A Study of Ethical Decision-Making in HIV-Related Psychotherapy

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Declaration

Unless specifically indicated to the contrary in the text, this dissertation represents my original work.

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Signature Date

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ABSTRACT

There are complex ethical and legal issues that arise when an HIV-positive client presents as a danger to others as a result of engaging in unprotected sex. The purpose of this study was to examine how and why psychologists deal with such a situation. The respondents were asked a combination of questions related to a case vignette in which a male client was diagnosed as HIV-positive after an extra–marital relationship with a work colleague. The client was not prepared to disclose his HIV-status to his wife.

A total of 154 psychologists within South Africa responded to the study, which was a response rate of 25%. The results of this study indicated that an overwhelming proportion (96.7%) of the respondents assessed the client to be very dangerous in terms of the HIV/AIDS risk to his wife. The majority of the respondents (65.1%) indicated that the primary goal in psychotherapy would be to guide the client to disclose his HIV status to his wife. Almost 59% of the respondents indicated that they would not breach confidentiality by contacting the client's wife. Examination of the psychologists' ethical decision-making process took into account the respondents' knowledge of the HPSCA (2004) guidelines to guide the client to disclose his HIV status to his partner. The study also assessed the respondents' knowledge of the foundational ethical principles. The findings of this study have implications regarding how psychologists function in their professional domain. Of particular concern is that a significant proportion of psychologists may not have adequate knowledge of the ethical principles and HPCSA guidelines in this area.

One of the limitations of this study was the low response rate (25%), which prevented the examination of a complete range of participant demographics. Given the low response rate, future research in this field is needed to better understand Psychologists' management of the duty to warn in HIV–related psychotherapy.

1. INTRODUCTION

In the past two decades since the outbreak of the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) epidemic, psychologists and other health care providers have been challenged by a complex array of ethical dilemmas associated with service provision for people living with HIV/AIDS. Although many books, articles and workshop presentations have been held to help professionals understand the issues related to HIV/AIDS, there has been relatively little training devoted to practical strategies for dealing with ethical situations presented by HIV-positive clients (Anderson & Barret, 2001).

Psychologists may face situations where their HIV-positive client is having unprotected sex and refuses to disclose his/her HIV status to his/her partner. In such a situation psychologists may find themselves facing an ethical dilemma when the client's right to confidentiality is at odds with their duty to warn.

While traditional psychotherapy has focused on the client, in HIV/AIDS psychotherapy the psychologist may find him or herself in a position that involves the protection of third parties by trying to determine the chances of the client actually transmitting the HIV virus to another person. The psychologist in such a situation has to decide on moral questions that are of great importance to society and to which society itself has no answer (Anderson & Barret, 2001). Questions such as, "Do I inform my client's sex partner that she is HIV-positive when it is apparent that such a disclosure might cause her partner to beat her, abandon her and leave her to the streets?" are some of the issues that psychologists may be confronted with when dealing with issues related to HIV/AIDS (Anderson & Barret, 2001, p. xviii).

In dealing responsibly and ethically with the problem, the psychologist has to acknowledge his or her own limitations. Assuming that the psychologist chooses to warn the third party, the question arises as to how he or she should proceed. The tools of psychotherapy work gradually, especially if the psychologist chooses to work with the patient to disclose his or her HIV status, and much depends on the client's insight and behaviour. In spite of all efforts made by the psychologist to this end, there are no guarantees that the client will act appropriately and yet, ethically, the psychologist is required to make a decision.

If the psychologist makes a decision to breach confidentiality and warn third parties, the psychologist cannot be guaranteed that the third party will act responsibly with the decision. Furthermore, an immediate breach of the client's confidence can sever the therapeutic alliance and decrease the possibility of the client seeking future psychotherapy.

In making the decision to warn the third party, the psychologist may be faced with both his or her professional responsibility to provide confidential psychological services to his or her client and the risk of litigation should he or she be found to have failed to warn the third party.

This study is an attempt to investigate and explore psychologists' responses and reasoning processes underlying the issues related to HIV/AIDS and their duty to warn the third party.

This study will take into account a model of ethical analysis with regard to HIV/AIDS and the responsibility to the other party.

2. Literature review

This chapter presents a contextual foundation for this study. The aim of this chapter is to critically evaluate the code, theories and principles, which inform the psychologist's decision-making process. This chapter begins by addressing the question of what is meant by the term ethics and then moves to explore the elements of an ethical dilemma.

2.1 Ethics

Ethics is a branch of philosophy that is concerned with the behaviour of individuals that positively or negatively affects other human beings, and in some instances, animals. It refers to a set of rules, principles, values and ideals of a particular group of people, with regard to what is right and wrong and the manner in which such behaviour and values may differ from society to society (Bersoff, 1995). Some philosophers have tried to distinguish ethics from morality. Bersoff (1999) describes morality as referring to the human belief structure and includes what people believe to be right and wrong or good and bad about a person's character or conduct. Ethics on the other hand refers to a philosophical study and the evaluation of that belief structure. However, Knapp and Vandecreek (2003) indicate that the distinction between ethics and morality is not always evident and some sources have used ethics as a synonym for morality.

Knapp and Vandecreek (2003) distinguish between 'ethics', the desire to understand proper conduct, and 'Ethics', which takes into account the specific code of the profession (p. 307). In the former sense 'ethics' deals with personal values, moral dilemmas, high ideals and overarching frameworks for analyzing moral problems. In the latter sense, 'Ethics' deals only with a limited set of standards to follow in the role of the psychologist and therefore reflects the consensual values of the profession.

An ethical dilemma occurs when moral claims are in conflict with each other (Green & Stewart, 1987). An example of an ethical dilemma is a situation in which something is considered to be good but is not necessarily right (Bersoff, 1999). For example euthanasia may be considered by some to be good (a virtue), but not right (a duty). According to Beauchamp and Steinbock (1999), moral issues arise in psychology when an individual's welfare is balanced with the welfare of others. The question then arises as to what ought to be done. The psychologist is therefore required to make a decision that incorporates his or her beliefs and values regarding what actions are appropriate in a particular situation. According to Knapp and Vandecreek (1993), to this end ethics can either be normative or descriptive. Descriptive ethics focuses on what is and normative ethics focuses on what ought to be done and takes into account the manner in which behaviour can be organized into rules to assist in decision-making (Beck,1985). These rules, according to Bersoff (1999), are bound into the profession in respect of ethical codes and principles, which will be discussed in greater depth in this chapter.

The following section takes into account the American Psychological Association's ethical code (APA, 2002) and Health Professions Council of South Africa (HPCSA, 2004) ethics

code and describes how the codes fit into ethical decision-making in HIV/AIDS related psychotherapy.

2.2 Ethical Codes in Psychology

Psychology's global view of practice is arguably, grounded in the APA (2002) ethics code (Hanson, Kerkhoff & Bush, 2002). According to Knapp and Vandecreek (2003), this new ethics code represents a conservative revision of the old ethics code (APA, 1992). The APA code provides an overarching structure for evaluating the psychologist's decision-making process. In South Africa psychologists are guided by the guidelines offered by HPCSA (2004). The South African code is also influenced by the APA (2002) code of ethics.

Bersoff (1999) indicates that the ethical codes for psychologists instruct the psychologist on how to relate to their colleagues and how to fulfil their professional responsibilities towards those whom they serve i.e., clients, patients, research participants, institutions, organizations and the public at large. The ethics code is intended to provide standards of professional conduct to cover most situations encountered by psychologists. Although the code by itself does not determine whether a psychologist is liable in a court action, compliance with or violation of the ethics code may be used as evidence in legal proceedings. According to Bersoff (1999) "each psychologist supplements but does not violate the Ethics code's values and rules on the basis of guidance, drawn from personal values, culture and experience" (p. 9).

The APA code (2002) contains two parts: An aspirational section and a sanctionable section. The aspirational section consists of the preamble and six general principles: competence; integrity; professional and social responsibility; respect for people's rights and dignity; concern for other's welfare; and social responsibility (Knapp & Vandecreek, 2003).

The sanctionable section of the code applies only to psychologists' work-related activities. It includes the clinical and counselling practice of psychology, research, teaching and supervision of trainees, development of assessment instruments, conducting assessments, social intervention, administration and other activities. These work-related activities can be distinguished from the private conduct of a psychologist which does not fall within the code.

Likewise the HPCSA code which is based on the APA code contains two parts. The first parts of the guidelines are aspirational and value-oriented, expressing the most honourable ideals to which members of the profession should aspire. The second part of the guidelines explains what a duty is, and catalogues the general ethical duties of psychologists.

As the standards are sanctionable, the codes act as a yardstick for the identification of unethical acts and provide psychologists with a relatively explicit basis for professional self-regulation (Sieber, 1994; Steere & Wassenaar, 1985). In this way the ethical codes help to regulate the psychologist's behaviour within the profession.

Ideally the code of ethics should serve as a guide for the psychologist to resolve the moral problems or dilemmas that he or she may confront within the profession. However, in reality the code of ethics is not able to provide the psychologist with the necessary guidance in every

situation. Koocher (1994) suggests that the code is broad but lacks clarity. Bersoff (1999) argues that the ethics code applies only to work-related issues and as such presents more as an educational document for the psychologist.

Wassenaar (1998) suggests that the code provides minimal guidelines and is not effective in anticipating or resolving all ethically challenging situations. The HPCSA (2004) guidelines support this view by suggesting that it is impossible, to develop a complete set of specific ethical prescriptions applicable to all conceivable real-life situations. In concrete cases, psychologists may have to work out for themselves what course of action can best be defended ethically.

Keith-Spiegel and Koocher (1985) describe the code as a document filled with moral compromise, and is largely reflective of the style of lawyers. They argue that it is a document designed to protect the interests of the psychologist rather than the public at large.

Anderson and Barret (2001) suggest that it is sometimes hard to understand how the ethics code can be applied to a particular situation. In other instances where the code recommends operating in the best interest of the client, it is difficult to determine what actions would best serve the client's interest. The vagueness of the code is more apparent in dealing with issues related to HIV/AIDS psychotherapy. For example, the APA code suggests that multiple relationships could be harmful, however at times the psychologist may be faced with requests to assist with a patient's care, or to help arrange a funeral. This is often experienced when treating patients who are terminally ill (Anderson & Barret, 2001). In view of the vagueness of the code, such a situation requires an analysis of the ethical dilemma, which can be described in this example as the welfare of the client versus the professional responsibility of the psychologist.

In theory, the code of ethics must serve as a guide for the psychologist to resolve the moral problems or dilemmas that he or she may confront in the profession. In reality the code of ethics is not able to provide the psychologist with the necessary guidance in every situation (Wassenaar, 1998). Therefore when the psychologist is unable to refer to a particular code or guideline, he or she may be forced to turn to his or her own value system for assistance in interpreting the code in order to resolve a particular moral problem (Bersoff & Koeppl, 1993).

When ethical dilemmas are not resolved easily the psychologist must also resort to underlying ethical theories in the continuing process of articulating ethical guidelines or codes (Kitchener, 1984). Some moral theories are briefly reviewed in the next section.

2.3 Moral Theory

Moral theory serves as a foundation for ethics. It is through an understanding of people's theories of the good life that one can make sense of why they regard actions or conduct as good or bad, right or wrong (Bersoff & Koeppl, 1993). The most general level of ethical reasoning consists of ethical frameworks or theories (Bersoff & Koeppl, 1993). In this study two of the most commonly articulated frameworks, Utilitarianism and Deontology, are described. The discussion of the theories will be brief and will highlight their common viewpoints.

2.3.1 Utilitarianism

This principle of utility is often associated with John Stuart Mill and Jeremy Benthan (Beauchamp & Walters, 1982). Utilitarianism represents a number of theoretical views about good conduct. This approach views a life well lived by the individual as the ultimate goal. It advocates that if an action causes harm, then it is ethically wrong (Burkemper, 2002). The act that is right promotes the greatest happiness for the greatest number. In this respect utilitarianism acknowledges the principle of beneficence (Carroll, Schneider & Wesley, 1985). It would appear that psychologists have a duty of beneficence towards others, or at least towards those who can be affected by their actions.

According to utilitarianism, engaging in morally correct behaviour is a matter of weighing alternatives in terms of their consequences. The premise of this theory is based on calculating which decision is likely to produce more happiness than pain (Steere, 1984). From the rule-utilitarian's perspective, no rule is ever absolute and the acceptability of any rule depends on the degree to which the rule maximizes utility. Accordingly, when certain rules conflict, the choice of action is selected on the basis of the degree to which it conforms to the basic principle of utility (Burkemper, 2002).

Critics contend that certain acts that are incompatible with common moral judgement might be justified by their beneficial consequences. This implies that utilitarianism permits anything to be done to a person or group if the consequences of that act are beneficial to a large number of people. Thus it can be seen that while utilitarianism provides for a theory of obligation, the rights of a person have no fundamental role. This is a major criticism of utilitarianism (Carroll et al., 1985).

2.3.2 Deontology

This perspective is associated with Immanuel Kant and is based on the major principle that one must act to treat every person as an end and never as a means (Beauchamp & Walters, 1982). This rule reflects the inherent respect for the dignity of all persons. If an individual transgresses a standard, he or she is then acting unethically according to the pre–established deontological agreement (Siegel, 1979). A second example of deontology is divine deontology. Rules or principles appear in the form of religious texts such as the Bible, Koran etc. A third type of deontology is intuitive deontology. This perspective views ethical conduct as that which any rational person would condone by using his or her intuitive ability to reason (Hadjistravropoulos & Malloy, 2000). The deontological perspective argues that even people who are unable to make decisions, such as profoundly mentally retarded individuals, children and institutionalized individuals require special protection and ethical consideration (Carroll et al., 1985). Even if we cannot attribute moral responsibility to them as we do to rational beings, they are entitled to basic rights such as the right to be cared for if they are in our custody (Carroll et al., 1985).

2.3.3 The use of the Utilitarian and Deontological Perspectives in HIV/AIDS and the Duty to Warn

The utilitarian perspective with regard to HIV/AIDS and the duty to warn involves a careful assessment of the benefits or costs of violating confidentiality and warning potential victims.

A deontological model would suggest that one should maintain confidentiality in all cases because an individual's right to privacy is a moral absolute and should never be violated.

In anticipating the ethical issues that arise in HIV/AIDS related issues and the duty to warn, the question arises as to whom the psychologist helps in particular? For example, the person that clinical psychologists help is their client, thereby supporting a deontologically based theory for making moral decisions. In some cases researchers aim to help the general public by attempting to increase their knowledge of human behaviour, which conforms more to utilitarian based theory. In practice therefore, the psychologist will have to weigh utilitarian considerations against the deontological principle (Carroll et al., 1985).

Beauchamp and Walters (1982) argue that in most cases the psychologist follows the deontological perspective, which suggests that the psychologist maintains confidentiality in all cases because an individual's right to privacy is paramount. However, because of the many duties that psychologists face within a particular situation, they are more likely to experience conflict within such situations and therefore they may be required to incorporate the utilitarian perspective into the decision–making process.

The solution of an ethical dilemma will therefore depend on whether a psychologist subscribes to rule-utilitarian or rule deontological approach. The use of the different approaches allows the psychologist to use the same facts yet still come to different conclusions, as the psychologist has to choose among contradictory and justifiable solutions (Kitchener, 1984). To this end, psychologists are encouraged to learn a system of formal analysis for analyzing ethical obligations when faced with an ethical dilemma (Steere, 1984).

2.4 The Duty to Warn Third Parties

Following from the moral theories, the deontological approach asserts that privacy and confidentiality are among the natural rights of a person. Therefore, a breach of confidentiality is a violation of one's rights (Knapp & Vandecreek, 1990). The utilitarian approach on the other hand moves away from absolute confidentiality and allows the psychologist to breach confidentiality in order to prevent harm from occurring to the greater community or to others. There is abundant evidence to suggest that in instances where the welfare of society or third parties is threatened, confidentiality must be breached. This is precedented in the Tarasoff case (Melchert & Patterson, 1999).

According to Stewart and Repucci (1994), HIV/AIDS adds an entirely new dimension to the already confounded and complex debate about whether it is better to maintain confidentiality or warn a third party. On the one hand, breaches in confidentiality may result in the deterioration of the psychotherapeutic relationship, which may be harmful to the overall well-being

of the client. On the other hand maintaining confidentiality may result in physical, mental and emotional harm to third parties (Gray & Harding, 1988). Chennnville (2000) maintains that such a "double bind can be extremely burdensome to psychologists" (p. 661). According to Melchert and Patterson (1999) the ultimate questions with regard to the duty to warn and interventions with the HIV-positive client is not whether to breach confidentiality but of how to protect third parties without destroying the psychotherapeutic alliance between the client and psychologist.

