will in all cases be released only with the express permission of the client, to be used only in the interests of the client, and presented in a form which,

> in the judgement of the clinical psychologist is clear and not likely to be misunderstood by the recipient" (Steere & Wassenaar, 1985, p.35).

This portion of the SAICP code was almost entirely based on the equivalent section in the former APA code (APA, 1981), which is preserved in the recent APA revision (APA, 1992). In all three of these documents, there are also further elaborations of the practical aspects of confidentiality, including the implications for maintaining client records, and injunctions to explain the limits of confidentiality to clients (*ibid.;* APA, 1981; Steere & Wassenaar, 1985). Most of these elaborations were included in the draft revision of the regulations submitted to the PBP by PASA in 1993 (PASA, 1993). However, in the most recent PBP regulations for psychologists (SAMDC, 1994), the 'professional secrecy' clause inexplicably remains substantially the same as the minimalist 1990 clause quoted above.

2.4.1.2 Rationale of Professional Confidentiality: In addition to the disciplinary action which may be taken by professional bodies, breaches in confidentiality can lead to psychologists being prosecuted in the public courts on the basis of several legal principles not applicable to broken confidences in non-professional contexts (including invasion of privacy, defamation, breach of contract, breach of fiduciary duty, and contravention of specific statutory legislation concerning professional confidentiality) (DeKraai & Sales, 1984; Fruman, 1991; Lindethal & Thomas, 1992; Taitz, 1991).

According to Luban (1992), these special standards of confidentiality for professional-client relationships can be justified by a two-step argument. "The first step says that professionals should keep confidences because carrying out their professional duties requires them to dig out information which will *only* be tendered in confidence" (*ibid.*, p.1132, emphasis added). There are two alternative second steps to the argument, which justify keeping the confidences so gained by professionals, either by *consequentially* arguing not doing so to usually result in negative effects, or by *non-consequentially* appealing to fundamental values "which trump social utility, and therefore should not be weighed in a flat-footed manner against the benefits of disclosure" (*ibid.*, p.1133).

Implicitly invoking the potentially embarrassing nature of many client disclosures to psychologists, Keith-Spiegel and Koocher (1985, p.55) provide a representative example of a consequentialist argument: "Without assurance of confidentiality, many potential clients might not seek psychological services", and "once services are sought, the lack of confidentiality might lead to concealment of information resulting in potentially ineffectual treatment".

Examples of non-consequentialist arguments include the Hippocratic oath's elevation of client confidences to the level of "holy secrets" (*cited in:* Joseph & Onek, 1991, p.313). As Luban suggests *(see above)*, the force of non-consequentialist arguments usually depends heavily on the value placed on the client's autonomy outweighing other factors, such as community welfare.

However, this is rarely the case, particularly given the impact of contemporary criticisms of Psychology's individual bias, and professional obligations of confidentiality are therefore nearly always qualified, both in law and in professional codes. DeKraai and Sales (1984) review the relevant governmental legislation for American jurisdictions, which are so disparate that these authors label the situation as one of "pandemonium" (*ibid.*, p.316). Finding an appropriate balance between the rights of the individual and of society is an enduring social problem which extends beyond the ethics of applied Psychology. The nature and limits of professional confidentiality in view of these issues can best be further elaborated by reference to the related - but distinct - legal concepts of privacy and privilege.

Legal privilege and its limits are defined in terms of clients' rights to compel professionals to withhold information about them from courts of law, whereas *"confidentiality* refers to a *general* standard of *professional conduct* that obliges a professional not to discuss information about a client with anyone" (Keith-Spiegel & Koocher, 1985, p.57, emphases added). Confidentiality thus extends the principal underlying privilege to situations other than during legal proceedings. On the other hand, ironically and sometimes agonisingly (*ibid.;* Taitz, 1991), normal standards of confidentiality may conflict with the statutory limitations of privilege. Conversely, professional rules of confidentiality are a specific practical expression of clients' broader legal rights to privacy, the latter applying also in other contexts *(ibid.;* Luban, 1992).

2.4.1.3 Confidentiality and Rights to Privacy: The legal ensconcement of rights of *privacy* (as yet only patchy and insecure) is one of the innovations of the Western liberal democratic tradition over the last two centuries. It represents an extension of the right to individual freedom in determining one's own beliefs and actions, to include also autonomy in determining access by others to both one's person and information concerning it (Joseph & Onek, 1991; Lindethal & Thomas, 1992). As such, legal rights to privacy are a recognition of the sanctity of (individual) human life and relationships (to significant others, including God), which has long been emphasised by religious traditions (Nicolson, 1983; Nxumalo, 1983; Oosthuizen, 1983).

The value placed on confidentiality in codes of ethics for applied Psychology similarly follows philosophically from the explicit endorsements of the value of the individual, and respect for individual autonomy (Hare-Mustin *et al.*, 1979), contained in the codes' preambles or fundamental ethical principles (*e.g.*, APA, 1981; APA, 1992; Steere & Wassenaar, 1985). Collectives such as countries, companies, or occupational groups have also on occasion claimed rights of privacy, respectively for strategic reasons (du Plessis, 1987), in order to protect commercially exploitable information from rivals (Dendy, 1991; Gomersall, 1983), or to defend guild interests (Hare-Mustin *et al.*, 1979; Larson, 1977). Nicolson (1983), however, undercuts such moves by suggesting a fundamental difference in the public's rights of access to facts in general (which is integral to modern democracies), and its rights of access to facts about *persons* (which deserve protection).

2.4.1.4 Qualifications of Professional Confidentiality: Nevertheless, like other duties involving individual rights, obligations to keep secrets are qualified in most religious traditions in the light of other moral principles, especially the rights of the community as a whole. Thus, in Judaism (Usdin, 1983), Islam (Navdi, 1983), and some Christian schools of thought (Watson, 1983), values such as justice, truthfulness, and prevention of harm to third parties may override values of secrecy. In Buddhism (van Loon, 1983) and Hinduism (Naidoo, 1983), considerations of reducing suffering, and possible negative karmic effects of keeping a secret, can have similar implications.

Similarly, even in liberal countries, the legal system generally subjugates the individual's rights to privacy to the community's right to justice, and demands access to any and all information relevant to resolving a particular case (Haysom, 1987; Joseph & Onek, 1991). The above-mentioned claims to privacy of collectives (such as the state, businesses, or occupational guilds) are also counterbalanced by potentially conflicting broader community interests such as justice and accountability (du Plessis, 1987; Gomersall, 1983; Luban, 1992; Matthews, 1983; Nicolson, 1983; van der Vyver, 1983).

The recognition of clients' rights to privacy embodied in conventions of professional confidentiality are not exempt from similar challenges. Vocal minority arguments for total and unconditional confidentiality persist, citing both consequentialist and non-consequentialist grounds (*cited in* Joseph & Onek, 1991; Keith-Spiegel & Koocher, 1985; McGuire *et al.*, 1985), and in one or two exceptional cases these are embodied in professional ethical codes (*e.g.*, that of Medicine in France) (Weil, 1993). Nevertheless, successive APA codes (APA, 1981; 1992), the SAICP code (Steere & Wassenaar, 1985), and the PASA draft code (PASA, 1993), are more typical in their not merely *permitting*, but

obliging psychologists to abandon their normal professional pledge of confidentiality under some unusual circumstances. These would apply when breaching confidentiality is the only way to prevent harm befalling either a third party, or the client themselves (for instance, in the respective cases of a homicidal or a suicidal client).

In a famous 1974 Californian case, the family of murder-victim Tatiana Tarasoff successfully sued the psychotherapist of the man who committed the crime, for failing to warn Ms Tarasoff of the perpetrator's homicidal capacity and intent (Joseph & Onek, 1991; Keith-Spiegel & Koocher, 1985). For the subsequent two decades, the professional psychological and medical literature on confidentiality has concentrated overwhelmingly on the implications and issues arising in the treatment of such (unusual) potentially dangerous clients *(e.g.,* Beck, 1990, *various contributions*; Moore, 1984).

Both in South Afrcia and elsewhere, similar principles have recently been extended to situations where a client negligently exposes others to danger by not disclosing a medical condition, *e.g.,* infection by the Human Immunodeficiency Virus (Fruman, 1991; Prinsloo, 1992; Strauss, 1992; Verschoor & Alberts, 1990; Weil, 1993).

The traditional privacy of client-psychologist relationships is also subject to more routine and less dramatic invasions. For instance, some third-party payers for services require psychologists to furnish a diagnosis before they will reimburse. Other third-parties, such as family-members or employers, allied professionals concerned with the case, or lawyers handling civil or criminal suits involving clients, may also request information about clients from psychologists. Both the legal and the professional regulations make it clear that - without client consent - most such disclosures are both illegal and unethical *(see above,* and in Chapter 7) (*ibid.;* SAMDC, 1994; Steere & Wassenaar, 1985; Strauss, 1974).

2.4.1.5 Professional Implications of Limitations of Confidentiality: The SAMDC (1994) regulations do not state whether clients should be informed of the limits of confidentiality, for instance as regards dangerousness to self or others, limitations of legal privilege, or in cases where psychologists are receiving professional supervision (which intern-psychologists are obliged to for all their cases). Nevertheless, various ethical codes developed by psychologists for themselves specify this clearly (APA, 1981; APA, 1992; PASA, 1993; Steere & Wassenaar, 1985), and APA ethics committee members Keith-Spiegel and Koocher (1985) recommend it without reservation in all cases except - interestingly - as regards disclosures during the psychologist's *own* psychotherapy.

DeKraai and Sales stated in 1984 that the presumed confidentiality of psychologist-client interactions had not been definitively proved to be essential to the effectiveness of

psychological services. Nonetheless, empirical evidence to this effect is accumulating, and the majority of both psychologists' clients and the public at large significantly value the convention (Claiborn *et al.*, 1994; McGuire *et al.*, 1985; Merluzzi & Brischetto, 1983; Miller & Thelen, 1986).

2.4.1.6 Confidentiality, the Law, and Legal Privilege: Returning briefly to religious traditions of secrecy, the exceptional *unconditional* confidentiality of Catholic confession (and some derivative Protestant rites) is - like the normal *limitations* on confidentiality stemming from dangerousness - defended by its proponents on the basis of community interests. The long-term value to the faithful of guaranteed safe access to the sacramental forgiveness of God, under all circumstances, is argued by the supporters of ritual confession to outweigh short-term social benefits such as the resolution of any particular legal or other mystery or conflict (Oosthuizen, 1983; Nicolson, 1983).

A secular parallel of this reasoning underlies the *legal* concept of *privilege*, which extends an individual's rights of privacy to control over whether circumscribed classes of communications may be revealed in judicial proceedings (Joseph & Onek, 1991; Keith-Spiegel & Koocher, 1985). Allowing certain types of information privileged exemption from the common-law right of courts to discovery is thus sometimes considered to be of such long-term, overall benefit to the community that it outweighs otherwise dominant values of justice (DeKraai & Sales, 1982; Haysom, 1987).

Legal privilege exists only when it is created by specific statutory legislation, which has varied widely over time and between jurisdictions (Joseph & Onek, 1991; Karasu, 1991; Keith-Spiegel & Koocher, 1985). The discretion to avail oneself of such legal privilege is always the client's, rather than the professional's (although the latter is bound by the former's decision), and the principle has gradually been extended to cover all stages of legal proceedings rather than merely what is revealed in open court (*ibid.;* Haysom, 1987).

Privilege for lawyer/ client communications is essential for the meaningful operation of judicial systems where a citizen may be represented in court by a lawyer. This form of privilege was the first recognised in law, and, although it has on occasion been disregarded in South Africa and other states, it is normative in democratic countries (Strauss, 1983; Haysom, 1987). Controversy and variability surrounds both the confidentiality and the legal privilege which should be afforded information imparted for professional purposes to journalists (de Villiers, 1983; Pakendorf, 1983), ministers of religion (Oosthuizen, 1983; Watson, 1983), and financial professionals (Heine, 1983; Smith, 1983).

Privileged status for communications to medical practitioners is not common in

countries with British-based or -influenced legal systems (Strauss, 1974); on the other hand, it has been widely enacted by American legislatures (Shapiro, 1983; Feldman, 1983) - to the frequently expressed (hardly disinterested) disgust of the legal profession (Strauss, 1974). Privileged protection of disclosures to psychologists follows a similar pattern, but is less prevalent (DeKraai & Sales, 1982; Keith-Spiegel & Koocher, 1985).

In South Africa, the legal protection afforded clients' confidences during medical or psychological treatment extends only to pre-trial legal proceedings (SAMDC, 1994; Strauss, 1974; Taitz, 1991; Verschoor & Alberts, 1990). Both doctors and psychologists are therefore legally *obliged* to reveal confidential client material in court, albeit under protest, if they are directly ordered to do so by the presiding judicial officer *(ibid.)*. Ironically, doing so at an earlier stage of legal proceedings can lead to disciplinary action by professional bodies *(ibid.)*. As is the case in the USA, when South African clients themselves place the content of professional services at issue through an allegation of malpractice, they waive their legal privilege, and release psychologists from their obligations of confidentiality, in resultant legal or professional disciplinary proceedings (Keith-Spiegel & Koocher, 1985; Verschoor & Alberts, 1990).

Even when such disclosures are regarded as legally privileged, however, this is sometimes undercut by other legal obligations of the professionals concerned - *e.g.*, to testify fully in court proceedings involving child abuse or peer malpractice (DeKraai & Sales, 1982; Keith-Spiegel & Koocher, 1985). As is the case with clients who are a danger to themselves or to others, professional codes and/or specifc legislation may further oblige psychologists to *proactively* report such cases to the authorities, rather than passively wait for their evidence to be subpoenaed (*ibid.;* DeKraai & Sales, 1984; Joseph & Onek, 1991).

2.4.2 Compliance of Psychologists with Ethical Codes

2.4.2.1 Methodological Difficulties in Measuring Ethical Behaviour: The most obvious place to start, when investigating (non-) compliance of psychologists with their ethical codes, would seem to be the cases brought to the attention of professional ethics committees. However, many clients may be unsure of how or when to appropriately lodge complaints about psychologists' behaviour, and at least some of those who *do* know are put off by the emotional risks and frustrations which are often involved in so doing (Keith-Spiegel & Koocher, 1985).

The actual incidence of various ethical infractions is, therefore, likely to be rather higher than is reflected in the statistics of ethics committees. The frequency distribution

across categories may also be different: Abbott (1983) suggests that the infringements of professional ethical codes which primarily concern disciplinary bodies are not necessarily either the most frequently occurring, or the most harmful to *clients*, but rather those which are most visible and/or potentially damaging to the public standing of the *profession* concerned.

Alternative means of assessing such behaviour also have their draw-backs, however. The results of self-report surveys and analogue studies of professionals, about their ethical behaviour, are likely to be distorted by respondents' reluctance to admit to negatively-valued behaviours. Nevertheless, a number of such studies have been conducted, and they can be assumed to at the very least demonstrate the minimum incidence of the behaviours they survey. Of particular significance is a survey by Pope, Tabachnick and Keith-Spiegel (1987). The measurement scale used in this study has been criticised as "ruining" it, through its vagueness (Koltko, 1989, p.845), but the methodology has been defended by its authors (Pope *et al.*, 1989), and the original study (Pope *et al.*, 1987) has gone on to spawn a number of comparative and/or derivative studies - some of which do modify the measurement scale in the light of the criticisms (Claiborn *et al.*, 1994; Pope & Bajt, 1988; Pope & Tabachnick, 1993; 1994; Tabachnick *et al.*, 1991).

The virtual dearth of surveys of psychotherapy clients regarding the ethicality of psychotherapist behaviour has recently been remedied by two such studies. Claiborn *et al.'s* (1994) relatively small study assessed the beliefs of former and current psychotherapy clients, and of non-clients, about the ethicality of various therapist behaviours. The (current or former) clients also reported on the incidence of these behaviours in their own psychotherapy. In Pope and Tabachnick's (1994) study, a very much larger survey-sample of psychologists reported on their personal experiences of being psychotherapy clients. The findings of all these alternative assessments of ethical conduct will be discussed under the behaviour-related headings below.

Another problem is that there are no published reports and statistics regarding the cases handled by the PBP and the various professional ethics committees in South African Psychology, and also no surveys of either psychologists or clients regarding the ethicality of South African psychologists' behaviour. The research component of this thesis aims primarily to fill part of this latter gap, but at this point reference can be made only to the results of American Studies, and the few resources on *medical* ethics published in South Africa.

2.4.2.2 Overall Incidence of Ethical Complaints: The first point that stands out from the the APA Ethics Committee's reports over the last decade is the increase both in the number of enquiries about the ethicality of psychologists' conduct, and in the number of complaints actually lodged. (The lengthy adjudication process results in intermittent backlogues, and the fluctuating annual rate at which cases are settled is therefore not a useful measure of the incidence of malpractice [APA-EC, 1993]). Between 1983 and 1987 enquiries were reported to have risen 76% and complaints 56%, with about 0,1% of the APA membership being implicated in such complaints in any given year (APA-EC, 1988). The subsequent annual rate of increase has fluctuated, but the general trend of increasing numbers of inquiries and complaints has continued, with 1992 and 1993 both reaching record numbers, and the proportion of the APA membership being implicated in complaints now standing at approximately 0,2% per annum (APA-EC, 1993; 1994).

These trends are not surprising in view of the increasingly critical attitude of Psychology's client public, previously discussed in Sections 2.2.4 and 2.2.5. Current or former psychotherapy clients, as well as people without any such experience, have an at least approximate knowledge of what constitutes ethical or unethical practice by psychologists or other therapists, with younger age and higher education being more strongly predictive of lay ethical knowledge than amount or type of therapy experience (Claiborn *et al.*, 1994; Hillerbrand & Claiborn, 1988). Therapists and clients differed significantly in their ethicality ratings only with regard to items such as questioning clients' beliefs, or making clients feel uncomfortable (Claiborn *et al.*, 1994).

As regards the relative frequency with which different aspects of the code are infringed, statistics published by the APA Ethics Committee confusingly reflect both 'primary' complaints, which come to the attention of the APA Ethics Committee directly, and complaints which came to the attention of the committee secondary to disciplinary action having already been taken by a state licencing board or psychological association. In the latter case, the APA member concerned is given the opportunity to contest the original finding or punishment; failure to satisfactorily do this results in the APA Ethics Committee implementing similar disciplinary steps to those imposed by the original disciplinary body, without further investigation (Keith-Spiegel & Koocher, 1985). In the discussions below, proportions quoted are those of *all* complaints adjudicated by the APA Ethics Committee which involve the particular behaviour under discussion, and not only those where this was the primary focus of the referral.

2.4.2.3 Dual Relationships: Given the very intimate nature of client-psychologist interactions, it is not surprising that in both of two major surveys of psychologists, 87% of respondents reported experiencing sexual attraction to clients on at least rare occasions (Pope & Tabachnick, 1993; Pope *et al.*, 1987). However, acting upon such feelings for clients is unambiguously condemned by medical and psychological ethical codes from the Hippocratic oath onwards, as exploitative of the power imbalance between client and professional (APA, 1981; Steere & Wassenaar, 1985). The 1992 APA *Ethical Principles* (APA, 1992) and 1993 PASA draft code (PASA, 1993) also place severe limitations on the circumstances under which sexual relationships can be formed with former clients. Most non-sexual dual relationships with clients or former clients are also proscribed, as potentially exploitative (*ibid.*; APA, 1981; Steere & Wassenaar, 1985).

Nevertheless, between 1983 and 1993, dual relationships between psychologist and client (largely but not exclusively of a sexual nature) were consistently the most common basis of complaints every single year (APA-EC, 1988; 1990; 1991; 1993; 1994). The proportion which this category formed of total complaints rose from 26% in 1988 (APA-EC, 1990) to a high of 47% in both 1992 (APA-EC, 1993) and 1993 (APA-EC, 1994).

Further evidence of the seriousness of this problem are reflected in the considerably higher incidence of dual relationships found by Claiborn *et al.* (1994) and Pope and Tabachnik (1994) in direct surveys of psychotherapy clients. Similarly the incidence of dual relationships confessed to by psychologists themselves, being comparable to that indicated by previous sources, does nothing to allay this anxiety (Pope *et al.*, 1987; Pope and Tabachnick, 1993; Tabachnick *et al.*, 1991). Perhaps most worrying of all, dual relationships seem to occur with at least the same frequency among psychologists who are members of ethics committees as among the profession at large (Pope & Bajt, 1988)!

One can infer from the heightened vigilance of state licencing boards in this area (APA-EC, 1994) that public concern about dual relationships is also increasing. Further discussion of dual relationships is beyond the scope of this thesis, but the issue is the focus of extensive and increasing research (Pope, 1990), and is addressed in stricter and more explicit terms in the latest APA (1992) and South African codes (PASA, 1993).

2.4.2.4 Failure to Maintain Professional Standards: Between 1983 and 1987, infractions of ethical rules focussing on "respect for and adherence to professional standards and guidelines, institutional regulations, and governmental laws" were reportedly the next most common bases (after dual relationships) for formal complaints adjudicated by

the APA Ethics Committee (1988, p.569). The (un)professional behaviours involved in such cases include: failure to maintain appropriate professional standards or practicing outside areas of competence (particularly commonly in child custody cases); infringements of the legal and/or civil rights of clients or research participants; and (especially) dishonest or negligent fee policies and practices *(ibid.)*. Between 1988 and 1993, these categories of offence continued to be the most common after dual relationships, with infringements of other aspects of the code occurring less frequently and more randomly (APA-EC, 1990; 1993; 1994).

In the both the Claiborn *et al.* (1994) and Pope and Tabachnick (1994) surveys of psychologists' clients, the category of unprofessional behaviour next most commonly reported (after dual relationships) also involves therapists' failure to maintain appropriate levels of technical competence or concern for client welfare. In the Pope *et al.* (1987) study, a quarter of the psychologists surveyed had practiced outside their area of competence on at least rare occasions, and more than half had at least rarely practiced when too distressed to be effective, failed to maintain standards of informed consent, and/or terminated therapy due to the client's inability to pay. Tabachnick *et al.* (1991) also found the psychologist-educators they surveyed to report alarming levels or a range of behaviours involving failures of competence or concern for student welfare.

2.4.2.5 Infractions of Professional Confidentiality: However, in the Haas *et al.* (1986) Pope & Vetter (1992) studies of psychologists' self-reported ethical behaviour, some of the most disconcerting and intriguing results have concerned neither dual relationships nor professional standards, but confidentiality. This area of professional conduct is a case in point as regards the unreliability of using formal ethical proceedings as an index of actual ethical conduct in the field.

Confidentiality does feature in the APA Ethics Committee statistics for every year between 1988 and 1993, being involved in a fluctuating proportion of between 4 and 16% of total cases adjudicated in these years (APA-EC, 1990; 1991; 1993; 1994). However, confidentiality receives much less emphasis or finer analysis in these reports than the two categories of malpractice already discussed. Keith-Spiegel (1977), and Keith-Spiegel and Koocher (1985), discuss representative examples of complaints about different aspects of professional confidentiality which reach the APA Ethics Committee, but without indicating their relative incidence. Similarly, representative cases involving confidentiality in the South African medical profession are occasionally discussed in published forums (Prinsloo,

1992; Strauss, 1974; 1992; Verschoor & Alberts, 1990). In most cases the same professional obligations would also apply to psychologists, but there is no published literature on the incidence and prevalence of various kinds of confidentiality breach.

Client reports of their psychotherapists' confidentiality-related behaviours shed a little, but not much, light on the subject. In the Claiborn *et al.* (1994) study, clients saw their therapists assuring them of the *absolute* confidentiality of their personal material as very ethical behaviour (which it may not be, in view of the numerous qualifications of confidentiality discussed in Section 2.4.1), yet oly 25% of female and 12% of male clients reported this behaviour to have occurred. Ironically, clients were ambivalent about the ethicality of the (highly appropriate) therapist behaviour of explaining the circumstances in which their confidentiality might be broken, and few reported it as having occurred (6% of both genders) Perhaps more significantly, clients viewed their therapist discussing their case outside of the agency or office as highly unethical, yet 11% of female and 6% of male clients believed this to have occurred *(ibid.)*.

In the (1994) Pope and Tabachnick study, 2% of psychologists who had experienced harmful effects as a result of having themselves been therapy clients identified therapist breaches of confidentiality as the most serious cause of this harm. The total incidence of confidentiality breaches (some of which may still be negative in their impact, albeit less devastating than 'the most serious cause of harm') is perhaps better indicated by the fact that 4,5% of these same clients believed their therapist to have violated their rights to confidentiality once, 2,7% 2-4 times, 1,3% 5-10 times, and 1,8% believed this to have occurred over 10 times *(ibid.)*. The accuracy of the client perceptions in either of these studies is not known, of course, but it would seem more likely that clients are on the whole more likely to be *unaware* of many breaches of confidentiality by their therapists than that they would paranoidly overestimate the incidence of this behaviour.

Unfortunately, this last speculation is supported by psychologists' reports of their own behaviour. Confidentiality was the most frequently occurring single category into which the ethical dilemmas submitted by psychologists to Pope and Vetter (1992) were classified. Five of the ten behaviours seen by Conte *et al.*'s (1989) psychotherapist-subjects as the most likely of the total list of 103 to be grounds for malpractice involve confidentiality. Similarly, of the 17 ethically difficult areas about which Haas *et al.* (1986) asked their psychologist-subjects, confidentiality and privilege issues were rated as occurring most frequently in their practice, and were rated second only to colleagues' sexual conduct in

seriousness. Significantly, although insurance company requests (*e.g.*, for diagnoses) were the area reported to occur next most frequently, they were regarded as third *least* ethically serious *(ibid.)*, which is in accord with the beliefs of clients discussed in Section 2.4.1.

Evidently, then, confidentiality issues occur frequently in psychologists' professional practice, but are highly disparate as regards both nature and seriousness. This heterogeneity is only patchily represented in the research into the actual ethical behaviour of psychologists (as opposed to in the attitude and frequency-of-occurrence studies discussed in the previous paragraph). As is the case with the theoretical literature on the topic *(see Section 2.4)*, most of the empirical studies of psychologists' confidentiality behaviours have focussed on breaching the confidentiality of homicidal or suicidal clients, on doing so in order to report child abuse, or on the right of clients' significant others (to confidential information concerning clients) (*eg.*, Ghali, Lindethal and Thomas, 1991; Zadik, 1993; Baird and Rupert, 1987)

In investigating the self-reported ethical behaviour of psychologists as therapists, Pope *et al.* (1987) asked six questions (from a total of 83) about confidentiality-related behaviour. Three of these concerned the familiar issues of breaking confidentiality to report child abuse, or if a client was either homicidal or suicidal, and results were predictable and unalarming (unalarming, that is, as regards the conduct of the psychologists, if not the life-circumstances of their clients). Between half and three-quarters of the respondents reported such dilemmas to occur in their practice, and their behaviour in response to these dilemmas appeared to be in accord with their ethical beliefs (and the standards of the profession), with only between 1 and 2% of subjects believing that breaking confidentiality under these circumstances could *never* be ethical *(ibid.)*.

However, all of the remaining three questions about confidentiality in the Pope *et al.* (1987) study were reported to have occurred with both worrying absolute frequency in psychologists' practice, and more frequently than subjects themselves believed to be ethical. Ethical behaviour failed to generally match ethical belief for only one other of the total list of 83 behaviours in this study (this was providing services outside of one's areas of competence, as discussed above) *(ibid.)*. More specifically, 76,4% of Pope *et al.*'s sample admitted to having at least rarely discussed clients (without names) with friends, 61,9% to having on occasion unintentionally disclosed confidential data, and 8,1% to at least rarely having discussed a client (by name) with friends *(ibid.)*.