2.4.1 Ascertaining the duty to warn and the duty to protect

An analysis of court decisions regarding the duty to warn shows that it requires three factors: a fiduciary relationship, an identifiable victim and the foreseeability of harm (Beck, 1985; Knapp & Vandecreek, 1990). These three factors are discussed in this section.

The first criterion the fiduciary relation pertains to the relationship of trust. Chenneville (2000) suggests that fiduciary relationships include parent-child, guardian-ward and doctor-client. Psychologists fall under the same special relationship as doctor and client.

A duty to warn third parties arises when the psychologist becomes aware that their client poses a potential threat of harm to others. In the literature, the duty to warn and the duty to protect have been used interchangeably, even though they refer to different ideas (Anderson & Barret, 2001; Chenneville, 2000; Knapp & Vandecreek, 1990). The duty to warn arises when a client has been assessed to pose a serious threat of physical violence to an identifiable victim and when the chain of causation that results in harm is clear (Truscott, Evans & Mansell, 1995).

In some circumstances disclosures may be statutorily required as is the case involving child abuse. In such an instance the duty to protect arises (Green, 1980). Another situation which involves the duty to protect is that of research subjects (Lanman, 1980). The code of ethics as applied to research requires that the subjects of the study be informed of the limitations of the study. The codes also require that researchers protect the subjects' privacy by withholding their names and other identifying characteristics. Roth and Miesel (1977) suggest that the duty to protect is different from the duty to warn, as the duty to protect involves absolute confidentiality. In this study the term 'duty to warn' will be used throughout.

2.4.2 Identifiability

Tarasoff versus The Board of Regents of the University of California is a case that established that psychologists, in certain cases, have a legal duty to warn the potential victim of their client's behaviour or the associated risks. In the Tarasoff case it was ruled that the psychologist had a duty to warn a woman that her former boyfriend intended to kill her (Miller & Thelen, 1986). However, in response to this ruling, it can be argued that it was difficult for the psychologist to make a straightforward decision to break client confidentiality based on merely knowing about the client's homicidal thoughts. In this respect much more information may be needed to determine whether there is an actual intention to kill another person.

Under the Tarasoff rule the duty to warn extends only to identifiable victims and not to all persons whom the client could conceivably harm. According to Knapp and Vandecreek (1990) this would most likely include spouses or lovers who live under an illusion of monogamy, but would not extend to casual sexual partners who might not be easy to identify. Elaborating on the above findings, DiMarco and Zoline (2004) found that identifiability was difficult when it involved various scenarios such as the sex worker scenario versus the homosexual scenario, and the intravenous drug user scenario or the bi-sexual scenario.

In the Tarasoff case the court seemed to believe that it was a simple matter for the psychologist to disclose information to warn a third party. The Tarasoff ruling did not take into account that it may be extremely difficult for the psychologist to predict dangerous behaviour on the basis of just knowing about the client's HIV status.

2.4.3 Forseeability

According to Knapp and Vandecreek (1990) the AIDS virus can remain dormant for years and even when diagnosed the client can remain asymptomatic for years. Therefore warning people of potential danger cannot be easily predicted. Becker and Joseph (1988) assert that a premature or an inaccurate report of an HIV infection can therefore damage the patient's reputation and social relationships.

According to Annas (1987), when sexual partners engage in safe sexual practices the danger of infection is chronic and not acute. The risk of immediate infection is lowered, although the risk of acquiring the infection is still higher. However in such a situation the psychologist has more time to persuade the client to disclose his HIV status to his partner voluntarily.

However, Annas (1987) suggests that if the risk of transmission is high then the focus in psychotherapy should be to support the client to make a voluntary disclosure, as such clients may present a more immediate threat of high-risk infection. Totten, Lamb and Reeder (1990) argue that if a psychologist finds that there is a need to warn a third party, an attempt should first be made to convince the client to reveal the information either him or herself, or to obtain the client's permission to do so. The client should therefore be informed that a disclosure is going to be made. They suggest that warning should be made with the client's consent or with the client present. Becker and Joseph (1988) report that such openness may help to reduce the suspicion of what might have been said and may in turn reduce the degree of harm to the psychotherapeutic relationship.

Resistant patients, on the other hand, may act in a manner that may be consistent with the behaviour of a potentially violent or aggressive patient (Morrison, 1989). According to Perry (1989) in such an instance the psychologist could consider committal to a mental institution. Although having such a client involuntarily committed to a mental institution is in keeping with the psychologist's legal obligation, it can be argued that this decision breaches client confidentiality and may result in irreparable damage to the therapeutic relationship.

2.5 Partner notification

Knapp and Vandecreek (1993) noted that some states in the USA have instituted partner notification programmes. They suggest that if clients are reluctant to tell their partners of their HIV status, psychologists should consider using the partner notification programme instead of warning the intended victim directly. According to Knapp and Vandecreek (1993), partner notification programmes are voluntary, and entail the notification of the partner by a trained employee, which is done at the request of the client.

Anderson and Barret (2001) found that in California physicians are the only health care providers permitted to notify a third party at risk for contracting HIV. Thus according to them psychologists who undertake notification of a third party are violating the law and standard 5.05 of the ethics code (APA, 2002).

Following the ruling in the Tarasoff case, there have been further instances in which the welfare of third parties or society as a whole have been seriously threatened, resulting in the breaching of confidentiality. These were the 1980 Lipari decision and the 1983 Petersen decision (Bersoff, 1995). Mills (1984) argued that such decisions have increasingly made it clear that psychologists not only serve their clients but also the larger society in which they work. This may be often to the detriment of the individual client. Mills (1984) reviewed many of the post-Tarasoff court decisions and found the majority of cases were not litigated, as at the time of reassessment the client no longer presented as a danger. In view of this Mills (1984) found that some states in the USA, such as Pennsylvania and Maryland, have decided against following the policy established in the Tarasoff. Hughes and Friedman (1994) found that only one statute (Utah) had legally extended the duty to warn to situations involving communicable diseases.

DiMarco and Zoline (2004), however, found that as a result of the Tarasoff ruling, other states have incorporated a legal duty to warn in cases where there is a threat of physical violence. Several studies have questioned the applicability of the Tarasoff ruling in situations where the HIV-positive client knowingly places his or her partner at risk (DiMarco & Zoline, 2004; Gray & Harding, 1988; Knapp & Vandecreek, 1990; Pais, 1998). It is argued that the risk that the HIV-positive client poses to the psychologist is different to the relatively straightforward risk posed in the Tarasoff case, and consequently the HIV-positive client's right to confidentiality outweighs the benefits of breaking their confidentiality to warn third parties of their possibility of contracting HIV (Melchert & Patterson, 1999).

On the other hand, it has been argued that because HIV is ultimately life threatening, breaching confidentiality is ethically justified (Appelbaum & Rosenbaum, 1989; Gray & Harding, 1988). According to this argument the rights of the endangered person override the rights of the client to confidentiality because of the fatal nature of HIV if left untreated. Attempts to alter client behaviours through clinical management should always be made before breaching confidentiality (Knapp & Vandecreek, 1990).

2.6 Application of the duty to warn

Advocates for maintaining client confidentiality argue that only a medical doctor can determine the infectious status or understand the test results of an HIV antibody test. They argue that the medical doctor is therefore the appropriate health care provider by training to breach confidentiality and to issue a warning if deemed necessary. The medical doctor's primary function is to diagnose and control diseases and failure to warn or diagnose constitutes a failure in the area in which the medical doctor has fiduciary trust (Ciccone, 1985). Medical doctors are trustees both of their patients' health and for broader social health concerns. Preventing HIV/AIDS therefore falls within the scope of the medical doctors' fiduciary duty.

Ciccone (1985) argues that the psychologist's duty is to control or forestall homicidal intentions of the client, which he feels does not include AIDS prevention. Ciccone (1985) suggest on the basis of fiduciary trust the psychologist has a duty to warn third parties of the homicidal intentions of their clients, just as the medical doctor has a duty to warn third parties of the danger of infection from their patients. Since preventing AIDS is not a fiduciary duty of psychologists, a psychologist's failure to warn third parties about a client's HIV status does not constitute negligence in performing a fiduciary duty (Ciccone, 1985).

It is also argued that the Tarasoff principles do not apply in such situations because non- disclosure of HIV status is not comparable to threats of physical harm. According to the Tarasoff principle, a threat must be specific, imminent and active. Kermani and Weis (1989, in DiMarco & Zoline, 2004) argue that the threat posed by an individual with HIV is passive, in that the patient does not normally verbalise his or her intention to infect another person.

The majority view on this issue appears to support the conclusion that psychologists do have a duty to warn the third party when an HIV-positive client presents as a danger to his or her partner as a result of unprotected sex (Melchert & Patterson, 1999).

2.7 Case law

Psychologists and other mental health professionals may often feel caught in a legal dilemma with respect to the client's HIV status. On the one hand there is the basic duty to keep client information confidential. This is especially true of information about HIV infection, which can be embarrassing or harmful to the client if revealed to others. On the other hand, there may be a duty to warn others if the client poses some threat to them.
In view of the above, it is therefore understandable that psychologists want clear guidelines about when to maintain confidentiality and when and to whom a disclosure must be made. Unfortunately the law does not always provide definitive answers.

Though guidelines have been developed to assist psychologists faced with potential duty to warn situations involving HIV-positive clients, no policy has been mandated concerning the protection of third parties of clients with HIV (Melchert & Patterson, 1999). Although not mandated, the APA (2002) and the HPCSA (2004) both maintain the following position: The guidelines indicate that a legal duty to warn third parties about HIV infection should not be imposed. A health care worker may not tell the patient's sexual partner that the patient has

HIV unless the partner appears to be at risk because the patient refuses to practice safer sex. The health care worker must counsel the patient on the need to tell their sexual partner and to practice safer sex. The health care worker must then warn the patient that if he or she does not tell their sexual partner or practice safe sex then the health care worker will be duty bound to inform the partner about the person's HIV status (HPCSA, booklet 8).

Psychologists are mandated by law to report any persons who are mentally ill to the degree that they present a danger to others (Mental Health Act No. 17 of 2002) as well as suspected cases of child abuse in respect of the Child Care Act No.74 of 1983. However, legally, psychologists are not obligated to warn third parties who are at risk for HIV infection. The APA (2002) and HPCSA (2004) policies do however suggest that psychologists and other health care workers may be morally obligated to warn third parties who are at risk of HIV infection.

Wood, Marks and Dilley (1990) indicate that before psychologists apply Tarasoff warning to HIV-positive clients, they must be certain of the diagnosis, the identity of the client's partner and the reality of the danger. It must be shown that the danger posed to partners by HIV-infected clients must be legally analogous to the danger posed to Tarasoff (DiMarco & Zoline, 2004). According to Schlossberger (1996), legal and ethical issues involving HIV and the duty to warn third parties have not been adequately addressed. Most of the attempts of the courts to grapple with the issue of a third party seem to have been associated with violence (DiMarco & Zoline, 2004).
Although many studies have discussed the applicability of the Tarasoff principles within an HIV-related psychotherapy context, few studies have taken into account factors that influence the psychologist's decision to breach confidentiality (Stewart & Repucci, 1994). Some studies have found that prejudice and negative bias toward the HIV infected person could affect professional ethical decision-making. Psychologists who had clinical experience working with HIV-positive clients were less likely to breach confidentiality than those who did not have such contact (DiMarco and Zoline, 2004). Totten et al. (1990) suggest that breach of confidentiality may be related to personal biases and found that psychologists were less likely to warn the client's partner of potential danger when the client was identified as having HIV/AIDS, compared to psychiatric patients who expressed homicidal ideation.

2.8 HIV/AIDS and confidentiality in psychotherapy

A widely accepted tenet in psychotherapy is the importance of trust between the client and the psychologist. The client expects that whatever is communicated in therapy will remain confidential unless explicit permission to communicate this to others is provided (Baird, Laing & Rupert, 1987). Siegel (1979) argues that for psychotherapy to be effective confidentiality must be absolute with the possible exception being when the client poses a danger to others. Beyond this, Botkin and Nietzel (1987) believe that unless an individual is assured from the outset that whatever is said will be kept confidential, the client will not only avoid making intimate disclosures but may not seek therapy at all.

Implicit in the literature on confidentiality are concepts related to privacy and privilege. In the following section confidentiality (which involves an explicit promise to reveal nothing), privacy (which can be considered as a basic human right) and privilege (a legal right which

exists by a statute) will be reviewed. These concepts are linked to limited access and the exclusion of others. This means that when a person enters into a relationship with the psychologist, that person gives up his or her own private thoughts, feelings and beliefs in exchange for therapeutic understanding and assistance. In this sense traditional psychotherapy has focused on the exclusive dyadic relationship of the psychologist and the client (Melchert & Patterson, 1999). Therefore, in this sense, no third parties have access to information disclosed in therapy.

Baird, Laing and Rupert (1987) argue that individual psychotherapy often occurs in a larger context of the therapeutic relationship and involves an array of third parties which includes family members, employers, courts, etc. Therefore when ethics or law conflict with the legal duty to protect the individual client's right to confidentiality, then the ethical issue takes precedence.

2.9 Confidentiality, Privacy and Privilege

2.9.1 Confidentiality

A historical legal development that has emerged out of the Tarasoff and other such cases is the way in which psychologists interpret confidentiality, privacy and privilege (Bersoff, 1995). Confidentiality is the psychologist's ethical obligation to safeguard client communication (Baird, Laing & Rupert, 1987; Miller &Thelen, 1986). It is a general ethical duty that is a feature of many professions. Research has shown that clients expect psychologists to maintain absolute confidentiality as a general rule (Miller & Thelen, 1986). Psychologists also have a primary obligation to respect the confidentiality rights of those with whom they work (Wassenaar, 1998). However, legally and ethically, clients cannot be promised absolute confidentiality. The matter of confidentiality is further complicated by technological advances in record-keeping and the storage and reproduction of material, which includes photocopying, computer storage and video tapes (Nowell & Spruill, 1993).

Psychologists may find themselves facing an ethical dilemma when their responsibility to maintain client confidentiality is at odds with their duty to warn third parties (Knapp & Vandecreek, 1990). According to the HPCSA guidelines (2004) psychologists and other health care workers have a legal duty to keep all information about an HIV-positive patient confidential. Any information about the HIV-positive patient cannot be given to another person unless the patient gives consent. If the patient is deceased then the doctor must obtain permission from the next of kin to divulge information.

In South Africa the well-known McGeary case (also known as Jansen van Vuuren and another v Kruger 1993) established the patient's right to confidentiality. In the McGeary case the Supreme Court of Appeal ruled that a doctor cannot disclose to other doctors the HIV status of a patient without the patient's consent. The case details are as follows: Mr. McGeary applied for a life assurance policy and the insurance company requested that he have an HIV test before they approved his application. The doctor received the results of the test and informed McGeary that he was HIV-positive. The following day the doctor discussed the results of the HIV test with another doctor and dentist. The news of McGeary's

condition then spread around the community. McGeary began a civil claim for compensation from his doctor for breaking his right to confidentiality. The court ruled in his favour and the doctor had to pay McGeary compensation (HPCSA, 2004).

In arguing the importance of maintaining client confidentiality, Landesman (1987 in Bersoff, 1995) suggested that breaching the client's confidentiality in a case such as the one described above might cause the client immediate harm and may also result in the client's failure to seek help at a later stage. Whilst wilful disclosure is a direct breach of an HIV-positive client's right to confidentiality, historically there has been no legal duty to rescue others from harm or warn them of impending harm from HIV infection (Melchert & Patterson, 1999). DiMarco and Zoline (2004) found that the APA code of ethics (2002) does not explicitly address professional decision-making in AIDS-related psychological practice. It is also unclear how rules regarding confidentiality that are written specifically for medical doctors can be generalized to the psychologist (Burchemper, 2002). Furthermore, the APA guidelines require development, as they do not explicitly address ethical decision-making in AIDS-related practice and leave the decision up to the psychologist and the particular situation. DiMarco and Zoline (2004) report that there has been no case concerning confidentiality that has interpreted Tarasoff with regard to HIV practice.

2.9.2 Privacy

Privacy and confidentiality are essential features of the psychotherapeutic relationship (Bersoff, 1995). Both are linked to the concept of limited access. Siegel (1979) defines privacy as the "freedom of individuals to choose for themselves the time and the circumstances under which and the extent to which their beliefs, behaviour and opinions are to be shared or withheld from others" (p. 251).

Once private information has been disclosed to the psychologist it becomes confidential unless the client provides explicit permission to communicate it to others. According to Chenneville (2000), implicit in the idea of confidentiality is the assumption by psychologists that clients expect privacy from their psychologist.

In most instances no third parties have access to private information which is disclosed to the psychologist, or even know that the relationship exists at all. For example, some clients may choose to pay cash for their psychotherapy rather than file a claim to their Medical-Aid. Some psychologists organize their offices to protect the privacy of the client by providing a separate entrance and exit and making use of answering machines instead of an answering service.

Vandecreek, Miars and Herzog (1987) indicate that obstacles to privacy occur increasingly in a larger context of between the psychologist, client and an array of third parties, which may include family members, employers, courts and government agencies. The psychologist's general obligation to protect client privacy may sometimes be overridden by specific obligations to disclose information at the client's request or when the law requires it.

2.9.3 Privilege

Privilege constitutes a particular legal right that the law gives to clients (Carroll et al., 1985). According to Ciccone (1985), "Privilege is a legal right belonging to the patient or client, not the psychologist" (p. 275). Gumper and Sprenkle (1981) define privilege as a "limited legal right that is usually vested in the client rather than the professional to refuse or prevent disclosure of therapy communications" (p. 12). This is compared to confidentiality, which refers to a general standard of professional conduct that obliges a professional not to discuss information about a client to anyone (Keith-Spiegel & Koocher, 1985). Confidentiality therefore extends the concept of privilege to include situations other than legal proceedings. Ironically normal standards of confidentiality may conflict with the statutory limitations of privilege, as communication between the client and psychologist can be subject of a subpoena in South Africa.

2.10 Legally permitted and legally forbidden dangers

According to the law, the psychologist's general duty of confidentiality must give way when disclosure is necessary to warn or prevent harm to an identifiable third party. According to Ciccone (1985), in at least two cases, Shaw v. Glickman (1980) and Hopewell v. Adibempe (1981), courts have ruled that certain client confidences remain privileged (must not be disclosed) even when the client poses a danger to others.

There are many sorts of dangers and risks. Some dangers and risks are legal while others are illegal (Ciccone, 1985). Mountain climbing is a dangerous sport, as climbers risk death, broken limbs etc. Clients who propose to climb a mountain pose a danger to themselves however there is no stipulated law that prevents them from mountain climbing. Society, through law, has decided that this is a danger that people are permitted to expose themselves to. Suicide, on the other hand, is not a legal right. Society, through law, has decided that people do not have a legal right to take their own lives. Ciccone (1985) suggests that the distinction between legally permitted and legally forbidden dangers is crucial to the duty to warn third parties. The psychologist has no duty to intervene when clients pose dangers that society, through law, permits them. It is therefore argued that if society, through law, grants an HIV-positive person the legal right to have sex without informing his or her partner, psychologists who overrule society and deny clients that right are claiming sovereignty over their client's lives (Ciccone, 1985). It is further argued that if people are given the *de facto* right not to inform their sexual partner that they have engaged in frequent unprotected sex, they do not lose that right by entering therapy. Thus equality under the law suggests that psychologists have no duty to warn third parties of client behaviour that is not generally prescribed by law (Ciccone, 1985).

According to Bersoff (1995), privilege and the general obligation of confidentiality are increasingly subject to limitations due to inconsistent state laws in America and changes in health care.

Pietrofesa, Pietrofesa and Pietrofesa (1990) note that, "disclosures not only jeopardize the therapeutic relationship but may also subject the therapist to liability for invasion of privacy,

defamation, or breach of confidentiality" (p.132). Psychologists must determine whether they have a legal duty to warn third parties of the danger posed by their client's sexual behaviour and if not, whether the client's information is legally protected, thus prohibiting the psychologist from disclosing the information.

In view of the above it is argued that while ethical codes attempt to act as guidelines for psychologists, they can be both abstract and imprecise as they are unable to approach issues that are contemporary and are at the cutting edge of the profession (Welfel & Kitchener, 1992). As with all sets of rules, they are never completely comprehensive, nor do they give consistent answers for what could be done in a given situation (Carroll et al., 1985).

Due to the ambiguity of the ethical codes, psychologists must sometimes move to a second stage to obtain clarity about ethical decisions. There are five foundational ethical principles that can help clarify the ethical issues involved and guide decision-making (Anderson & Barret, 2001). These ethical principles are central to ethical discussions in psychology (Beauchamp & Childress, 2001).

The next section focuses on describing and clarifying these principles and their usefulness in dealing with ethical issues related to HIV and the duty to warn. The manner in which they are integrated in psychotherapy is critical in respect of the management of confidentiality in the relationship (Anderson and Barret, 2001).

2.11 Ethical Principles

In the introduction to the *APA Ethical Principles of Psychologists*, it is stated that, "psychologists should respect the dignity and worth of the individual and honour the preservation and protection of fundamental human rights" (Carroll et al., 1985, p. 15).

"Although ethical codes should be the first documents to consult when making an ethical decision there are times when codes are silent or give ambiguous advice"(Anderson & Barret, 2001, p. 47). When the law is silent psychologists must decide from an ethical standpoint whether to break confidentiality when a client is knowingly exposing others to HIV/AIDS. In making the decision to break confidentiality, psychologists need to identify certain ethical considerations, evaluate the importance of these considerations and arrive at an ethically sound decision. The ethical codes (APA, 2002; HPCSA, 2004) do not address the issue as to whether the psychologist should break confidentiality in cases where the HIV-positive client poses a danger to his or her partner.

Kitchener (1984) has suggested that when the psychologist finds that the professional codes are limited, consideration needs to be given to the fundamental ethical principles. Steere (1984) has observed that in real life the ethical issues people face often present as extremely difficult choices. While individuals may rely on their moral intuition in responding to such issues, in some cases one's moral sense may be misleading or inadequate. In such cases even when the code of ethics is vague psychologists are obligated to evaluate their ethical choices in the light of the ethical principles. Schlossberger (1996) believes that psychologists cannot formulate a disclosure policy without a clear understanding of the basic underlying funda-

mental ethical principles. These ethical principles guide the action of psychologists and should affect their professional roles as advocates for change. These principles are respect for autonomy, beneficence, nonmaleficence, fidelity and justice.

According to Augustus and Naomi (1990), in the past popular approaches may have emphasised the role of one principle over others. For example Kohlberg (1970) focused on the justice principle with a view to providing objective and universally valid interpretations to an ethical dilemma. Gilligan (1982) called for a consideration of an ethic of care which focused on the principle of beneficence and took into account a standard of morality measured by intuitive reactions to concrete situations rather than the ability to stand outside of a situation. Gilligan's ethic of care is often discussed in contrast to Kohlberg's ethic of justice principle (Haas, Malouf & Mayerson, 1988).

According to Beauchamp and Childress (2001) the limitations that stem from the ethical codes can be addressed by considering the fundamental ethical principles. Bersoff and Koeppl (1993) state that each of the *prima facie duties* of the principles can be translated in some form in the code, which will be presented in the following section.

2.12 Foundational ethical principles

2.12.1 Respecting Autonomy

Respect for autonomy refers to respecting the unconditional worth of each individual, especially his or her right to make life decisions if competent to do so (Kitchener, 1984). This concept is both fundamental to any ethical system and the foundation of a therapeutic relationship. Beauchamp and Childress (2001) suggest that the core idea of autonomy derives from the concept of self-rule or living according to a plan that the person has chosen for him or herself. Respect for autonomy is highlighted in the ethics code in Principle D and Principle E (APA, 2002) and Standard 10:4 of HPCSA (2004).

Principle D reminds the psychologist to respect the rights of the individual to privacy, confidentiality, self-determination and autonomy. Principle E advises the psychologist to be aware of the real and ascribed difference in power between themselves and their clients and to avoid abusing this potential imbalance (Bersoff & Koeppl, 1993).

This principle implies that psychologists should not impose their opinions or beliefs on clients by force or coercion (Engelhardt, 1986). It is argued that breaking confidentiality (informing third parties without the client's consent) appears to violate client autonomy in HIV/AIDS and the duty to warn (Schlossberger, 1996). Psychologists who break confidentiality deprive clients of their *de facto* legal right to keep their HIV status from sexual partners (Engelhardt, 1986). Cohen (1990) points out that those clients who choose not to reveal their HIV status to their partners violate the autonomy of their partners. He adds that informing third parties does not violate a client's autonomy if the act of informing is consistent with the psychologist's disclosure policy. The terms of the policy should be made clear to the client at the first consultation before the client freely decides to reveal the information to the psychologist. The disclosure policy is more explicitly reiterated in Provision, 4.02, APA, 2002;

Standard, 27, HPCSA, 2004, which requires that the client be sufficiently informed and be given the right to consent before entering into psychotherapy.

Similarly, Beauchamp and Childress (2001) indicate that autonomous choices have three characteristics; they must be intentional, they must be based on adequate understanding and they must not result from controlling forces. For the person who is HIV-positive the social stigma surrounding the disease is such that one of those parameters is to know both the extent of and limits of confidentiality. One of the ways in which the psychologist can respect the client's right to autonomy is to provide the client with informed consent to treatment. This would include providing the client with enough information to make a reasonable decision and also ensuring that they understand the information.

It is further argued that distributing a written disclosure policy or a general statement that confidentiality may be broken when a client's behaviour may harm him or herself (themselves) or others may not clearly convey to the client that their HIV status might be revealed. Psychologists need to beware of distributing disclosure statements that lull clients into a false sense of security (Beauchamp & Childress, 2001).

2.12.2 Beneficence

Being beneficent means acting in a way that benefits or helps others; in short it means to "do good." This principle underlies much of the code of ethics (APA, 2002) particularly principle E: Concern for Others' Welfare and Principle F: Social Responsibility (Bersoff, 1999). This principle is highlighted in Standard 10.2 and 10.3 (APA, 2002) and Standard 27 (HPCSA, 2004). At a minimum, beneficence requires that psychologists balance the good that will result from their actions against the harm. Although it is easy to say that psychologists should do good, it is difficult to determine what course of action is good for the client and to decide on limits of beneficence in respect of HIV and the duty to warn (Anderson & Barret, 2001). Cohen (1990) points out that confidentiality of a person's HIV status is important because of the potential personal, social and economic harm that may result from disclosure of a positive HIV status.

The psychologist's failure to warn the third party may result in the uninformed party perceiving the psychologist as aligned with the HIV positive person. On the other hand revealing the information may cause the HIV-positive person to perceive the psychologist as aligned with his or her partner (Ciccone, 1985).

Perhaps the scenario of HIV/AIDS and the duty to warn or protect is analogous to a psychotherapy situation in which the client is engaging in an adulterous relationship. Progress in psychotherapy may depend upon dealing with the adulterous behaviour and the structural dynamics of the relationship that prompt adultery (Ciccone, 1985; Schlossberger, 1996). Psychologists who have knowledge of the adulterous relationship but remain silent may be in an ethically questionable position in continuing treatment. Moreover, the existence of the secret itself influences family dynamics. Schlossberger (1996) notes that secrets in the psychotherapeutic process produce anxiety and give the secret holder a sense of power that constitutes a "relational nuclear bomb that can be kept for later use" (p. 297). When the uninformed part-

ner is also a client, as in the case of couple or family therapy, not informing the partner may violate the psychologist's responsibility to advance the client's interest (Schlossberger, 1996).

The majority decision in the Tarasoff case argued that there was a duty to protect others based on balancing the social good that came from taking steps to protect the victim against the harm that arose from breaking confidentiality (Anderson & Barret, 2001). Bersoff and Koeppl (1993) indicate that historically, psychology in general has focused primarily on the good of the individual and as a result psychologists have a *prima facie* obligation to make the client's best interests their primary concern. On the other hand, it can be argued that psychology is conducted in a social - system and psychologists therefore have an ethical obligation to that system and to prevent harm from occurring to others within that system, particularly when the harm is life threatening (Anderson & Barret, 2001).

Beauchamp and Childress (2001) suggest that when dealing with potentially life threatening situations, psychologists should consider both the magnitude and the probability of harm to others. As both the magnitude and the probability of harm increase, the ethical obligation to intervene becomes stronger. Harm that is life-threatening is more severe than the harm involved in hurting someone's feelings. If the harm is minor or the probability of harm is low, there may be no ethical obligation to intervene.

If a decision is made to breach the client's confidentiality in order to warn a third party, the client should be informed beforehand (Bersoff, 1999). According to Bersoff (1999), informing the client first and explaining the legal and ethical basis for the decision may help minimize the harm to both the client and the therapeutic relationship.

2.12.3 Do No Harm/ Nonmaleficence

This idea is articulated in the APA ethics code in Standard, 14. APA, 2002, Standard 26, HPCSA, (2004). Psychologists take reasonable steps to avoid harming their patients or clients and others with whom they work. It is generally held to be a stronger requirement than beneficence (Anderson & Barret, 2001).

Steere (1984) argues that while psychologists are expressly prohibited from intentionally inflicting harm, exposure to the risk of harm is tolerated under special circumstances.

An example would be maintaining confidentiality even when a client threatens to deliberately infect as many people with HIV as possible. Under such circumstances most will think it justifiable to break confidentiality even though a professional had promised to keep it (Anderson & Barret, 2001). Steere (1984) has argued that no one should expect professionals to maintain confidentiality under such circumstances because to do so would lead to immoral decisions. On the other hand, Kitchener (1984) indicates that before interpreting the ethics code or considering the ethics principles, the psychologist needs to be sure he/she has the correct facts both about the disease and the client.

Melton (1988) suggests that when there are conflicts between ethical obligations, psychologists should act in a way that does the least amount of avoidable harm. In other words there must be a stronger obligation to avoid hurting people than to help them. This seems particularly important in working with people who are HIV-positive because of the stigma associated with the disease (Anderson & Barret, 2001).

Sometimes psychologists may have to weigh up the harm to clients against the potential harm they may do to others. Therefore, what this perspective suggests is that psychologists need to think carefully about the effects of their actions on their clients as well as others. The overriding concern will be to choose the path that is both responsible and does the least amount of long term harm that is possible to foresee (Anderson & Barret, 2001).

2.12.4 Fidelity

Fidelity is best exemplified by Provision, 1.19 APA, (2002), Standard 26, HPCSA, (2004), which states that the primary goal of the code is the welfare and protection of the individuals and groups with whom psychologists work (Bersoff, 1995).

The principle of fidelity involves keeping promises, being truthful and loyal all of which are central to building trust and maintaining confidentiality in the therapeutic relationship (Kitchener, 1984). One of the central obligations that a psychologist incurs in therapy is to keep information confidential. This is especially important when working with those who are HIV-positive, as discussion about the persons HIV status typically involves the most private aspects of a person's life (Anderson & Barret, 2001). Clients need to trust their psychologist in order to reveal such information, Melton (1988) indicates that breaking promises can further destroy trust in the psychologist and may deter the HIV-positive person from seeking help. On the other hand, many modern philosophers have pointed out that following such principles absolutely could lead to immoral decisions. For example, maintaining confidentiality even when a client threatens to infect other people with HIV.

2.12.5 Justice

The principle of justice is concerned with fairness and appropriate treatment according to what is due or owed to the person (Anderson & Barret, 2001). In the realm of psychotherapy, justice sometimes involves deciding who should receive the benefits of treatment. Psychologists tend to be engaged in decisions that involve the notion of justice. These decisions may be about how to treat one particular client over another (Anderson & Barret, 2001). This suggests that aspects that are irrelevant to a person's need for treatment, such as age, gender and ethnicity, should not be considered in allocating services. This aspect is highlighted in the ethics code Standard 1.10: nondiscrimination (APA, 2002) and Standard 12: unfair discrimination (HPCSA, 2004).

At first glance issues of justice do not seem particularly relevant for psychologists when they engage in HIV- related practice. However it is important to bear in mind that research suggests that many psychologists and social workers hold biased and negative attitudes towards

those who are infected with AIDS and are resistant to working with them in a therapeutic manner (Crawford, Humfleet, Ribordy, Ho & Vickers, 1991).

To tell the truth is regarded as moral behaviour. This means that not to tell the truth to a client is to treat them unjustly. Accordingly, to withhold information from a client is similarly unjust (Melton, 1988). This suggests that a client's autonomy holds more weight and to override it requires stringent justification. It follows that to compromise a client's autonomy is to treat them unjustly. However, in cases that involve the duty to warn, what the client considers as best for themselves in the light of their individual autonomy, although just, may not be the healthiest decision for all parties (Anderson & Barret, 2001).

In essence what these principles suggest is that psychologists need to think carefully about the effects of their actions on clients as well as on others, particularly in the field of HIV- related psychotherapy.

Engelhardt (1986) suggests that when tough ethical decisions must be made, the best way to do so is "to act so as to lose as few goods as possible and to violate as few rights as possible" (p. 99). This position suggests that when balancing ethical obligations the client's right to privacy and autonomous decision-making are always important considerations.

What is implied by the above is that in making tough ethical decisions the psychologist's moral responsibility may at times be compromised in order to uphold another, stronger, ethical obligation. Such is the case when a psychologist makes the decision to break confidentiality in order to prevent harm from occurring to a third party.