Such behaviour is unambiguously unethical (see Section 2.4.1), and cases do therefore

come to the attention of the APA ethics committee (Keith-Spiegel, 1977; Keith-Spiegel & Koocher, 1985). Still, *all* cases involving professional confidentiality taken together have in the last ten years involved a maximum of 16% of the committee's total case-load (APA-EC, 1988; 1990; 1991; 1993; 1994), and this includes the more widely-researched 'dilemma' breaches (*e.g.*, about clients dangerous to themselves or others), as well as informal (and/or unintentional) breaches of confidentiality. In other words, Pope *et al.*'s (1987) figures suggest alarmingly that the instances of informal (and unintentional) breaches of professional confidentiality which have disciplinary repercussions represent only the proverbial tip of the iceberg.

"The widespread disclosure of confidential information - with or without names - is a practice that needs attention from the profession" (*ibid.*, p.1003). Futhermore, the fact that psychologists seem to be less able to live up to ethical standards regarding confidentiality, which they know and endorse, than they are other ethical principles, would seem to suggest that stricter enforcement or policing is not the most appropriate kind of attention required. Addressing the lack of attention in the literature to these problems and questions is the primary research objective of this thesis: informal breaches of confidentiality form the dependent variable in the empirical study, and the next two chapters discuss possible independent variables.

CHAPTER 3:
DISCREPANCIES BETWEEN BEHAVIOUR AND ETHICAL BELIEF

The argument underlying the review of literature in the previous chapter culminated in the isolation of certain aspects of psychologists' (possibly unwittingly) unethical behaviour as the dependent variables for the empirical portion of this study. Consequently, Section 3.3 of this chapter addresses previous theoretical and empirical research relating to discrepancies between stated moral belief and actual behaviour more generally. Moral or ethical education emerges from this review as a possible independent variable influencing the congruence of belief and action, and is therefore discussed in Section 3.4. Before tackling these issues directly, however, it is first neccessary to sketch the more general research background regarding on moral thinking. This is done with regard to Psychology in Section 3.1, and with regard to Philosophy in Section 3.2.

3.1 PSYCHOLOGICAL THEORIES OF MORAL THINKING

3.1.1 Psychoanalytic, Behaviourist, and Biological Theories

3.1.1.1 Psychoanalytic Theories of Moral Thinking: If we accept Straughan's (1982; 1988) suggested limitation of the adjective 'moral' to those of our thoughts and actions which potentially impinge on the rights of others, it could be argued that much of the psychoanalytic corpus at least indirectly concerns moral thinking. In *Civilization and Its Discontents,* for instance, Freud suggests that "Individual development seems to us a product of the interplay of two trends, the striving for happiness, generally called 'egoistic', and the impulse towards meeting with others in the community, which we call 'altruistic'" (*cited in* Radke-Yarrow, Zahn-Waxler, and Chapman, 1983, p.471).

Formulations such as this pave the way for dismissive interpretations of Freud's having reduced moral thinking to no more than egoism, reigned in by rational prudence, and de-hypocritised by a generalisation to all life contexts of the absolute frankness required for (therapeutic) psychoanalysis (*eg.,* Rieff, *cited in* Peters, 1981). It will be argued below that this approach is not necessarily without its merits; nevertheless, Peters (1981) suggests that Freud's most important contributions to the understanding of moral thinking and behaviour

are actually indirect rather than explicit. In fact, at least faint echoes of much of the work of other theorists discussed in this chapter can be found in Freud's work.

Firstly, as will also be addressed in more detail later (Section 3.3), Freud's theories of the Unconscious and of the the Id provide an hypothesis for explaining the all too familiar situations when people's behaviour seems to contradict their conscious intentions or beliefs (*ibid.*).

Secondly, in addressing the potential for aberrations of moral thinking processes to lead to psychopathology (for instance, in obsessive guilt) (*ibid.*), Freud paved the way for later psychoanalytic and other thinkers. For instance, Sperling (*cited in* Radke-Yarrow *et al.*, 1983) and [J.] Gilligan (1976) postulate that mature moral thinking is driven by the positive application of highly sublimated forms of love, rather than merely the harried avoidance of Superego censure. Similar possibilities are more directly addressed by the likes of Kohlberg (1976; 1986) and [C.] Gilligan (1988).

3.1.1.2 Behaviourist, Learning, and Biological Approaches: As might well be anticipated, behaviourist psychologists such as B.F. Skinner disregard the topic of moral thinking or internal states altogether, and account for behaviour's compliance or non-compliance with moral norms in terms of the operant conditioning history of the individual concerned with regard to that particular behaviour (Radke-Yarrow *et al.*, 1983). Concommitant internal states of the actor (*e.g.*, putative altruism) are similarly attributed only to the history of relevant reinforcement contingencies, which are described as usually operating on an intermittent schedule (*ibid.*).

The restrictiveness of such views is to some extent trancended by social learning theorists. Thus, for instance, Bandura and Mowrer argue that the relatively quick acquisition of a wide range of moral behaviours in early childhood implies that mechanisms of vicarious learning and social modelling must be involved in addition to instances of specific reinforcement (*ibid.*).

Eysenck (1976) extends the implications of this approach to moral thinking and behaviour by postulating that at least some patterns of apparently a- or immoral behaviour (for instance, in the antisocial personality) may be due to individual differences in biological receptiveness to conditioning. He recommends that such differences be taken into account in differentially modulating moral education.

In the social-learning model, intercultural differences in moral beliefs and behaviours can be accounted for by the different norms and approaches reinforced by different

societies (Garbarino & Bronfenbrenner, 1976). This point raises again the vexed critical issue of the place of values in an aspirantly objective science such as Psychology (*see* Sections 2.2.2 and 2.2.3): can - or *should* - psychologists even attempt to isolate or postulate universal or absolute values (*ibid.;* Lickona, 1976b; Mischel & Mischel, 1976)?

A final critical issue raised by Lickona (1976b) with regard to behaviourist and social-learning approaches to moral thinking and behaviour is central to the issues investigated in the empirical portion of this study. This concerns the extent to which moral thinking and behaviour is situation-specific, and/or is in some way related to relatively enduring psychological structures or processes, and hence more reliably and generally applied. The empirical evidence is complex and at first sight ambiguous (*ibid.;* Straughan, 1982; 1988), and in attempting to clarify the issue most social-learning theorists (*e.g.,* Mischel & Mischel, 1976) have drawn on cognitive-developmental theories, to which we now turn.

3.1.2 Cognitive-Developmental Approaches, and Beyond

3.1.2.1 Kohlberg: Since the 1960's, Kohlberg has become overwhelmingly the most influential psychologist in the field of moral thinking (Lickona, 1976b). He has produced and inspired a voluminous canon of theoretical and empirical literature, influenced the concepts even of competing theorists and in other fields of Psychology, and provoked extensive critical comment from both psychologists and philosophers (*see* Modgil & Modgil, 1986, for an extensive representative sample).

In many respects, Kohlberg's theories of moral development and thinking can be considered extensions of Piaget's. To start with, although Kohlberg expands Piaget's two levels of moral thinking to three, and subdivides each level into two stages, his lower two overall levels substantially correspond to Piaget's (Kohlberg, 1976; 1986). Thus, for Kohlberg, the child moves from the *Preconventional* moral stage, which is characterised by concrete thinking and adherence to relatively unquestioned rules for reasons of expedient self interest, to the *Conventional* moral stage, where the focus shifts to maintaining some form of community (and one's status within it), by adhering to the rules consensually agreed upon by community members as necessary to promote their net interests (*ibid.*).

However - although Piaget saw the 'justice' aspect of morality as having gained precedence over the 'law and order' aspect in his second moral level *(see above)*, Kohlberg sees this as occurring only at *his* proposed *third* level, that of *Postconventional (Principled)* morality. Here conduct is decided after a weighing of the effects of different potential

courses of action for all the parties potentially affected, with the selection of the final course of action being guided by reference to abstract universal moral principles (principally justice) (ibid.; Locke, 1986; Peters, 1981). In terms of Kohberg's definition of postconventional morality, the validity of these universal moral principles is both descriptively independent of social (non-) endorsement (and hence cultural variation), and (even more arguably) the application of them in all moral contexts is *prescriptively* binding (*ibid.*). Justice is defined as "equal consideration of the claim or points of view of each person affected by the moral decision to be made" (Kohlberg, 1986, p.497).

In passing, it is interesting to note that Kohlberg has more recently speculated on the existence of a seventh moral stage (presumably grouped with his previously described Stages 5 and 6, in the posconventional moral level) (Petrovich, 1986). Postulated partly in response to the criticisms of [C.] Gilligan and others during the 1980's, Stage 7 moral thinking would apparently be concerned with the quasi-religious extension of postconventional concerns with universal justice beyond the human realm to the the cosmos more generally (*ibid.*).

Kohlberg sees the developmental attainment of the minimum neuro-cognitive capacities required as a necessary but not sufficient condition for operating at a particular level of moral thinking, as did Piaget, but, compared to the latter, he sees progression to maturer levels of moral thinking as much less inevitable (Kohlberg, 1976; Peters, 1981). This is partly due to the relatively greater intellectual sophistication of Kohlberg's proposed highest level of moral thinking, the formulation of which relies at least as heavily on the thinking of moral philosophers as it does on empirical psychological findings (Locke, 1986; Straughan, 1986). (Questions about the validity of Kohlberg's reading of some aspects of these moral philosophers will emerge in Section 3.2.3.)

However, a more fundamental reason lies in Kohlberg's relatively greater elaboration of the second of the two mechanisms recognised by both theorists as fuelling advance to higher levels of moral thinking, namely, facilitative social interactions with others. Kohlberg (1976) stresses that the nature of the social interactions involved is crucial, and not only (as might be expected) because they should ideally extend the individual by stimulating ever more sophisticated levels of (moral) thinking. To be facilitative of moral maturation, formative social interactions should also provide so-called "role-taking opportunities", or practice in "taking the attitude of others, becoming aware of their thoughts and feelings, putting oneself in their place" (*ibid.*, p.49). Thus, although the

neuro-cognitive apparatus necessary for postconventional moral thinking would usually be present from adolescence onwards, maturation in level of moral thinking would be dependent on the nature of moral education, and might continue well into adulthood, making Kohlberg's theory of moral thinking potentially relevant to adult - including professional - moral or ethical education.

Kohlberg mentions both the cognitive and the affective aspects of insight into others' perspectives in moral situations, but, as in his description of postconventional moral thinking, the accent is strongly on the former. A number of critics (*e.g.*, Straughan, 1986) have questioned whether high level moral thinking is *necessarily* conducive to moral behaviour - the point is succinctly put in the title of an essay by Straughan (1986, p.149): "Why act on Kohlberg's moral judgements? (Or how to reach Stage 6 and remain a bastard)". This criticism, and Kohlberg's response, is discussed in Section 3.3; a related critique was first raised by [C.] Gilligan.

3.1.2.2 **Gilligan's Critique of Kohlberg:** [C.] Gilligan (hereafter referred to simply as 'Gilligan'), and her associates (*e.g.*, Gilligan, 1977; 1988; Gilligan *et al.*, 1988, *various contributions*), question Kohlberg's theory on the basis of research findings that Piaget and Kohlberg and their followers report that female subjects consistently score lower than male subjects on ratings of moral reasoning. Gilligan (1977; 1988) suggests that women and girls are no less mature in their moral thinking than are men and boys (whether because of repressive socialisation or for any other reason). Rather, she argues that their moral thinking is often simply qualitatively different from the male norm, in ways not taken into account by Kohlberg's theory, or, therefore, his scoring systems (*ibid.*).

Gilligan proposes an alternative, parallel hierarchy of moral thinking levels to Kohlberg's, to account for these differences. In this scheme, maturation in moral thinking is marked by increasing sophistication in the application in one's social interactions of principles of compassion and a sense of autonomous responsibility for others - as opposed to the more intellectual Kohlbergian 'justice' (Gilligan, 1977; Gilligan & Attanucci, 1988). Thus Gilligan (1977) proposes that the development of women's moral thinking passes through three levels characterised, in succession, by an orientation to individual survival, followed by an identification of goodness with self-sacrifice, and culminating in a widely inclusive morality of non-violence (Gilligan, 1977). These proposals are bolstered by the argument that a schema of moral development structured around issues of personal interconnectedness is more compatible than Kohlberg's with the developments in the post-Quantum Physics philosophy of science discussed earlier in Section 2.2.3 (Gilligan, 1988).

In reply to Gilligan and her followers, Kohlberg (1986) has suggested that applying the principle of justice in moral decision-making includes taking others' feelings into account. However, Gilligan's critique does not merely question the *content* of the principle(s) whose application Kohlberg posited to be central to mature moral thinking; she also suggests that the elaborate rational *process* he stipulates must precede mature moral behaviour is not, in fact, *definitively* neccessary for actions to be considered morally advanced (Gilligan, 1977; 1988).

Kohlberg (1986) draws on the Kantian and analytical traditions in moral philosophy to justify his stance: within this tradition, the description of a thought or action as 'moral' necessarily implies explicit logical justification based on abstract principles. On the other hand, the Gilligan camp draws on an alternative, minority tradition in moral philosophy (often identified especially with the philosopher Murdoch), which holds that immediacy of response and enhancement of interpersonal relationships are equally important criteria in assessing the morality of thoughts or actions (Blum, 1986; 1988; Gilligan & Antanucci, 1988; Goldman, 1993; Lyons, 1988).

Gilligan's approach is to some extent shared also by the so-called Virtue Theory school of moral philosophy (Putman, 1991), and Blum (1988) and Goldman (1993) raise the question of whether an ethic of care and relatedness is necessarily the only alternative to justice as a guiding moral principle. This in turn raises the possibility that the relatively poor performance of members of some non-western cultures on Kohlbergian rating-scales of moral thinking (Vine, 1986) might reflect deficiencies in the scales and their underpinning theory, rather than in the respondents or their culture.

But these are side-issues - the most important point is Gilligan's more explicit concern with the link between moral thinking and moral behaviour, which is crucial to this thesis. Before this question can be explored further, however, it is necessary to sketch in some background from moral philosophy, which already intrudes more and more into the discussion.

3.2 PERSPECTIVES FROM MORAL PHILOSOPHY

3.2.1 R.M. Hare's Moral Philosophy

Hare is described in the recent *Encyclopedia of Ethics* as "one of the leading moral philosophers of the century", and as "perhaps the only one who has contributed

significantly to meta-ethics, normative theory, and applied ethics" (Frey, 1992, p.436). In similar vein, the *Encyclopaedia Britannica* main article on ethics (Gewirth, 1985) mentions Hare several times more frequently than any other modern philosopher, and even opposing schools in moral philosophy feel compelled to at least address his arguments.

The intellectual ancestry of Hare's ideas lies within the Anglo-American, linguistic/analytic school of philosophy. His metaethical position is one of non-descriptivism and anti-cognitivism: Hare's account of the nature of moral language is that it is primarily *prescriptive* in nature, in other words, that it serves the emotional purpose of commending certain actions over others, rather than the cognitive function of describing some absolute quality inherent in such actions (Gewirth, 1985; Hare, 1981). In addition, Hare sees moral actions as being, by definition, both *universalisable* (*i.e.*, acknowledged by the moral actor as justifiable for *anyone* in similar circumstances, on utilitarian grounds, regardless of whether in a situation of reversed roles this would no longer be to the immediate advantage of the initial actor), and *overriding* (in that they are not permitted to be overridden by *any* other considerations, such as personal hedonic preferences, non-moral values, *etc.*).

Hare has addressed questions of applied ethics more vigorously than any other recent philosopher (Frankena, 1988), and that his interest in applied medical and psychiatric ethics is particularly strong (*e.g.*, Hare, 1977; 1991). His most useful contributions to the field of applied ethics are his promotion of rule utilitarianism, and (especially) his so-called 'levels theory' of moral thinking.

3.2.1.1 Rule Utilitarianism: This version of utilitarianism is espoused by Hare (*eg.*, Hare, 1991), although it is not unique to him (Gewirth, 1985). Rule utilitarianism proposes that, in the long run, the general good is most likely to be maximised by adhering to sets of pre-agreed rules, rather than by attempting to compute a calculus of benefits for each separate action (Hare, 1977; Steere, 1984). Thus, for example, while there might well be occasions when transgressing a particular rule (*e.g.*, a traffic speed limit, or the confidentiality clause of an ethical code) might maximise the general good, such occasions are in the minority, and one is on average more likely to serve the general good by routinely adhering to the rules.

Where rule utilitarianism differs from deontological ethics, however, is firstly in the origin of the rules (from an utilitarian assessment of the nett benefit of adhering to them, as opposed to by authoritarian fiat or linguistic sleight of hand), and, secondly, in the

rationale for adhering to them (maximising the general good rather than simply complying with some or other authority) (Gewirth, 1985).

Steere (1984) suggests several reasons why rule utilitarianism may be a particularly useful foundation upon which to base a code of professional ethics. For instance, it permits more specific stipulations of conduct regarding a range of situations than does a (necessarily limited) palette of absolute principles (as is often the case in deontological ethical theories). Also, in its final appeal to the single principle of maximising the general good in formulating rules and in resolving conflicts between them, rule utilitarianism avoids the confusion which emerges under pluralistic deontological approaches, where the appropriate relative weight to be given to conflicting principles can vary from case to case.

The possibility of conflicts between ethical principles - in other words, of ethical dilemmas - was mentioned in the previous paragraph. Hare's two-level theory of moral thinking provides a sophisticated means of tackling this difficulty, as well as providing an account of moral weakness, which is the focus of Section 3.3.

3.2.1.2 The Two-Level Theory of Moral Thinking: Hare's most significant contribution to moral philosophy, and the one with the widest theoretical and practical implications, is his proposal that moral thinking can occur on two distinct levels. Even more important than the basic levels thesis is the inference Hare draws from it, namely that the morality of conduct is maximised by clearly distinguishing between the two levels of thinking and the situations where each is applicable (as well as, less contentiously, by proficiency in the types of thought involved on each level) (Gewirth, 1985; Seanor & Fotion, 1988b).

The first level of moral thinking distinguished by Hare is the *intuitive level*, "at which we are faced with particular pressing moral problems without much time for reflection about them" (Hare, 1991, p.33). An example of moral thinking at this level would be a psychologist's decision-making process in facing any one of the many particular case management choice-points which arise during the course of every working day. On such occasions there is rarely the opportunity to indulge in Kohlbergian-type moral calculus, and Hare suggests that action is *appropriately* determined by reference to standardised norms.

Rigorous philosophical thinking does nevertheless have a place in Hare's schema, but only at the second, *critical level* of moral thinking. To engage in critical moral thinking, according to Hare one *needs to* step back from the pressures of immediate moral decisions, and decide or refine the working-rules intuitively applied during the course of busy everyday life through a philosophically rigorous process of critical argument and

reflection. This process may take various subsidiary moral principles into account, but ultimately refers to utilitarian criteria for validation (Hare, 1977; 1991; Seanor & Fotion, 1988b). Critical moral thinking may also be suggested in response to a moral dilemma (where two rules appear to advocate opposing courses of action) - *but should not be undertaken unless circumstances permit it to be done with adequate rigour.*

The italicised emphases in the previous two paragraphs highlight the fact that Hare's account of moral thinking levels has prescriptive as well as descriptive elements; the intersection of these two very different aspects of the levels theory is central to the empirical portion of this thesis. This nexus is Hare's suggestion that people's capacity for rationalisation in the service of their self-interest is so pervasive, and so easily facilitated by the sloppiness with which language (particularly moral language) is commonly used, that attempts to engage in the critical level of moral thinking in facing everyday moral decisions, when there is not the time to do so with appropriate philosophical rigour, leads *on average* to less moral behaviour than does relatively unquestioning adherence to pre-agreed rules (Gewirth, 1985; Hare, 1977; 1981; 1988). However, this condition will only hold if the fullest possible rigour is applied to the critical thinking process involved in determining these rules in the first place (*ibid.*).

The prescriptive element of Hare's levels theory of moral thinking has myriad implications for professional and applied Psychology, which will be explored in Sections 3.2.2, 3.3, and 3.4.

3.2.2 The Significance of Hare for Theoretical and Applied Psychology

3.2.2.1 Hare and the Kohlberg/ Gilligan Debate: At first sight, Hare's background in the analytical philosophical tradition would seem to make his philosophical analysis of moral thinking more compatible with Kohlberg's impartialist and deliberative theories of moral psychology than with Gilligan's proposals, which by contrast emphasise particularism and spontaneity.

For instance, Blum (1988) does not mention Hare by name, but argues that a two-level approach to moral thinking fails to accord considerations of care and responsiblity the fully equivalent status to impartialist considerations (of justice *etc.*) which Gilligan and Murdoch would maintain they deserve. This argument hinges on the interpretation that the status of care *etc.* as specifically *moral* attitudes (in terms of the levels view) depends on their justifiability on impartialist grounds at the critical level of moral thinking (*ibid.*;

Adler, 1989). Thus, while care *etc.* may be accorded the status of legitimate guiding principles at the intuitive level of moral thinking, their status as moral principles is subsidiary to impartialist evaluation *(ibid.)*.

On the other hand, Blum (1986; 1988) himself acknowledges that Gilligan and Murdoch do not see either partialist considerations of care and responsibility, or the virtues of spontaneous as opposed to deliberated moral action, as completely replacing Kohlbergian considerations of justice and rational deliberation as the hallmarks of moral thinking and behaviour. Rather, these considerations and approaches are seen as complementary and interdependent *(ibid.)*.

Similarly, Adler (1989) argues that the moral thinking processes described by Gilligan and associates apply to Hare's intuitive level of moral thinking, while the equivalent Kohlbergian processes apply to the critical level. However, Adler goes further than simply attempting to separate the squabbling Gilligan and Kohlberg camps by placing them into non-competitive slots within the common framework of Hare's levels theory. He also argues *(ibid.)* that Gilligan's theories of moral thinking are more compatible with Hare's than Kohlberg's, and that Hare's insights enable Gilligan's theory to subsume Kohlberg's.

For instance, while Kohlberg proposes that advancing to higher levels of moral thinking involves the application of ever more abstract principles to practical problems, Hare would suggest that more advanced moral thinking involves both ever-greater acknowledgement of contextual specificity in the principles which are formed at the critical level for application at the intuitive level, and also that one strays from the intuitive to the critical level at one's peril. Hare's approach here echoes Gilligan's emphasis on particularity and spontaneity *(ibid.)*. Both Hare and Gilligan consider the attempted routine application of critical-level moral reasoning to everyday moral decisions to be likely to lead to less moral behaviour in the long run: time-pressures prevent this being done with sufficient rigour *(ibid.)*, and (as for the Virtue Theorists) morality for both theorists includes consideration of a person's spontaneous behavioural tendencies *(ibid.*; Putman, 1991). In the latter connection, Hare (1991, p.37) remarks:

> "One of the qualities we look for in a good man is a readiness to do the right thing without hesitation. A man would not, for example, have the virtue of dependability if, when the time came to fulfil some undertaking he had made, he first had to spend some time thinking about whether he ought, after all, to fulfil it".

3.2.2.2 Hare and Professional Ethics in Psychology: As has already been mentioned, Hare has contributed significantly to applied ethics in general, and to medical and psychiatric ethics in particular. In his contribution to an influential text on psychiatric ethics (S. Bloch & P. Chodoff, Eds., 1991), Hare (1991) argues persuasively for the applicability of his two-levels approach to moral thinking to the structuring and implementation of a code of professional ethics for psychiatrists.

The pressures favouring rationalising special pleading, and other abberations consequent to inappropriate attempts to engage in critical moral thinking under less than optimum conditions, are perhaps more dangerous in the field of psychiatry than in less subjective fields of medicine (or other applied sciences) *(ibid.)*. For instance, countertransference reactions to clients, which are a particular occupational hazard of the mental health disciplines (and which form the focus of Chapter 4 of this thesis), can powerfully distort the psychiatrist's capacity for sufficiently rigorous rationality in facing decisions with moral implications during the course of busy everyday practice. These arguments would apply in at least equal measure to psychologists.

Basing the empirical portion of this thesis in part on Hare's theory of moral thinking can also be justified on the practical grounds that the current South African code of professional ethics for psychologists clearly bears his fingerprints. In the most significant independent publication on professional psychological ethics to have appeared to date in South Africa, Steere (1984) argues strongly for the adoption of a rule-utilitarian approach to the area, and cites Hare with approval. The thinking embodied in Steere's book *(op cit.)* can be assumed to have been influential in the development of the 1985 SAICP *Ethical Principles of Clinical Psychologists* (Steere & Wassenaar, 1985); Swartz (1988) certainly assumes as much in his critique of the document. Hare is not cited in the 1985 SAICP code (Steere & Wassenaar, 1985), but its indebtedness to his thinking is evident in the document's structure, and in the explanation of this structure and its application offered in the code's *Preamble*.

As was mentioned in Section 2.3.3, the bulk of the 1985 SAICP code consists of detailed rules, called practical (ethical) principles, which are stated in the *Preamble* to "arise out of the application of... fundamental ethical principles" to specific professional contexts (*ibid.*, p.25). Psychologists are enjoined to be *"committed to"* the fundamental ethical principles (of autonomy, nonmaleficence, and beneficence), and to *"adhere to"* the "specific regulations for conduct derived from this basis" *(ibid., italics added)*.

The relevance of Hare's two-levels view to this structure becomes even clearer when the *Preamble* sets out to guide the conduct of psychologists faced with ethical dilemmas, which are stated to "arise when two or more of the regulations laid out in an ethical code are equally applicable and dictate opposing courses of action" *(ibid.)*. Under such circumstances, the psychologist is directed to move from the intuitive to the critical level of moral thinking, by referring back to:

> "... the fundamental ethical principles on which the code is based. The ethical course of action would be that which best fulfils the dictates of the basic principles of autonomy, non-maleficence, and beneficence" *(ibid.)*.

The underlying Hare-like rule-utilitarian orientation of the 1985 SAICP code is brought out by the *Preamble's* continuing that:

> "Where no resolution is possible, in that the ethical principles themselves are in conflict, the clinical psychologist is required make a careful assessment of the effects of each conflicting course of action on all people who may be affected by them and choose the course of action which produces the least overall harm" *(ibid.)*.

The *Preamble* also demonstrates an awareness that, as per Hare (1977; 1991), any move from intuitive to critical moral thinking is potentially perilous to acceptably ethical conduct, and should be undertaken only with care and after circumspection:

> "In such difficult situations it is strongly advised that the clinical psychologist should seek the advice of professional colleagues or the governing professional body" *(ibid.)*.

There is a further reason why Hare's two-levels approach to moral thinking is an appropriate theoretical basis to inform the empirical portion of this thesis, and possibly also other empirical approaches to professional ethical behaviour. The two-levels view, more than exclusively critical moral thinking approaches like Kohlberg's, both addresses and suggests solutions to the problem of work-a-day ethical decision-making, when circumstances may not permit of appropriately unharried critical moral thinking. This is precisely the context conducive to the kinds of informal breaches of confidentiality identified in Chapter 2 as cause for concern, and hence the dependent variable of this thesis.

3.3 THE PROBLEM OF 'MORAL WEAKNESS'

3.3.1 Empirical Studies of Moral Thinking and Actual Behaviour

The term 'moral weakness' is common in moral philosophy, but not in the more consciously non-judgemental, putatively merely descriptive discipline of Psychology. Nevertheless, it will be used extensively throughout this dissertation, both because it is central to R.M. Hare's moral philosophy, and because it is stylistically less cumbersome than more value-neutral expressions like 'discrepancies between moral thinking and moral behaviour'.

Less empirical research has been conducted on behaviour with moral significance than on moral thinking processes. Furthermore, some of the research which has been done predates Kohlberg and his successors' contributions to the field, or for other reasons does not establish the implications of these theories of moral thinking for behaviour in contexts other than the simulated dilemmas used in Kohlbergian research (Straughan, 1986). Once again, Hare's contributions may be crucial to informing more fruitful future research *(ibid.)*.

Blasi (1980) somewhat simplistically distinguishes between approaches to studying moral behaviour which discount the mediating role of cognitive processes as irrelevant (such as, in his account, learning theory, social psycholoigical, and psycho-analytic approaches), on one hand, and those which (again, by his reckoning) do do so. Blasi *(ibid.)* goes on to thoroughly review only research informed by Kohlbergian theory (which he classifies in the second category), and in so doing raises points pertinent to this thesis. However, relevant insights are also contained in both earlier and subsequent research, and it is to the former that we first turn.

3.3.1.1 Situational and Personal Factors Influencing 'Moral' Behaviour: The earliest empirical studies of overt behaviour with moral implications were Hartshorne and May and associates' frequently-cited late 1920's studies of scholastic cheating (Burton, 1976; Kutnick, 1986). Contra what would have been predicted by the trait theories of personality which were then dominant in Psychology, Hartshorne and May *et al.* found situational factors to be the most influential factor contributing to whether or not subjects enhanced their perceived interests by the use of active deception *(ibid.)*. However, Hartshorne and May's associate Maller later demonstrated that dishonest behaviour in these studies was also to

some extent influenced by a common trait factor, which he suggested might be linked to an individual's capacity to delay gratification *(ibid.)*.

Over the next forty years, various studies (*cited in* Burton, 1976) added empirical support to the common-sense hypothesis that (dis-) honest behaviour on any given occasion is influenced by interactions between personal and situational characteristics. Specific situational factors which have been established as significant in this regard include (unsurprisingly) the subjects' perception of the risk of detection, the presence of appropriate incentives for success, and fear of failure (Burton, 1976). Deviant norms regarding cheating in subjects' value-reference groups is similarly predictive of cheating, but, more unexpectedly, "findings suggest that the norms for moral conduct are not rigidly fixed... but can be manipulated in the immediate situation" (*ibid.*, p.183).

Empirical findings regarding personal factors inluencing (dis-) honest behaviour are more ambiguous. Taken overall, research on the correlation between subjects' honesty and their age, gender, and I.Q. suggests that these factors rarely independently affect moral behaviour, but rather do so via interactions with differing specific situational factors (Burton, 1976). And Burton *(ibid.*, p.187) summarises subsequent research on Maller's proposed honesty-enhancing personality trait of capacity to delay gratification as follows: "...delay of reward and honesty indexes both reflect an underlying dimension of self-control, but may not always be significantly correlated with one another". In fact, greater ego-strength has even been found by some studies to *increase* the likelihood of dishonest behaviour under certain conditions *(ibid.)*, a point which is currently receiving widespread attention in both scientific and popular literature (Gibbs, 1995), and which will be taken up in Sections 3.3.1.3 and 3.3.2.

Inappropriate disclosure of client material by psychologists is obviously a different kind of moral weakness to the scholastic cheating investigated by the above-mentioned studies, among other reasons because the rewards for engaging in such behaviour are less tangible. Research on failure by psychologists to apply understood and/or accepted moral (or ethical) principles was discussed in Section 2.4.2: it is sparse, and largely merely descriptive, rather than attempting to discern *why* this behaviour occurs. The findings regarding the roles of ego-strength, self-control, and/or capacity to delay gratification, discussed in this section, will later be shown to be possibly relevant in this regard.

3.3.1.2 Kohlbergian Levels of Moral Thinking and Actual Behaviour: The above-mentioned early research on the judgement-action nexus is argued by Blasi (1980, p.6) to have investigated "trait consistency" (which he defines as "the tendency to behave in a similar way at different times and in different situations"), whereas Kohlbergian-informed research investigates "the agreement between what an individual states about his actions and the actions themselves", which Blasi calls "personal consistency". While both trait- and personal-consistency are relevant to the broad area covered by this thesis, the latter is more crucial to empirically testing the inferential hypotheses.

Blasi *(ibid.)* goes on to a widely-inclusive review of published and even unpublished empirical research on the possible links between sophistication of Kohlbergian moral reasoning and actual moral behaviour. Thus he reports that ten out of 15 reviewed studies of juvenile delinquents found such individuals to use moral reasoning characteristic of lower stages of Kohlbergian moral thinking than did control groups. Also, eleven of the 19 reviewed studies which investigated the relation of moral reasoning level to the likelihood of altruistic behaviour also yielded an unambiguously positive relationship between these variables.

However, although another eleven cited studies all found higher Kohlbergian levels of moral thinking to predict decreased likelihood of *intellectual* deference to unreasonable authority figures, Kohlbergian level did *not* predict *behavioural* resistance to the apparently immoral demands of authority figures under Milgram-type experimental conditions. Similarly, when viewed overall, twelve studies investigating the correlation between various measures of pro-social behaviour and moral reasoning proficiency produced conflicting and ambiguous results, as did 17 studies investigating the hypothesised correlation between subjects' moral reasoning capacity and their resistance of the temptation to cheat under supposedly low-risk circumstances.

Blasi *(ibid.)* rationalises the failure of these latter studies to support Kohlbergian theory as being due in some instances to potentially rectifiable methodological errors, and in others to problems possibly inherent to investigations in this area: for example, the possibility that two individuals conscientiously applying a particular level of moral thinking might arrive at different solutions to a given moral dilemma. However, one of Kohlberg's most disputed theses includes his argument that, at the highest of his proposed levels of moral thinking, the solution to moral dilemmas becomes *more* predictable to an impartial observer, rather than less (Straughan, 1986).

Another Kohlberg apologist, Kutnick (1986, p.131), also concedes that "Kohlberg's theory has received quite controversial support" (with regard to the moral thinking / moral action nexus), and also notes further adverse empirical findings not mentioned by Blasi (such as the apparent regression of high-level subjects' moral thinking to lower levels under certain circumstances). Kutnick *(ibid.)* goes on to chart various attempts which have been made by Kohlberg and others to defend Kohlbergian hypotheses, for instance, by re-interpreting previous findings, or (in later studies) by adapting research designs and/or further subdividing the stages of moral thinking.

According to Blasi (1980, p.41), Kohlberg and his associates (like Piaget and his before them) have tended to "study cognitive, including moral reasoning, structures, and cognitive reasoning processes as disengaged from their psychological context, as if they were not parts of a more complex organism", and to (in particular) ignore the role of affective structures and processes. Blasi *(ibid.)* notes that "integrity and its failure cannot be studied without taking seriously into account the self and related constructs", and suggests that addressing this core theoretical inadequacy of Kohlbergian theory is likely to shed more light on the empirically observed discrepancies between moral reasoning and moral behaviour than mere tinkering with details of methodology or of the theory of specific stages.

Gilligan's theories of moral thinking differ from those of her former mentor Kohlberg on precisely this point (*viz,* the role of affect and self-concept in moral decision-making). However, research concerning Gilligan's theories is relatively in its infancy compared to research on Kohlberg's, and thus still focuses more on the core aspects of the theory (such as the stages of moral thinking) than on more peripheral issues such as moral weakness.

3.3.2 R.M. Hare's Account of 'Moral Weakness'

As was mentioned in Section 3.2.2, the theories of philosophical ethicist R.M. Hare explicitly acknowledge the role of affective factors in the moral judgement-behaviour nexus, and for this reason supplement psychologist Gilligan's account of moral thinking and behaviour. In Section 3.2.3.1, in turn, the possibility was raised that Hare's two-level view of moral thinking might even provide Gilligan with the philosophical muscle necessary to transcend and subsume Kohlberg's theories. Any attempt to produce a systematic theoretical synthesis between Hare's theories of moral thinking and of moral weakness, and Kohlberg's and/or Gilligan's, is clearly beyond the scope of this thesis: at time of writing,

only a few tentatively exploratory articles of this nature have appeared in even the specialist literature of philosophical ethics (*e.g.*, Adler, 1989; Blum, 1986; 1988; Goldman, 1993).

However, as was mentioned in Section 3.2.3.2, Hare's theories clearly informed the construction of the ethical codes applicable to South African psychologists at the time of the empirical investigation included in this thesis, and for this reason fairly taunt an investigator from an avowedly empirical discipline to *test* them empirically - for all that the fine points of relation between Hare-the-philosopher's theories and those of Gilligan and/or Kohlberg-the-psychologist(s) may not yet have been established.

3.3.2.1 Moral Weakness and Selection of Moral Thinking Level: At the simplest level, Hare addresses the reality of moral weakness in his very proposal of the levels theory of moral thinking (as described in Section 3.2.2.2). Thus, for instance, in describing the intuitive level of moral thinking (at which most of us, per necessity, operate most of the time), he remarks that:

> "At the intuitive level, we have these intuitions about duties, and it is a good thing that we do. A wise utilitarian, bringing up his children, would see to it that they developed a conscience which gave them a bad time if they told lies. *He would do this because people with such a disposition are much more likely to do, on the whole, what is best than somebody who does cost-benefit analyses on particular occasions; he will not have enough time or information to do them properly, and will probably cook the results to suit his own convenience...*" (Hare, 1991, p.36., italics added).

On the other hand, however, Hare goes on to note the inadequacies of intuitive-level moral thinking in dealing with situations:

> "...when conflicts arise, or when the question is asked, *what* intuitions we ought to have, or *what* duties we ought to acknowledge, or what would be the *content* of a sound moral education" *(ibid.*, emphases in original).

In response to this problem, Hare argues that the potential for moral weakness will be at least *minimised* if a carefully circumscribed (but essential) role for critical moral thinking is acknowledged - *despite* the fact that (given human fallibility) "it is sometimes even dangerous" to attempt critical moral thought *(ibid.*, p.38). Thus, he proposes that:

> "By doing the best critical thinking of which we are capable, when we have leisure for it, we may be able to get for ourselves a set of fairly simple, general, *prima facie* principles for use at the intuitive level, whose prescriptions for particular cases will approximate those which would be given by a being who had... superhuman powers. This is really the best that in our human circumstances we can do" (*ibid.*, p.39).

Stalwart adherence to pre-established intuitive principles in the vast majority of circumstances is nevertheless Hare's first proposed response to the reality of moral weakness - however strong the temptation to resort to inadequate or simulated 'critical' thinking under unpropitious circumstances may be (Hare, 1991).

This first of Hare's several accounts of moral weakness is of direct relevance to the non-compliance of psychologists with ethical codes: for instance, Wilkins *et al.* (1990) cite Snyder's (1985) finding that self-serving rationalisations figure prominently in the justifications for their conduct advanced by violators of ethical codes. With regard to the empirical portion of this thesis, it is of particular relevance to the hypotheses relating to ethical education (which is discussed in Section 3.4).

3.3.2.2 **Moral Weakness and Weakness of Will:** Hare gives a number of other accounts of moral weakness, many of which are extremely complex and more relevant to moral philosophy proper than to this relatively empirically-focussed dissertation. This discussion therefore can do no more than note in passing Hare's more complex, linguistically-based, meta-ethical explanations of moral weakness as arising from inconsistencies in moral actors' understanding of the universalisability, overridingness, and/or prescriptivity implied by words like 'ought', and 'can' (*see* Hare, 1963; 1981; and 1988; and commentary by Frankena, 1988). More relevant to the current study, Hare also addresses the possibilities that moral weakness might also arise from either contextually appropriate but conceptually inadequate critical-level thinking, or from inappropriate application of the critical level of moral thinking in pressurised circumstances where it can not be done rigourously.

Nevertheless, Frankena (1988) implies that Hare fails to acknowledge the possiblity of forms of moral weakness originating purely in weakness of will as much as Kohlberg does. Frankena *(ibid.)* argues while Hare might address subtle or unconscious cant as a source of moral weakness, he does not acknowledge the possiblity of unwitting and undesired failure to apply what one sincerely believes to be right. Straughan (1982) expresses similar reservations about Hare.

This apparent gap in Hare's thinking may in part be due to the rationalistic slant of his analytical philosophical background, which could in turn be fruitfully complemented by the more holistic accounts of human nature offered by psychological theory. Thus, the discussion of countertransference in Chapter 4 will argue for one possible affective origin of weakness of will, in the highly specific context of practicing psychlogists.

3.4 EDUCATION IN ETHICS IN PROFESSIONAL PSYCHOLOGY

Liberal secular moral education has become something of a growth area in the U.K. and U.S.A. since the 1980's (Jarrett, 1991), but (as is the case with moral thinking, the literature on moral education focusses overwhelmingly on children and on school education (*e.g.*, Hersh, Miller & Fielding, 1980; Peters, 1981; Spiecker & Straughan, 1988, *various contributions;* Straughan, 1982). Michels and Kelley (1991) thus report that virtually nothing has been published on education in professional psychiatric ethics; the situation regarding professional Psychology is similar.

The remainder of this chapter will attempt to draw some implications for professional ethics education from the existing literature dealing with the acquisition of more global moral thinking much earlier in development. The discussion will be structured around Straughan's (1982) distinction between what he dubs the dishonesty, language, and immediacy aspects of moral weakness.

3.4.1 Values Clarification and Preventing Dishonesty in the Moral Actor

Straughan (1982) suggests that moral weakness is frequently due to the moral actor's failure to explicitly spell out relevant aspects of, and connections between, relevant aspects of the moral situation and of the competing moral (and possibly also *non-moral)* values which dictate different courses of action.

Hersh *et al* (1980), Jarrett (1991) and Straughan (1982) all discuss several approaches to (school) moral education which involve open-ended discussion aimed at clarifying both moral and non-moral motivations which might impact on behaviour. On logical (rather than empirical) grounds, Straughan (*ibid.)* identifies these methods as most likely to decrease in school children the incidence of moral weakness due to the kind of dishonesty described in the previous paragraph, but he goes beyond the relatively naive enthusiasm of the other authors cited to point out that such discussion is only likely to increase genuine self-awareness when the teacher is completely non-prescriptive and non-censorious. There is no *prima facie* reason why this point should not apply equally to psychologists-in-training, and no enormous leap of logic is required to infer that personally undergoing psychotherapy could fulfil a similar function for this (or any other) group. The relevance of personal experience of psychotherapy to psychologists' ethical behaviour regarding confidentiality will be further explored in Sections 4.4 and 4.5.

Non-directed discussion precludes in principle the promotion of particular moral values over others (Straughan, 1982). While this is in line with the liberal sentiments of most contemporary writing on moral education (*ibid.;* Jarrett, 1991), it seems poorly suited to inculcating the specific ethical values and regulations of a profession to its intitiates, particularly given the role which ethical codes fulfil in mediating between the sectarian interests of professionals and the interests of society at large *(see Section 2.2.5)*. In the context of professional training, therefore, open-ended discussion and values clarification clearly need to be supplemented by other approaches to teaching ethics.

3.4.2 Moral Thinking and Language: Philosophy-Based Moral Education

Failure to correctly understand or apply moral terms and reasoning with due philosophical rigor is the cause of moral weakness most frequently addressed by writers on moral education. Thus Hersh *et al* (1980), Jarrett (1991) and Straughan (1982) each describe a number of subtly different approaches to moral education which have the common aim of teaching students how to apply sophisticated philosophical reasoning and definitional skills to moral questions.

Among these approaches is Kohlberg's, which aims to 'improve' moral reasoning by exposing students to moral thinking characteristic of a level in his proposed developmental hierarchy one above that which they currently normally use (*ibid.;* Hersh *et al,* 1980; Jarrett, 1991; Peters, 1981). Although they do not mention Kohlberg, Michels and Kelley (1991) seem to be influenced by his thinking when they advocate that specialist philosophers be used to teach neophyte psychiatrists both the meanings of moral and ethical terms, and logically rigorous ways of applying them.

Having reviewed Kohlberg's and others' suggestions of this sort, Straughan (1982) makes some recommendations of his own regarding the content of formal philosophical approaches to moral education. Most relevant to the current purpose is his recommendation that teaching the binding and overriding prescriptivity of moral terms (as outlined by Hare) is essential if this kind of moral education is to move beyond being a merely academic exercise, and bear fruit in practice - and even then only if the teaching enables students to root such bindingly prescriptive moral terms in their own interests and value systems (as opposed to seeing them as the imposed requirements of an external deontological authority).

This point recalls the logical *(see Sections 3.1.2.3., 3.2.2, and 3.3.2.1)* and empirical *(see*

Section 3.3) challenges to rationally-loaded conceptions of morality which have already been raised. Thus, while formal training in philosophical ethics might well equip the members of a profession to compile a logically coherent and socially defensible ethical code, as well as to resolve difficult moral dilemmas in contexts where Hare's second (critical) level of moral thinking is appropriate, this emphasis does not directly prepare them for the incidental daily ethical challenges which form the focus of this thesis.

3.4.3 Moral Weakness and Immediacy Issues: Implications for Moral Education

The approaches to moral education discussed so far attempt to facilitate the development of moral thinking in general, as outlined in Sections 3.1 and 3.2. The indadequacies of these approaches which have been noted mostly stem from failure to even acknowledge (still less address) the problems of moral weakness as described in Section 3.3, which Straughan (*ibid.*, pp.137ff) calls the "immediacy" aspect of moral weakness. Such concerns are of course central to the Virtue theorists' and Gilligan's conception of morality as implying more than simply intellectual proficiency in moral casuistry (Spiecker, 1988; *see Section 3.1.3.1*). They also recall Hare's comment (1991, p.37) that "a man would not, for example, have the virtue of dependability if, when the time came to fulfil some undertaking he had made, he first had to spend some time thinking about whether he ought, after all, to fulfil it".

Rather than the inculcation of intellectual moral knowledge or procedures, Virtue Theory approaches to moral education tend to stress the development of global character in altruisitic directions, particularly through the cultivation of a capacity - and habit - of immediate empathy for others (Michels & Kelley, 1991; Spiecker, 1988). Thus, in the school context, Hersh *et al.* (1981) describe programmes which expose students to people culturally different from, or less fortunate than, themselves, and which encourage social action and community service to develop from these contacts.

As usual, Straughan (1982) adds a cautionary caveat, namely that such approaches will only produce the results desired by the Virtue Theorists if such approaches engage as much as possible with the personal values and life situations which students bring to the educational context, and if it emphasise the consequences (for both self and others) of alternative moral or non-moral responses to these situations.

3.4.4 Integration: Hare's Levels Thesis and Professional Ethics Education

Straughan's contributions excepted, the approaches discussed above are vague about quite what psychological mechanisms might be involved in the acquisition of pro-social values through these methods. Hare has not developed a complex theory of moral education *per se*, but he clearly states (Hare, 1981; 1991) that his levels theory of moral thinking implies that moral (and ethical) education should prominently include both the learning of specific practical rules as well as critical philosophical skills. This seems to fly in the face of both the rationalist and the Virtue Theory approaches, but Steutel makes several points which suggest intersections between all three philosophical approaches, and Gilligan's psychological theory as well.

Steutel (1988) argues that self control (relevant to avoiding forms of moral weakness such as undeliberated breaches of professional confidentiality), in common with other virtues, encompasses psychological *abilities* as well as moral values. He goes on to suggest that possessing cognitive strategies for reminding oneself of the moral implications and practical consequences of non-moral courses of action are central to this ability *(ibid.)*. The learning of specific moral or ethical rules as suggested by Hare can be argued to provide the moral actor with an immediately accessible points of reference - in Steutel's terms a cognitive strategy - at the intuitive level of moral thinking emphasised by Gilligan and the Virtue theorists.

However, Straughan's (1982) point about the ineffectiveness of attempting to impose particular rules without allowing students to integrate these with their existing value systems *(see Section 3.4.2)* suggests that some sort of exploration of the values underlying and informing these rules is also necessary. This aspect of moral or ethical education would in turn almost inevitably flounder in inconclusiveness without the application of at least a modicum of critical philosophical skills, the teaching of which would have the added advantage of equipping students for ethical thinking at the critical level as well.

Hare's (1981; 1991) suggested application of his levels theory of moral thinking to ethical education thus seems highly compatible with the psychological literature in this area: it suggests ways of combating some of the shortfalls of Kohlbergian moral education raised by empirical studies *(see Section 3.3.1)* and by Gilligan (1982), without sacrificing critical moral thinking altogether (Adler, 1989).

Specifically in respect of the training of psychologists, Hare's approach would suggest that ethical education should include specific focus on the practical ethical regulations as well as on the underlying fundamental ethical principles and on the critical skills needed to relate the latter to the former. Emphasis on critical thinking alone could have the paradoxical effect of *decreasing* the ethicality of behaviour in the sort of pressurised contexts in which informal breaches of confidentiality occur, while incorporation of specific regulations as intuitive moral responses is most likely if these are taught along with more critical ethics. Similarly, although critical thinking cannot be adequately taught except in the context of subject-dedicated ethics classes, internalisation of both ethical regulations and values is likely to be most effective if these are regularly emphasised in applied aspects of training such as case-conferences and supervision.

CHAPTER 4:
COUNTERTRANSFERENCE AND
INFORMAL BREACHES OF CONFIDENTIALITY

4.1 INTRODUCTION

In Chapter 3, reference was made to the apparent lack of research into the gaps between moral cognition and moral action, and particularly into the relation of self structures to these gaps. This chapter seeks to present one possible component of the specific gap between the ethical cognitions and the ethical actions of psychologists, at least with regard to informal breaches in confidentiality. This component is *countertransference*, which is a relatively under researched possible emotional complication of the relationship between psychologists and their clients, and which originates in some of the distinctive characteristics of this category of relationship. The concept of countertransference is psychoanalytic in origin, and it will therefore be primarily discussed here from this theoretical perspective, and specifically with reference to its manifestation in *therapeutic* (as opposed, say, to assessment-oriented) interactions between psychologist and client. However, it will be argued (Section 4.2.3) that countertransference complications can arise regardless of the theoretical orientation of the psychologist, and of the nature of his or her professional role.

The concept of countertransference is intimately tied up with that of the preferred analytic attitude, and is often defined in relation to it. Therefore, before exploring the various definitions and theories of countertransference later in this chapter, psychoanalytic views on empathy and the preferred attitude of the analyst will be briefly examined first. The following two sections will deal with the manifestations of countertransference in the work of psychologists, and with how these can most appropriately be responded to. Finally, the possible relevance of countertransference factors to informal breaches of confidentiality will be discussed, and the specific hypotheses which test this possibility in this research project will be presented.

4.2 PSYCHOANALYTIC CONCEPTS OF EMPATHY

4.2.1 Background: The Objectives and Rationale of Psychoanalysis

The primary function of the psychoanalyst is to effect change in the patient's emotional structures, and hence to assist him or her to move from "neurotic misery to ordinary unhappiness" (Malcolm, 1982). As the name of the discipline implies, this is achieved by means of analysis of the patient's underlying psychodynamics, by the analyst, and by the initiation of the client into this knowledge. Acquiring at least some understanding of the nature of childhood psychosexual crises and their (usually incomplete) resolution is conventionally seen as giving the client the opportunity to belatedly resolve them, or at least to acquire some measure of control over their power to subconsciously and destructively influence the course of later life events (*ibid*; Jackson & Haley, 1963).

As will be shown below, however, the initiation of the client into knowledge of his or her own psychodynamics must be strategically done - mere explanation will not usually suffice, due to the analysand's paradoxical resistance to change (Freud, 1910). The distinctive qualities of the psychoanalytic situation are an important determinant of the success both of the acquisition of the analyst's understanding of the analysand's psychodynamics, and of the effective transmission of this understanding to the analysand (Saul, 1972). In fact, it has even been suggested (Jackson & Haley, 1963) that the healing potential of psychoanalysis lies at least as much in the nature of the therapeutic relationship as in the insights gained through this.

Schafer (1983, p.14-33) proposes that an "atmosphere of safety" is the characteristic of the analytic situation which is most essential to the emergence of unconscious material as grist to the mill of analytic work. All other characteristics of the analytic situation, such as the scientific rigour and open mindedness of the analyst, his or her unjudgemental openness to whatever material the patient produces, the disciplined refusal by the analyst to use the analytic situation to fulfil his or her own needs, and so on, can be reformulated in terms of maintaining this atmosphere of safety (*ibid*; Saul, 1972). The assurance that the material presented by the client will be held in strict confidentiality by the analyst/psychologist (as discussed in Chapter 2), is an essential component of this atmosphere of safety.

4.2.2 The Role and Nature of Empathy in Psychoanalysis

Empathy is an essential component of the creation of an atmosphere of safety, and also of the analyst's effectively using the material produced in that atmosphere to the benefit of the client. The term is defined by the Concise Oxford Dictionary (Sixth Ed., 1976) as the "power of projecting one's personality into (and so fully comprehending) (an) object of contemplation", and is derived from the German *einfuhlung* (literally, "in-feeling") (*ibid.*; Wolf, 1983, p.309). Demonstrated empathy contributes to the unjudgemental openness of the analytic situation which is essential for the patient to access deeply unconscious material, but its primary importance for analytic effectiveness is as the analyst's only means of *understanding* the patient's inner life and dynamics (Wolf, 1983).

However, if the analyst is either to understand the *full* existential significance of the material produced in analysis, or to make the client's later initiation into this understanding a healing experience, this understanding has to be more than merely coldly cognitive. The analyst must therefore utilise not only the freely hovering cognitive attention described by Freud, but also a "freely roused emotional sensibility" (Heimann, 1949, p.141; also Sandler, 1976).

It is important to note, that while empathizing with the client is a prerequisite for accessing his or her experience, it is a distinct activity from those of analysing this experience and its unconscious dynamics, and of assisting the client to share and use the fruits of this analysis. Fliess (1942, p.236), is careful to specify that "a person who uses empathy on an object introjects this object *transiently*, and projects the introject again onto the object", in order that the subjective insights so gained can be clinically interpreted. With slightly different emphasis, Little (1951) suggests that the preservation of an awareness of the separateness of analyst and patient is crucial to therapeutic effectiveness.

Whatever way it is conceived, however, failure of the analyst to maintain this delicate balance between subjective involvement *with* and objective clinical detachment *from* the patient is accepted by all theorists as preventing (or at the very least making more difficult) the realisation of the healing objectives of psychoanalysis. Where the theorists differ, and hence where confusion creeps in, is with regard to whether the term "countertransference" refers only to aberrations of empathy, or subsumes both empathy as defined above, and its unproductive mutations. Section 4.3 will examine some of these differing conceptions of countertransference. First, however, it is necessary to address the fact that psychotherapists from different schools use a wide variety of explanatory

theoretical frameworks (some of which are explicitly - even vehemently - opposed to psychoanalysis).

4.2.3 Relevance of Countertransference to Applied Psychology Generally

Attempts to identify common elements in the plethora of approaches to psychotherapy invariably include empathy (as the appropriate balance between scientific objectivity and compassionate identification) as a precondition for the effectiveness of whatever interventions the psychotherapist makes (*e.g.*, Frank, 1974; Frank, 1978; Garfield, 1973; Strupp, 1973). In that it helps explain destructive failures to maintain appropriate empathic balance (without presupposing wider-ranging subscription to psychoanalytic tenets), psychoanalytic thinking on countertransference is relevant to other therapeutic schools.

Furthermore, Jackson and Haley (1963, p.366) suggest that the increasing attention devoted to countertransference in the psychoanalytic literature (which has accelerated since publication of their article) "goes along with the current tendency to see the patient in terms of his interpersonal and social relationships and not merely in terms of his intrapsychic dynamics", and thus provides a bridging common ground between psychoanalysis and other schools.

Writers on psychological assessment use the concept of empathy *per se* less often than do therapists. However, they still stress both the necessity of the psychologist interpreting the information about the client in the context of the client's experiential life history, and the fact that the final assessment ultimately relies as heavily upon the psychologist's 'subjective' clinical judgement as on 'objective' test results or biographical facts (Maloney and Ward, 1976; Sundberg, 1977). And even with regard to psychological testing, Anastasi (1982) emphasises the necessity of testers establishing adequate rapport with subjects undergoing objective psychological testing, if they are either to elicit their clients' optimal performance, or to be aware of extraneous factors (*e.g.*, test anxiety) affecting test behaviour. The possibly destructive impact of deficient empathy under these circumstances is obvious.