2.13 Ethical decision-making

In fundamental ways HIV-related psychotherapy has led to introspection about existential concerns such as life and death, suffering and joy, end-of-life decisions and debates regarding duty to warn and duty to protect issues (Anderson & Barret, 2001). According to Beauchamp and Childress (2001), ethical decisions are therefore made in a larger real-life context, which involves personal stresses, administrative responsibilities, the law and numerous other impinging events.

In view of the above situations it is understandable that when a conflict of duties arises the psychologist must make a decision as to which duty takes precedence. The concept of autonomy embodies the client's right to privacy and self-determination. This means that the individual has a right to make his or her own choices without interference from others. In the context of ethics, the concept of autonomy is expressed as a continuum between total incapacitation at one end, and total autonomy in decision-making on the other (Beauchamp & Childress, 2001). Beauchamp and Childress (2001) define competency as the "ability to perform a task" (p. 70). This concept therefore reflects the client's ability to carry out the appropriate action (Hanson, Kerkhoff, & Bush, 2002).

In order to assess the client's decision-making capacity, Beauchamp and Childress (2001) suggest that the psychologist should take into account the client's abilities, the issues sur-

rounding the situation and the consequences of the decision. The psychologist should be aware of false positives and negatives. The former refers to the incorrect assessment of an individual as incapacitated and therefore unable to make a decision. A false negative refers to the psychologist's failure to prevent a mentally incapacitated individual from making harmful decisions (Hanson, Kerkhoff & Bush, 2002).

2.14 Models of ethical decision-making

Based on the ethical codes, ethical principles and ethical theories, Rest (1983) postulates a model for dealing with moral behaviour. The first component of the model involves interpreting the situation as a moral one and is referred to as "moral sensitivity". The second component involves deciding which course of action is just or fair and is referred to as "moral reasoning". This capacity, according to Rest (1983), is informed by the code of ethics, ethical principles and ethical theory. Deciding what one needs to do is the third component of Rest's model and involves choosing whether or not to carry out the action. The fourth component is the implementation of the action. While Bersoff (1995) strongly recommends Rest's model in training students to behave ethically, Kitchener (1984) suggests the use of more elaborative models to assist in decision-making processes.

Several authors have developed problem-solving models with regard to ethical decision-making. A common pattern across all models comprises the following steps: The development of alternatives, analysis, choice of action and evaluation. Several models deal directly with ethical concerns. Keith-Spiegel and Koocher (1985) offer an eight step model which includes the following: describing the parameters of the situation; defining the issues involved; consulting relevant guidelines; evaluating the rights of all affected parties; generating alternative decisions for each issue; enumerating the consequences of making the decision; presenting any evidence that the various consequences or benefits resulting from each decision will occur; making the decision.

Tymchuk (1986) presents a useful approach that includes seven steps, which is similar to that of Koocher (1994). The most important step in the model presented by Tymchuk (1986) is when the psychologist determines which action to implement in the decision-making process. The selected course of action is determined by anticipating as carefully as possible the short and long term consequences and the psychological, social and economic costs which impact on the action.

The problem-solving model recommended by the Canadian Psychological Association (CPA) committee on ethics (2001) is similar to that of the Tymchuk approach. However the CPA committee on ethics (2001) included a seventh step: this includes the psychologist taking responsibility for the consequences of the action. This might include the correction of negative consequences or re-engaging in the decision-making process if the ethical issue is not resolved.

Tymchuk (1986) argues that even if the psychologist follows a code of conduct, there is no guarantee that the decisions made will prevent harm and that he or she will not face an ethical complaint or a lawsuit. There may be conflicts among the provisions of the code and legal

requirements. An example of this is the lack of competence in some area of practice when there is no other competent referral source available. Another is the potential breach of an ethical confidence when the psychologist has to face a court subpoena. Such decisions, suggests Tymchuk (1986), should not be taken lightly and should be done in consultation with one's supervisor or colleague.

2.15 Ethical decision-making in HIV-related psychotherapy

Chenneville (2000) presents a detailed model of ethical decision-making. The model takes into account major premises outlined in the Tarasoff case while emphasizing professional ethics and the best interest of the client. The first step of the decision-making model involves determining whether disclosure is warranted. According to Chenneville (2000), this determination requires an assessment of the forseeability of harm and identifiability of the victim. This assessment takes into account the personality characteristics of the client and the reasons for the client's unwillingness to self-disclose. The second step involves an examination of professional guidelines. The final step involves an examination of state guidelines.

Anderson and Barret (2001) argue that the model by Chenneville (2000) does not guide the psychologist through the actual decision-making process. The model emphasizes that the primary goal of the psychologist should be to guide the client to disclose their HIV status to their sexual partner. According to Melchert and Patterson, (1999) guiding the client to disclose his or her HIV status not only protects the therapeutic relationship but also instills in the client a sense of responsibility in life and personal control over their own life.

The model presented by Anderson and Barret (2001) requires a careful review of the psychologist's reactions to the case and is a recommended model for use in HIV/AIDS related psychotherapy. It outlines the following stages in the decision-making process: The psychologist is first required to identify countertransference issues that can influence the outcome of therapy. He or she then reviews the facts by taking into account the client's presenting circumstances and social situation and conceptualizes an initial plan based on the presenting issues. The next step is to consult the ethical code and foundational ethical principles. The psychologist would focus on identifying the legal issues and assess options for intervention. In the final stage the psychologist chooses a course of action, which is then implemented.

While ethical decision-making is viewed as an abstract process, the use of a model provides a framework to assist the psychologist to identify and articulate the possible components involved in the decision-making process, which can then be applied to the specifics of the client's situation. Gray and Harding (1988) argue against decision-making models and recommend a more directive method by directly informing the client's sexual partner of the imminent danger when the client is unwilling to do so. Miller and Thelen (1986) maintain that there are no clear or easy answers, however the ideal situation would be to guide the client to disclose his or her HIV status. In this way the psychologist helps to minimize the harm to both the client and the psychotherapeutic relationship.

Kalichman, Ostrow and Ramachandran (1998) recommend that it is important for psychologists to keep abreast of major research advances regarding HIV/AIDS. They maintain that despite recent advances in treatment options for HIV, such as protease inhibitor medications, there is still no cure for HIV/AIDS. Therefore until a successful vaccine or cure is developed psychologists need to take into account ethical principles and guidelines regarding HIV/AIDS and the duty to warn.

2.16 Summary of the literature review

A review of the literature suggests that the decision to breach client confidentiality presents a serious ethical issue in the practice of professional psychology (Melchert & Patterson, 1999). While the psychologist may be willing to breach confidentiality in order to protect the client and others from harm, the AIDS epidemic presents a complex set of ethical dilemmas for psychologists and other health care professionals. Despite the far-reaching professional, ethical and legal considerations of the AIDS epidemic, the ethical codes and the ethical principles for psychologists do not adequately address decision-making in HIV related psychotherapy (Knapp & Vandecreek, 1990).

When faced with ethical problems psychologists are taught to consult their professional ethical standards. The codes fulfil a function of both defining how professionals ought to behave towards others and identifying when they should be criticized for their behaviour. However it is evident from the literature that the ethics code cannot address every specific set of facts (Anderson & Barret, 2001). As a result the decisions that psychologists face with HIV infected patients and their relatives are not easily resolved by consulting the ethics code.

While the ethical principles focus on important moral issues, they seem to be fairly general and do not offer straightforward answers as to what can be done by the psychologist in a given situation (Bersoff, 1995). Noddings (1984) argues that the principles are vague in that they are unable to provide guidelines as to how the psychologist ought to act in their relationships with others. Deciding what it means to 'do good' is not an easy task. However, being ethical depends on remaining in a caring relationship with the client.

The review of the literature suggests that the scope of ethics literature in respect of the duty to warn in HIV related psychotherapy is narrow, especially within the South African context. The vast majority of articles tend to concentrate on whether psychologists have a responsibility to breach confidentiality and are theoretical in their approach (Anderson & Barret, 2001).

To a great extent the discussion with regard to confidentiality versus the duty to warn has been dominated by the question of whether the rulings of the Tarasoff case apply to clients with HIV. Some studies have viewed the Tarasoff decision as indicating that the psychologist is required to warn the third party of the client's HIV status (Gray & Harding,1988), whereas others have argued that the application of the Tarasoff rule to HIV/AIDS related practice is problematic as the risk does not involve the use of violence (Knapp & Vandecreek, 1990). There are no legal precedents with regard to HIV clients who are endangering the lives of others.

Given the relative paucity of guidance and information on psychologists' obligations in HIV–related work, this study aims to explore the extent to which a sample of South African psychologists engage in HIV–related psychotherapy and explores their decision- making process in relation to a case vignette.

3 Aims and hypotheses

The literature reviewed in the previous section suggests that the guidance and practice related to the decision to breach client confidentiality in order to protect third parties in HIV/AIDS related psychotherapy is not clear.

While professional ethics may be informed by codes of ethical principles and professional standards, there is clearly no unambiguous right answer in dealing with the decision to breach client confidentiality when an HIV-positive person is endangering another person by knowingly exposing them to HIV.

The research question guiding this study is to examine how and why psychologists deal with such a situation and to explore the reasons for their decision. The study therefore aims to assess the extent of experience that psychologists have in the field of HIV/AIDS related psychotherapy. The second aim was to assess whether psychologists are prepared to make interventions to protect third parties from HIV infection.

3.1 Hypotheses

3.1.1 This study predicted that higher ratings of dangerousness would be positively associated with the amount of training and clinical experience of psychologists.

3.1.2 Psychologists with less experience with HIV-positive clients would be more likely to breach confidentiality than psychologists with more clinical experience in the field.

3.1.3 The perceived danger of the client's sexual behaviour will vary as a function of the psychologist's (A) age, (B) gender and (C) work setting.

3.1.4 The perceived likelihood of disclosure would vary as a function of the psychologist's (A) age, (B) gender, and (C) work setting.

3.1.5 Psychologists with experience with HIV are more likely to actively intervene and guide the client to disclose his HIV status.

3.1.6 Individually based orientations are more likely to give the individual's right to confidentiality higher priority.

3.1.7 Psychologists with experience and training in HIV-related work are more likely to refer to HPCSA guidelines.

3.1.8 Clinical psychologists would be more familiar with the foundational ethical principles compared to other categories of psychologists namely: research, counseling, educational and industrial.

4 METHOD

4.1 Instrument

The questionnaire utilized in this study was derived from DiMarco and Zoline (2004). The questionnaire consisted of two sections (cf. Appendix B).

In the first part of the questionnaire psychologists were requested to supply information regarding their age, gender, qualification, major therapeutic orientation, primary work setting and clinical and training experience in HIV/AIDS. The questionnaire did not solicit the respondents' names or other identifying information.

The second part of the questionnaire consisted of a case vignette. The vignette involved a story of a 33-year-old who was diagnosed as HIV-positive after an affair with a work colleague. The client was not in a state of readiness to disclose his HIV status to his wife.

4.2 The Case Vignette

This section pertains to the case vignette described in this study.

> You have been seeing Mr.X in therapy for the past three months. Mr. is 33 years old and has been married for the past six years. He has two children: a boy and a girl, ages 5 and 3 respectively.
>
> Mr. X recently admitted to you in the course of a psychotherapy session that he had an extra-marital affair with a work colleague. His wife never found out about the affair, which lasted for about two years. He recently found out that the person with whom he had an affair had died of HIV/AIDS related illnesses. This prompted Mr. X to have an HIV test, the results of which were positive. Mr. X told you that he has no intentions of telling his wife about the test results. He becomes very emotional as he imagines her hurt feelings and the shame it would bring to the family. He is also afraid that his wife will keep the children away from him.

Respondents were asked a combination of questions related to the case vignette (cf. Appendix B). These included rating the extent of dangerousness regarding the client. Respondents answered questions regarding the primary goal in therapy and whether they would breach confidentiality. In addition they were required to motivate the factors that influenced their decision to breach confidentiality.

The study also took into account other factors in the decision-making process. Respondents' were asked to rate the importance of referring to the HPCSA guidelines. The respondents were required to indicate whether they were familiar with the foundational ethical principles and were required to list the principles. Respondents were asked to tick an applicable management plan if the client refused to disclose the information to his wife. Finally respondents

had to indicate whether they had dealt with such a case before and to tick the applicable course they may have taken.

4.3 Reliability

Due to time constraints the questionnaire was not tested first in a pilot study so validity is questionable. The alpha value of .625 with regard to reliability is considered to be satisfactory and suggests that similar results would be obtained from a larger sample size.

4.4 Procedure and Sample

Psychologists from the register with the Health Professionals Council of South Africa were identified by random computer selection. A sample size of 600 psychologists represented 35% of registered psychologists.

A survey questionnaire, a cover letter and a return envelope were posted to each individual (cf. Appendices A & B). The covering letter explained the nature of the research. A total of 154 questionnaires were returned yielding a 25% response rate. Of these, 93 questionnaires, which comprised 60.3% of the replies, were incomplete and these were eliminated from the data analysis.

This study is thus based on 61 complete replies, comprising a rather low 10% of the original mailing. Procedures to increase the response rate such as reminder letters to the respondents were not undertaken due to time and resource constraints. Such measures would possibly have resulted in an increase in the response rate.

5 Results

This chapter presents the results of the study. Characteristics of the sample are described first followed by the results and analyses of the data in respect of the hypotheses. All results were analysed using the Statistical Package for the Social Sciences (SPSS).

5.1 Characteristics of respondents

The results presented in this section show the distribution of the respondents by gender.

Table 1

Distribution of respondents according to gender

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Male	24	39.3	39.3	39.3
	Female	37	60.7	60.7	100.0
	Total	61	100.0	100.0	

The sample, as shown in table 1, comprised of 24 males and 37 females. (There were almost 1.5 times more females than males in this survey). The females constituted 60.7% and the males constituted 39.3% of this sample. This distribution concurs with the prediction made by Richter and Griesel (1999) of a trend towards female dominance of the register after 1996 as paralleled by reports from the USA (DiMarco & Zoline, 2004; Pingitore, Scheffler, Hayley, Sentell & Schwalm, 2001).

5.2 Age

The following graph shows the age of the respondents.

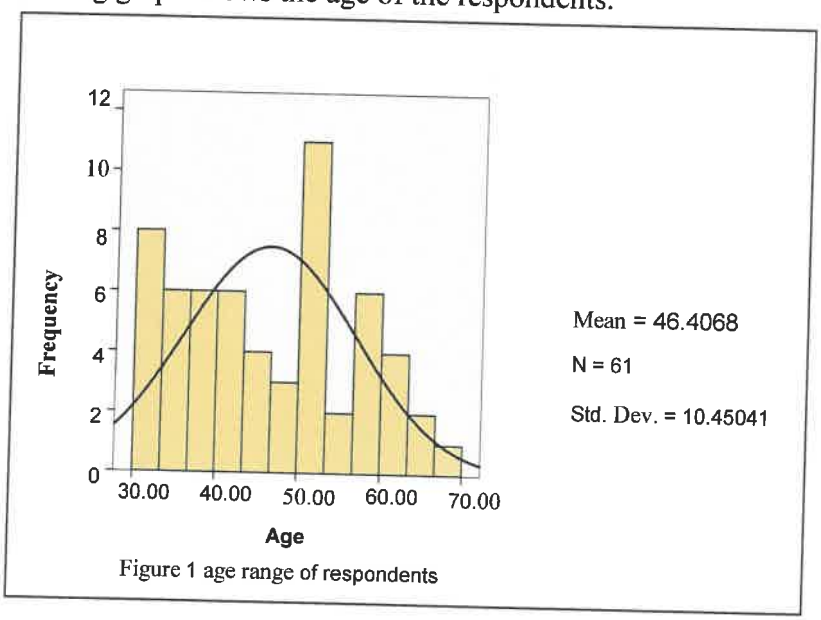

Figure 1 age range of respondents

The mean age of the respondents was 46.4 years. The ages ranged from 30 years to 70 years. The distribution of the ages of the respondents was roughly bell shaped as shown in figure 1. The findings parallel samples on similar issues from the USA (DiMarco & Zoline, 2004; Pais, 1998).

5.3 Years of experience

This section describes the cumulative years of experience of the respondents.

Table 2

Cumulative years of experience of the respondents

Registration Year	Number of persons	Years of experience
1967	1	36
1970	1	33
1977	2	52
1979	2	48
1981	2	44
1982	2	21
1985	1	18
1987	7	16
1989	1	14
1992	3	33
1993	3	30
1994	7	63
1995	7	56
1997	3	18
1998	6	30
1999	4	16
2000	2	6
2001	6	12
2003	1	-
Total	61	546
Average years of experience		9.0

Table 2 shows the total amount of years of experience for the sample of this study which was 546 years. The mean number of years since they registered with the professional board was 9.0 years.