4.3 CONCEPTS OF COUNTERTRANSFERENCE

4.3.1 The Classic Psychoanalytic View

Traditional psychoanalysts such as [A.] Reich (1951, p.154) define countertransference narrowly, as "the effects of the analyst's own unconscious needs and conflicts on his understanding or technique". Just as the client, under the influence of transference, responds affectively to the analyst in a way that has more to do with repressed emotions regarding some other significant person in his or her life than with the qualities or actions of the analyst, so too the analyst, under the influence of countertransference, interprets or responds to the client in the same way (*ibid.*; Little, 1951). It is as if the glass of the mirror which the analyst is supposed to be, neutrally reflecting the patient's mental life, has become pigmented with issues from the analyst's own inner life; the image of the patient which is reflected is then inaccurately coloured. The key word in Reich's definition is *unconscious*: the inability of the analyst to respond objectively to the client under countertransference conditions robs the analytic situation of the one quality - described above by Schafer (1983) as the atmosphere of safety - which distinguishes it from all other human interactions, and which is also responsible for its healing potential.

Although Reich's above definition could be interpreted as including positive effects on analysis of the analyst's unconscious needs and conflicts, Brenner (1985) notes that Reich includes only *negative* effects. Because an inappropriate focussing of (ideally unfocussed) attention or emotional responsiveness causes the analyst to miss or misinterpret important clues to the patient's psychodynamics, it prevents him or her from dispassionately understanding the patient, and from responding appropriately.

Another possible effect of countertransference defined in this narrow sense, which is more worrying than mere clouding of analytic vision, and more relevant to the focus of the current study, is acting out by the analyst. In this context, *acting out* refers to situations where the psychologist's activities related to the client have a significance of which he or she is not consciously aware (Reich, 1951). The analyst may use the client as a means to the end of fulfilling his or her own needs, either directly (by using the client as an actual or substitute love object), or vicariously (by identification with the client) (*ibid.*). These unconscious meanings can for instance include the seduction, parenting, or domination of the client (*ibid.*), they negatively affect the atmosphere of safety, and they are more likely to complicate the patient's pathology than to aid in its resolution.

4.3.2 Variations on the Mainstream View of Countertransference

Tower (1956) shares Reich's view of countertransference in the analyst as being directly analogous to transference in the patient, but differs from Reich not only in that she sees absolute control by the analyst of his or her unconscious as impossible, but in that she sees the implied inevitability of countertransference as an asset to the therapeutic process. Because it is frequently a response to some aspect of the patient's transference, perhaps an aspect which has not yet been consciously perceived by the analyst, analysis of countertransference phenomena can yield valuable fresh insights into both the transference and the deeper dynamics underlying it. This view of countertransference has been much more fully developed by the Object Relations school, as is discussed below.

According to Langs (1981) and Sandler (1976), Tower's view that countertransference could potentially be constructive was first put forward by Heimann (1949). Heimann had in mind a much broader definition of countertransference, namely, as covering "*all* the feelings which the analyst experiences towards his patient" (*ibid.*, p.140, italics added). She does nevertheless distinguish between helpful and unhelpful manifestations of the phenomenon - in her case, on the basis of the *intensity* of the analyst's emotional response. High intensity emotional responses tend to impel a person to action, and will therefore have a destructive influence on the analytic situation when experienced by an analyst in reaction to the material presented by the client which the analyst does not yet fully understand (*ibid.*).

4.3.3 The Object Relations View of Countertransference

Writing from an Object Relations point of view, Racker (1972, p.182) also defines countertransference broadly, as "the totality of the analyst's response to the patient", but like Heimann (1949) and in fact all theorists who use the term countertransference in this much broader sense, he too distinguishes positive and negative aspects of the phenomenon. Also, like Tower (1956), Racker (1972) questions whether assuming the neutral analytic stance can ever fully insulate the analyst from experiencing towards the analysand the whole gamut of feelings normally felt by any one person for another.

Racker (*ibid.*) distinguishes positive instances of countertransference from negative ones (or, in conventional psychoanalytic terms, empathy from countertransference) in two ways. Firstly, both positive and negative countertransference are seen as identifications of the analyst with the client, with the difference that negative countertransference involves

complementary identifications, of the analyst's ego with the patient's id or superego. As a result, an object relation much the same as the majority of human interactions is formed. On the other hand, positive countertransference (empathy to mainstream Psychoanalysis) is seen to result in *concordant* identifications, where each part of the analyst's personality (id, ego, super-ego) is identified with the corresponding part of the client's personality, "which in a certain sense annuls the 'object relationship', properly speaking" (*ibid.*, p.182).

The second basis used by Racker to distinguish positive from negative countertransference is the degree of ego involvement of the analyst in the emotions which he or she experiences as a result of identifying with the patient. This goes beyond Heimann's (1949) simple use of intensity of emotional experience as a distinguishing criterion, however. Countertransference "thoughts" are the clinically useful free associations and low intensity emotions which are experienced in a state of concordant identification, and from which the analyst's ego is able to maintain a critical distance, while countertransference "positions" are the overwhelming and insight-crippling emotional experiences resulting from complementary identifications (Racker, 1972). This distinction between positive and negative countertransference therefore fills in the phenomenological correlates of the processes of concordant and complementary identification.

4.3.4 Integration: Countertransference as Used in this Thesis

The major source of confusion in the above survey of psychoanalytic thinking on countertransference lies *not* in the different ways the mechanisms of empathy and/or countertransference are described, but in the inconsistency with which the boundaries between these processes are drawn. However, even those theorists who use the term countertransference to describe both the positive and the negative aspects of the analyst's emotional functioning find it necessary to distinguish between these contradictory aspects. Given the existence of an alternative unambiguous term for describing the insightful and productive emotional responses of the analyst to the patient - *empathy* - it would therefore seem more economical to reserve the term countertransference for unconsciously influenced and analysis-disruptive emotional responses of analyst to patient.

This suggested usage would also seem semantically more defensible: although Racker (1972) defends the broad usage of the term on the grounds that transference is equally broadly used, to include *all* feelings experienced by the client towards the analyst, the root word *transfer* would seem to restrict both transference and countertransference to emotions

whose nature and intensity is derived from some other person or situation than the one towards whom they are currently directed (Arlow, 1985). Faimberg (1992) notes that this usage appears to enjoy wider currency, although confusion continues to exist. Despite the fact that the term countertransference continues to be used in a number of different ways, it will be used in this thesis in this more narrow sense, *i.e.*, to denote situations where the objectivity of a psychologist's reactions to his or her client is compromised by their own unresolved psychological issues.

4.4 COUNTERTRANSFERENCE AS AN OCCUPATIONAL HAZARD IN APPLIED PSYCHOLOGY

4.4.1 The Ubiquity and Variability of Countertransference

A common thread running through the discussions of countertransference is the fact that it virtually inevitably occurs at least sometimes in the work of all analysts. As Anna Freud (1954, cited in Silverman, 1985, p.176) once put it, "a psycho-analyst ideally should be no more than a blank screen reflecting back to the analysand what is being projected onto him, without introducing anything from his own feelings and attitudes, but, of course, she stated, none of us can do that". This point is also made by Brenner (1985), Racker (1972), and Tower (1956), among others.

An early landmark study by Cutler (1958) provided some empirical indications that therapists' responses to client material tended to be least appropriate when this material related to areas of unresolved conflict in the therapist's own life. Similarly, Peabody and Gelso (1982) found counsellors' empathy to be positively related to openess to countertransference feelings, and negatively to countertransference acting out, while Hayes and Gelso's (1991) found higher therapist anxiety levels to be significantly correlated with countertransference acting out.

As Silverman (1985) points out, it is impossible for anyone ever to be so completely analysed that they have *no* unresolved personal psychological issues, and it is therefore only a matter of time before some or other patient's analytic material or transference reaction intersects with a chink in the analyst's armour and sparks off a countertransference reaction. This point would apply equally to activities of psychologists other than in psychotherapy, and to psychologists from schools other than psychoanalysis.

This difficulty may, however, differ for different permutation of patient-therapist pairings. For instance, Marcus (1980) has described distinctive countertransference pitfalls in the psycho-analysis of children, as have Wylie and Wylie (1987) with regard to patients who are significantly *older* than the analyst. In similar vein, Pines (1986) has shown how the analysis of massively traumatised patients - in her case, holocaust survivors - can be especially fraught with countertransference dangers. In the face of material concerning intense experiences of agony and of loss, and of correspondingly powerful transferences, it is exceptionally difficult for the analyst to tread the empathic tightrope without falling off, either on the side of over identifying with and drowning in the patient's intense emotions, or on that of self-defensively distancing oneself from any empathic response (*ibid.*).

Finally, regardless of their general level of functioning, psychologists are particularly vulnerable to countertransference responses when their own emotional equilibrium is disrupted by personal life stressors (Abend, 1986). Applied psychology generally is an extremely stressful occupation, precisely because of "the demands of sustaining a precarious equilibrium of intimacy and objectivity" (Hellman, Morrison & Abramowitz, 1987, p.171), and there are consequently relatively high rates of anxiety, depression, suicide, alcoholism and interpersonal problems among practitioners (Guy & Liaboe, 1986). Along with physiological disturbances, low morale, and poor job performance and stability, these problems have been linked (particularly by Maslach and co-workers) to the syndrome of burnout, to which human service professionals are particularly prone (Raquepaw & Miller, 1989). This proneness derives especially from from the one-sidedness of the frequently intensely intimate relationship between psychologist and client - the "sense of isolation within an intimate relationship" (Bion, *cited in* Caper, 1992, p.288) - the maintenance of which is essential to professional effectiveness (Caper, 1992; Caruth, 1985).

4.4.2 Minimizing the Negative Effects of Countertransference

Since countertransference, as here defined, interferes with applied psychologists' professional effectiveness (by clouding their perspicacity and threatening the emotional safety ideally enjoyed by their clients) and if it is also inevitable to some degree, it obviously requires serious attention. Freud's view of this imbroglio grew increasingly grave over the course of his career (Silverman, 1985); in 1910, the recognition of countertransference phenomena led him to recommend rigorous self analysis as a way of

countering it; by 1912, only two years later, he felt it necessary to extend this recommendation to a prophylactic "training analysis" for all aspirant psycho-analysts; and in his 1937 paper *Analysis Terminable and Interminable*, he had progressed to recommending every analyst "to undergo periodic re-analysis with another analyst, without shame and without regret" (cited *ibid.*, p.179).

Thorough and ongoing awareness of his or her own psychodynamic processes and needs remains the only means universally recommended to analysts for dealing appropriately with countertransference (Norcross, 1988), along with hypervigilance for manifestations of the problem and conscientiousness in minimizing their impact. Schwaber (1992, p.349) notes that even theorists who see countertransference as a valuable component of an analyst's functioning agree that it "must, at least, be located by the analyst in order to further the clinical endeavour". Consequently, although Silverman (1985) has described the perfectly analysed analyst as a myth, personal analysis remains a component of traditional psychoanalytic training, and some form of psychotherapy is widely recommended by other schools of applied psychology as well (*ibid.*; Abend, 1986; Wolf, 1983).

Pope and Tabachnick (1994) found 84% of their sample of psychologists to have personally been in psychotherapy. Although most had entered therapy for reasons of personal distress or dysfunction, the three aspects of therapy by far the most commonly rated as the most beneficial were (in decending order) self-awareness or self-understanding, self-esteem or self-confidence, and improved skills as a therapist *(ibid.)*. A substantial majority of respondents (regardless of whether they themselves had been in therapy) - 70%, in fact - stated that professional training programmes for psychologists should 'probably' or 'absolutely' require therapy for therapists-in-training *(ibid.)*. Similarly, Norcross *et al.* (1988) found 71% of psychotherapists they surveyed to have had at least one episode of psychotherapy, and that 90% of these respondents (like those in the Pope and Tabachnick study) believed the experience to have increased their professional effectiveness (these findings were most marked for psycho-analytic therapists).

Empirical support for such beliefs is provided by MacDevitt (1987), who found that the number of hours of therapy psychologists had received was the strongest predictor of their dealing appropriately with countertransference-prone hypothetical situations, and Cutler (1958), who found higher levels of personal therapy to be predictive of lower incidences of therapist acting out. Ongoing peer supervision, and other appropriate opportunities for discussing clinical work after completion of basic training, although barely mentioned in the literature, would seem likely to serve a similar purpose (Caruth, 1985; Olinick, 1980).

Vulnerability of psychologists to countertransference responses forms one of the variables in this thesis, and is operationalised in terms of the risk factors discussed in this, and the preceding subsection *(see Chapter 5)*.

However, a number of authors (Alonso & Rutan, 1988; Silverman, 1985; Tower, 1956) have noted that certain attitudes within both the psychoanalytic and the psychological professions *discourage* a constructive approach to countertransference, and to personal psychotherapy and post-registration supervision. Psychoanalytic training inculcates in the analyst a habit of repressing fantasy about him- or herself, as part of the analytic attitude, and a tendency to overlook countertransference phenomena is an unfortunate by-product of this; also, countertransference experiences can be highly anxiety-provoking and ego-threatening after the rigorous selection and training an analyst has gone through to gain admission to the profession (Tower, 1956), and may be denied at all costs to save face (Alonso and Rutan, 1988). Silverman (1985) and Schwaber (1992) note that a false confidence that the analyst's training and personal analysis place him or her "beyond" the danger of negative countertransference in fact leads to maximum vulnerability, and almost all the writers cited above stress that an openness to countertransference effects is the only way to minimise their destructive influence.

4.5 INFORMAL BREACHES OF CONFIDENTIALITY AS COUNTERTRANSFERENCE PHENOMENA

4.5.1 The Psychology of Gossip

The various positive and negative meanings of 'gossip' (as it applies to a type of communication, or the content thereof) are probably best summarised in the Oxford English Dictionary definition of "easy, unconstrained talk or writing, especially about persons or social incidents" (*cited in:* Medini and Rosenberg, 1976, p.454). In this sense, the informal breaches of confidentiality for non-professional purposes, which form the focus of this thesis, can be classified as gossip.

Medini and Rosenberg (1976) argue that most people use gossip as an important means of supplementing their personally accumulated understanding of life and how best to live it, with the vicarious experience of others. They also suggest that gossiping to a third party may provide an important means of gaining perspective on uncomfortable feelings

(such as envy or threatened self-esteem) which are aroused within a relationship, and develop this point to draw parallels between the psychological functions served by gossip and by psychotherapy.

Other writers are less positive about the psychological functions served by gossip. While acknowledging motivations for gossiping similar to those outlined by Medini and Rosenberg (1976), Olinick (1980) suggests that dealing with social anxieties this way is more prone to defensive than to mature encounter with either the emotional material gossiped about, or its impact on the gossiper's sense of psychological well-being.

Caruth (1985) also acknowledges the role of gossip as an attempt to integrate threatening emotional material evoked by the person or situation gossiped about, but elaborates on Olinick's reservations about its effectiveness in achieving this. She suggests that gossiping is diagnostic of an incapacity in the gossiper to sustain mature intimacy, which she defines as 'a feeling that (one) is... able to maintain a sufficient distance for separation alongside a sufficient closeness for connection' (*ibid.*, p.550). Caruth hypothesises that a gossiper "betrays the intimacy of the first relationship with the gossiped of, ...(and) also spoils the potential intimacy with the second relationship - with the gossiped to - by bringing in the third person - the gossiped of - thus repeating a need to turn dyad into triad" (*ibid.*, p.551).

Both Caruth and Olinick see addressing the anxieties that fuel gossip through *direct* and serious examination (possibly in the context of a mature intimate relationship), as being more conducive to the growth-enhancing benefits proposed by Medini and Rosenberg (1976) than easy, unconstrained talk. These intriguing possibilities will be examined more fully in the following section, with reference to the particular kind of intimacy subsisting between psychologist and client.

Before moving on to this, however, it is worth noting Medini and Rosenberg's (1976, p.461) point that, "much of the knowledge we have about the world and ourselves is derived from gossip and our evaluation of it... the activity itself cannot define whether it is going to be put to the use of good or evil". They suggest that moral evaluations can only be made for *particular* instances of what they see as a generic human activity; such evaluations would have to take into account the motives, context, and possible consequences of the behaviour.

4.5.2 Informal Breaches of Confidentiality, and Countertransference

The discussion in Chapter 2, of the nature and rationale of the ethical regulations concerning the disclosure by psychologists of confidential client information to third parties, will not be reiterated here. However, it is clear from this discussion that informal breaches of client confidentiality by psychologists, for non-professional purposes, is a category of gossip rendered unacceptable by its contravention of the distinctive contractual terms of the relationship between psychologist and client. Further, moving beyond the practical to the fundamental ethical regulations, such behaviour is an infringement of the client's autonomy, and potentially injurious to the atmosphere of safety upon which the psychologist's potential professional effectiveness depends. Although Olinick (1980) finds gossip by psychoanalysts worrying merely because it does not obviously *enhance* the healing potential of psychoanalysis, Caruth (1985) suggests that it indicates countertransference acting out, which is at the very least an impediment to benefiting the client, and often downright harmful.

Caruth *(ibid.)* sees the psychodynamic processes underlying gossip by psychologists about their clients as being the same as that underlying gossip in the context of other relationships (as described in the previous sub-section). However, the distinctiveness of the relationship between psychologist and client is rooted in the assumption that the psychologist has been trained to *avoid* just these kinds of dynamics, or to deal with them in more professionally appropriate ways (as was discussed above in Sections 4.2 to 4.4). A psychologist gossiping about a client results (in terms of Caruth's proposed dynamic of gossip) from an earlier failure by the psychologist to sustain the ideal balance between objective detachment *from* and subjective involvement *with* the client (for instance, by envying or rejecting the client, or by over identifying with him or her). Such a failure in empathy is clearly classifiable as a countertransference response, and the subsequent gossiping as countertransference acting out (in terms of the definition of countertransference arrived at above - and shared by Caruth) *(ibid.)*.

The final hypotheses tested in this research project, as set out Chapter 5, are an attempt to operationalise Caruth's (1985) theoretical proposals in empirically testable form. If verified by the results of the research, they could provide an indication both of one possible component of the perturbing gap between psychologists' ethical beliefs and their ethical behaviours, and of possible ways of closing this.

CHAPTER 5:
RESEARCH QUESTIONS AND HYPOTHESES

5.1 THE INCIDENCE OF INFORMAL BREACHES OF CONFIDENTIALITY

As was discussed in Sections 2.1.4, 2.2.4, 2.2.5, and 2.3.4.3, increasing emphasis is being placed on the accountability of psychologists for the welfare and dignity of their clients. The importance to client welfare and dignity of psychologists maintaining the confidentiality of client material was argued in Sections 2.4.1 and 4.5.2. The reported high incidence of informal breaches of professional confidentiality by American psychologists, as was discussed in Section 2.4.2, is therefore cause for serious concern, as is the absence of any empirical research on this (or any other) aspect of the ethical compliance of South African psychologists.

Consequently, the first hypothesis tested in the empirical portion of this study concerns the incidence of various confidentiality-related behaviours among South African clinical, educational, and counselling psychologists (who are bound by an identical ethical code in this respect, as was discussed in Section 2.3.5).

Hypothesis 1: *Informal breaches of confidentiality among a sample of South African clinical, counselling, and educational psychologists will approximate those in the Pope* et al *(1987) study of American psychologists.*

Furthermore, (as was discussed in Section 2.4.2), informal breaches of confidentiality have emerged in overseas studies as virtually unique among unethical behaviours by psychologists, in that they are amongst the very few in which psychologists' actions are not in accordance with their ethical beliefs. Hypothesis 2 investigates whether this situation pertains also among South African psychologists.

Hypothesis 2: *A sample of South African clinical, counselling, and educational psychologists will report informal breaches of confidentiality as actually occurring more frequently in their own practice than they consider such behaviour to be ethical.*

5.2 ETHICAL EDUCATION AND INFORMAL BREACHES OF CONFIDENTIALITY

In the light of the discussion in Section 3.4.4, Hypothesis 3 seeks to investigate the influence of formal and of informal education in professional ethics on the later ethical behaviour of psychologists (specifically regarding informal breaches of confidentiality).

Hypothesis 3: *a) The incidence of informal breaches of confidentiality reported by a sample of South African clinical, counselling, and educational psychologists will be independently and negatively correlated with:*

i) the number of reported hours of formal education in professional ethics;

ii) the net emphasis on the various aspects of professional ethics in this formal education in ethics; and

iii) the net emphasis reported to have been placed on all aspects of professional ethics in the course of other components of professional training.

b) These correlations will be significantly greater for later-mentioned than for earlier-mentioned factors in the list.

The next hypothesis seeks to put aspects of R.M. Hare's levels theory of moral thinking (as discussed in Sections 3.2.1 and 3.3.2) into empirically testable form.

Hypothesis 4: *a) The incidence of informal breaches of confidentiality by psychologists will be independently and negatively correlated with the emphasis placed in both formal and informal ethical education on:*

i) the fundamental ethical principles;

ii) the practical ethical principles; and

iii) applied ethical decision-making skills.

b) These correlations will be significantly greater for later-mentioned than for earlier-mentioned factors in the list.

5.3 COUNTERTRANSFERENCE FACTORS AND INFORMAL BREACHES OF CONFIDENTIALITY

As was discussed in Section 4.5.2, psychotherapists' unrecognised and/or poorly dealt with countertransference responses to client material have been proposed as a possible explanation for subsequent inappropriate informal breaches of confidentiality about this material by the psychotherapist. Hypothesis 5 puts this possibility in empirically testable terms regarding South African psychologists.

Hypothesis 5: *The strength of anti-therapeutic countertransference reactions to client-related information or behaviours, by a sample of South African clinical, counselling, and educational psychologists, will be greater for such client material which is later inappropriately disclosed by these psychologists than it will be for such material which is not later inappropriately disclosed.*

Similarly (and pursuant to the discussion in Section 4.4.2), Hypothesis 6 investigates the same question from an alternative perspective. It proposes a relationship between the vulnerability of the sample of psychologists to anti-therapeutic countertransference responses to client material, on the one hand, and subsequent inappropriate disclosure of that material, on the other.

Hypothesis 6: *The vulnerability to anti-therapeutic countertransference reactions of a sample of South African clinical, counselling, and educational psychologists will be greater at the time of occurrence of client information or behaviour which is later inappropriately disclosed than it will be at the time of occurrence of similar material which is not later inappropriately disclosed.*

In the light of the discussion in Section 4.2.3 and 4.4, the final hypothesis tested in this study investigates whether familiarity with (and/or commitment to) psychodynamic theory influences the incidence of informal breaches of confidentiality.

Hypothesis 7: *Emphasis on psychodynamic theory in psychologists' training, theoretical orientation, and personal therapy experiences will be negatively associated with the incidence of informal breaches of confidentiality, and this effect will be more marked than for emphasis on any other theoretical perspective.*

CHAPTER 6:
METHOD AND RESULTS

The questionnaire which was used to gather the empirical data for this research study is reproduced in Appendix 1. The construction of this questionnaire is described in Section 6.1, the data collection procedures in Section 6.2, and the statistical operations performed, with the results thereof, in Section 6.3.

6.1 CONSTRUCTION OF THE QUESTIONNAIRE

6.1.1 Rationale for Constructing New Questionnaire Using Likert Scales

Previously standardised scales for the variables of interest in this study were unavailable, and purpose-built scales were therefore constructed *a priori*. Specific validity assessments of items relating to ethical behaviour and belief, and to countertransference, are described in Sections 6.1.3.3 and 6.1.4.4 respectively. The construction of questions on each page of the questionnaire is described in turn in the following four sub-sections. Before the main study, the questionnaire was also completed by three registered psychologists of the researcher's personal acquaintance, to assess the time it would take to fill in, and whether there were any ambiguities in the instructions or questions. No such problems were reported, and the information on time was incorporated in the covering letter sent to the main sample *(see Section 6.2.2)*.

Various methods of attitude scaling attempt to render attitudes amenable to quantitative analysis. These methods can also be applied to measure other subjective attributes (such as evaluations) (Nunnally, 1978). Scales constructed according to the Likert method are both easier to produce and more reliable than earlier methods based on differentially weighted responses, developed by Thurstone and others (Edwards, 1957).

In a Likert-type questionnaire, the probability of subjects endorsing a high degree of agreement with any particular statement is assumed to increase with increasing strength of their target attitude, over the full range of possible attitude strengths (*ibid.*; Nunnally, 1978). Similarly, the probability curves of item endorsement are not assumed to conform to any particular mathematical function, and the sum of item scores can be taken as a fairly accurate interval scale representation of the subjects' strength of attitude (*ibid.*).

Likert demonstrated that the integer values assigned on an *a priori* basis to the various possible levels of response on a Likert scale can legitimately be used to represent strengths of attitude on an interval scale (Edwards, 1957). Although developed primarily to assess *attitudes*, Likert-type scales were also used in this study to measure the reported *incidence* of various forms of (un)ethical behaviour. In this, the methodological lead was taken from Pope *et al.* (1987), and their (*ibid.*, 1989) rebuttal of Koltko's (1989) attack on this usage.

6.1.2 Suitability of Measurements for Statistical Procedures Used

Almost all the measurements in this study use ordinal scales, while most sources (*e.g.*, Kerlinger, 1973; Nie *et al.*, 1975; Younger, 1979) state firmly that at least interval measurement is required for the correlational and multiple regression techniques which the original research design intended to use. However, although this approach has virtually acquired the status of dogma, Gaito (1980) notes that it has been challenged by various authors after Lord (1953) first declared that "Since the numbers don't remember where they came from, they always behave just the same way, regardless" (*ibid.*, p.751). Gaito (1980) suggests that the only requirement for reliable *qualitative* inference from parametric tests is an approximately normal distribution of measured values.

6.1.3 Page 1: Background Information and History of Psychotherapy

Because subjects were to be asked to report on sensitive and possibly unethical behaviour, identifying personal information was not requested - as is the norm in studies of this nature (*e.g.*, Conte *et al.*, 1989; Haas *et al.*, 1986; Pope *et al.*, 1987; Tabachnick *et al.*, 1991). However, to facilitate comparison of this study with previous ones, multiple-choice format questions on the first page of the questionnaire requested information on subjects' gender and age group, and on their registration status and period since completion of internship in Clinical, Counselling, and/or Educational Psychology.

In view of the controversies and divisions in South African professional Psychology discussed in Section 2.1.4 and 2.2.4, it was possible that some psychologist-subjects might either not be familiar with, or not approve of, the ethical code in force at the time of the survey (*e.g.*, Swartz, 1988). Using a five-point Likert scale, subjects were therefore requested to report on their familiarity with, and attitudes to, various aspects of professionalism and ethical codes.

Testing Hypotheses 6 and 7 requires information about subjects' personal history of psychotherapy, which was therefore requested. In previous studies, confidentiality-related behaviours have been reported to be influenced by psychologists' theoretical orientation *(see Section 2.4.2)*. The influence of various theoretical orientations as regards three areas was assessed using a Likert scale: subjects' original professional training, their current orientation, and the theoretical orientation of the personal experience of psychotherapy they found most useful. Professional training in South Africa is frequently very eclectic, so different orientations were not made mutually exclusive (as they usually are in American studies).

6.1.4 Page 2: Confidentiality-Related Behaviours and Beliefs

6.1.4.1 Format and Measurement Scales: The second page of the questionnaire attempted to measure subjects' practice and beliefs regarding the dependent variable of this study: various confidentiality-related behaviours *(see Appendix 1)*. Using five-point Likert scales, subjects were asked to respond to two questions about each of 17 behaviours. Both questions and scales were taken verbatim from Pope *et al.* (1987). The questions were, firstly, *"To what extent have you engaged in the behaviour in your professional practice?"*, and, secondly, *"To what extent do you consider the behaviour to be ethical?"*.

6.1.4.2 Behaviours, and Rationale for Inclusion: The first three of the 17 behaviours were taken unaltered from the Pope *et al.* (1987) study, and were the three confidentiality-related behaviours in which the behaviour of the subjects in that study was not in accord with their beliefs *(see Section 2.4.2.5)*.

The rest of the questions were formulated by the present writer to extend the net used by Pope *et al.* (1987) to a broader range of confidentiality-related behaviours. Thus, Questions 4 and 5 concern psychologists discussing client material (with and without names) in their own intimate personal relationships.

In the light of the discussion in Sections 4.4.2 and 4.5, Question 6 concerned subjects' discussion of clients in their personal individual therapy, and Questions 7 and 8 discussion of clients in personal group therapy (with and without names). Similarly, Questions 9 to 12 concerned discussing clients in formal individual supervision and in formal group supervision, either with or without client consent.

In the Baird and Rupert (1987) study, the majority of psychologists stated that they would require neither client knowledge nor client consent before consulting a colleague (*see*

Section 2.4.2.5). Questions 13 to 15 investigated such behaviour. Finally, Questions 16 and 17 covered discussing clients for teaching or supervision purposes (with and without client consent).

6.1.4.3 Validity Study: A sample of experts in professional ethics in Psychology was surveyed regarding their opinion of the ethicality of the 17 confidentiality behaviours about which subjects in the main study reported. The experts were selected on the basis of their current or former membership of the PASA or SAICP ethics committees. The questionnaire completed by the ethical experts, and a sample of the accompanying covering letter, are reproduced in Appendix 2. Seven of the eight ethical experts surveyed returned the questionnaires, and their responses were taken into account when interpreting the results of the hypothesis-testing statistical operations *(see Section 6.3)*. Unstructured comments by the ethical experts are recorded in Appendix 6.

6.1.5 Page 3: Countertransference and Informal Breaches of Confidentiality

6.1.5.1 Format and Measurement Scales: The third page of the questionnaire sent to the main sample attempted to assess the influence of countertransference factors on two behavioural incidents per subject *(see Appendix 1)*. Using Likert scales, subjects were asked to respond to 17 questions about each of two occasions. The occasions were, firstly, *"The* most recent *occasion on which you* engaged *in one of the* asterisked *behaviours in Section E"* (to which subjects responded in Column I), and, secondly, *"The* most recent *occasion on which you felt* strongly inclined *to engage in one of the* asterisked *behaviours in Section E*, but did not do so" (to which subjects responded in Column II). (Section E was the section covering confidentiality behaviours, as described in Section 6.1.3., and the asterisked behaviours were those about whose unethicality there is consensus in literature *[see Section 2.4.1]*.) Comparing subjects' reactions to these two types of situation was necessary in order to test Hypotheses 5 and 6.

6.1.5.2 Questions Assessing Countertransference Reactions: The first nine questions were prefaced with the statement *"Looking back on the* original situation/client disclosure *which you* later *discussed (column I) or nearly discussed (column II) would you say that, at the time:..."*. The statements printed below this general prefacing statement were constructed *a priori* by the present writer (on the basis of the literature reviewed in Section 4.3 and 4.4) to have a face-value capacity to discriminate between psychologist-subjects who had

experienced a potentially anti-therapeutic countertransference reaction to their clients during the situations described in the column headings, and those who had not.

6.1.5.3 Questions Assessing Vulnerability to Countertransference: The remaining eight of the 17 questions on the third page of the questionnaire were prefaced with the statement *"Looking back on the occasions described in the column headings, would you say that,* at the time *you discussed (or did not discuss) the client material:...".* The statements printed below this general prefacing statement concerned aspects of the psychologist-subjects' personal and professional lives at the time of the situations described in the column headings. These statements were constructed *a priori* by the present writer (on the basis of the literature reviewed in Sections 4.3 and 4.4) to have a face-value capacity to discriminate between psychologist-subjects who were vulnerable to anti-therapeutic countertransference reactions at the time of the original incidents (which were later inappropriately discussed or not discussed), and those who were not.

6.1.5.4 Validity Study: A sample of experts in psychodynamic psychotherapy was surveyed regarding their opinion of the validity of the questions used in the main study. The experts were selected on the basis of their reputation (among the professionally registered staff of the Pietermaritzburg Psychology Department) as competent psychodynamic psychotherapists.

The questionnaire completed by the psychodynamic experts, and a sample of the accompanying covering letter, are reproduced in Appendix 3. Several points about this survey of psychodynamic experts need to be noted. Firstly, the research component of this thesis was completed before the formation of the PsySSA Division of Psychodynamic Therapy, and there was therefore no more formal means of assessing psychodynamic competence, other than by peer reputation. Secondly, unlike the ethical experts, the psychodynamic experts submitted their questionnaire responses anonymously. Finally, given the variety of senses in which 'countertransference' is used in the literature, the specific (*anti*-therapeutic) interpretation of the term argued for in Section 4.3.5 is specified in the letter.

The psychodynamic experts used the same five-point Likert scale for their responses as did the subjects in the main study. The first nine questions, which aimed to assess the extent to which potentially anti-therapeutic countertransference reactions, were introduced in the psychodynamic expert validity study with the following bold-face preface:

"Using the scale above, please rate the extent to which you would consider a psychologist who agreed with the following descriptions of his/her reactions to a specific client behaviour or disclosure as likely to have been experiencing a countertransference reaction:...".

Similarly, the following eight questions, which aimed to assess vulnerability to negative countertransference reactions, were introduced with the following bold-face preface: *"Using the scale above, please rate the extent to which you would consider a psychologist who agreed with the following descriptions of his/her life at a specific point in time as likely to have been vulnerable to countertransference reactions:...".*

Seven of the 13 psychodynamic experts surveyed returned their questionnaires (all of which were used, even though one expert rated only the countertransference-vulnerability questions). Their responses are reported in 6.3, as are the ways in which these were used in interpreting the responses of the main sample to this section of the questionnaire. Unstructured comments by psychodynamic experts are recorded in Appendix 6.

6.1.6 Page 4: Subjects' Education in Professional Ethics

6.1.6.1 Format and Measurement Scales: The final page of the questionnaire *(see Appendix 1)* attempted to assess the extent and nature of subjects' education in professional psychological ethics.

The first question asked subjects' to estimate *"Approximately how many hours of your professional education has been devoted to* formal education in professional ethics *in Psychology"*. Separate spaces were provided for subjects' estimates of hours spent in their masters and internship programmes, and in their post-registration training.

The remaining eight in this section of the questionnaire concerned the nature of subjects' education in professional ethics. For each of these eight questions, subjects used a five-point scale to separately rate the emphasis given to a particular aspect of professional psychological ethics in their masters, internship, and post-registration professional training. Subjects were asked to further distinguish between the emphasis given these aspects in *"i) In classes and seminars specifically addressing professional psychological ethics"*, and *"ii) In other aspects of training,* e.g., *case conferences, supervision, other seminars"*.

6.1.6.2 Questions, and Rationale for Their Inclusion: All the questions in this section were formulated by the present writer, in order to test Hypotheses 3 and 4.

The (first) question concerned the number of hours spent on formal ethics education. Along with the other questions on this page of the questionnaire, Question 1 distinguished between ethical education received in different levels of subjects' training: masters, internship, and post-registration. In addition, the remaining questions (on the emphasis given different aspects of ethical education) also distinguished between formal education specifically dedicated to ethics, and ethical input to others aspects of training (*eg.*, case conferences, supervision, and other seminars).

Questions 2 to 4 asked subjects to assess the extent to which various specific ethical regulations were emphasised in their professional training. These specific ethical regulations were *"The provisions and regulations of* The Medical, Dental, and Supplementary Health Professions Act (Act 56 of 1974)", *"Specific* practical ethical principles *for psychologists"*, and *"The importance of* maintaining the confidentiality of client information, *and the circumstances under which this principle may be overridden"*.

Similarly, Questions 5 to 7 concerned subjects' assessments of the emphasis given to underlying fundamental ethical principles in their professional training. More specifically, one question each was devoted to the fundamental principles set out by Steere and Wassenaar (1985), namely, the principles of *"promoting the autonomy of clients to exercise free choice regarding their actions and beliefs"*, of *"avoiding inflicting harm on clients (or society)"*, and of *"benefitting clients (and society)"*.

Questions 8 and 9 of the questionnaire attempted to assess the emphasis given to ethical processes (as opposed to content) in subjects' professional training. With regard to their professional training, subjects were asked to rate the extent to which *"Ethical decision making skills were* applied to practical case examples", and to which *"Guidelines on* how to resolve professional ethical dilemmas *were emphasised"*.

Assessment of the validity of subjects' responses to these questions, as an measure of the ethical education which they actually received, was both beyond the scope of this study, and impossible to achieve without compromising the confidentiality of subjects (which was crucial to the research design).

6.2 DATA COLLECTION PROCEDURES

6.2.1 Selection of Main Sample

A sample of 250 clinical, counselling, and educational psychologists was randomly selected from the most up-to-date edition of the SAMDC *Register of Psychologists* then available (SAMDC, 1992). Many South African psychologists are registered in more than one category, and the list thus includes industrial and research psychologists interfiled in one alphabetical list with members of the three categories who form the focus of this study. When the random selection fell on an industrial or research psychologist who was not also registered in at least one of the categories clinical, counselling, and/or educational psychology, the name of the next person on the list who *was* so registered was taken in its stead. A further ten subjects were personally recruited by the researcher from among registered psychologists of his acquaintance, bringing the total main sample to 260 subjects.

6.2.2 Questionnaire Administration and Follow-Up

This aspect of the research design is based on that used by Pope *et al.* (1987). All 260 subjects in the main study were posted (or handed) an envelope containing an unmarked copy of the questionnaire (reproduced in Appendix 1), along with a stamped return envelope, and a stamped, reply postcard, on which subjects were asked to indicate whether or not they wished to participate in the study (the card is reproduced in Appendix 4).

In addition, the envelope contained a covering letter (also reproduced in Appendix 4), which explained the purpose of the study, stated how long the questionnaire would take to complete (20 - 30 minutes), and requested the subject's participation. Subjects were requested to return the enclosed postcard within a few days.

After two weeks, a few questionnaires and 36 postcards had been received. All those subjects who had not returned the postcard were at this stage sent a reminder postcard (also reproduced in Appendix 4). In the end, 81 postcards (31% of the sample) and 59 questionnaires (23% of the sample) were returned. Twelve of the questionnaires returned proved usuable *(see Section 6.3.1)*, yielding a final main sample of 47.

Although several of the questionnaires were not completed in full, all were used with regard to the data they did contain. Of the postcards received, 44 stated an intention to return the questionnaire and 33 a refusal to participate, while one was returned blank, and three with notes from third parties stating that the subject was resident overseas.

The reply postcard returned by subjects contained a space where they could comment on the study if they wished. A number did so, and a number wrote comments onto their questionnaires. These comments are reproduced in Appendix 5.

6.3 STATISTICAL OPERATIONS AND RESULTS

(Results reported in this section were computed using the Statistical Package for the Social Sciences (versions *SPSS/PC+* and *SPSS for Windows*)

6.3.1 Exclusion of 12 "Maverick" Subjects from Further Analysis

When initial statistical analyses using all 59 questionnaires returned yielded extremely disappointing results, a subject-by-subject analysis of questionnaires was completed. On the basis of this analysis, for the reasons outlined below, three distinct minority sub-groups of subjects were identified.

Firstly, a group of seven subjects had responded to *all* items on pages 2 to 4 of the questionnaire with consistently high extreme ratings (of "5" on the Likert scales). Similarly, a second group of three subjects had conversely responded to *all* items on pages 2 to 4 of the questionnaire with consistently low extreme ratings (of "1" on the Likert scales). The responses of both these groups of subjects were overwhelmingly likely to reflect a response-set in answering the questionnaire rather than a true reflection of the variables concerned.

A third group of two subjects was identified who had consistently responded to *all* the questions on Section E of the questionnaire (which dealt with confidentiality-related behaviours and beliefs) with extreme ratings in the opposite direction to the ethical expert sample - regardless of the direction of the ethical experts' mean rating. Many other subjects also evidenced such discrepancies between their own behaviour and/or beliefs and the beliefs of the ethical expert sample on *some* items, and on some items the mean ratings of the main sample as a whole were similarly at odds with those of the ethical expert sample. However, the consistency with which this occurred across *all* items in the two subjects under discussion suggested that they had either misunderstood the questions or rating-scales in the column headings, or that their beliefs and behaviours (or their reporting of these) were consciously oppositional to prevailing norms.

All 12 of the subjects falling into the above three categories were excluded from the sample, and statistical results for the final (reduced) main sample of 47 subjects showed some improvement in the significance of results obtained.

6.3.2 Demographic Characteristics and Attitudes to Ethical Codes

Of the 47 subjects submitting usable questionnaires, 3 *(6.4%)* were younger than 30, 22 *(46.8%)* were between 30 and 45 years of age, and the remaining 22 *(46.8%)* were older than 45. Only 46 of these 47 subjects reported their gender: 18 *(39.1%)* of these were male, and 28 *(60.9%)* were female.

The registration details of the final main sample are summarised in Table 1.

Table 1: Registration Status of Main Sample Subjects (N=47)

	Clinical	Counselling	Educational
No. of Subjects Reporting Registration in Category *	21	14	16
% of Main Sample Reporting Registration in Categogy*	41.2%	27.5%	31.4%
No. of Subjects Reporting Years of Registration	16	8	10
Average No. of Years Registration Reported	12.0	8.8	7.3

** Row totals > N / 100% due to some subjects reporting multiple registrations*

Section C of the questionnaire assessed subjects' attitudes to, and self-perceived familiarity with, the existing ethical codes in South African professional psychology. All subjects answered these questions, and their responses are summarised in Table 2.

Table 2: Summary of Main Sample Subjects' Attitudes To, and Familiarity With, Existing Ethical Codes in South African Professional Psychology (N=47)

	Attit. 1a	Attit. 1b	Attit. 1c	Attit. 1d	Attit. 2	Attit. 3	Attit. 4	Attit. 5
Mean	4.32	4.34	4.51	3.57	4.00	4.04	3.60	3.53
S.D.	.86	1.01	.75	1.12	.81	.72	.90	.80

6.3.3 Results Relating to Hypothesis 1

6.3.3.1 Format of Results: Pope *et al.* (1987) report the percentage of subjects rating a particular behaviour as "Not applicable to my practice" as a percentage of the *total* sample, and the percentage of subjects rating a particular frequency with which they engage in each behaviour as a percentage of subjects who did *not* describe the behaviour as

inapplicable to their practice. This somewhat confusing format has been used to present the results of the current study in Table 3, in order to facilitate comparison of the results of this study with those of Pope *et al.* (1987) (whose results are also recorded in Table 3 in marked columns alongside equivalent results from the current study). The frequency tables of the ethical expert sample's ratings of behaviours are also included in Table 3, to facilitate the reporting in Sections 6.3.3.3 below.

6.3.3.2 Results of This Study Compared to Pope et al. (1987): Since Pope *et al.* (1987) do not provide statistics beyond the percentages mentioned above, formal statistical comparisons of this study and theirs were not made. Results will therefore be discussed using the approach in Pope *et al.* (1987). The percentage of subjects in the current study who admit to at least rarely engaging in Behaviour 1 (63.8%) and Behaviour 3 (85.1%), are of the same order as the equivalent percentages reported by Pope *et al.* (1987): 61.9% and 76.4% respectively. The percentage of subjects in the current study who admit to at least rarely engaging in Behaviour 2 (17.7%) is more than twice the percentage (8.1%) of subjects in the Pope *et al.* (1987) study who admit to doing so. *(These percentages exclude subjects who rated the behaviour as not applicable to their practice - see 6.3.3.1 above.)*

6.3.3.3 Ethical Experts' Ratings, and Discrepancies With Main Sample: The small size of the ethical expert sample and the highly skewed distribution of their ratings precluded the use of parametric tests to determine the significance of differences between this sample and the main sample. The ethical experts ratings of the behaviours were all within one scale point of one another for 12 of the 17 behaviours: only for Behaviours 6, 7, 10, 11, and 17 did the experts' scores have a range of greater than 1, or include at least one expert who did not rate the behaviour.

For three behaviours (Behaviours 2, 3, and 4), the ethical experts were united in rating the behaviour as unethical under *all* circumstances (scale point 1), yet respectively 17.7%, 85.1%, and 43.5% of main-sample subjects who saw these behaviours as applicable to their practice admitted to engaging in them at least rarely. Similarly, 12.8% of all main sample subjects rated Behaviour 2 as ethical under at least rare circumstances, as did 76.6% Behaviour 3 and 40.4% Behaviour 4.

Table 3: Frequency Table for Subject Ratings of Ethical Behaviours & Beliefs: Main Sample, Ethical Expert Sample, and Pope et al. (1987) Study
(N.B.: Data from Pope et al. (1987) Study in Columns Denoted with "# " Symbol)

BEHAV./ BELIEF No. ⇒	1	#1	2	#2	3	#3	4	5	6	7
SUBJECT RATINGS: ⇓										
A: Ratings of Behaviour (Main & Pope Samples)										
Rating 1: *a) No. of Subjects.*	16	?	36	?	6	?	24	6	22	21
b) % of Subjects [1]	34.0	36.0	80.0	91.2	12.8	22.8	52.2	12.8	57.9	77.8
Rating 2: *a) No. of Subjects*	27	?	6	?	20	?	13	23	7	4
b) % of Subjects [1]	57.4	58.6	13.3	7.5	42.6	46.3	28.3	48.9	18.4	14.8
Rating 3: *a) No. of Subjects*	3	?	1	?	19	?	5	14	4	1
b) % of Subjects [1]	6.4	3.3	2.2	0.4	40.4	22.4	10.9	29.8	10.5	3.7
Rating 4: *a) No. of Subjects*	0	?	0	?	1	?	2	3	1	0
b) % of Subjects [1]	0	0	0	0.2	2.1	5.7	4.3	6.4	2.6	0
Rating 5: *a) No. of Subjects*	0	?	1	?	0	?	0	0	0	0
b) % of Subjects [1]	0	0	2.2	0	0	2.0	0	0	0	0
No Response.: *a) No. of Subj.*	1	?	1	?	1	?	2	1	4	1
b) % of Subjects [1][3]	2.1	2.3	2.2	0.7	2.1	0.8	4.3	2.1	10.5	3.7
TOTAL: 1 - 5 & No Resp										
a) No. of Subjects	47	?	45	?	47	?	46	47	38	27
b) % of Subjects [2][3]	100.0	97.1	95.7	96.5	100.0	99.1	97.9	100.0	80.9	57.4
Rating 'Not Applicable':										
a) No. of Subjects	0	?	2	?	0	?	1	0	9	20
b) % of Subjects [2]	0	2.9	4.3	3.5	0	0.9	2.1	0	19.1	42.6
Total No. of Subjects [2]:	47	465	47	465	47	465	47	47	47	47
B: Ratings of Belief (Main and Pope Samples)										
Rating 1: *a) No. of Subjects*	29	?	39	?	9	?	25	7	19	32
b) % of Subjects [2]	61.7	75.2	83.0	94.5	19.1	32.9	53.2	14.9	40.4	68.1
Rating 2 *a) No. of Subjects*	12	?	4	?	30	?	15	29	11	5
b) % of Subjects [2]	25.5	14.3	8.5	3.5	63.8	38.6	31.9	61.7	23.4	10.6
Rating 3: *a) No. of Subjects*	1	?	0	?	4	?	2	6	7	2
b) % of Subjects [2]	2.1	4.6	0	0.7	8.5	13.8	4.3	12.8	14.9	4.3
Rating 4: *a) No. of Subjects*	2	?	0	?	0	?	1	1	4	0
b) % of Subjects [2]	4.3	1.8	0	0.4	0	9.4	2.1	2.1	8.5	0
Rating 5: *a) No. of Subjects*	1	?	2	?	2	?	1	2	2	1
b) % of Subjects [2]	2.1	1.8	4.3	0.4	4.3	4.6	2.1	4.3	4.3	2.1
No Response: *a) No. of Subj.*	2	?	2	?	2	?	3	2	4	7
b) % of Subjects [2][3]	4.3	2.3	4.3	0.5	4.3	0.7	6.4	4.3	8.5	14.9
Total No. of Subjects [2]	47	465	47	465	47	465	47	47	47	47
C: Ratings of Belief (Ethical Expert Sample)										
Rating 1: *a) No. of Subjects*	3		7		7		7	5	3	6
b) % of Subjects [2]	42.9		100.0		100.0		100.0	71.4	42.9	85.7
Rating 2: *a) No. of Subjects*	4		0		0		0	2	2	0
b) % of Subjects [2]	57.1		0		0		0	28.6	28.6	0
Rating 3: *a) No. of Subjects*	0		0		0		0	0	0	0
b) % of Subjects [2]	0		0		0		0	0	0	0
Rating 4: *a) No. of Subjects*	0		0		0		0	0	0	0
b) % of Subjects [2]	0		0		0		0	0	0	0
Rating 5: *a) No. of Subjects*	0		0		0		0	0	1	0
b) % of Subjects [2]	0		0		0		0	0	14.3	0
No Response: *a) No. of Subj.*	0		0		0		0	0	1	1
b) % of Subjects [2]	0		0		0		0	0	14.3	14.3
Total No. of Subjects [2]	7		7		7		7	7	7	7

NOTES: (1) Figures calculated on basis of total which excludes subjects who rated behaviour as "Not applicable to my practice" *(see Section 6.3.3 of text)*.
(2) Figures calculated on basis of total main sample (Sections A and B of Table 3) and of total ethical expert sample (Section C of Table 3) *(see Section 6.3.3 of text)*.
(3) Figures for Pope *et al.* study not stated in that study, but back-calculated from that study *(see Section 6.3.3 of text)*.

Table 3 (Contd.): Frequency Table for Subject Ratings of Ethical Behaviours & Beliefs: Main Sample, Ethical Expert Sample, and Pope et al. (1987) Study
(N.B.: Data from Pope et al. (1987) Study in Columns Denoted with "# " Symbol)

BEHAV. / BELIEF No. ⇒	8	9	10	11	12	13	14	15	16	17
SUBJECT RATINGS: ⇓										
A: Ratings of Behaviour (Main & Pope Samples)										
Rating 1: *a) No. of Subjects.*	8	7	12	10	16	7	8	1	6	5
b) % of Subjects [1]	17.8	16.3	27.3	34.5	57.1	14.9	17.0	2.2	16.7	13.9
Rating 2: *a) No. of Subjects*	11	8	9	6	4	14	18	4	7	4
b) % of Subjects [1]	24.4	18.6	20.5	20.7	14.3	29.8	38.3	8.7	19.4	11.1
Rating 3: *a) No. of Subjects*	5	12	15	5	4	18	14	14	9	15
b) % of Subjects [1]	11.1	27.9	34.1	17.2	14.3	38.3	29.8	30.4	25.0	41.7
Rating 4: *a) No. of Subjects*	1	8	2	3	0	5	5	20	5	9
b) % of Subjects [1]	2.2	18.6	4.5	10.3	0	10.6	10.6	43.5	13.9	25.0
Rating 5: *a) No. of Subjects*	0	6	3	3	1	1	0	5	7	1
b) % of Subjects [1]	0	14.0	6.8	10.3	3.6	2.1	0	10.9	19.4	2.8
No Response.: *a) No. of Subj.*	20	2	3	2	3	2	2	2	2	2
b) % of Subjects [1][3]	44.4	4.7	6.8	6.9	10.7	4.3	4.3	4.3	5.6	5.6
TOTAL: 1 - 5 & No Resp										
a) No. of Subjects	45	43	44	29	28	47	47	46	36	36
b) % of Subjects [2][3]	95.7	91.5	93.6	61.7	59.6	100.0	100.0	97.9	76.6	76.6
Rating 'Not Applicable':										
a) No. of Subjects	2	4	3	18	19	0	0	1	11	11
b) % of Subjects [2]	4.3	8.5	6.4	38.3	40.4	0	0	2.1	23.4	23.4
Total No. of Subjects [2]:	47	47	47	47	47	47	47	47	47	47
B: Ratings of Belief (Main and Pope Samples)										
Rating 1: *a) No. of Subjects*	11	4	13	3	15	5	9	1	2	4
b) % of Subjects [2]	23.4	8.5	27.7	6.4	31.9	10.6	19.1	2.1	4.3	8.5
Rating 2 *a) No. of Subjects*	24	4	15	7	7	22	15	3	4	11
b) % of Subjects [2]	51.1	8.5	31.9	14.9	14.9	46.8	31.9	6.4	8.5	23.4
Rating 3: *a) No. of Subjects*	3	3	5	7	14	6	7	1	3	12
b) % of Subjects [2]	6.4	6.4	10.6	14.9	29.8	12.8	14.9	2.1	6.4	25.5
Rating 4: *a) No. of Subjects*	2	13	5	8	2	9	12	12	12	12
b) % of Subjects [2]	4.3	27.7	10.6	17.0	4.3	19.1	25.5	25.5	25.5	25.5
Rating 5: *a) No. of Subjects*	1	18	4	15	2	3	2	27	22	4
b) % of Subjects [2]	2.1	38.3	8.5	31.9	4.3	6.4	4.3	57.4	46.8	8.5
No Response: *a) No. of Subj.*	6	5	5	7	7	2	2	3	4	4
b) % of Subjects [2][3]	12.8	10.6	10.6	14.9	14.9	4.3	4.3	6.4	8.5	8.5
Total No. of Subjects [2]	47	47	47	47	47	47	47	47	47	47
C: Ratings of Belief (Ethical Expert Sample)										
Rating 1: *a) No. of Subjects*	2	0	4	0	5	4	2	0	0	2
b) % of Subjects [2]	28.6	0	57.1	0	71.4	57.1	28.6	0	0	28.6
Rating 2: *a) No. of Subjects*	5	0	2	1	2	3	5	0	0	2
b) % of Subjects [2]	71.4	0	28.6	14.3	28.6	42.9	71.4	0	0	28.6
Rating 3: *a) No. of Subjects*	0	0	0	0	0	0	0	0	0	0
b) % of Subjects [2]	0	0	0	0	0	0	0	0	0	0
Rating 4: *a) No. of Subjects*	0	2	1	3	0	0	0	0	1	2
b) % of Subjects [2]	0	28.6	14.3	42.9	0	0	0	0	14.3	28.6
Rating 5: *a) No. of Subjects*	0	5	0	3	0	0	0	7	6	1
b) % of Subjects [2]	0	71.4	0	42.9	0	0	0	100.0	85.7	14.3
No Response: *a) No. of Subj.*	0	0	0	0	0	0	0	0	0	0
b) % of Subjects [2]	0	0	0	0	0	0	0	0	0	0
Total No. of Subjects [2]	7	7	7	7	7	7	7	7	7	7

NOTES: (1) Figures calculated on basis of total which excludes subjects who rated behaviour as "Not applicable to my practice" *(see Section 6.3.3 of text)*.
(2) Figures calculated on basis of total main sample (Sections A and B of Table 3) and of total ethical expert sample (Section C of Table 3) *(see Section 6.3.3 of text)*.
(3) Figures for Pope *et al.* study not stated in the [illegible]

6.3.4 Results Relating to Hypothesis 2

The *Wilcoxon Matched-Pairs Signed-Ranks Test* was used to test discrepancies between subjects' reported practices and beliefs with regard to Behaviours 1 to 17. Results of this procedure which were significant at at least the 5% level are reported in Table 4.