5.4 Qualifications

The results presented in this section show the qualifications of the psychologists that participated in the study and also took into account the highest degree obtained. In South Africa the statutory requirement for registration as a psychologist is an approved Masters degree.

Table 3

Qualification categories of the respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	M.Psych	1	1.6	1.6	1.6
	MA	37	60.7	60.7	62.3
	MBL	1	1.6	1.6	63.9
	MSc	6	9.8	9.8	73.8
	MSOC SC	4	6.6	6.6	80.3
	PhD	12	19.7	19.7	100.0
	Total	61	100.0	100.0	

Table 3 shows that of the 61 respondents (19.7%) indicated that they obtained a PhD with the remainder (80.3%) having obtained a Masters degree. These findings are consistent with the findings of Wassenaar (2002) and are thus likely to be representative of the distribution of these degrees amongst registered psychologists.

5.5 Registration category of respondents

This section describes the sample by registered categories.

Table 4

Registration category of respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
Clinical	37	60.7	60.7	62.3
Counselling	23	37.7	37.7	100
Missing	1	1.6	1.6	1.6
Total	61	100.0	100.0	

Table 4 shows that 60.7% of the respondents were in the Clinical category while 37.7% were counselling psychologists. Research, educational and industrial psychologists did not respond to the study. Wassenaar (2002) found that clinical psychologists were over represented in the register. Scherrer, Louw and Moller (2002) found that clinical psychologists are the largest single category on the register, but did not present data for other categories, stating only that clinical psychologists were numerically over-represented in proportion to the register (35%). The over–representation of clinical psychologists in this study was higher than that reported by Scherrer et al. (2002) but is nevertheless consistent with their findings, and can probably be considered representative in relation to proportions of registered psychologists.

5.6 University of Training

An analysis of the representation of the graduates from the country's training universities was done to determine the representation of the universities in the study. Data from Wassenaar[1] (2002) was included for comparison.

Table 5

University of training of the respondents

University	(n=61)	Percent	Wassenaar (n=4631)
UPE	11	18.0	4.0
Pretoria	7	11.5	21.0
Rhodes	6	9.9	2.0
OFS	5	8.2	7.0
UNISA	5	8.2	10.6
UKZN	4	6.6	2.6
Medunsa	3	4.9	3.5
Stellenbosch	3	4.9	11.0
WITS	3	4.9	6.7
RAU	2	3.3	11.9
UDW	2	3.3	2.0
UWC	1	1.6	0.9
Zululand	2	3.3	3.5
USA	6	9.8	2.0
Other	1	1.6	11.3
TOTAL	61	100	100.0

Table 5 shows the relative distribution of the sample by university of training. Due to a smaller sample size, these figures are less likely than those of Wassenaar (2002) to be proportional to the outputs of these universities. However the Pearson correlation coefficient of 0.960581 indicated a strong correlation between this study and Wassenaar (2002). Of the total, 7 respondents were from overseas institutions and 54 respondents studied at local institutions.

[1] Wassenaar (2002).

5.7 Primary therapeutic orientation

To help with the interpretation of the results of this study respondents were asked to indicate their primary therapeutic orientation.

Primary therapeutic orientation of the respondents

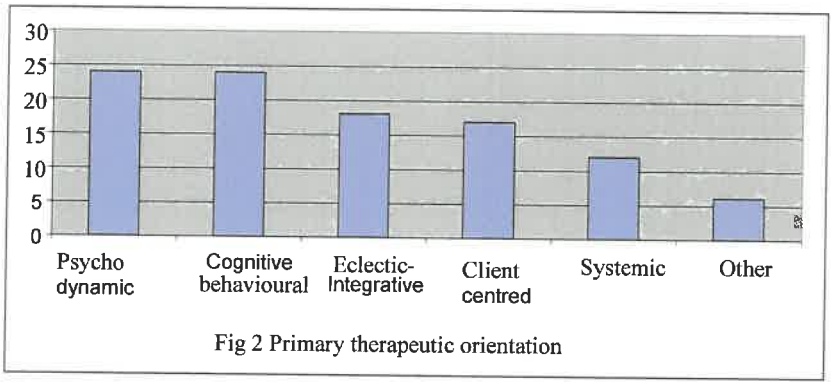

Fig 2 Primary therapeutic orientation

Figure 2 provides an indication of the primary therapeutic orientation of the psychologists who replied to the questionnaire. This hopefully provides a guide to the primary therapeutic orientation of South African psychologists overall. Fig 2 shows that the Psychodynamic and Cognitive behavioral approaches are most commonly used (23.8%) respectively, followed by Eclectic-integrative (17.8%). The results concur with the findings of Bassa and Schlebusch (1984) that individual psychotherapy is the major activity of South African psychologists and parallel patterns described in the USA (DiMarco & Zoline, 2004; Pingitore et al., 2001).

5.8 Primary work setting

A breakdown of the primary work setting provided a useful representation of the major employment setting of the respondents.

Primary work setting of the respondents

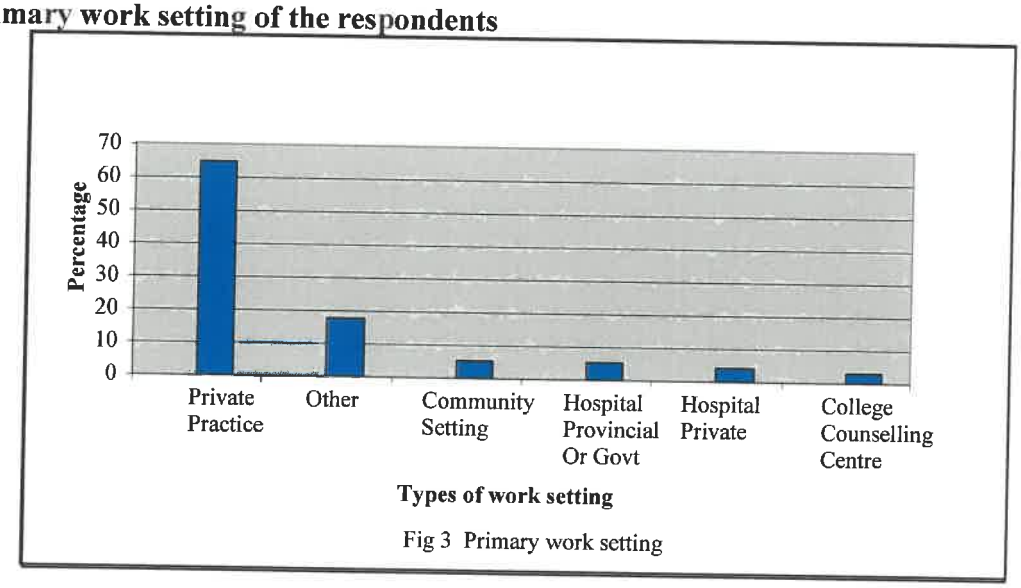

Fig 3 Primary work setting

Figure 3 shows that the overwhelming majority of psychologists who replied to this study were primarily involved in private practice (64.9%), followed by (17, 6%) 'Other' settings (which included government departments other than health and non governmental organisations) (5.4%); government hospital settings, (5.4%), community setting (4. %), private hospital setting, (2.7%) college counselling centres. While the findings of this study are similar to the findings of Wassenaar (2002), university settings were under-represented in this sample compared to the findings of Wassenaar.

The lower number of hospital settings was comparable with American data (Pingitore, Scheffler, Hayley, Sentell & Schwalm, 2001). The present data is possibly a useful representation of major employment settings of South African psychologists (Wilson, Richter, Durrheim, Surendorff & Asafo-Agyei, 1999). No published studies on employment settings of all categories of South African psychologists could be found. However, several studies have reported data on settings of South African clinical psychologists (Bassa & Schlebusch, 1984; Manganyi & Louw, 1986;Slack & Wassenaar, 1999) and one study reported on the settings of clinical and counseling psychologists (Pillay & Petersen, 1996).

5.9 HIV/AIDS Education

In this section respondents were asked whether they had undergone any training in HIV/AIDS as this variable is described as having a significant influence in the decision making process within an HIV-related psychotherapy context (DiMarco & Zoline, 2004).

Table 6

HIV/AIDS Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	32	52.5	52.5	52.5
	No	29	47.5	47.5	100.0
	Total	61	100.0	100.0	

Table 6 indicates that 52.5% had some training in HIV/AIDS education and 47.5% had no training in HIV/AIDS education. These findings are similar to those of DiMarco and Zoline (2004).

5.10 HIV/AIDS Clinical Experience

Following the above section a breakdown of the respondents' clinical experience in HIV/AIDS was considered as a variable in the decision making process with regard to the duty to warn in HIV/AIDS psychotherapy.

Table 7

HIV/AIDS Clinical Experience

	Frequency	Percent
None	16	26.2
Minimal up to 10 cases	27	44.3
Extensive more than 10 cases	18	29.5
Total	61	100..0

Table 7 shows that 26.2% of psychologists with no experience see up to 16 HIV/AIDS related cases, compared to 29.5% of psychologists with extensive experience who see 18 HIV/AIDS related cases. This suggests that psychologists with the least amount of experience are still seeing the same number of cases as psychologists with extensive experience. This trend is consistent with studies in the USA (DiMarco & Zoline, 2004).

5.11 Cross tabulation of the duration of HIV/AIDS education and HIV/AIDS clinical experience

Table 8

Cross tabulation of HIV/AIDS education and HIV/AIDS clinical experience

	Duration of HIV Study	none	Minimal up to 10 cases	Extensive more than 10	Total
	No study	10	14	22	37
	5 Hours	0	1	0	1
	12 Hours	0	1	0	1
	2 days	2	2	1	5
	3 days	1	0	0	1
	5 days	0	1	0	1
	1 week	0	0	1	1
	2 weeks	1	0	1	2
	6 weeks	0	1	0	1
	2 months	0	2	0	2
	3 months	0	1	1	2
	1 year	1	1	2	4
	2 years	1	1	0	2
	7 years	0	1	0	1
Total Mean hours	189.5 hours or (5 months)				
Total		16	27 (3424.63 hours)	18 (1124 hours)	61

Table 8 shows that psychologists with no training and minimal training see almost the same number of cases compared with psychologists with extensive training. The total amount of training as noted is not high, averaging 5 months for a sample that had a mean of 9.0 years' experience.

5.12 Summary of study sample

There were almost 1.5 times more females than males that participated in this survey. Females constituted 60.7% and males constituted 39.3% of the sample. The average age of the respondents in this study was 46.4 years. The average range of experience of this sample was 9.0 years. A majority (80.3%) of the respondents was qualified with a degree in psychology at the Masters level. At least 23% of the respondents graduated in 1994 and 1995. There were proportionally more graduates from UPE, Pretoria, Rhodes and UNISA. A majority of the respondents (60.7%) was in the clinical category and 37.7% were counseling psychologists. Psychodynamic and cognitive behavioural approaches were respectively the most common psychotherapeutic approaches used in this sample. The primary work setting was overwhelmingly private practice, constituting 64.9% of the sample. The HIV/AIDS education level showed that 52.5% of the respondents stated "yes", they did have HIV/AIDS education and 47.5% stated "no", they did not have any HIV/AIDS education. Most of the respondents who did have HIV/AIDS education had received it in a variety of places or institutions. The average length of HIV/AIDS education and training undertaken by the respondents was 5 months.

6 Results of the case vignette

6.1 Assessment of dangerousness

Ratings of the client's dangerousness in terms of the HIV/AIDS risk to his wife ranged from no danger, through to little danger, and to very dangerous.

Table 9

Assessment of dangerousness

		Frequency	Percent	Valid percent	Cumulative percent
	Little danger	1	1.6	1.7	1.7
	Very dangerous	59	96.7	98.3	100.0
	Total	60	98.4	100.0	
Missing	System	1	1.6		
Total		61	100.0		

Table 9 shows that an overwhelming majority (96.7%) of the respondents assessed the patient to be very dangerous in terms of the HIV/AIDS risk to his wife.

6.2 Perceived primary goal in psychotherapy

Respondents were asked to consider their primary goal in psychotherapy. There were four choices, listed below.

(1) To guide the client to disclose his HIV status to his wife
(2) To guide the client not to disclose his HIV status to his wife.
(3) Ignore HIV status as it is unrelated to the psychotherapy
(4) Advise the client to be 100% compliant with condom use.

Ratings of dangerousness in terms of HIV/AIDS risk to wife ranged from no danger, little danger, to very dangerous.

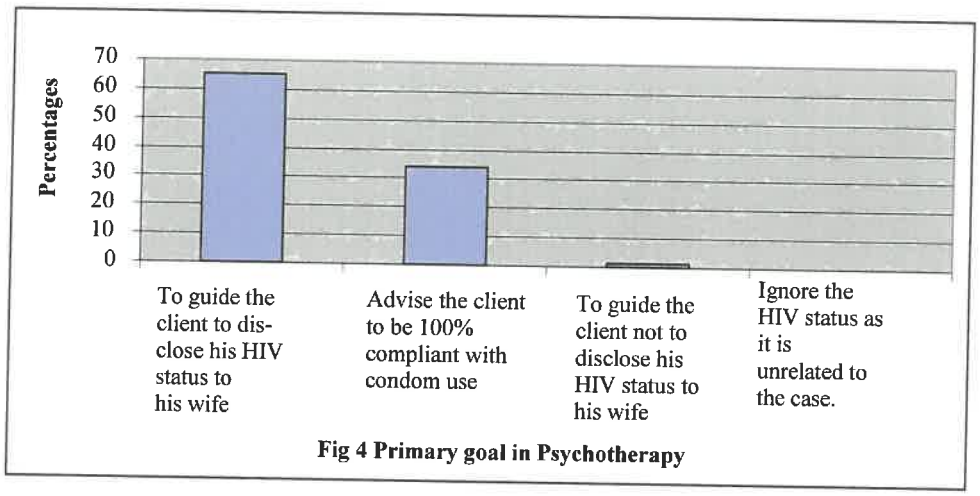

Fig 4 Primary goal in Psychotherapy

Figure 4 shows that 65 % of the respondents indicated that the primary goal in psychotherapy was to guide the client to disclose his HIV status to his wife, while 33.7% of them indicated that they would advise the client to be 100% compliant with condom use.

6.3 Breach of Client Confidentiality

Respondents were asked to decide whether they would breach client confidentiality. Their choice was either yes or no.

Table10

Breach of Client Confidentiality

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Yes	22	36.1	37.9	37.9
	No	36	59.0	62.1	100.0
	Total	58	95.1	100.0	
Missing	System	3	4.9		
Total		61	100.0		

Table 10 indicates that if the client refused to disclose his condition to his wife, 36.1% of the respondents would breach confidentiality by contacting Mrs. X, while 59% would not breach confidentiality and would not contact Mrs. X

6.3.1 Respondents were asked to provide a brief motivation for their decision

Following on from Table 10, 59% would maintain absolute confidentiality, while 36.1% felt it was the duty of the psychologist to disclose information to the wife as her life was in danger.

Figure 5 shows the arguments given by respondents and their relative ranking for maintaining absolute confidentiality.

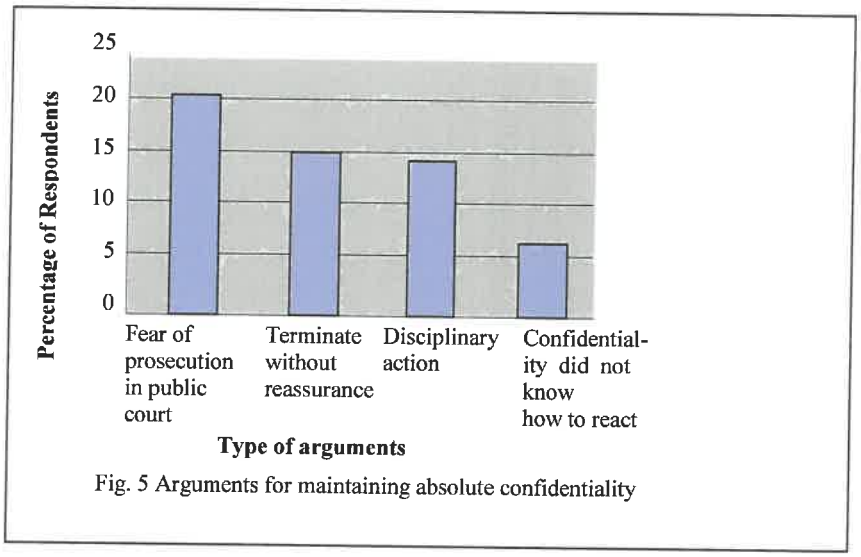

Fig. 5 Arguments for maintaining absolute confidentiality

21% feared prosecution in public courts.
16% feared that the client would terminate without the reassurance of absolute confidentiality, as absolute confidentiality in the therapeutic relationship is taken for granted.
15% indicated fear of disciplinary action
7% would maintain confidentiality as they did not know how they themselves would react.