Table 4: Wilcoxon Matched-Pairs Signed Ranks Test for Main Sample: Significant Discrepancies Between Behaviour and Belief (p=.05, two-tailed)

Behav./Bel. Pair No.:	Neg. Ranks (Bel < Beh)	Pos. Ranks (Bel. > Beh.)	Tie Ranks (Bel = Beh)	No.of Pairs	Z score	Significance (2-tailed p)
3	19	3	23	45	-2.4674	.0136
6	2	13	19	34	-2.6694	.0076
9	4	24	12	40	-3.7573	.0002
11	1	18	8	27	-3.6419	.0003
12	3	11	11	25	-2.3541	.0186
16	1	19	14	34	-3.7893	.0002

6.3.5 Results Relating to Hypothesis 3

6.3.5.1 Attempts to Compute a Composite Index of Informal Breaches of Confidentiality to Test Hypotheses 3, 4, and 7: To increase the power of statistical operations, the original research design encompassed computing composite indices (comprised of several items on the quesionnaire) to test key variables. Several attempts to do this for informal breaches of confidentiality were not successful, however. The first attempted composite scale was composed of subjects' responses to all the behaviours asterisked on the questionnaire (*i.e.*, those viewed negatively in the literature), with each response weighted in proportion to the ethical expert sample's mean rating of these behaviours. Due to the large amount of missing data from Section E of the questionnaire, this index could be computed for only six subjects, and correlated poorly and apparently randomly with other variables. In further attempts, items with particularly high levels of missing data (such as Behaviours 8, 12, and 17), and items about which the ethical experts were internally divided (such as Behaviours 7 and 10) were successively eliminated. Although (after this process) a composite index composed of weighted responses to Behaviours 1-5, 13, and 14 could be computed for 26 subjects, it produced significant correlations only with variables which had contributed to its composition. Regretfully, a more piece-meal approach of examining statistical relationships between the various independent variables and *individual* behaviours from Section E of the questionnaire had to be adopted.

6.3.5.2 Computation of Composite Variables for Testing Hypothesis 3: Similar problems to those described in the previous paragraph were also experienced in attempts to compute two composite variables comprising all items from Section G of the questionnaire reflecting emphasis given to ethics respectively in formal ethics classes, and in other aspects of training. Significant correlations (at the 5% level) were obtained only when each of these two composite variables were further subdivided into three lower-order composite variables: emphasis on practical ethical regulations (from Questions 2-4 - a, b, and c), fundamental ethical principles (from Questions 5-7 - a, b, and c), and ethical decision-making skills (from Questions 8-9 - a, b, and c)in each context of ethical education (formal *versus* informal ethical education).

6.3.5.3 Statistical Operations Testing Hypothesis 3: a) Pearson correlation coefficients were calculated between all 17 ethical behaviours, on one hand, and the number of hours of ethical education reported at masters, internship, and postgraduate levels, as well as the total number of hours of ethical education reported. None of these correlations was significant at the 5% level.

b) Pearson correlations were computed between all ethical behaviours, and each of the six composite variables relating to formal and informal ethical education described at the end of Section 6.3.5.2. Table 5 shows only those correlations which were significant at the 5% level.

Table 5: Significant Correlations (p=.05, two-tailed) in Main Sample Between Ethical Behaviours and Aspects of Formal and Informal Ethical Education

Behav. No.	Context of Ethical Educ.: Formal *vs.* Informal	Aspect Ethics Emphasised: Regulations/Skills/Principles	Correl ation	No. of Subj's	2tailed p
A: Behav's Correlating W. Aspects Formal Ed:					
Behav 5	Formal	Principles	-.5422	27	.002
Behav 10	Formal	Principles	-.4707	25	.009
Behav 11 a)	Formal	Principles	.4488	15	.047
b)	Formal	Regulations	.5122	13	.037
c)	Formal	Skills	.4974	15	.030
Behav 16 a)	Formal	Principles	.6960	19	.000
b)	Formal	Regulations	.5362	19	.009
c)	Formal	Skills	.4534	20	.022
Behav 17 a)	Formal	Regulations	.4410	19	.029
b)	Formal	Skills	.6101	20	.002
B: Behav's Correlating W. Aspects Inform. Ed.					
Behav 4	Informal	Skills	.4056	23	.027
Behav 5	Informal	Skills	.4614	24	.012
Behav 13	Informal	Skills	.4940	24	.007
Behav 17 a)	Informal	Principles	.4183	17	.047

c) The absence of significant correlations between any ethical behaviours and either any measure of hours of ethical education, or any global composite measure of formal or informal ethical education precluded multiple regression procedures being used to test Hypothesis 3, as originally planned.

6.3.6 Results Relating to Hypothesis 4

6.3.6.1 Computation of Composite Variables to Test Hypothesis 4: Subjects' responses to Questions 2-4 on Page 4 (at all levels of training, and in both formal and informal contexts) were summed to yield composite variables reflecting the emphasis placed on practical ethical regulations in subjects' ethical education. Composite scores were similarly obtained for emphasis on fundamental ethical principles from Questions 5-7, and for ethical decision-making skills from the total summed responses to Questions 8 and 9.

6.3.6.2 Statistical Operations Testing Hypothesis 4: Given the failure to generate a composite variable for informal breaches of confidentiality *(see Section 6.3.5.1)*, Pearson correlations were computed between all 17 ethical behaviours, and each of the three composite variables described in the previous paragraph. Only results which were significant at the 5% level are presented in Table 6.

Table 6: Significant Correlations (p=.05, two-tailed) in Main Sample Between Ethical Behaviours and Theoretical Emphasis in Ethical Education

Behaviour: ⇓	Aspect Emphasised in Ethical Educ.: (Principles *vs.* Regulations *vs.* Skills)	Correlation	No. of Subjects	2-tailed p
Behaviour 5	Skills	.3665	24	.039
Behaviour 10	Principles	-.4131	22	.028
Behaviour 13	Skills	.4805	24	.009
Behaviour 16	Principles	.5419	17	.012
Behaviour 17 a)	Regulations	.5573	16	.012
b)	Skills	.6275	16	.005

6.3.7 Results Relating to Hypothesis 5

6.3.7.1 Counter-Therapeutic Countertransference Reactions and Informal Breaches o Confidentiality in the Main Sample: The *Wilcoxon Matched-Pairs Signed-Ranks Test* wa used to test differences between subjects' assessment of the presence of the countertransference indicators described by Questions F 1-9 in the situation in which they committed an informal breach of confidentiality with their assessment of the presence of these indicators in a situation in which they did not breach confidentiality. Results of this procedure which were significant at at least the 5% level are reported in Table 7.

Table 7: Wilcoxon Matched-Pairs Signed-Ranks Test for Main Sample: Significant (p=.05, two-tailed) Differences Between Countertransference Reactions in Confidentiality-Breaching versus Non-Confidentiality-Breaching Situations

C/transference Manifestation	Neg.Ranks (Non-Gossip < Gossip)	Pos. Ranks (Non-Gossip > Gossip.)	Tie Ranks (Non-Gossip = Gossip)	No.of Pairs	Z score	2-tailed p
Question F (2)	7	3	22	32	-2.0628	.0391
Question F (6)	2	8	23	33	-2.1534	.0313

6.3.7.2 **Psychodynamic Experts' Ratings of Countertransference Indicators:** The psychodynamic experts' ratings of the extent to which the therapist reactions described in Questions F 1-9 (Section F of the questionnaire) indicated the presence of counter-therapeutic countertransference reactions are sumarised in Table 8. The experts were in reasonable agreement regarding items F 2, 5, 6, and 8 - although ratings for item F 5 cluster around the mid-point of the scale. However, the other five items evoked widely disparate ratings from the psychodynamic experts (range > 2).

Table 8: Frequency Table of Psychodynamic Experts' Ratings of Indicators of Counter-Therapeutic Countertransference Reactions

Rating Scale Points ⇒ / Question No. ⇓	Rating Point 1	Rating Point 2	Rating Point 3	Rating Point 4	Rating Point 5	No Response
Question F (1)	1	4	0	0	1	1
Question F (2)	0	0	0	3	3	1
Question F (3)	1	1	2	1	1	1
Question F (4)	2	1	1	1	1	1
Question F (5)	0	1	3	2	0	1
Question F (6)	0	0	1	3	2	1
Question F (7)	0	1	0	2	3	1
Question F (8)	0	0	0	2	4	1
Question F (9)	1	1	2	0	1	1

6.3.7.3 **Attempts to Compile a Composite Countertransference Variable:** The psychodynamic expert samples' mean ratings of items F 2, 5, 6, and 8 were used to derive weightings for each of these items, such that mean ratings below scale point 3 carried a negative weight, and those above this a positive weight. Main-sample subjects' ratings on these four items were then weighted accordingly, and summed to produce for each subject one composite score for countertransference reactions in the confidentiality-breaching situation, and another for such reactions in the non-confidentiality-breaching situation. A Wilcoxon Matched-Pairs Signed Ranks Test was computed for these composite scores, but did not approach significance even at the 10% level.

6.3.8 Results Relating to Hypothesis 6

6.3.8.1 Psychodynamic Experts' Ratings of Indicators of Vulnerability to Countertransference Reactions: The psychodynamic experts' ratings of the extent to which the life-situations described in Questions F 10-17 of the questionnaire indicated vulnerability to counter-therapeutic countertransference reactions are sumarised in Table 9. The experts were in reasonable agreement regarding all items except F 15 and 17 (in which range > 2).

Table 9: Frequency Table of Psychodynamic Experts' Ratings of Indicators of Vulnerability to Counter-Therapeutic Countertransference

Rating Scale Points ⇒ / Question No. ⇓	Rating Point 1	Rating Point 2	Rating Point 3	Rating Point 4	Rating Point 5	No Response
Question F (10)	2	3	2	0	0	0
Question F (11)	2	4	1	0	0	0
Question F (12)	1	4	2	0	0	0
Question F (13)	3	3	1	0	0	0
Question F (14)	1	5	1	0	0	0
Question F (15)	1	4	1	1	0	0
Question F (16)	0	0	0	3	4	0
Question F (17)	0	1	0	1	5	0

6.3.8.2 Vulnerability to Counter-Therapeutic Countertransference Reactions and Informal Breaches of Confidentiality in the Main Sample: Exactly analogous statistical operations to those described in Sections 6.3.7.1 and 6.3.7.3 above were also completed for main-sample subjects' responses to Questions F 10-17. In the case of deriving a composite variable assessing vulnerability to countertransference reactions, the expert sample's responses to Questions F 10-17 was used to derive weightings, and responses to 15 and 17 eliminated on the same basis as in the composite countertransference variable. However, the results of the Wilcoxon did not even approach significance at the 5% level for either the composite variable or any single question number.

6.3.9 Results Relating to Hypothesis 7

6.3.9.1 Computation of Composite Variable for Theoretical Orientation: Main-sample subjects' ratings of the significance of each theoretical orientation in their training, own current theoretical orientation, and most helpful therapy experience were summed together to derive a single composite score for theoretical orientation.

6.3.9.2 Statistical Operations to Test the Relationship Between Theoretical Orientation and Informal Breaches of Confidentiality: As was the case with Hypotheses 3 and 4 *(see Section 6.3.5.1)*, the independent variables involved in Hypothesis 7 had to be compared with the ethical behaviours item by item, rather than overall. Pearson correlations between each of the 17 ethical behaviours and each of the composite theoretical orientation variables were computed. Only Behaviours 10, 12, and 17 were significantly correlated with any orientation at the 5% level, as is shown in Table 10 (empty cells in the table indicate non-significant correlations). In interpreting these correlations, is important to note that a *low* score for a particular theoretical orientation implied that this orientation was *highly* significant in the subject's training, theoretical orientation, or personal experience of psychotherapy.

Table 10: Significant Correlations (p=.05, two-tailed) for Main Sample Between Theoretical Orientation and Ethical Behaviours

Theoretical Oritentation	Beh.10			Beh.12			Beh.17		
	Correl.	*No.Su*	*p*	*Correl.*	*No.Su*	*p*	*Correl.*	*No.Su*	*p*
Psychodyn.									
Cognitive	.4634	38	.003						
Gestalt							.4058	30	.026
Humanistic	.4657	37	.004	.4416	22	.040			
Existential	.4199	39	.008	.5374	24	.007			
Systems									
Behaviourist	.3844	37	.019	.3844	37	.019			

Some inferences regarding Hypothesis 7 can be derived from these correlations *(see Section 7.7.1)*. However, since psychodynamic theoretical orientation had no significant correlations with any ethical behaviour, full testing of Hypothesis 7 by means of multiple regression (as was originally intended) becomes both redundant and impossible.

However, indirect support for the hypothesis might be derived from the demonstration of an inverse relationship between experience of personal psychotherapy and breaches of confidentiality (Caruth, 1985). Table 11 summarises the descriptive statistics for subjects' therapy experiences.

CHAPTER 7:
DISCUSSION

7.1 HYPOTHESIS 1: THE INCIDENCE OF INFORMAL BREACHES OF CONFIDENTIALITY

7.1.1 Incidence of Behaviours Studied by Pope et al. (1987)

As noted in Section 6.3.3, Hypothesis 1 could not be formally tested by statistical means; however, *prima facie* support for the hypothesis can can be derived from the fact that the incidence in the present sample of the three types of informal breach of confidentiality also studied by Pope *et al.* (1987) study were at least as high in the present sample as those found by Pope *et al.* (1987). (Particularly worrying is the fact that subjects in the present sample were more than twice as likely as those in the Pope *et al.* (1987) sample to admit to discussing clients by name with friends.)

The results of this study should ideally be replicated by others before firm conclusions are drawn about the incidence among South African clinical, counselling, and educational psychologists of behaviours such as discussing clients with friends (with or without names), and of unintentionally disclosing confidential client information. However, the exploratory results obtained here suggest that the concerns expressed in Pope *et al.* (1987) about the reported incidence of these behaviours in their study seem to also be apposite regarding South African psychologists' behaviours. As discussed in Section 2.4.2, such behaviours are clearly a serious infringement of client rights, and their incidence (in one case) among more than three quarters of South African clinical, counselling, and educational psychologists should be grounds for serious concern and remedial action by the profession.

7.1.2 Discrepancies Between the Main and the Ethical Expert Samples

7.1.2.1 Discrepancies in Belief: The discrepancies between the *beliefs* of the main and the ethical expert samples regarding three other confidentiality-related behaviours (two of which were also emphasised in the Pope *et al.* [1987] study) are grounds for concern. Although the ethical expert sample consistently judged psychologists discussing clients with friends (with *or* without names), and their discussing clients by name with friends, as

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unethical under *all* circumstances, 12.8% of the main sample believed that on at least rare occassions it was ethically acceptable to discuss clients by name with friends, while 40.4% had the same belief regarding discussing clients by name with one's immediate family, spouse, or lover, and a disturbing 76.6% the same belief regarding discussing clients (without names) with friends.

Given that the ethical expert sample had all served on professional disciplinary bodies, acting on such beliefs seems likely to expose psychologists being to the risk of malpractice conviction of an ethical offence. The fact that such a high proportion of South African clinical, educational, and counselling psychologists seem to be either unaware of this fact, or to disregard it, confirms Steere and Dowdal's (1991) speculation of significant variance of the ethical beliefs of the profession, and should be of serious concern to the ethical committees of PsySSA and the SAMDC. Clearly, professional structures need to redefine or even renegotiate such beliefs with both their rank and file members and other stakeholders (such as the public - *see Section 2.2.5).*

7.1.2.2 Discrepancies Between Ethical Expert Beliefs and Main Sample Behaviours: The main sample report engaging in the three behaviours discussed above as occurring at rates that are alarming, given the attitudes of the ethical expert sample: 17.7% of subjects who rated discussing clients by name with friends as applicable to their practice admitted to doing so on at least rare occasions, while 85.1% similarly admitted to discussing clients (without names) with friends, and 43.5% to discussing clients by name with their immediate family, spouse, or lover.

The possibility that some instances of such behaviour are examples of moral weakness (as discussed in Section 3.3) will be explored in Section 7.2. Nevertheless, the beliefs of subjects concerning these behaviours, as discussed in the previous paragraph, strongly suggest that the high incidence of these three behaviours is at least partly due to subjects' belief that such behaviour is ethical under at least some circumstances. This reinforces the concluding argument of Section 7.1.2.1.

7.2 HYPOTHESIS 2: FAILURES TO ACT IN ACCORDANCE WITH ETHICAL BELIE

The six statistically significant discrepancies between the main sample's beliefs and their behaviours concerning confidentiality *(see Section 6.3.4)* have very different implications.

7.2.1 Behaviour 3: An Example of 'Moral Weakness'?

Hypothesis 2 was directly supported only with regard to only one confidentiality-related behaviour: discussing clients (without names) with friends. Main sample subjects reported engaging in this behaviour more frequently than they believed it to be ethical to do so at a rate that approached significance at the 1% level. Although formal statistical tests were not used to assess this discrepancy in the Pope *et al.* (1987) study, it is interesting that a similar inconsistency with regard to the same behaviour appeared in that study, and was the subject of considerable expressed concern by the authors *(see Section 2.4.2)*. It would appear that the main sample subjects of this study experience particular difficulty in implementing even their relatively tolerant beliefs *(see Section 7.1.2 above)* regarding this area of confidentiality.

Although this finding needs to be verified by future research, it reinforces the findings discussed in Section 7.4 and 7.5 below.

7.2.2 Behaviour 16: A Discrepancy Based on a Nuisance Variable?

Main-sample subjects reported discussing clients with students or supervisees (without identifying data, but with consent) very significantly ($p=.0002$) *less* often than they believed such behaviour to be ethical. It seems probable, however, that this finding is simply due to most of the sample working in situations which do not involve either teaching or supervision.

7.2.3 Behaviours 6, 9, and 11: Indications of Underutilised Resources?

Main sample subjects also reported discussing their clients in either individual or group supervision (with consent), and in their own personal therapy, very significantly ($p<.01$) *less* often than they believed such behaviour to be ethical. Notwithstanding the dissenting voice of one of the ethical expert sample in this study (who believed that both discussing one's clients in one's own therapy sessions, or group supervision, even with consent, was only rarely ethical), the discussion in Sections 4.4 and 4.5 clearly demonstrates that such behaviour is overwhelmingly positively viewed in the literature (*eg.*, Keith-Spiegel & Koocher, 1985). These results suggest that the more common view is apparently shared by most main-sample subjects of this study *(see also Table 3)*. Particularly in view of the possible benefits of such behaviour *(see Sections 4.4 and 4.5)*, the apparent underutilisation by subjects of a known potential resource seems a pity, and the reasons for it need to be

explored by subsequent research. For instance, is this underutilisation a reflection of the availability of these resources, or of their perceived usefulness?.

7.2.4 Behaviour 12: Failure to Take Account of the Principle of Consent?

Main-sample subjects also reported discussing their clients in formal group supervision (*without* consent) considerably less frequently ($p < .05$) than they believed this behaviour to be ethical. Unlike the three behaviours discussed in the previous paragraph, however, this behaviour was universally viewed by the ethical experts as generally *un*ethical *(see Table 3)*. Given that Behaviours 11 and 12 differ only with regard to the codicil of acquiring client consent, this result suggests that main-sample subjects poorly understand the importance of this principle. Further weight will be leant to this possibility by the results discussed in Sections 7.3 and 7.4.

7.3 HYPOTHESIS 3: TIME AND EMPHASIS GIVEN TO ETHICAL EDUCATION

7.3.1 Ethical Behaviour and Hours of Ethical Education Reported

As already reported in Section 6.3.5.3, the number of hours of ethical education reported for masters, internship, and post-graduate levels, as well as the total number of hours of ethical education reported, failed to correlate significantly with any of the confidentiality-related behaviours. Thus, portions (a) (i) and (b) of Hypothesis 3 could not be tested, and remain moot pending further research.

7.3.2 Ethical Behaviour and Reported Emphasis on Ethics in Formal Training

As explained in Section 6.3.5.3, portions (a) (ii) and (a) (iii) of Hypothesis 3 could not be directly tested statistically, although some inevitably inconclusive *indications* of the hypothesis' validity could be inferred from the figures in Table 5. Since the different emphases given to ethical regulations, principles, and skills in ethical education forms the primary focus of Hypothesis 4, distinctions between these aspects of ethical education will not be made until Section 7.4.

7.3.2.1 Qualified Support for Hypothesis 3 (a) (ii): Reported Emphasis on Ethics in Formal Education: Reported emphasis by main-sample subjects on various aspects of ethics in formal ethics classes was significantly *negatively* correlated with the *un*ethical behaviours

of discussing clients (without names) with one's immediate family, spouse or lover (Behaviour 5), and discussing clients in formal individual supervision (without consent) (Behaviour 10). Similarly, the *ethical* behaviours of discussing clients in formal group supervision (with consent) (Behaviour 11), and discussing clients for teaching or supervision purposes (with consent) (Behaviour 16) were significantly *positively* correlated with reported emphasis on aspects of ethics in formal ethics classes.

All four of these findings lend support, albeit inconclusively, to Hypothesis 3 (a) (ii). More specifically, in line with the discussion in Section 3.4.1-3, they suggest that the probability of unethical behaviours is decreased, and the probability of ethical behaviours increased, by formal education dedicated specifically to ethical issues.

Behaviour 17 (discussing clients with students/ supervisees for teaching purposes, *without* either consent or identifying data) is significantly *positively* correlated with the emphasis they report on several aspects of ethics in both formal and informal education. However, the ethical expert sample was more divided about the ethicality of this behaviour than about any other *(see Table 3)*. Thus, although it is possible that once again subjects were endorsing an unethical behaviour due to failure to take sufficient account of the principle of client consent *(see Section 7.2.4 above)*, the implications of this finding are unclear *(see also Section 7.4.3)*.

7.3.2.2 Qualified Discrediting of Hypothesis 3 (a) (iii): Reported Emphasis on Ethics in Informal Education: The frequency with which subjects reported engaging in unethical Behaviours 13 (discussing clients informally with other psychologists or related professional *not* directly concerned with the case), and Behaviours 4 and 5 (discussing clients, by name and without names respectively, with one's immediate family, spouse or lover), were all significantly *positively* correlated with the emphasis they reported ethics to have received in the informal aspects of their professional training.

These findings clearly do not support Hypothesis 3 (a) (iii), and in fact directly contradict it. However, on closer re-reading of Hare (1977; 1981; 1991) *(see also Sections 3.3.2 and 3.4.4)*, and taken in conjunction with the findings discussed in Section 7.3.2.1, they may in fact provide *firmer* support for his theory of moral weakness than support of Hypothesis 3 (as formulated in Chapter 5) would have done. It seems entirely likely that the ethics input in aspects of professional training not specifically dedicated to ethics would lack the philosophical rigour of ethics input in ethics-dedicated classes, since ethics would be only a secondary focus in the former. Consequently (in terms of Hare's two-levels theory), informal ethics input might actually lead to *less* ethical behaviour, in at

least two ways. Specifically, such incidental ethics input could encourage inappropriate transitions to the critical level when circumstances either do not permit this to be done with adequate rigour, or are professionally inappropriate *(eg.*, with friends or randomly available other professionals who have no right of access to the client material concerned) *(see also Section 7.7.2)*. Although these speculations must perforce remain merely speculations until tested by future research, they are leant further support in Section 7.4.

7.4 HYPOTHESIS 4: THE RELATIVE SIGNIFICANCE FOR ETHICAL BEHAVIOUR OF EMPHASIS ON PRINCIPLES, REGULATIONS, AND SKILLS IN ETHICAL EDUCATION

7.4.1 Behaviour 10: Ambiguous Support for Hypothesis 4

7.4.1.1 Apparent Support for Hypothesis 4: The two-level theory of moral thinking (Hare, 1977; 1981; 1991) is the direct focus of Hypothesis 4, and of the results presented in Section 6.3.6, and Table 6. Of the six significant ($p=.05$) correlations obtained between particular confidentiality-related behaviours, on one hand, and specific emphasis on fundamental ethical principles, specific ethical regulations, or ethical decision-making skills, on the other, only one offers *prima facie* support for Hypothesis 4 (a). This is the negative correlation between reported emphasis on fundamental ethical principles in ethical education, and the reported incidence of Behaviour 10 (discussing clients in formal individual supervision *without* client consent).

7.4.1.2 Qualifications to Apparent Support for Hypothesis 4: However, even this apparent support for the hypothesis is undercut by several factors. Firstly, there is no corresponding significant positive correlation between the ethical equivalent of Behaviour 10, *viz* Behaviour 9 (discussing clients in formal individual supervision *with* client consent). This objection is leant force by the fact that the percentage of the main sample who rated the behaviours applicable to their practices and who reported engaging in Behaviour 9 on at least rare occasions (79.1%, *see Table 3*) was higher than the equivalent percentage (65.9%) in respect of Behaviour 10.

Secondly, in terms of part (b) of Hypothesis 4, on fundamental ethical principles is the aspect of ethical education which would be *least* expected to correlate with ethical behaviour, since it apparently involves the application of critical-level moral thinking, which Hare *(ibid.)* argues leads on average to less moral behaviour in day-to-day, pressurised, ethical decision-making contexts *(see Sections 3.2 and 3.4.4)*.

7.4.1.3 Possible Paradoxical Support for Hare's Two-Levels Theory: On the other hand, it is possible that subjects actually find the fundamental ethical principles (particularly the principle of autonomy, for instance) *simpler* to remember and apply in day-to-day ethical decision-making contexts than they do the relatively longer specific practical ethical regulations regarding confidentiality - especially since the latter are embedded among many other specific regulations relating to a broad spectrum of professional issues. In this hypothetical case, focus in ethical education on the fundamental ethical principles might actually encourage intuitive-level moral thinking in pressurised work-a-day contexts more effectively than focus on specific ethical regulations, as was assumed in Chapter 3 and in the formulation of Hypothesis 4. Such an hypothetical situation is leant (admittedly inconclusive) support by the fact that *only* emphasis on fundamental ethical principles in ethical education is also positively correlated with ethical Behaviour 16.

However, this alternative interpretation of the practical implications of Hare obviously remains merely speculative until verified by further research, and even if it *was* so verified, would add still more grounds for rejecting Hypothesis 4 on the basis of the finding currently under discussion. However, the negative correlation between Behaviour 10 and emphasis on fundamental ethical principles would then lend support to Hare's *(ibid.)* two-level theory of moral thinking.

7.4.2 Behaviours 5 and 13: Qualified Rejection of Hypothesis 4

7.4.2.1 Rejection of Hypothesis 4 as Formulated: The ethical expert sample consistently rated both Behaviours 5 (discussing clients without names with their own immediate families, spouses, or lovers) and 13 (discussing clients with other psychologists or related professionals *not* directly concerned with the case) as unethical in the overwhelming majority of situations. The significant ($p < .05$) *positive* correlations between the reported likelihood of main sample subjects to engage in these behaviours, and the emphasis on ethical decision-making skills they reported regarding their ethical education, is therefore in direct contradiction of Hypothesis 4 as originally formulated.

7.4.2.2 Possible Support for Hare: Once again, however, this negative finding may reflect more on the *interpretation of* Hare's two-levels theory *(ibid.) (see Sections 3.2, 3.3, and 3.4.4)* embedded in Hypothesis 4 than on Hare's theory *per se.* In terms of Hare's *(ibid.) (see Sections 3.2-4)* theories, emphasis on ethical decision-making skills during ethical

education could indeed be expected to improve subsequent ethical behaviour (as predicted by Hypothesis 4), but only if the skills emphasised were in line with Hare's idiosyncratic approach of positively discouraging critical-level moral thinking in pressurised, day-to-day decision-making contexts. Since the majority of ethical-decision making approaches in current in ethical education in fact *encourage* critical-level thinking in these contexts *(see Sections 3.1 and 3.4)*, Hypothesis 4 does not test Hare's theory of moral thinking.