6.4 Familiarity with HPCSA guidelines

Respondents in this study were asked whether they were familiar with the HPCSA guidelines (2004) regarding management and confidentiality of HIV in-patient care.

Table 11

Familiarity with HPCSA guidelines about informing the client's sexual partner about her risk

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	17	27.9	27.9	27.9
	No	44	72.1	72.1	100
	Total	61	100.0	100.0	

Table 11 shows that 72.1% of the respondents were not familiar with the HPCSA guidelines about informing the client's sexual partner about her risk.

6.5 Familiarity with the Foundational Ethical Principles

Respondents were asked whether they were familiar with the foundational ethical principles to assist in understanding the ethical issues contained in this case.

Table 12

Familiarity with the foundational ethical principles

		Frequency	Percent	Valid percent	Cumulative percent
Valid	Yes	29	47.5	50.0	50.0
	No	29	47.5	50.0	100.0
	Total	58	95.1	100.0	
Missing	System	3	4.9		
Total		61	100.0		

There was an equal number of respondents (47.5%) who indicated 'yes' and who indicated 'no' regarding familiarity with the foundational ethical principles that would assist in the understanding of ethical issues in this case.

6.5.1 Ethical Principles

Respondents were asked to list the five foundational ethical principles or as many as they could recall. These principles are as follows: respect for autonomy, beneficence (do good), nonmaleficence, (do no harm), fidelity (be faithful or trustworthy), and justice (Anderson & Barret, 2001).

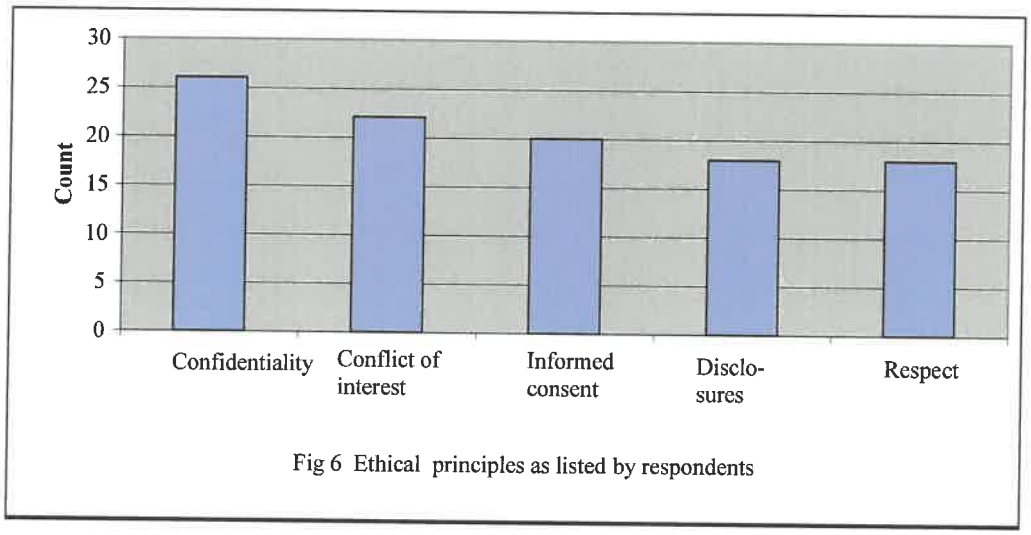

Fig 6 Ethical principles as listed by respondents

None of the respondents in this study were able to identify or correctly list the foundational ethical principles. Instead, they listed the concepts seen above in Figure 6. These concepts, which are considered to be vague, indicate a lack of knowledge of the actual principles.

6.6 Management Plan

In this study respondents were asked about their management plan if the client refused to disclose his HIV/AIDS status to his wife. The following options were provided:

(1) Terminate therapy with the client;
(2) Contact the wife and inform her about the client's decision;
(3) Address the issues that discourage disclosure;
(4) Respect the client's wish and continue with psychotherapy;
(5) Other options that they could specify.

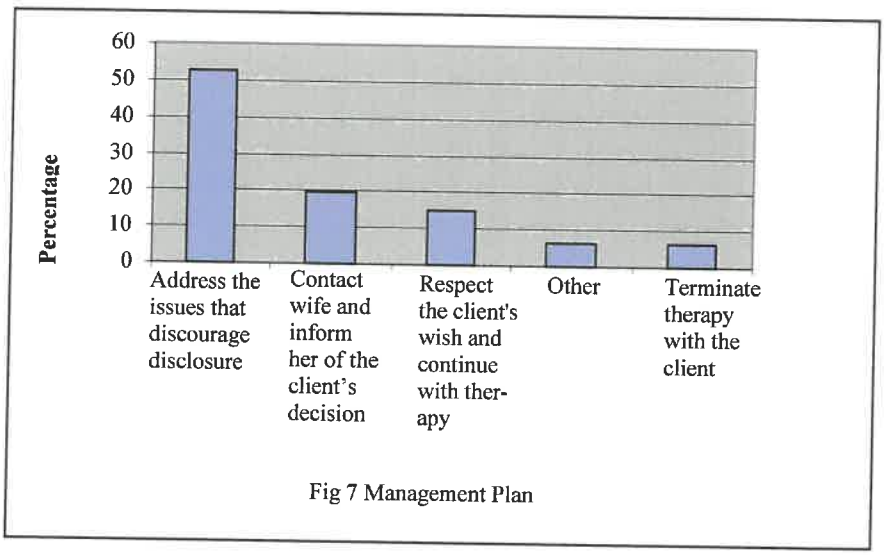

Fig 7 Management Plan

Figure 7 shows that the majority (56.9%) would address the issues that discourage disclosure. While 19.7% of the respondents in this study would contact the wife and inform her about the client's decision. A further 11.5% said they would respect the client's wish and continue with therapy.

6.7 Experience

In this section respondents were asked whether they had experience with such a case.

Table 13

Experience with such a case

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	13	21.3	21.3	21.3
	No	48	78.7	78.7	100.0
	Total	61	100.0	100.0	

Table 13 shows that in practice 21.3% had dealt with a case similar to that in the case study, while 78.7% had never dealt with such a case

6.8 Intervention

In this section respondents were asked to indicate the nature of their intervention in dealing with such a case. The options provided included:

(1) Consult a supervisor or colleague;
(2) Consult the HPCSA guidelines;
(3) Consult a decision-making model;
(4) Refer to another professional;
(5) Ignore the issue;
(6) List other options that may be considered.

Table 14

Nature of intervention

	Frequency	Percent
Consult supervisor/colleague	26	43
Consult the HPCSA guidelines	8	13
Refer to another professional	5	8.2
Consult a decision making model	9	14.6
Other	6	9.8
Ignore the issue	7	11.4
Total	61	100..0

Table14 shows that 43% would consult a supervisor or colleague, while 13% would consult HPCSA guidelines. A small proportion (11.5%) said they would ignore the issue.

6.9 Summary of results of the case vignette

An overwhelming 96.7% of the respondents in this study assessed the patient to be very dangerous in terms of HIV/AIDS risk to his wife. A large percentage (65%) of the respondents indicated that the primary goal in psychotherapy was to guide the client to disclose his HIV status to his wife. Only 36.1% of the respondents indicated that they would breach confidentiality, while 59% indicated that they would not breach confidentiality and would not contact Mrs. X. A large percentage of the respondents in this study (72.1%) were not familiar with the HPCSA guidelines about informing the client's sexual partner about her risk. There was an equal number of respondents (47.5%) who indicated 'yes' and who indicated 'no' regarding familiarity with the foundational ethical principles. However none of the respondents in this study were able to correctly list the foundational ethical principles. With regard to the management plan, 56.9 % indicated that they would address the issues that discourage disclosure while 11.5% indicated that they would respect the client's wish and continue therapy. A large majority 78.7% of the respondents had not dealt with such a case. A further 43% of the respondents suggested that they would consult a supervisor or colleague with regard to the nature of the intervention that they would choose.

7 Hypotheses

This section presents the results of the hypotheses

7.1 Ratings of dangerousness as a function of respondents training and clinical experience

The following results relate to Hypothesis 3.1.1 of this study. Hypothesis 3.1.1 predicted that higher ratings of dangerousness would be positively associated with the amount of training and clinical experience of psychologists. Spearman's rank order coefficient was used to test this hypothesis and the results are summarized in table 15. Significant results are indicated in bold type.

Table 15

Spearman's rank order correlation coefficient of the relationship between ratings of dangerousness and the amount of training and clinical experience

			Q5	Q6	Cv1	Cv2	Cv3a
Spearman's Rho	Q5	Correlation Coefficient	1	0.005	-0.135	0.071	-0.098
		Sig. (2-tailed)		0.97	0.305	0.589	0.464
		N	61	61	60	61	58
	Q6	Correlation Coefficient	0.005	1	-0.169	391(**)	0.052
		Sig. (2-tailed)	0.97		0.197	0.002	0.701
		N	61	61	60	61	58
	Cv1	Correlation Coefficient	0.071	391(**)	0.039	1	0.122
		Sig. (2-tailed)	0.589	0.002	0.766		0.361
		N	61	61	60	86	58
	Cv3a	Correlation Coefficient	-0.098	0.052	-0.106	0.122	1
		Sig. (2-tailed)	0.464	0.701	0.433	0.361	
		N	58	58	57	58	58

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

Table 15 shows that at the 5% significance level Question 6 of the questionnaire (HIV/AIDS clinical experience) and Question 1 (degree of dangerousness) of the case vignette are dependent since the p-values are less than 0.05. The findings indicate a positive association between the two questions, suggesting that higher ratings of dangerousness are positively associated with the amount of training and clinical experience of the psychologists. The p-values for the rest of the questions were greater than 0.05, which indicates that higher ratings of dangerousness were not positively associated with them. These results provide partial support for Hypothesis 3.1.1 of this study.

7.2 Breaches of confidentiality as a function of psychologists' experience

The following results relate to Hypothesis 3.1.2 of this study, which predicted that psychologists who had experience with AIDS patients in psychotherapy would be less likely to breach confidentiality compared to those with no experience.

The breach of confidentiality variable was determined by comparing the extent of clinical experience (Question 6, table 16) and HIV/AIDS education (Question 5) to the perceived primary goal in therapy (Question 2 of the case vignette).

Table 16

The cross tabulation of Hypothesis 2 related to Question 6

Professional categories		Cross tabulation of Question 6 of the case vignette. None	Minimal up to 10 cases	Extensive more than 10 cases	Total
Clinical Experience	Clinical	16	21	1	38
	Counselling	0	6	17	23
Total		16	27	18	61

Table 17
Results of Chi-square tests of breaches of confidentiality with regard to Question 6

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	40.259(a)	2	.000
Likelihood ratio	51.277	2	.000
Linear-by-linear association	34.823	1	.000
Number of Valid Cases	61		

Table 17 shows the Chi-square test, which indicates that at the 5% level Question 2 (primary goal in therapy, table 18) and Question 6 (HIV/AIDS clinical experience, table 16) are associated since the p-values are less than 0.05. This indicates a positive association between these questions.

Table 18

The cross tabulation of Hypothesis 2 related to Question 2 of the case vignette

Professional categories		Cross tabulation of question 2 of the case vignette.			Total
		guide the client to disclose	guide the client not to disclose	ignore the HIV status	
Clinical Experience	Clinical	37	0	0	37
	Counselling	19	2	3	24
Total		56	2	3	61

Table 19

Results of Chi-square tests of breaches of confidentiality in Question 5

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.894(a)	2	.032
Likelihood Ratio	8.138	2	.017
Linear-by-Linear Association	6.362	1	.012
N of Valid Cases	61		

Table 19 shows the Chi-square test, which indicates that at the 5% level, Question 5 (HIV/AIDS education) and Question 2 of the case vignette (primary goal in therapy) are associated since the p-values are less than 0.05. This indicates a positive association between these questions.

The chi-square tests (tables 17 and 19) and cross tabulation (tables 16 and 18) indicate that psychologists with HIV/AIDS education and with clinical experience are likely to guide the client to disclose his HIV-positive status rather than breaching confidentiality. This finding provides support for Hypothesis 3.1.2 of this study.

7.3 Perceptions of danger and psychologists' demographics

The results in this section relate to Hypothesis 3.1.3 of this study, which predicted that the perceived danger of the client's sexual behaviour would vary as a function of the psychologists' (A) age, (B) gender and (C) work setting.

ANOVA tests exploring the relationship between the psychologists' perceived danger of the client's sexual behaviour and the psychologists' demographics (age, gender and work setting) yielded certain significant associations. These results are summarized in the following tables.

7.3.1 Perceived danger of the client's sexual behaviour and the psychologists' age

Table 20

ANOVA results of the psychologists' perceived danger of the client's sexual behaviour and the psychologists' age

Age group	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	.036	3	.012	.691	.562
Within Groups	.947	55	.017		
Total	.983	58			

Table 20 shows that the p-value at the 5% level is greater than 0.05. It can therefore be concluded that the perceived danger of the client's sexual behaviour did not vary as a function of the psychologist's age. The results did not provide support for Hypothesis 3.1.3 (A) of this study.

7.3.2 Perceived danger of the client's sexual behaviour and the psychologists' gender

Table 21

ANOVA results of the psychologists' perceived danger of the client's sexual behaviour and the psychologists' gender

Gender	Sum of Squares	Df	Mean Square	F	Sig.
Between groups	.027	1	.027	1.626	.207
Within groups	.957	58	.016		
Total	.983	59			

Table 21 shows that the p-value at the 5% level is greater than 0.05. It can therefore be concluded that the perceived danger of the client's sexual behaviour did not vary as a function of the psychologist's gender. The results did not provide support for Hypothesis 3.1.3 (B) of this study.

7.3.3 Perceived danger of the client's sexual behaviour and the psychologists' work setting

Table 22

ANOVA results of the psychologists' perceived danger of the client's sexual behaviour and the psychologists' work setting

Work setting	Sum of Squares	Df	Mean Square	F	Sig.
Between groups	.233	4	.058	4.278	.004
Within groups	.750	55	.014		
Total	.983	59			

Table 22 shows that the p-value at the 5% level is less than 0.05. It can therefore be concluded that the perceived danger of the client's sexual behaviour did vary as a function of the psychologist's work setting. Least Square Differences in Appendix C shows that psychologists in private settings were more likely to perceive the client's sexual behaviour as dangerous. The findings provide support for Hypothesis 3.1.3 (C) of this study.

7.4 Likelihood of disclosure and psychologist's demographics

The results in this section relate to Hypothesis 3.1.4 of this study, which predicted that the perceived likelihood of disclosure would vary as a function of the psychologists' (A) age, (B) gender and (C) work setting.

ANOVA tests exploring the relationship between the perceived likelihood of disclosure and the psychologists' demographics (age, gender and work setting) yielded certain significant associations. These results are summarized in the following tables.

7.4.1 Perceived likelihood of disclosure and the psychologists' age

Table 23

Anova results of the perceived likelihood of disclosure and the psychologists' age

Age group	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	1.174	3	.391	1.489	.228
Within Groups	14.453	55	.263		
Total	15.627	58			

Table 23 shows that the p-value at the 5% level is greater than 0.05. It is concluded that the likelihood of disclosure did not vary as a function of the psychologist's age. The results did not provide support for Hypothesis 3.1.4 (A) of this study.

7.4.2 Perceived likelihood of disclosure and the psychologists' gender

Table 24

Anova results of the perceived likelihood of disclosure and the psychologists' gender

Gender	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	.444	2	.444	1.718	.195
Within Groups	15.229	59	.258		
Total	15.672	61			

Table 24 shows that the p-value at the 5% level is greater than 0.05. It is therefore concluded that the likelihood of disclosure did not vary as a function of the psychologist's gender. The results did not provide support for Hypothesis 3.1.4 (B) of this study.

7.4.3 Perceived likelihood of disclosure and the psychologists' work setting

Table 25

Anova results of the perceived likelihood of disclosure and the psychologists' work setting

Work setting	Sum of Squares	Df	Mean Square	F	Sig.
Between groups	51.779	56	10.356	1056.297	.000
Within groups	.667	5	.010		
Total	52.446	61			

Table 25 shows that the p-value at the 5% level is less than 0.05. It is therefore concluded that the likelihood of disclosure varied as a function of the psychologist's work setting. Least square differences in Appendix D shows that psychologists in private practice were more likely to make a disclosure compared to other work settings. The results provide partial support for Hypothesis 3.1.4 (C) of this study.