In fact, the positive correlation between main-sample subjects' reported propensity to engage in unethical Behaviours 5 and 13, and the emphasis they report ethical decision-making skills to have received in their ethical education, could be directly *supportive* of Hare's theories of moral thinking. Similarly, subjects' training in ethical decision-making skills apparently did not include caveats about the circumstances (such as formal supervision) under which it is professionally appropriate to exercise these skills on client material. As a result, the skills seem to be casually applied in the most easily available fora (such as personal relationships and with circumstantially accessible professionals who have no right of access to the client material concerned). Clarification of these intriguing possibility would require further research which distinguishes more clearly between different kinds of education in ethical decision-making skills.

7.4.3 Behaviours 16 and 17: Inconclusive Results

7.4.3.1 Behaviour 16: Qualified Support for Hypothesis 4: The significant ($p<.05$) positive correlation between main-sample subjects' propensity to engage in Behaviour 16 (discussing clients with students or supervisees for teaching purposes, *without* identifying details but *with* client consent) and the emphasis subjects' reported on fundamental ethical principles in their ethical education lends *prima facie* support to Hypothesis 4 (a). However, the caveats mentioned in Section 7.4.1.2 in respect of Behaviour 10 apply also here, as do the reservations expressed in Section 7.4.3.2.

7.4.3.2 Behaviour 17: Inconclusive Results: Behaviour 17's significant ($p<.05$) positive correlations with reported emphasis in ethical education on both specific practical ethical regulations and ethical decision-making skills indicate nothing conclusive about either Hypothesis 4 or Hare's theories. Firstly, as was mentioned in Section 7.3.2.1, the ethical experts were hopelessly divided on the ethicality of this behaviour. Secondly, given the correlation with Behaviour 16 discussed in Section 7.4.3.1, it seems possible that lack of emphasis by main-subjects on the importance of gaining client consent for discussing client

material even in otherwise appropriate contexts may function as a nuisance variable in this correlation - as it seems to possibly also do in other contexts *(see Sections 7.2.2 and 7.4.1.2)*.

7.5 HYPOTHESIS 5: COUNTERTHERAPEUTIC COUNTERTRANSFERENCE REACTIONS IN DISCLOSURE VS. NON-DISCLOSURE SITUATIONS

The comparison of indicators of countertherapeutic countertransference in a situation in which subjects disclosed information inappropriately with one in which they did not do so, as required to test Hypothesis 5, failed to yield significant results when composite measures of countertransference were used. However, two of the nine countertransference indicators, taken individually, did yield statistically significant results regarding differences between the disclosure *vs.* the non-disclosure situations *(See Section 6.3.7.)*.

7.5.1 Countertransference Indicator F (2): Support for Hypothesis 5

Main-sample subjects were significantly ($p<.05$) more likely to report having been emotionally aroused by client disclosures or behaviour which they later inappropriately disclosed than they were about disclosures or behaviours which they did *not* later disclose inappropriately *(see Table 7)*. Members of the psychodynamic expert sample who rated this mooted indication of countertherapeutic countertransference all either agreed or strongly agreed that its presence indicated the presence of countertherapeutic countertransference *(see Table 8)*.

In accord with the discussion in Sections 4.3 and 4.5, Hypothesis 5 is therefore apparently supported in respect of this finding: psychologists in this sample were seemingly more likely to later inappropriately disclose client material which had evoked this kind of countertherapeutic countertransference reaction in them than they were to disclose material which had not evoked such reactions. However, this positive result is undercut by the factors discussed in Section 7.5.2.3 below.

7.5.2 Countertransference Indicator F (6): Contradiction of Hypothesis 5

7.5.2.1 Prima Facie Implications of Statistical Result: Main-sample subjects were significantly more likely to report having felt comfortable to disclose to a client their feelings towards them in response to client material which they later *did not* disclose inappropriately than in response to client materal which the psychologist later *did* disclose

inappropriately *(see Table 7)*. The psychodynamic expert sample rated willingness of a psychologist to disclose to a client their feelings towards the client as an indication of the *presence* of countertherapeutic countertransference *(see Table 8)*. Consequently, Hypothesis 5 is *not* supported by this result, since the result implies that countertransference reactions by psychologists to client material decreases the probability of later inappropriate disclosure of that material.

7.5.2.2 Implications of Statistical Result for Concepts of Countertransference: Firstly, the psychodynamic expert sample's ratings regarding countertransference indicator F (6) appear to clearly contradict the views of Medini and Rosenberg (1976), and (less clearly) those of Olinick (1980) *(see Section 4.5)*. Since these authors argue that inappropriate disclosure of information about a second party to a third is a defensive rather than a growth-enhancing way of dealing with unresolved personal issues activated by the disclosed material, it would be possible to argue that the integrity of the working relationship between psychologist and client would be enhanced by relatively free disclosure on the part of the psychologist. If this view of countertransference indicator F (6) is taken - in opposition to the psychodynamic expert sample's views, the result obtained would in fact support Hypothesis 5.

However, the views of the psychodynamic expert sample are in line with those of Caruth (1985), as well as with those who write about the knife-edge balance between empathy and countertransference, as discussed in Sections 4.2 and 4.4 (*eg.*, Arlow, 1985; Saul, 1972; Schafer, 1983; Silverman, 1985). The apparent contradiction between this assertion and the argument of the previous paragraph lies in the distinctive nature of the relationship between psychologist and client: maintaining some level of personal disengagement from the unchecked ebb and flow of normal human interactions with their clients is essential to the psychologist's professional role *(ibid.)*. The views of Olinick (1980) and of Medini and Rosenberg (1976) regarding gossip in general, therefore, probably do not apply to the highly unusual relationship between psychologist and client. The contradiction of Hypothesis 5 implied by the result discussed in Section 7.5.2.1 can therefore apparently not be explained away by this line of reasoning.

7.5.2.3 Other (Untested) Manifestations of Countertherapeutic Countertransference It is also possible that the negative relationship between countertransference indicator F (6) and informal breaches of confidentiality is both valid, *and* an indication that this particular indicator is associated with *other* unprofessional behaviours (such as acting out by the psychologist) which dissipate the tension created by the countertransference reaction

in neurotic and/or countertherapeutic ways, and incidentally decrease the need to disclose the provocative client material. This possibility is sufficiently disturbing to merit further investigation not possible in the current research.

7.5.2.4 Possible Role of Quesionnaire Format in Influencing Result: With the wisdom of hindsight, the format of the questionnaire may have contributed to the apparently contradictory statistical results obtained regarding Hypothesis 5. Subjects were asked to compare a situation where they *had* inappropriately disclosed client material with one in which they had "felt strongly inclined to ... [inappropriately disclose client material] but did not do so". However, a more valid formulation of the non-disclosure situation would probably have asked subjects to recall an occasion on which their reactions to client material were similar to in the disclosure situation, but on which these reactions had not lead to inappropriate disclosure.

This explanation would discount the puzzling result obtained regarding countertransference indicator F (6), but would be a two-edged blade, discounting also the apparently positive result obtained regarding countertransference indicator F (2). Given this doubt, and the contradictions between the results obtained for Hypothesis 5, in balance it can only be concluded that the hypothesis is not supported by the results of this research.

7.6 HYPOTHESIS 6: VULNERABILITY TO COUNTERTHERAPEUTIC COUNTERTRANSFERENCE IN DISCLOSURE VS. NON-DISCLOSURE SITUATION

As explained in Section 6.8, no statistically significant results were obtained which were relevant to Hypothesis 6. Particularly in view of the relative homogeneity of the psychodynamic experts' ratings of the indicators of vulnerability to countertransference *(see Table 9)*, Hypothesis 6 is therefore not supported by the results of this research.

The failure of this research to support Hypothesis 6 may (of course) indicate that the theories on which it is based (as discussed in Section 4.5) are incorrect. However, the operationalisation of these theories in this study could also have contributed in similar ways to which it might have done so regarding Hypothesis 5 *(see Section 7.5.2.3)*. As is the case with Hypothesis 5, therefore, a scottish verdict of "not proven" seems most appropriate regarding the implications of this research for Hypothesis 6.

7.7 HYPOTHESIS 7: THEORETICAL ORIENTATION AND INFORMAL BREACHES OF CONFIDENTIALITY

Note: On the questionnaire, a *low* numerical rating for a particular theoretical orientation implied a *strong* emphasis on that orientation.

7.7.1 Hypothesis 7 Not Supported by Direct Evidence

There were no significant ($p < .05$) correlations between a strong reported emphasis on a psychodynamic orientation and the frequency with which main-sample subjects reported engaging in *any* of the confidentiality-related behaviours *(see Table 10)*. Hypothesis 7's prediction that emphasis on a psychodynamic orientation would be negatively correlated with unethical confidentiality behaviours is therefore not supported by the results of this research.

Furthermore, subjects' propensity to engage in unethical Behaviours 10 and 12 (discussing clients - without consent - in formal individual or group supervision respectively) are significantly ($p < .05$) correlated with a *low* reported emphasis on humanistic, existential, and behavioural theoretical orientations *(see Table 10)*. In other words, subjects who are strongly influenced by these three orientations appear to be less likely to engage in these two unethical behaviours than subjects who are less strongly influenced by these orientations. A similar relationship exists between Behaviour 10 and emphasis on a cognitive theoretical orientation, with similar implications.

The latter findings would appear to suggest that Hypothesis 7 is more than simply 'not supported' by the research findings, but is in fact flatly contradicted by them. However, such a strong position is mitigated against by the fact that the ethical equivalents of Behaviours 10 and 12 (*i.e,* Behaviours 9 and 11, where supervision is preceded by client consent) were not significantly ($p < .05$) correlated with these orientations. It is therefore possible (if unprovable on the evidence available in this study) that all the significant correlations between theoretical orientation and Behaviours 10 and 12 reflect a low rate of seeking supervision under any consent conditions.

7.7.2 Indirect Evidence Questioning Hypothesis 7: Hours of Personal Psychotherapy

There is consensus among the theorists and previous research findings discussed in Section 4.4.2 (especially MacDevitt [1987]; Norcross *et al.* [1988]; Pope and Tabachnick [1994]; and Silverman, [1985]) about the salutary effects of personally undergoing

psychotherapy on psychologists' professional effectiveness. The results discussed in Section 6.3.9 (Table 12) intimate the opposite possibility regarding informal breaches of confidentiality - merely 'intimate', given the generally small (in some cases, extremely small) numbers of cases upon which the correlations are based. Although these findings do not relate directly to Hypothesis 7, they do reflect on the theories (*ibid.;* Alonso & Rutan, 1988; Caruth, 1985; Tower, 1956) on which this hypothesis is based. Obviously, the speculations below require verification by future research before firm inferences can be drawn. (The correlations between Behaviour 17 and hours of therapy main-sample subjects reported can be disregarded given the ethical experts' division among themselves about the ethicality of this behaviour.)

7.7.2.1 Behaviours 10 and 13: At least three interpretations are possible of the significant ($p<.05$) correlations between Behaviour 13 and the number of hours of individual therapy subjects reported, and between reported hours of both individual and group psychotherapy and Behaviour 10. Firstly, barely half the main sample reported any individual therapy at all, and less than that any group therapy, and entering psychotherapy seems to have prejudicial implications of personal inadequacy even for many psychologists (Alonso & Rutan, 1988; Silverman, 1985). Consequently, rather than implying a directly negative effect on ethical behaviour by psychotherapy, the result obtained could be the result of a greater level of personal distress or disturbance among the subjects who have had therapy than among those who have not. Such distress or disturbance might undermine the ego-strength necessary for scrupulous compliance with ethical codes.

Secondly, as might be the case with some ethical education focussing on ethical decision-making skills *(see Sections 7.3.2.2 and 7.4.2.2)*, the habit of dialectical introspection appropriate to and fostered in psychotherapy clients might be indisciminately applied in inappropriate contexts by psychologists who are themselves such clients.

Thirdly, these results may reflect subjects' failure to set sufficient store by the principle of obtaining client consent before any disclosure *(see Sections 7.4.3.2 and 7.2.4)*.

7.7.2.2 Behaviours 11 and 12: The number of subjects contributing to correlation statistics for these behaviours is so small (<10) as to render inferences from the statistics extremely tenuous. However, the second and third points under the previous heading may also apply here.

CHAPTER 8:
CONCLUSIONS

8.1 LIMITATIONS OF THE STUDY

8.1.1 Possible Sample Bias

The anonymous survey format used in this study follows the lead of previous research in this area (*eg.*, Claiborne *et al.*, 1994; Pope *et al.*, 1987; Pope & Tabachnick, 1993; 1994; Tabachnick *et al.*, 1991), and is possibly the only way to gather data about ethically sensitive behaviour. Nevertheless, such a method of data collection must inevitably run the risk that the members of the subject pool who respond to the survey pool may not necessarily be representative even of the original subject pool, let alone the population which this represents. The fact that the questionnaires were sent to the main sample at the end of November, shortly before the summer school and university holidays, may intensify this risk.

However, the similarity of the results obtained in this study to those obtained in the Pope (1987) study for the same items would tend to suggest that whatever nuisance variables of this type which were operating (if any) were not distinctive to this study, but generic to the medium.

8.1.2 Data Based on Ex-Post Facto Subject Reports

None of the variables in this study was directly observed or measured by the researcher: all were in fact at a double remove direct empirical measurement. The accuracy of subjects' recall of the experiences they were asked to report on can not be assessed under the methodology used, nor can the influence of social desirability effects on their answers. These limitations, however, are almost unavoidable in investigations of phenomena like the dependent variable of this study, which permits of only a limited range of data gathering techniques. They may also have been influential in respect of the measures of both sets of dependent variables.

Although subjects manifesting particularly gross response sets were eliminated from the study *(see Section 6.3.1)*, the influence of more subtle response sets could not be assessed under the methodology used.

8.1.3 Absence of Standardised Measures for Variables

Standardised measurement instruments suitable for use in the context of unsupervised questionnaire responses by subjects do not exist for any of the variables investigated in this study. The mirroring of the questionnaire format used by Pope *et al.* (1987) facilitates comparison of the results of portions of this study with that one, but this format lends itself to inferential statistical analysis less easily than alternatives might have done. Although attempts were made to facilitate more powerful statistical analyses through limited validity studies and attempts to compute composite variables *(see Sections 6.3.5.1 and 6.3.6.1)*, these were not successful, and more comprehensive instrument development techniques were beyond the scope of the study. The only statistical analyses of the data which were possible under these circumstances were therefore perforce relatively limited, piece-meal, and superficial. These deficits were especially apparent in respect of the hypotheses related to countertransference phenomena.

8.1.4 Limitations Inherent in Ex-Post Facto Correlation Studies

The strength of the causal inferences which can be drawn from correlation statistics based on ex-post facto investigations are necessarily limited - as some of the convolutions and multiple qualifications of the discussion in Chapter 7 makes painfully evident. Again, however, the nature of the phenomena under investigation does not easily permit of experimental research.

8.1.5 Incremental Effect of Missing Data on Statistical Power of Results

The length and sprawling scope of the questionnaire used in this study lead to a very high rate of missing data, either because subjects simply impatiently skipped portions of the questionnaire, or because at least some of the phenomena covered were simply not applicable to many subjects' practice. The incremental effect of this missing data was particularly devastating on the power of statistical analyses using composite variables. This problem had a particularly noticeable effect on the formal statistical testing of Hypotheses 3, 4, and 7.

8.2 IMPLICATIONS OF FINDINGS FOR THE PROFESSIONAL PRACTICE OF PSYCHOLOGY IN SOUTH AFRICA

Notwithstanding the reservations about the findings of this study expressed in Section 8.1 and Chapter 7, some tentative conclusions can be drawn.

8.2.1 Disturbing Incidence of Informal Breaches of Confidentiality

The high incidence of at least some types of informal breach of professional confidentiality among the sample is grounds for serious concern for the profession (as suggested also by Pope *et al.* [1987] in respect of their American sample). As has already been mentioned in Section 7.1.2.2, three behaviours which the ethical expert sample judged unethical under *all* circumstances were reported by the main sample to occur with disturbing frequency. These were discussing clients (by name) with friends, discussing clients (without names) with friends, and discussing clients (by name) with one's own immediate family, spouse, or lover. (Other behaviours which none of the ethical expert sample rated as ethical under any more than rare circumstances also occurred very frequently, but the impossibility of determining how many of the instances of these behaviours which main sample subjects reported would be judged unethical by the ethical experts unfortunately excludes these behaviours from the current discussion.)

The credibility of this result is supported by similar figures for the first two in the Pope *et al.* (1987) study. Such behaviour is both clearly an infringement of the rights to privacy of clients *(see Section 2.4.1)*, and could (if discovered) both seriously undermine the working relationship between psychologists and clients, and be grounds for malpractice complaints. The causes of such behaviour among psychologists need to be more fully investigated than was possible in the present study, and remedial steps taken.

8.2.2 Differences in Ethical Beliefs of Main and Expert Samples

The present study provides some preliminary indications that South African clinical, counselling, and educational psychologists in general may hold ethical beliefs discordant with those of professional ethical bodies (as represented here by the ethical expert sample). Three areas emerge from the present study as being of particular concern.

Starting with the area of least concern, the ethical acceptability of consulting colleagues directly concerned with the case (with client consent) is not clear to at least some of the sample, despite being unambiguously endorsed by the ethical expert sample. The acceptability of this behaviour could, therefore, perhaps be more explicitly communicated by ethical officials and educators.

The high percentage of South African clinical, counselling, and educational psychologists who believe that it is ethical to discuss clients (with or without names) with friends, or to discuss clients (by name) with their own immediate family, spouse, or lover is disturbing, given the unanimous condemnation of such behaviours by the ethical expert sample. These beliefs doubtless contribute to the high reported incidence of these behaviours, and need to be addressed by formal ethical structures. Such action by these structures could take the form either of communicating their current beliefs more clearly and forcefully to general membership of the profession, or of renegotiating these ethical standards with general membership and other stakeholders.

8.2.3 Failure to Take Sufficient Account of the Principle of Client Consent

The results of the current study contain several indirect indications that many South African psychologists neither endorse nor apply the principle of first obtaining client consent before disclosing client material even in otherwise appropriate circumstances (such as supervision or consulting other professionals involved in the case). (Such indications were discussed in Sections 7.2.4, 7.4.1.2, 7.4.2.1, and 7.4.3.1.) The recommendations for action by ethical bodies and educators put forward in Section 8.2.2 with regard to other aspects of ethical practice apply also here.

8.2.4 Possible Relevance of Hare's Levels Theory to Professional Ethics

The hypotheses relating to Hare's two-levels theory of moral thinking (Hare, 1981), as originally formulated, were not supported by the results of this study. Nevertheless, the results do provide indirect indications of the relevance of this theory to professional ethical practice, as both an explanatory framework and as a principle around which to structure ethical education. Subjects who reported higher emphasis on ethical decision-making skills in their ethical education were consistently *more* likely to engage in various forms of unethical breaches of confidentiality than subjects who reported lower emphasis on ethical skills flies in the face of the other theories of ethical education discussed in

Section 3.4. The possibility that this tendency can indeed be explained by Hare's theory (as provisionally speculated in Sections 7.3.2.2 and 7.4.1.3) needs to be empirically tested in ways which avoid the pitfalls which emerged in attempts to do so in the present study. The relevance of Hare's theory to areas of ethical behaviour other than confidentiality also needs to be similarly empirically tested. If such research does indeed confirm the possible relevance of Hare's levels theory identified in this study, re-structuring of ethical education in the light of this theory would seem likely to assist in improving the ethicality of psychologist's practice.

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APPENDIX 1:

QUESTIONNAIRE SENT TO SUBJECTS IN MAIN SAMPLE

A 1.1 PAGE 1 OF MAIN SAMPLE QUESTIONNAIRE

QUESTIONNAIRE

THANK YOU FOR YOUR TIME AND ASSISTANCE. YOUR ANONYMITY IS ASSURED, SO PLEASE ANSWER ALL THE QUESTIONS AS HONESTLY AS POSSIBLE, AND WITHOUT USING ANY REFERENCE SOURCES. PLEASE ANSWER THE VARIOUS SECTIONS IN SEQUENCE.

A: BIOGRAPHICAL DATA

1. YOUR AGE:
   * Below 30 ☐
   * 30-45 ☐
   * Over 45 (001) ☐

2. YOUR SEX:
   * Male ☐
   * Female (002) ☐

3. YOUR REGISTRATION STATUS:

a) Clinical Psychology:
   * Registered ☐
   * Not Registered (003) ☐
   * Years since completion of internship (if applicable) (004) _____ years

b) Counselling Psychology:
   * Registered ☐
   * Not Registered (005) ☐
   * Years since completion of internship (if applicable) (006) _____ years

c) Educational Psychology:
   * Registered ☐
   * Not Registered (007) ☐
   * Years since completion of internship (if applicable) (008) _____ years

B: YOUR PERSONAL HISTORY OF PSYCHOTHERAPY

1. Have you personally undergone individual psychotherapy?
   * No (009) ☐
   * Yes (010) ☐
   * Approx. no. of hours: _____

2. Have you personally undergone group psychotherapy?
   * No (011) ☐
   * Yes (012) ☐
   * Approx. no. of hours: _____

C: YOUR ATTITUDES TO PROFESSIONAL ETHICS

Please respond to the statements below using following rating scale:

1 Strongly Disagree; 2 Disagree; 3 Don't Know/ Not Sure; 4 Agree; 5 Strongly Agree

1. The classification of applied psychologists as professionals is justifiable on the basis of:
   a) Their specialised knowledge and skills 1 2 3 4 5 (13)
   b) Their adherence to a code of ethics 1 2 3 4 5 (14)
   c) The need to protect the public from unscrupulous practice 1 2 3 4 5 (15)
   d) The need to promote the interests of psychologists themselves 1 2 3 4 5 (16)
2. I am familiar with the fundamental principles (autonomy, non-maleficence & beneficence) which underlie the detailed practical ethical regulations 1 2 3 4 5 (17)
3. I am familiar with the detailed practical ethical regulations for psychologists 1 2 3 4 5 (18)
4. The existing ethical regulations for South African psychologists are in general adequate and/or appropriate 1 2 3 4 5 (19)
5. The existing ethical regulations for South African psychologists are adequate and/or appropriate as regards confidentiality 1 2 3 4 5 (20)

D: YOUR THEORETICAL BACKGROUND

Please rate the significance of each of the theoretical perspectives below, in the areas of your professional life listed to the right

1 - Very Significant
2 - Moderately Significant
3 - Minimally Significant
4 - Don't Know / Not Sure
5 - Definitely Not Significant
X - Not Applicable (i.e., have never had personal psychotherapy)

	i) Your original training as a psychologist	ii) Your current theoretical orientation	iii) The personal experience of psychotherapy you found most helpful
* Psychodynamic	1 2 3 4 5 (21)	1 2 3 4 5 (22)	1 2 3 4 5 X (23)
* Eclectic	1 2 3 4 5 (24)	1 2 3 4 5 (25)	1 2 3 4 5 X (26)
* Cognitive	1 2 3 4 5 (27)	1 2 3 4 5 (28)	1 2 3 4 5 X (29)
* Gestalt	1 2 3 4 5 (30)	1 2 3 4 5 (31)	1 2 3 4 5 X (32)
* Humanistic	1 2 3 4 5 (33)	1 2 3 4 5 (34)	1 2 3 4 5 X (35)
* Existential	1 2 3 4 5 (36)	1 2 3 4 5 (37)	1 2 3 4 5 X (38)
* Systems	1 2 3 4 5 (39)	1 2 3 4 5 (40)	1 2 3 4 5 X (41)
* Behavioural	1 2 3 4 5 (42)	1 2 3 4 5 (43)	1 2 3 4 5 X (44)
* Other	1 2 3 4 5 (45)	1 2 3 4 5 (46)	1 2 3 4 5 X (47)

A 1.2 PAGE 2 OF MAIN SAMPLE QUESTIONNAIRE

E: BEHAVIOURS For each of the behaviours listed below, please answer the questions given in columns i) and ii), using the separate rating scales provided.	i) To what extent have you engaged in the behaviour in your professional practice? X - Not Applicable to my practice 1 - Never 2 - Rarely 3 - Sometimes 4 - Fairly often 5 - Very often	ii) To what extent do you consider the behaviour to be ethical? 1 - Unquestionably not 2 - Under rare circumstances 3 - Don't know/ not sure 4 - Under many circumstances 5 - Unquestionably yes
* 1. Unintentionally disclosing confidential client information	(048) X 1 2 3 4 5	(065) 1 2 3 4 5
* 2. Discussing clients (by name) with friends	(049) X 1 2 3 4 5	(066) 1 2 3 4 5
* 3. Discussing clients (without names) with friends	(050) X 1 2 3 4 5	(067) 1 2 3 4 5
* 4. Discussing clients (by name) with your own immediate family, spouse, or lover	(051) X 1 2 3 4 5	(068) 1 2 3 4 5
* 5. Discussing clients (without names) with your own immediate family, spouse, or lover	(052) X 1 2 3 4 5	(069) 1 2 3 4 5
6. Discussing clients in personal individual therapy	(053) X 1 2 3 4 5	(070) 1 2 3 4 5
* 7. Discussing clients (by name) in personal group therapy	(054) X 1 2 3 4 5	(071) 1 2 3 4 5
* 8. Discussing clients (without names) in personal group therapy	(055) X 1 2 3 4 5	(072) 1 2 3 4 5
9. Discussing clients in formal individual supervision (with client consent)	(056) X 1 2 3 4 5	(073) 1 2 3 4 5
*10. Discussing clients in formal individual supervision (without client consent)	(057) X 1 2 3 4 5	(074) 1 2 3 4 5
11. Discussing clients in formal group supervision (*eg.*, Balint group) (with client consent)	(058) X 1 2 3 4 5	(075) 1 2 3 4 5
*12. Discussing clients in formal group supervision (*eg.*, Balint group) (without client consent)	(059) X 1 2 3 4 5	(076) 1 2 3 4 5
*13. Discussing clients informally with other psychologists or related professionals not directly concerned with case (excluding cases of formal supervision)	(060) X 1 2 3 4 5	(077) 1 2 3 4 5
*14. Discussing clients informally with other psychologists or related professionals directly concerned with case (without client consent)	(061) X 1 2 3 4 5	(078) 1 2 3 4 5
15. Discussing clients with other psychologists or related professionals directly concerned with case (with client consent)	(062) X 1 2 3 4 5	(079) 1 2 3 4 5
16. Discussing clients with students/supervisees for teaching purposes, without identifying data (with client consent)	(063) X 1 2 3 4 5	(080) 1 2 3 4 5
*17. Discussing clients with students/supervisees for teaching purposes, without identifying data (without client consent)	(064) X 1 2 3 4 5	(081) 1 2 3 4 5

A 1.3 PAGE 3 OF MAIN SAMPLE QUESTIONNAIRE

F: DISCUSSING CLIENT DATA WITH THIRD PARTIES

Please answer the questions below in turn as regards each of the two situations described in the column headings on the right, using the rating scale below.

If you have never been in one of the situations described in the column headings, draw a line through the column.