7.5 HIV/AIDS clinical experience as a function of the psychologists' active intervention to guide the client to disclose

The results in this section relate to Hypothesis 3.1.5 of this study, which predicted that psychologists with experience with HIV will be more likely to actively intervene and guide the client to disclose his HIV status. The results of the ANOVA are summarized in table 26. A

cross tabulation of this hypothesis by using least square differences is presented in Appendix E of this study.

Table 26

ANOVA results of the psychologists' decision to actively intervene

Clinical experience	Sum of Squares	Df	Mean Square	F	Sig.
Between groups	3.172	3	1.586	7.359	.001
Within groups	12.500	58	.216		
Total	15.672	61			

Table 26 shows that the p-value at the 5% level is less than 0.05. It is concluded that psychologists with experience with HIV are more likely to actively intervene and guide the client to disclose his HIV status. The findings provide support for Hypothesis 3.1.5 of this study.

7.6 Relationship of the psychologists' theoretical orientation to confidentiality

The results in this section relate to Hypothesis 3.1.6 of this study, which predicted that individually based orientations are more likely to give the client's rights to confidentiality higher priority compared with system approaches. The results of the ANOVA are summarized in table 27.

Table 27

ANOVA results of the psychologists' theoretical orientation to confidentiality

		Sum of Squares	Df	Mean Square	F	Sig.
Question 6 of the case vignette	Between groups	181.977	5	36.395	357.679	.000
	Within groups	9.667	95	.102		
	Total	191.644	100			
Question 8 of the case vignette	Between groups	42.569	3	14.190	62.758	.000
	Within groups	15.375	58	.226		
	Total	57.944	61			

Table 27 shows that the p-value at the 5% level is less than 0.05. It can therefore be concluded that individually based orientations are more likely to give the client's rights to confidentiality higher priority than the systems approaches. Least square differences in Appendix F show exactly where these differences are. The results provide support for Hypothesis 3.1.6 of this study.

7.7 HIV/AIDS clinical experience and training as a function of referral to HPCSA guidelines

The results in this section relate to Hypothesis 3.1.7 of this study, which predicted that psychologists with clinical experience and training in HIV/AIDS would be more likely to refer to HPCSA guidelines. Results of the Chi-square tests are summarized in table 28 with significant results indicated in bold type.

Table 28

Results of Chi-square tests of clinical experience and training in HIV/AIDS and referral to HPCSA guidelines

Question 4 of case vignette	None Vs up to 10 cases	None Vs more than 10 cases	Education Vs no education
Mann-whitney U	135.500	69.500	361.500
Wilcoxon W	486.500	240.500	796.500
Z	-1.734	-2.547	-1.219
Asymp. Sig. (2-tailed)	.083	.011	.223

a Not corrected for ties.
b Grouping variable: redo6

Table 28 shows that the p-value at the 5% level is less than 0.05 for the first two columns. This indicates that psychologists with more clinical experience in HIV/AIDS are likely to refer to HPCSA guidelines. The results provide support for Hypothesis 3.1.7 of this study.

7.8 Psychologists' registration categories versus familiarity with foundational ethical principles

The results in this section relate to Hypothesis 3.1.8 of this study, which predicted that clinical psychologists would be more familiar with the foundational ethical principles than other categories of psychologists.

Table 29

Results of chi-square tests of psychologists' registration categories and familiarity with the foundational ethical principles

	Question 6 of case vignette
Mann-whitney U	22.500
Wilcoxon W	725.500
Z	-6.506
Asymp. Sig. (2-tailed)	.000

A grouping variable: Clinical experience

Table 29 shows that the p-value at the 5% level is less than 0.05. It is therefore concluded that clinical psychologists were more familiar with the foundational ethical principles as

compared to other categories of psychologists. Table 30 shows a cross tabulation of this hypothesis which further confirms the result. The results provide support for Hypothesis 3.1.8 of this study.

Table 30

Cross tabulation of Hypothesis 8

	Clinical	Counselling	Total
Conflict of interest	11	6	17
Disclosures	13	8	21
Informed consent to professional procedures	16	9	25
Rights to confidentiality and limits of that rights (Autonomy)	11	6	17
Respect for human rights and others (fidelity)	12	7	19

7.9 Summary of results of the hypotheses

In this study the degree of dangerousness was not positively correlated with the amount of training and clinical experience of psychologists. The findings suggested that psychologists, on the whole, regarded the client to be very dangerous with regard to HIV/AIDS risk to his wife. Despite similarities in gender and age, psychologists' work setting significantly influenced the psychologists' perceptions of the client's sexual behaviour and the likelihood of disclosure. The findings of the study suggest that psychologists' in private practice were more likely to perceive the client as dangerous and therefore more likely to make a disclosure to the wife compared to other work settings. The findings of this study also suggest that psychologists with greater experience were more likely to actively intervene and would guide the client to disclose his HIV status to his wife compared to psychologists with less clinical experience who would be more likely to breach confidentiality. The results of this study also found that HIV experienced psychologists are more likely to refer to HPCSA guidelines. While the results provide support for the hypothesis that clinical psychologists are more familiar with foundational ethical principles, the findings also reflect a greater response rate from clinical psychologists compared to the other categories. The implications of these findings are discussed in a later section.

8 Discussion

In this section, the results of this study and its limitations are discussed and integrated with relevant research. Since the findings of the case vignette and hypotheses are similar their findings are combined and described in greater detail in this section.

8.1 Assessment of dangerousness

In this study a majority (96.7%) of the respondents assessed the client to be very dangerous in terms of HIV/AIDS risk to his wife, irrespective of the amount of training and clinical experience in HIV/AIDS related psychotherapy. These findings support previous research findings that psychologists considered the degree of dangerousness to be the most important factor in HIV/AIDS related psychotherapy (DiMarco & Zoline, 2004; Pais, 1998; Stewart & Repucci, 1994; Totten, Lamb & Reeder, 1990).

DiMarco and Zoline (2004) argued that in assessing the degree of dangerousness, psychologists must take into account the credibility of the patient, the perceived degree of concern for the identifiable sexual partner and the overall sense of social responsibility. A limitation of this study compared to the one cited above is that it only took into account an assessment of the degree of dangerousness and it failed to take into account the exact meaning of dangerousness and how it could be assessed. Thus, future research in this area could focus on examining specific variables associated with the assessment of dangerousness.

8.2 Breach of Client Confidentiality

Respondents were asked whether they would breach confidentiality by contacting the client's wife if the client refused to consider informing her himself.

In this study almost 59% of the respondents reported that they would not breach confidentiality and 36.1% reported that they would breach confidentiality and contact the client's wife. On the other hand this study indicated that respondents with HIV clinical experience were less likely to breach confidentiality than respondents with minimal or no clinical experience.

In keeping with these findings DiMarco and Zoline (2004) found that 67% of psychologists who considered breaching confidentiality rated the degree of risk that the client presented to their unsuspecting spouse as significant in the decision to breach confidentiality. They also found that psychologists with less experience who breached confidentiality considered the degree of risk to be the client's inability to contract for safe sex and the level of client denial. These factors had significantly more influence in their decision-making compared to those who maintained confidentiality. They also felt that they had a moral obligation and duty to the partner. In their study, DiMarco and Zoline (2004) also found that 33% of the respondents who reported that they would maintain absolute confidentiality were primarily concerned with maintaining the psychotherapeutic relationship. Previous studies (Pais, 1998; Schlossberger, 1996) however, found that psychologists who lacked experience in

HIV/AIDS counselling were less thoughtful about the therapeutic alliance and therefore were more likely to breach confidentiality. According to Schlossberger (1996), experienced psychologists were more interested in helping the client with the psychological responses (denial, anger, shame, depression and anxiety) associated with HIV/AIDS. She also found that experienced psychologists also took into account psychological obstacles such as the client's inability to negotiate safer sex, disempowerment, and low self-esteem, which influenced the client's ability to act responsibly. Schlossberger (1996) indicated that compared to inexperienced psychologists, experienced psychologists viewed the client's external behaviour as mirroring an internal process of struggle and conflict, which she maintained could not be resolved by a therapeutic breach of confidence.

Baird, Laing and Rupert (1987) reported that 95% of psychologists in their study believed that clients expected communication to remain confidential. However many psychologists stated that they would breach confidentiality under circumstances where there was a danger for third parties or because of statutory requirements.

On the whole the findings of this study were consistent with those found in earlier work, indicating that exposure to HIV/AIDS clinical experience has a significant effect on the decision whether to breach confidentiality or not. A limitation of this study was that it did not take into account the factors that influenced the psychologists to breach confidentiality and therefore comparisons with other studies could not be made.

8.3 The perceived danger of the client's sexual behaviour as a function of the psychologist's age, gender and work setting

Many theorists have postulated that ethical decisions may be consistently linked to the individual characteristics of decision-makers (Tymchuk, 1986; Keith-Spiegel & Koocher, 1985; Gilligan, 1982). On the whole, the results of this study did not show that that perceived danger of the client's sexual behaviour varied as a function of the psychologist's age and gender. These findings were consistent with the findings of Pais (1998) and Totten et al. (1990). Haas et al. (1988) similarly found that generally female and male psychologists did not differ from each other with regard to the choices they make. They found that despite differences in gender, age and experience levels, respondents in their study were more alike than dissimilar in their choices of ethical dilemmas.

The findings of this study on the other hand suggest that perceptions of the client's sexual behaviour varied as a function of the psychologist's work setting. Psychologists' in private practice were more likely to perceive the client as dangerous compared to other work settings. This inversely supports the findings of Pais (1998), who found that psychologists who practiced in urban areas tended to perceive clients engaging in unprotected sex as more dangerous than psychologists practicing in rural areas. Contrary to Pais (1998) and the present study, previous studies (Totten et al., 1990; Haas et al., 1988) found no relationship between work setting and the choice of action. They attributed this to the possibility that there may be a general professional ethic to which psychologists subscribe, regardless of the particular pressures of their work setting.

8.4 The perceived likelihood of disclosure as a function of the psychologist's age, gender and work setting

Pais (1998) found that older psychologists, as compared to younger psychologists, were more likely to make a disclosure when the client was engaging in unprotected sex. They also found that other characteristics such as the psychologist's religious background and degree of religiosity were influential with regard to the perceived danger of the client's sexual behaviour and perceived likelihood of disclosure.

The findings of this study did not find any differences with regard to psychologists' age and gender and the likelihood of disclosure, which supports earlier findings discussed in the previous section (Haas et al., 1988). However this study found that the likelihood of disclosure varied considerably according to the work setting. Psychologists' in private practice were more likely to make a disclosure to the wife compared to other work settings. This finding supports the view of Pais (1998), which suggests that varied responses with regard to work setting are possibly due to variations in the central concepts of privacy and confidentiality, especially with regard to the location of the psychologists' practice, which was discussed in the previous section.

8.5 Clinical experience

This study showed that psychologists with more clinical experience were more likely to actively deal with the issue and guide the client to disclose his HIV status. This lends support to the findings of DiMarco and Zoline (2004). However the findings are contradictory to the findings of Haas et al. (1988). Their study found that psychologists with greater experience were less likely to deal actively with ethical issues. Haas et al. (1988) maintain that their study may have reflected the general ethic of that time insofar that only in recent years has the psychologist's duty to actively intervene become more clearly defined. Furthermore, they intended to interpret their finding as evidence of a greater level of cynicism that accrues to experienced psychologists with regard to their ability to actively intervene to bring about change. In line with their reasoning, the results of this study are encouraging in that this sample of South African psychologists indicated a tendency to be active about ethical issues, thus providing support for the findings of Slack (1997).

8.6 Theoretical orientation

The results of this study support the assumption that theoretical perspectives influence ethical decision-making, which was postulated by Haas et al. (1988). This study found that psychologists with individually-based orientations gave higher priority to confidentiality than those with a systems approach, which is consistent with the findings of Haas et al. (1988).

However the difference in the findings is that Haas found systems theorists to be evenly divided on the issue of confidentiality, which was not explored in this study. Haas argues that this finding is consistent with the theoretical understanding of the whole system as the client.

8.7 Familiarity with HPCSA guidelines

While the findings of this study showed a significant relationship between HIV/AIDS clinical experience and referral to HPCSA (2004) guidelines, the majority of respondents were not familiar with HPCSA (2004) guidelines which advocate guiding the client to disclose his/her status to his/her partner. This finding clearly highlights two critical areas in the field of ethics training. The first is that the respondents clearly do not refer to HPCSA guidelines in their practice. The second may imply that the guidelines may be vague and therefore may not provide the psychologist with specific and tangible guidance related to the disclosure to third parties.

Another critical finding, emphasized by Bersoff (1995), is that ethical issues in general may be relatively neglected in the professional literature. He reviewed 250 counselling and psychotherapy texts and found that only 2.8% dealt with ethical guidelines (APA, 1992). Pais (1998) found that due to a lack of clarity in the guidelines psychologists find the decision-making process a struggle when counselling HIV-positive clients who refused to disclose to third parties at risk. In an earlier study Slack (1997) found that respondents in her study experienced existing guidelines to be inexact and difficult to apply to a specific situation. The results therefore suggest that uncertainty about ethical guidelines is still widespread.

8.8 Familiarity with the foundational ethical principles

Respondents were asked whether they were familiar with the foundational ethical principles related to the case vignette and to list as many of the principles as they could recall. There were an equal number of respondents (47.5%) who indicated 'yes' and who indicated 'no' regarding familiarity with the foundational ethical principles. However none of the respondents in this study were able to identify or correctly list the ethical principles. It is important to note that while the findings of this study provide support for the hypothesis that clinical psychologists were more familiar with foundational ethical principles, such findings should be interpreted with caution as the sample of this study consisted mainly of clinical psychologists, with only a small percentage from other categories responding to the study.

The findings of this study suggest either that respondents may lack clarity about the foundational ethical principles or that they may lack adequate training in ethics. Furthermore, it is possible that these findings suggest that the respondents lack the willingness to take action when confronted with an ethical dilemma.

None of the studies reviewed attempted to relate the registration categories of psychologists to the foundational ethical principles. Many studies, however, made recommendations for more training in the implementation of the foundational ethical principles. This will be discussed in a later section.

8.9 Perceived primary goal in therapy

A majority (65.1%) of the respondents in this study indicated that their primary goal in psychotherapy would be to guide the client to disclose his HIV status to his wife, while 33.7% indicated that they would advise the client to be 100% compliant with condom use.

These results are consistent with DiMarco and Zoline (2004) who found that a majority of participants in their study (68%) indicated that they would guide the client to disclose his HIV status to his partner. Their study found that 45% of male heterosexual respondents had lied about their past sexual behaviour to their partners and more than 30% would lie to their sexual partners about their positive HIV status. The findings of DiMarco and Zoline (2004) could not be compared with this study as it did not take into account the perceptions of the client.

Pais (1998) suggests that in guiding the client to disclose his HIV status, the psychologist needs to consider ways to improve the couple's relationship, as an improvement in the relationship may eventually lead to a voluntary disclosure. No such association was made in this research, as psychologists were not required to explain how they would guide the client to disclose his HIV-status. Perhaps future research could focus on how to encourage voluntary disclosure, since there is very little literature on this subject related to HIV-psychotherapy.

8.10 Intervention

The findings of this study indicate that 43% of the respondents would consult a supervisor or colleague. This is consistent with DiMarco and Zoline (2004), who reported that the same percentage of respondents in their study where prepared to seek out both peer and legal consultation.

Knapp and Vandecreek (1993) suggest that seeking out professional consultation offers the psychologist support and may also assist in highlighting the state laws or guidelines regarding the duty to warn. Totten et al. (1990) suggest that given the disparity of opinions regarding the applicability of Tarasoff principles to HIV-related psychotherapy, psychologists need to focus on an agreement of appropriate factors that may be part of the decision-making process related to the duty to warn.

8.11 Experience with such a case

The findings of the present study indicate that in practice only 21.3% had dealt with a similar case to that of the vignette, while 78.7% had never dealt with such a case. These findings are consistent with DiMarco and Zoline (2004), who reported that 77% of the respondents in their study had minimal or no experience working with HIV populations and 23% reported a moderate level of experience. DiMarco and Zoline (2004) further report that of those participants with minimal or no experience 72% considered breaching confidentiality.

These results indicate that a high percentage of clinical psychologists may not have adequate experience in the field of HIV-related psychotherapy. In view of the findings, DiMarco and Zoline (2004) suggest that more discussion and training is needed in this area. Training is also important so that psychologists become familiar with the complexities of ethical decision-making with HIV-positive clients before encountering them in practice.

8.12 Management plan

In this study 56.9% of the respondents indicated that they would address the issues that discourage disclosure, while 11.5 % of the respondents indicated that they would respect the client's wish and continue with psychotherapy. These findings are consistent with earlier research. DiMarco and Zoline (2004) reported that at least 62% of the respondents in their study would address the issues that discourage disclosure. The common thread however in both the studies is that the respondents still value confidentiality. This is consistent with the findings of Chenneville (2000), that psychologists strongly emphasize confidentiality in their management plan in ethics courses.