1 Strongly disagree | 2 Disagree | 3 Don't know/ Not sure | 4 Agree | 5 Strongly Agree

	i) The most recent occasion on which you engaged in one of the asterisked behaviours in Section E.	ii) The most recent occasion on which you felt strongly inclined to engage in one of the asterisked behav--iours in Section E. but did not do so.
Looking back on the original situation/client disclosure which you later discussed (column I) or nearly discussed (column II), would you say that, at the time:		
1. You found it relatively easy to empathise with your client?	(082) 1 2 3 4 5	(099) 1 2 3 4 5
2. You yourself were in any way emotionally aroused by the client's behaviour/disclosure?	(083) 1 2 3 4 5	(100) 1 2 3 4 5
3. You felt confident about your understanding of the client's disclosure/behaviour?	(084) 1 2 3 4 5	(101) 1 2 3 4 5
4. You felt confident about your competence to respond appropriately to the client's disclosure/behaviour?	(085) 1 2 3 4 5	(102) 1 2 3 4 5
5. You would have felt comfortable to freely disclose to the client your understanding of his/her case?	(086) 1 2 3 4 5	(103) 1 2 3 4 5
6. You would have felt comfortable to freely disclose to the client your feelings about him/her?	(087) 1 2 3 4 5	(104) 1 2 3 4 5
7. There were aspects of the client's feelings towards you which made you feel uncomfortable?	(088) 1 2 3 4 5	(105) 1 2 3 4 5
8. There were aspects of your feelings towards the client which made you feel uncomfortable?	(089) 1 2 3 4 5	(106) 1 2 3 4 5
9. There were aspects of the client's situation or feelings which were very similar to aspects of your own life?	(090) 1 2 3 4 5	(107) 1 2 3 4 5
Looking back on the occasions described in the column headings, would you say that, at the time you discussed (or did not discuss) the client material:		
10. You were satisfied with the quality of your most important personal relationship?	(091) 1 2 3 4 5	(108) 1 2 3 4 5
11. You were satisfied with the quality of your other personal relationships?	(092) 1 2 3 4 5	(109) 1 2 3 4 5
12. You were satisfied with the quality of your relationships to professional peers?	(093) 1 2 3 4 5	(110) 1 2 3 4 5
13. You had regular/easy access to formal individual peer supervision?	(094) 1 2 3 4 5	(111) 1 2 3 4 5
14. You had regular/easy access to formal group peer supervision?	(095) 1 2 3 4 5	(112) 1 2 3 4 5
15. You had regular/easy access to occasions for discussing your clinical work with other psychologists/related professionals (*eg.*, case conferences)?	(096) 1 2 3 4 5	(113) 1 2 3 4 5
16. Your self esteem was threatened in your professional life in general?	(097) 1 2 3 4 5	(114) 1 2 3 4 5
17. Your self esteem was threatened in your personal life in general?	(098) 1 2 3 4 5	(115) 1 2 3 4 5

A 1.4 PAGE 4 OF MAIN SAMPLE QUESTIONNAIRE

G: YOUR EDUCATION IN PROFESSIONAL ETHICS

NB: If you are registered in more than one of the three categegories of Clinical, Educational, or Counselling Psychology, please answer the questions about your masters and internship as they apply to your training prior to your first registration.

Using the following rating scale, please respond to the questions below. 1 Strongly disagree; 2 Disagree; 3 Don't know/ Not sure; 4 Agree; 5 Strongly Agree	i) In classes and seminars specifically addressing profesional psychological ethics	ii) In other aspects of training, *eg:* case conferences, supervision, other seminars
1. Approximately how many hours of your professional education has been devoted to formal education in professional ethics in Psychology?		
a) In your masters programme:	(116) ___hours	
b) In your internship programme:	(117) ___hours	
c) In your post-registration training (*eg:* conferences, peer supervision, reading, *etc)*	(118) ___hours	
2 The provisions and regulations of The Medical, Dental and Supplementary Health Professions Act (Act 56 of 1974) were emphasised in:		
a) Your masters training programme:	(119) 1 2 3 4 5	(143) 1 2 3 4 5
b) Your internship training programme:	(120) 1 2 3 4 5	(144) 1 2 3 4 5
c) Your post-registration training (*eg:* conferences, peer supervision, reading, *etc)*	(121) 1 2 3 4 5	(145) 1 2 3 4 5
3. Specific practical ethical principles for psychologists were emphasised in:		
a) Your masters training programme:	(122) 1 2 3 4 5	(146) 1 2 3 4 5
b) Your internship training programme:	(123) 1 2 3 4 5	(147) 1 2 3 4 5
c) Your post-registration training (*eg:* conferences, peer supervision, reading, *etc)*	(124) 1 2 3 4 5	(148) 1 2 3 4 5
4. The importance of maintaining the confidentiality of client information, and the circumstances under which this principle may be overridden, were emphasised in:		
a) Your masters training programme:	(125) 1 2 3 4 5	(149) 1 2 3 4 5
b) Your internship training programme:	(126) 1 2 3 4 5	(150) 1 2 3 4 5
c) Your post-registration training (*eg:* conferences, peer supervision, reading, *etc)*	(127) 1 2 3 4 5	(151) 1 2 3 4 5
5. The principle of promoting the autonomy of clients to exercise free choice regarding their personal actions and beliefs was emphasised in:		
a) Your masters training programme:	(128) 1 2 3 4 5	(152) 1 2 3 4 5
b) Your internship training programme:	(129) 1 2 3 4 5	(153) 1 2 3 4 5
c) Your post-registration training (*eg:* conferences, peer supervision, reading, *etc)*	(130) 1 2 3 4 5	(154) 1 2 3 4 5
6. The principle avoiding inflicting harm on clients (or society) was emphasised in:		
a) Your masters training programme:	(131) 1 2 3 4 5	(155) 1 2 3 4 5
b) Your internship training programme:	(132) 1 2 3 4 5	(156) 1 2 3 4 5
c) Your post-registration training (*eg:* conferences, peer supervision, reading, *etc)*	(133) 1 2 3 4 5	(157) 1 2 3 4 5
7. The principle of benefitting clients (and society) was emphasised in:		
a) Your masters training programme:	(134) 1 2 3 4 5	(158) 1 2 3 4 5
b) Your internship training programme:	(135) 1 2 3 4 5	(159) 1 2 3 4 5
c) Your post-registration training (*eg:* conferences, peer supervision, reading, *etc)*	(136) 1 2 3 4 5	(160) 1 2 3 4 5
8. Guidelines on how to resolve professional ethical dilemmas were emphasised in:		
a) Your masters training programme:	(137) 1 2 3 4 5	(161) 1 2 3 4 5
b) Your internship training programme:	(138) 1 2 3 4 5	(162) 1 2 3 4 5
c) Your post-registration training (*eg:* conferences, peer supervision, reading, *etc)*	(139) 1 2 3 4 5	(163) 1 2 3 4 5
9. Ethical decision making skills were applied to practical case examples in:		
a) Your masters training programme:	(140) 1 2 3 4 5	(164) 1 2 3 4 5
b) Your internship training programme:	(141) 1 2 3 4 5	(165) 1 2 3 4 5
c) Your post-registration training (*eg:* conferences, peer supervision, reading, *etc)*	(142) 1 2 3 4 5	(166) 1 2 3 4 5

THANK YOU FOR YOUR CO-OPERATION

APPENDIX 2:
COVERING LETTER AND QUESTIONNAIRE SENT TO ETHICAL EXPERT SAMPLE

A 6.1 COVERING LETTER SENT TO ETHICAL EXPERTS

Dear

In your capacity as a present (or former) member of the PASA ethics committee, would you be prepared to participate in the pilot study for my M.A. (Clin.Psych) thesis? Your participation will be limited to filling in the enclosed questionnaire, which will take approximately 5 to 10 minutes of your time.

The dependent variable of the thesis will be the extent to which registered South African clinical, counselling, and educational psychologists actually comply, in their day to day practice, with priniple 4.1 of *Ethical Principles of Clinical Psychologists* (Steere and Wassenaar, 1985, p.35), and equivalent principles in *Ethical Principles for Counselling Psychologists* and *Ethical Principles for Educational Psychologists*. This principle reads:

> "Information obtained in clinical or consulting relationships, or evaluative data concerning children, students, employees and others, is discussed only for professional purposes and only with persons clearly concerned with the case. Such information will in all cases be released only with the express permission of the client, to be used only in the interest of the client, and presented in a form which, in the judgement of the clinical psychologist, is clear and not likely to be misunderstood by the recipient".

The subjects of the main portion of the study will be asked to report how frequently they engage in a number of behaviours which appear at face value to infringe this principle, as well as how frequently they engage in other, more appropriate, behaviours involving the disclosure of confidential client information.

Integrating the questionnaire responses of a number of experts in the professional ethics of Psychology (such as yourself) will enable us to establish the validity of using these behaviours as a measure of poor ethical practice.

Many thanks for your time and assistance.

Supervised by:

M.S. Peel
(M.A. Clin Psych Student)

D.R. Wassenaar
Senior Lecturer

A 2.1 QUESTIONNAIRE SENT TO ETHICAL EXPERTS

QUESTIONNAIRE

Using the rating scale provided, please state to what extent you consider each of the behaviours below to be ethical:

1 Unquestionably Not	2 Under Rare Circumstances	3 Don't Know/ Not Sure	4 Under Many Circumstances	5 Unquestionably Yes

1. Unintentionally disclosing confidential client information	1 2 3 4 5	(167)
2. Discussing clients (by name) with friends	1 2 3 4 5	(168)
3. Discussing clients (without names) with friends	1 2 3 4 5	(169)
4. Discussing clients (by name) with your own immediate family, spouse, or lover	1 2 3 4 5	(170)
5. Discussing clients (without names) with your own immediate family, spouse, or lover	1 2 3 4 5	(171)
6. Discussing clients in personal individual therapy	1 2 3 4 5	(172)
7. Discussing clients (by name) in personal group therapy	1 2 3 4 5	(173)
8. Discussing clients (without names) in personal group therapy	1 2 3 4 5	(174)
9. Discussing clients in formal individual supervision (with client consent)	1 2 3 4 5	(175)
10. Discussing clients in formal individual supervision (without client consent)	1 2 3 4 5	(176)
11. Discussing clients in formal group supervision (*eg.*, Balint group) (with client consent)	1 2 3 4 5	(177)
12. Discussing clients in formal group supervision (*eg.*, Balint group) (without client consent)	1 2 3 4 5	(178)
13. Discussing clients informally with other psychologists or related professionals not directly concerned with case (excluding cases of formal supervision)	1 2 3 4 5	(179)
14. Discussing clients informally with other psychologists or related professionals directly concerned with case (without client consent)	1 2 3 4 5	(180)
15. Discussing clients with other psychologists or related professionals directly concerned with case (with client consent)	1 2 3 4 5	(181)
16. Discussing clients with students/supervisees for teaching purposes, without identifying data (with client consent)	1 2 3 4 5	(182)
17. Discussing clients with students/supervisees for teaching purposes, without identifying data (without client consent)	1 2 3 4 5	(183)

APPENDIX 3:
COVERING LETTER AND QUESTIONNAIRE SENT TO PSYCHODYNAMIC EXPERT SAMPLE

A 3.1 COVERING LETTER SENT TO PSYCHODYNAMIC EXPERTS

Dear

Would you be prepared to assist me in the pilot study for my M.A. (Clin.Psych) thesis? Your participation would be limited to filling in the enclosed questionnaire, which will take approximately 5 to 10 minutes of your time.

The subjects of the main study will be registered clinical, educational, and counselling psychologists. One of the independent variables of the study will be the extent to which particular clinical incidents evoked countertransference reactions in the psychologists. Another will be the extent to which the psychologists are judged to be vulnerable to countertransference reactions.

As you are aware, the term countertransference is used in a variety of ways by different authors. It is used in this thesis in a relatively narrow sense, as applying to situations where the objectivity of a psychologist's reactions to material or behaviour presented by his or her client is compromised by his or her own unresolved psychological issues.

Integrating the responses to the attached questionnaire of a number of psychodynamically-oriented academic psychologists (such as yourself) will enable me to establish the validity of using these criteria as measures of countertransference reactions, and of vulnerability to these. Although the questionnaire is anonymous, any additional comments you might wish to forward would be very welcome.

Many thanks for your time and assistance.

Supervised by:

M.S. Peel
(M.A. Clin Psych Student)

D.R. Wassenaar
Senior Lecturer
Clinical Psychologist

A 3.2 QUESTIONNAIRE SENT TO PSYCHODYNAMIC EXPERTS

QUESTIONNAIRE

1	2	3	4	5
Strongly Disagree	Disagree	Don't Know/ Not Sure	Agree	Strongly Agree

Using the scale above, please rate the extent to which you would consider a psychologist who agreed with the following descriptions of his/her reactions to a specific client behaviour or disclosure as likely to have been experiencing a countertransference reaction:

1. You found it relatively easy to empathise with your client?	1 2 3 4 5	(184)
2. You yourself were in any way emotionally aroused by the client's behaviour/disclosure?	1 2 3 4 5	(185)
3. You felt confident about your understanding of the client's disclosure/behaviour?	1 2 3 4 5	(186)
4. You felt confident about your competence to respond appropriately to the client's disclosure/behaviour?	1 2 3 4 5	(187)
5. You would have felt comfortable to freely disclose to the client your understanding of his/her case?	1 2 3 4 5	(188)
6. You would have felt comfortable to freely disclose to the client your feelings about him/her?	1 2 3 4 5	(189)
7. There were aspects of the client's feelings towards you which made you feel uncomfortable?	1 2 3 4 5	(190)
8. There were aspects of your feelings towards the client which made you feel uncomfortable?	1 2 3 4 5	(191)
9. There were aspects of the client's situation or feelings which were very similar to aspects of your own life?	1 2 3 4 5	(192)

Using the scale above, please rate the extent to which you would consider a psychologist who agreed with the following descriptions of his/her life at a particular point in time as likely to have been vulnerable to countertransference reactions:

10. You were satisfied with the quality of your most important personal relationship?	1 2 3 4 5	(193)
11. You were satisfied with the quality of your other personal relationships?	1 2 3 4 5	(194)
12. You were satisfied with the quality of your relationships to professional peers?	1 2 3 4 5	(195)
13. You had regular/easy access to formal individual peer supervision?	1 2 3 4 5	(196)
14. You had regular/easy access to formal group peer supervision (*e.g.*, Balint groups *etc.*)?	1 2 3 4 5	(197)
15. You had regular/easy access to occasions for discussing your clinical work with other psychologists/related professionals (*eg.*, case conferences)?	1 2 3 4 5	(198)
16. Your self esteem was threatened in your professional life in general?	1 2 3 4 5	(199)
17. Your self esteem was threatened in your personal life in general?	1 2 3 4 5	(200)

APPENDIX 4:
COVERING LETTER AND POSTCARDS SENT TO MAIN SAMPLE

A 4.1 COVERING LETTER SENT TO MAIN SAMPLE

Dear Colleage

You are cordially requested to assist in a research project into certain aspects of the beliefs and behaviours of South African registered psychologists. Participation is of course entirely voluntary, and would be limited to filling in the enclosed questionnaire, and returning it in the stamped envelope provided. The questionnaire takes between 20 and 30 minutes to complete, and is unmarked in any way, so your responses will be completely anonymous.

However, in order to assist us in administering this project, without in any way compromising the confidentiality of your responses, please fill in and return the enclosed, stamped postcard within the next day or two, whether or not you wish to participate further in the research project. If you *are* prepared to assist us by completing the questionnaire, please return it within a week of receiving it.

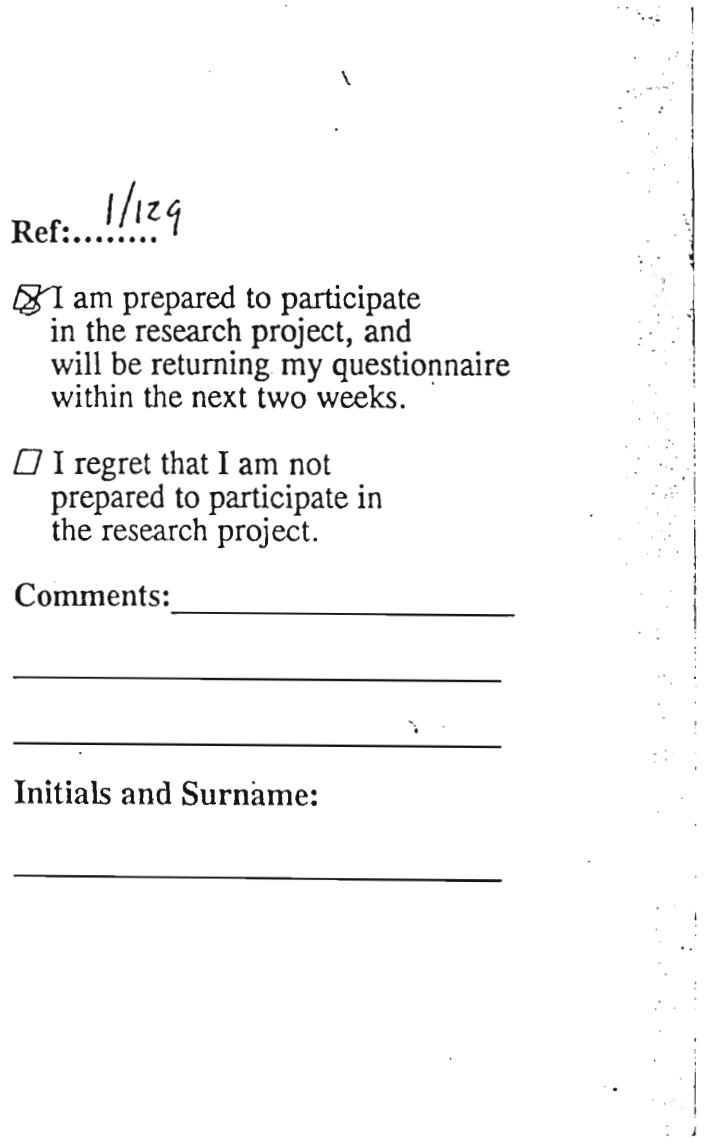
Many thanks for the sacrifice of some of your valuable time.

Supervised by:

M.S. Peel
(M.A. Clin Psych Student)

D.R. Wassenaar
Senior Lecturer
Clinical Psychologist

A 4.2 POSTCARD IN WHICH MAIN SAMPLE INDICATED THEIR INTENTIONS TO PARTICIPATE (OR NOT PARTICIPATE) IN THE STUDY



Ref:..... 1/129

☒ I am prepared to participate in the research project, and will be returning my questionnaire within the next two weeks.

☐ I regret that I am not prepared to participate in the research project.

Comments:_____

_____

_____

Initials and Surname:

_____

A 4.3 FOLLOW-UP POSTCARD SENT BY RESEARCHER TO MAIN SAMPLE

Ref:.....

Dear _____,

About two weeks ago, you received a questionnaire on the beliefs and behav -iours of South African psychologists.

Unfortunately, we have not yet received the reply-paid postcard which was enclosed with the questionnaire, on which you could indicate whether or not you intended to participate in the research project.

If you have already completed and posted the postcard, or the question- aire, please ignore this reminder.

However, if you have not yet done so, please complete and return the ques- tionaire (or the postcard, if you do not intend to participate) *as soon as possible.* Many thanks for your help.

_____

APPENDIX 5:

UNSTRUCTURED COMMENTS BY SUBJECTS IN THE MAIN STUDY

5.1 COMMENTS ON POSTCARDS PROMISING PARTICIPATION IN THE STUDY

5.1.1 Breakdown of Postcards:

Total No. of Postcards Promising Participation:	56
- No. Without Comments:	32
- No. With Comments:	24

5.1.2 Subjects' Comments on Postcards:

1. Ek is Afrikaans sprekend en jou vraelys vul baie moeilik in.
2. I have some strong feelings/ ideas about ethics and other areas mentioned which I was not able to indicate here. Some questions became very technical and arbitrary - depending on the case/ s I had in mind.
3. I'm not familiar with the Balint model of group supervision and would appreciate some information on it. A well planned and necessary research.
4. Good luck!
5. Good questionnaire.
6. Quite difficult to complete - not always clear what was being asked.
7. Q. 'F' was not very clear to me.
8. Interested in results of research.
9. Questionnaire is too complicated, especially F.
10. Second survey from Natal in one week!
11. Most of my knowledge of ethics is from self study - no real guidance available.
12. What a shit time of the year to request this of one!
13. Thought provoking questions! Good luck! May you receive many answers fast to all your questionnaires.
14. Questionnaire rating dimensions seemed confusing in relation to the questions of certain sections.
15. Some of the questions are a bit confusing.
16. Your questionnaire is too complicated and time consuming for busy people!
17. I'll post it as soon as possible.
18. Sorry about the delay - end of year...!

19. I wish you well with an important study.

20. I found it difficult and did not fully complete it - time pressure - about to leave for U.S.

21. Delay due to incorrect postal address.

22. # A: Scale needs to be one of degree perhaps? (none to lots, *etc.*) Otherwise looks good - send me a few more protocols & I'll send them to certain individuals whose responses (if genuine) ought to astound you; or I'll give you addresses (phone me at XYZ).

23. It's a pain but hopefully for a good cause!

24. Good luck!

5.2 COMMENTS ON POSTCARDS DECLINING TO PARTICIPATE IN THE STUDY

5.2.1 Breakdown of Postcards:

Total No. of Postcards Declining Participation:	21
- No. Without Comments:	8
- No. With Comments:	13

5.2.2 Subjects' Comments on Postcards:

1. I only have limited registration - not a practicing psychologist.

2. I'm so sorry, I've been covered with work. If I do get a moment I will still send the questionnaire.

3. Heavily involved in completing D.Ed. research.

4. * Bad time of the year.
   * Questionnaire far too long & too intricate.

5. *(Letter from subject's secretary, explaining subject is overseas for several months.)*

6. Began filling it in and found it unclear (especially Section F) and wasn't prepared to battle through it - sorry! (spent at least + hour on it)

7. I am not S.A. trained - I studied overseas and only did an internship here, so much of your questionnaire is not applicable.

8. I'm very sorry and would like to help, but circumstances make it impossible.

9. I am in the Transvaal Education Department and don't have much experience of what you need. I work mostly with <u>remedial</u> work.

10. I'm unconvinced about the validity of "Questionnaire research".

11. I had an academic Masters (1970's) - did a part-time internship through the N.I.P.R. and slowly moved into counselling. The way the questions are asked makes it impossible to answer for me.

12. Not a practising psychologist.
13. Benodig $ Afrikaanse weergawe.

5.3 COMMENTS ADDED ON QUESTIONNAIRES

5.2.1 Breakdown of Questionnaires:

Total No. of Usable Questionnaires	59
- No. Without Comments:	40
- No. With Comments:	19

5.2.2 Subjects' Comments on Questionnaires

1. *(Next to question G6:)* I really don't remember!

2. *(At end:)* Good luck!

3. *(Next to both questions B2 & Diii:)* Only in the context of internship training etc.
   (Next to Section F:) No longer in practice (2+ years) - but, historically - ...

4. *(Next to question E6:)* With whom? By name?

5. *(Next to section F, which was completed in full:)* Difficult to work out the rationaal *(sic.)*.

6. *(Next to column heading Fi:)* In order to plan therapeutic intervention; with an intern psychologist; *re:* private practice client. (Refer to 13)
   (Next to column heading Fii:) Refer to 5: Client and daughter app. same age (*re:* learning experience for daughter).

7. *(Next to question G1:)* Don't remember.

8. *(Next to question G1:)* Too long ago - don't remember.

9. *(Next to question G1:)* I really can't remember.

10. *(Next to Sections E & F, neither of which was filled in:)* I do not practice as a Counselling Psychologist. I now practice as an Industrial Psychologist/ Ergonomist.

11. *(Next to instruction above question F1:)* Which one? They are not all the same.
    (Above both answer columns in Section F, which were not completed:) This takes far too much thought - sorry!

12. *(Below column Gi:)* No doubt prejudiced due to generally poor sense of time spent in M1.
    (At bottom of page 4:) To me ethics (or the teaching of ethics) cannot be divorced from sound theoretical fundamentals - *eg.*, Eclecticism doesn't necessarily reinforce ethical/ practical values.

13. *(On notepaper attached to questionnaire:)* Regret, cannot be of much help to you. Long been retired from academic life. Since retiring work only in the field of *mental handicap* involving policy making, community work, supervision of psychologists working in field of mental handicap, assessment and research in mental handicap. Several of you sections or items do not really apply or cannot be answered with any accuracy. Hope you get a good response.

14. *(Next to question E16:)* Asking clients' consent I believe interferes with the process of therapy. *(Both E16i & E16ii marked '1'.)*

15. *(Next to question E3:)* In small town, 'friends' of client mention first.

16. *(At start of Section F:)* I am unable to answer this section as I cannot understand your instructions!
(Next to question G1:) These answers are extremely subjective! *(Subject answered as follows: G1a) plenty; G1b) a small number; G1c) occasionally.)*

17. *(At head of Section F, which was left blank:)* Sorry, but this section is unclear to me; I hope you can use the rest.

18. *(At beginning of questionnaire:)* Jammer dis so laat, maar dis darem $ moeilike vraelys!!

19. *(At beginning of questionnaire:)* Mr Peel, this is a very important study. I wish you well with it.

APPENDIX 6:

UNSTRUCTURED COMMENTS BY SUBJECTS IN EXPERT SAMPLES

1 COMMENTS BY ETHICAL EXPERTS

1.1 **Ethical Expert 3:** *(after statement 13:)* such as training and not mentioning the client's names

1.2 **Ethical Expert 4: a)** *(after statement 12:)* Note: I changed this from 4 to 1 when I recalled one catastrophic case of disclosure of incest which was relayed to a group member's family and the perpetrator was one of the family!
b) *(at foot of questionnaire:)* I found this very hard, because I know how many times I have slipped up, especially on Q. 12, 13, 14, 17, not to mention 5! A very worthwhile investigation. Best of luck.

1.3 **Ethical Expert 5: a)** *(after statement 6, which was not rated:)* with whom?
b) *(after statement 7, which was not rated:)* with whom? about whom?

1.4 **Ethical Expert 7:** *(at foot of questionnaire:)* My apologies for my late response on a very important research topic.

2. COMMENTS BY PSYCHODYNAMIC EXPERTS

2.1 **Psychodynamic Expert 2: a)** *(next to a bracket enclosing statements 6,7, & 8:)* These can be used very effectively as a therapeutic skill or technique.
b) *(at foot of questionnaire:)* I found it difficult to respnd to the above questionnaire as I make use of countertransference responses as part of my work. In this case it is important to to work at separating a ___ *(illegible)* response (your definition) from a therapeutic response.

2.2 **Psychodynamic Expert 3:** *(next to instruction above statement 1, in which the word "consider" was underlined:)* Do you mean consider as a potential therapist for myself / others / or what do I think of ...

2.3 **Psychodynamic Expert 5:** *(at foot of questionnaire:)* I found this questionnaire extraordinarily difficult to answer - the questions & format are dense and obtuse - I hope I did justice, but most items could have indicated countertransference or not. I would need a lot more detail to feel comfortable with my ratings.

2.4 **Psychodynamic Expert 7:** *(This subject circled 1, 3, and 5 for statements 1 to 9, and noted at the top of the column of ratings "could be both"; consequently, no ratings entered for this expert on these statements)*

a) *(same comment repeated next to statements 2 and 7 - 9:)* Depends on how he acted.

b) *(indicating the word "feelings" in statement 7:)* explicit or implicit?

c) *(below statement 9:)* This happens all the time!

d) *(illegible comment regarding instruction above statement 10)*

e) *(next to statement 10:)* Too global

f) *(next to statement 11:)* Can't say - not specific enough

g) *(next to statement 12:)* Far too global

h) *(indicating statements 13 and 15:)* This won't guarantee low vulnerability

i) *(next to statement 16:)* Too vague.

j) *(on back of questionnaire:)* I have a lot of difficulty with this questionnaire: The definition used is "objectivity of ... reaction ... is compromised ..."

* Does reaction mean internal subjective reaction OR therapeutic (re)action to patient?
* I have a lot of difficulty giving one reaction to the statement
* Countertransference reactions are often highly specific to context and person - difficult to generalise.