9 Summary of discussion

Respondents in this study agreed that the client was very dangerous with regard to HIV/AIDS risk to his wife. A significant majority (65.1%) also seemed to agree that the primary goal in psychotherapy would be to guide the client to disclose his HIV status to his wife. The findings of this study are consistent with results of earlier research with regard to the duty to warn in the context of HIV/AIDS related psychotherapy (DiMarco & Zoline, 2004; Pais, 1998). The findings in this study further indicate that respondents still value absolute confidentiality within the psychotherapeutic relationship. Some of the reasons given for absolute confidentiality appear to reflect a fear of being prosecuted in court (DiMarco & Zoline, 2004). Many other researchers (e.g., DiMarco & Zoline, 2004; Anderson & Barret, 2001), including this study, found evidence of a lack of experience amongst the respondents in dealing with the duty to warn in the case of HIV/AIDS related psychotherapy. There is also evidence of poor ethical awareness regarding ethical guidelines and the foundational ethical principles.

The findings of this study can be interpreted as indicating that there is still a need for guidance in the area of HIV/AIDS related psychotherapy. An alternative interpretation could be that psychologists need to be sensitive to ethical decision-making when dealing with ethical dilemmas rather than being comfortable with the ethical decisions that they make (Bersoff, 1995).

10 Study limitations

There are several limitations of this study that reduce the generalisability of the findings. These factors include the hypothetical case scenario, the small sample, and the relatively weak reliability and untested validity of the instrument.

Firstly, the case vignette was a hypothetical situation rather than a real case study. Though the scenario may have seemed unrealistic, this was not pointed out by any of the respondents. The scenario was constructed as a person, alone in a session with a psychologist, causing or potentially causing harm, which thus provokes an ethical dilemma for the psychologist. Although this may have achieved its purpose in this study, this scenario must be viewed as limited in scope. Bersoff (1995) argues that given the hypothetical situations in most research, many trainee psychologists fail to recognize ethical issues in a clinical setting which therefore limits their competency in the field. Furthermore, the psychologist's ability to apply all relevant standards of the codes to case vignettes is limited (Pais, 1998). Therefore, the use of hypothetical situations in future research in ethics is of limited use.

Furthermore, it is possible that the scenario in this study is based on Western philosophical thinking, which may appear incongruent to other cultural standards and values. In view of the aforementioned, the study failed to take into account the views of psychologists in smaller rural communities, or from various cultural groups. The results of the study therefore appear to present the view of a more urbanized population. Bersoff (1995) argues that an ethical violation is usually quite clear within an urban setting, however in rural settings personal and professional roles can become blurred. Yet urban and rural differences have yet to be adequately addressed in research.

The response rate of 25% with 10% (±) usable responses may reflect a bias in respondents and raises a concern about the degree to which the final sample may be representative of the population of practicing psychologists.

The responses to this study may be representative of those psychologists who show greater concern over ethical issues thereby biasing the results (Kalichman et al., 1998). Furthermore, there is the possibility that the respondents have given responses that corresponded more closely to ethical regulations in order for responses to appear socially desirable.

Further limitations of this study relate to the questionnaire used to assess ethical decision-making. As the validity of the questionnaire was not established, the extent to which the instrument reflects what respondents would ethically do in real life is limited.

Another limitation of the questionnaire was that it elicited forced choices and did not take into account complex multifaceted responses. Whether these results are representative of the actual course of action psychologists would take when faced with such a dilemma is therefore questionable. Moreover, the forced choices may have excluded responses that psychologists consider to be crucial in their decision-making process (Beauchamp & Childress, 2001). Furthermore, the forced choice responses did not present the psychologists in this study with

an opportunity for unethical choices, which may have been responsible for creating a bias in the direction of ethically acceptable responses. Bersoff (1995), however, seems to support forced choice responses, as they suggest that it is the specificity which respondents are forced into that allows an investigation of those issues that elicit widespread agreement and those that do not.

An important limitation of this study was that it did not consider the level of ethics training and the time spent in training among the respondents. Kitchener (1984) suggests that a singular focus on ethical standards may not be enough and that ethical standards need to be considered within the psychologist's unique context. Welfel and Kitchener (1992) suggest that more attention should be given to ethical awareness and training, areas which appear to be neglected in current research. Literature reviewed by Wassenaar (2002) suggests that the professional postgraduate component of ethics training should involve around 25 hours of study time, combining directed reading, formal didactic inputs, workshops and assignments on applied decision-making. The level of ethics training should therefore be explored as a variable in future research studies.

Despite the limitations of this study, the results provide information about the professional decision-making of South African psychologists in the field of HIV/AIDS related psychotherapy. The results also provide practical implications for the content and style of current ethical regulations. These are discussed in the following section.

11 Implications for practice

The information in this study is relevant to psychologists' awareness and understanding of ethical decision making in HIV/AIDS related psychotherapy when a duty to warn arises.

Research shows that there are no easy solutions to the ethical dilemmas poised in HIV-related psychotherapy (Gray & Harding, 1988) and that practicing psychologists face many challenges in caring for people living with HIV infection. DiMarco and Zoline (2004) identified the following ethical areas that may be a problem to psychologists in the area of HIV/AIDS related psychotherapy: confidentiality; competence when working with unfamiliar client issues, and blurred, dual or multiple relationships. The findings of this study suggest that psychologists need to consider these issues when managing the clinical situation with the client.

A common weakness amongst the respondents in this study was the lack of training in HIV/AIDS in compliance with ethical duty of competence. Training in the field is therefore a very important component in rendering effective psychotherapy. Psychologists need to keep pace with information related to the AIDS pandemic and participate in continuing workshops to update their information on a regular basis. According to Kalichman et al. (1998), it would be unreasonable to expect the psychologist to render psychotherapy within an HIV/AIDS context without adequate knowledge of new treatments and their impact on the psyche. Melchert and Patterson (1999) recommend that it is important for psychologists to keep abreast of major research advances regarding HIV/AIDS because these advances affect interventions that will be helpful to HIV-positive clients and their partners. Research shows that news about advances and setbacks in HIV treatments influence the psychological adjustment of people with HIV/AIDS (Anderson & Barret, 2001).

When faced with a problem psychologists should first consult the ethics code (APA, 2002; HPCSA, 2004) to identify whether there is an explicit standard that addresses the issue or whether advice can be gleaned from the general principles about what course of action may be best (Anderson & Barret, 2001). In order to carry out the latter, psychologists need to be familiar with the ethics code and principles.

A concern revealed by this study was that the respondents were not familiar with professional guidelines and fundamental ethical principles. It can be speculated that many psychologists who participated in this study were trained prior to the publication of the most recent code and may not be familiar with some of the changes therein. Psychologists therefore need to stay abreast of current guidelines that regulate the decisions that are required in HIV/AIDS related psychotherapy.

On the other hand, the findings may imply that the training in ethics offered by institutions is inadequate, or that ethical principles and guidelines are not well implemented in practice (Bersoff, 1995). The findings of this study therefore suggest that continued educational courses in ethics to inculcate ethical reasoning processes could be appropriate even for the experienced psychologist. A further implication of this study is that efforts to develop graduate course-work in ethics should be pursued, perhaps with particular attention to real-world

ethical problems involving confidentiality, competency and third party access. In addition, the findings suggest that psychologists need to consult relevant literature. Articles regarding the implications of APA ethics code for HIV-related practice are beginning to appear in the literature. Anderson and Barret (2001) have suggested ways in which the APA ethics code can give explicit advice regarding the treatment of those with HIV/AIDS.

The essence of being a professional is having specialized knowledge that is not accessible to the general public. In this context specialized knowledge consists of assessment, diagnosis and treatment related to HIV/AIDS psychotherapy and knowledge of risk assessment in particular which appears to be an important implication of this study. In this respect articles regarding clinical decision making in practice should be consulted. Truscott, Jim and Mansell (1995) present a model that can be used quickly in the assessment of high-risk situations.

According to Chenneville (2000), regardless of whether there is a duty to warn, psychologists need to be clinically competent in their assessment of clear and imminent danger and therefore consultation and supervision with other psychologists is needed. Knapp and Vandecreek (1993) made an important distinction between assessment and the prediction of danger and noted that psychologists were found to be liable when they failed to conduct a thorough assessment of the client's level of dangerousness rather than being held responsible for predicting danger.

Results from this study suggest that breaching confidentiality is a step that respondents in this study were hesitant to take. It is also evident that confidentiality is an issue that plagues psychologists especially where third parties are involved (Chenneville 2000). From an ethical perspective it is critical that clients' understand the limitations to confidentiality if they are to make informed decisions about whether to enter into treatment and whether to disclose personal information during sessions (Knapp & Vandecreek, 1993). The APA ethical standard 5.01 and HPCSA ethical standards 24 and 25 direct that a discussion of confidentiality occurs at the onset of a therapeutic relationship and thereafter as new circumstances may warrant (APA, 2002, p. 1606; HPCSA, 2004, p. 8).

The above suggests that psychologists should examine their informed consent practices in the light of a duty to warn third parties that requires them to disclose confidential information (Anderson & Barret, 2001). It has been suggested that thorough informed consent procedures may help to prevent traumatic experiences for both the psychologist and the client (Bersoff, 1999).

Regardless of the duty to warn, Knapp and Vandecreek (1993) recommend that psychologists keep abreast of other third party situations. These include court ordered disclosure of confidential information (e.g., on receipt of a subpoena). Knapp and Vandecreek (1993) note that this is especially true when working with individuals who are currently involved or are likely to be involved in legal proceedings (e.g., divorce, custody or criminal matters).

A final implication of this study is that psychologists need to be aware of particular areas of decision-making that deserve scrutiny and consideration (Haas et al., 1988). It can be speculated that a relevant area to this study is that of confidentiality, where psychologists need to

question the implications of preserving or upholding it. Another area relates to HIV/AIDS psychotherapy and diagnoses, where psychologists need to reconsider for who are diagnoses been done. Consideration also needs to be given to the issue related to stigmatisation especially around the HIV/AIDS related scenario (Bersoff, 1995).

In summary the ethical issues involved in HIV/AIDS related psychotherapy are complex and may never be totally agreed on or resolved. However it is ethically incumbent on psychologists working in this area to receive continued training and guidance in the field. Ethical training should therefore be an integral part of the professional training programmes. Workshops, seminars and in-service training should be used to facilitate discussion and development of feasible ethical guidelines. In order to be competent in the field, psychologists need to keep abreast of ethical standards, which are periodically updated. Furthermore, the development of HIV/AIDS directives and policies is needed to assist psychologists in decision-making. Finally, it is the responsibility of the psychologist to deal with issues related to HIV/AIDS in an uncompromising and competent manner.

12 Future research

Among all the daunting problems that psychologists face in HIV/AIDS related psychotherapy, the duty to warn is perhaps the most significant with regard to ethical decision making. This specific area still remains an important area of exploration (DiMarco & Zoline, 2004).

It is evident that while there is a voluminous amount of literature pertaining to the ethical decision making there is an absence of empirically based data concerning the ethical reasoning of psychologists in HIV/AIDS related psychotherapy especially within the South African context. More research is needed that takes into account a practical analysis of the decision-making process. Future research should therefore consider a closer examination of the ethical obligations and choices that psychologists make when working with HIV-positive clients. Slack (1997) found that the relationship between the action taken by the psychologist and the reasoning process deserves additional study.

Dealing with ethical dilemmas requires knowledge of the ethical codes and principles (Anderson & Barret, 2001). No attempt was made in this study to assess the psychologist's knowledge of ethical codes or to identify which code the psychologists were using. Perhaps future research might attempt to directly asses the psychologist's knowledge of the ethics code with regard to how the dilemma related to HIV/AIDS psychotherapy is assessed.

Implicit in the action taken with regard to the ethical dilemma is the need to focus on existing ethical and legal guidelines. Pais (1998) found that most psychologists encounter dilemmas in which legal requirements and ethical guidelines seem to be ethically and clinically wrong, which then places the client or third parties at needless risk for harm and injustice. Research has yet to consider and evaluate such guidelines that are available that inform psychologists of their choices when faced with an ethical dilemma.

Understandably, psychologists seek straightforward answers about when to maintain confidentiality and when to disclose as the penalties for failure to warn or wrongful disclosure can be serious. According to Gray and Harding (1988), this issue is in need of further debate, scrutiny and consideration for future research.

Future research also needs to consider how psychologists define confidentiality at the outset of the psychotherapeutic relation with the HIV-positive client. In line with this, future research needs to also take into account the type of clinical intervention that psychologists use in the area of HIV/AIDS and the duty to warn.

As the range of ethical issues in HIV/AIDS related psychotherapy expands, future research might sample a wider range of ethical situations including amongst others issues related to boundaries, multiple roles and end of life issues. In this respect future research might also investigate the ethical decision-making practices of psychologists registered in categories other than clinical psychology. This may yield a more comprehensive understanding and evaluation of the ethical decision-making process among psychologists.

Finally, more information is needed to determine the extent and scope of ethics instruction that psychologists are receiving in the area of HIV/AIDS related psychotherapy. Research also needs to take into account the psychologists' perception of the efficacy of such instruction.

13 Conclusion

The purpose of this study was to explore aspects of the ethical decision-making process of psychologists when faced with the ethical dilemma of the duty to warn in a situation where an HIV-positive client has not disclosed his status to his partner and continues to engage in unsafe sexual practices. The primary question addressed in this study was whether psychologists adhere to ethical principles and codes when faced with a duty to warn situation. The second major question was whether psychologists operate on the premise that client confidentiality is central to the psychotherapeutic process.

Confirming the findings and speculations of Anderson and Barret (2001), this study significantly found that none of the respondents were able to correctly list or identify the foundational ethical principles. Psychologists listed, amongst others, confidentiality and respect as the foundational ethical principles. While the findings must be interpreted with caution in view of the low response rate, these findings nonetheless point to the need for more training in the implementation of the foundational ethical principles as suggested in prior research (DiMarco & Zoline, 2004; Anderson & Barret, 2001).

While a significant number of respondents would guide the client to disclose his HIV status in the context of providing psychotherapy, it was also evident that respondents in this study were not familiar with HPCSA guidelines advocating guiding the client to disclose his/her HIV-positive status to his or her partner. These findings fit well with the findings of Bersoff (1995) who observed a general lack of motivation among professional psychologists to implement professional guidelines.

The dilemma of concern which has been repeatedly outlined in this study is the protection of client confidentiality versus the disclosure of information to warn a third party. It was evident that respondents in this study were significantly less likely to breach confidentiality even though a significant number of respondents rated the degree of dangerousness presented by the client as significant. The results are consistent with prior research with regard to major Tarasoff issues as they relate to confidentiality with AIDS patients (Botkin & Nietzel, 1987; DiMarco & Zoline, 2004; Gray & Harding, 1988; Totten et al., 1990; Schlossberger, 1996). Other diverse responses justifying the maintenance of absolute confidentiality in this study involved fear of having to be prosecuted in public courts and fear of disciplinary action which is consistent with prior research (DiMarco & Zoline, 2004).

Consistent with previous research (DiMarco & Zoline, 2004; Anderson & Barret, 2001) the findings of this study suggest that there is a general lack of experience and training amongst psychologists in dealing with the duty to warn in the case of HIV/AIDS related psychotherapy. A significant finding with regard to the sample was that though the average range of experience was nine years, the length of HIV/AIDS education averaged only five months.

On the whole, the results of this study did not show that identifiable background characteristics of respondents such as the psychologist's age and gender were significantly linked with the perceived danger of the client's sexual behaviour and the perceived likelihood of disclo-

sure. The findings are consistent with prior research (Haas et al., 1988). On the other hand this study found that the work setting of psychologists was significantly related to the perceived danger of the client's sexual behaviour and the perceived likelihood of disclosure. Psychologists in private practice were more likely to regard the client as dangerous and were thus more willing to make a disclosure to the wife. This finding seems to support the view of Pais (1988) that varied responses with regard to work setting are possibly due to variations in the central concepts of privacy and confidentiality especially with regard to location of the psychologist's practice.

While not statistically significant, a small proportion of respondents indicated that they would respect the client's wish and will continue psychotherapy. A significant percentage on the other hand indicated that they would consult a supervisor as part of their intervention in guiding the client to disclose his HIV-positive status to his wife, which is consistent with prior research (DiMarco & Zoline, 2004).

Finally, the conclusions reached in this study are consistent with those found in earlier work (Anderson & Barret, 2001; DiMarco & Zoline, 2004; Pais, 1998), supporting the suggestion that there is still a need for more training and research in the area of duty to warn issues with HIV-positive clients.

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Appendix A

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UNIVERSITY OF
KWAZULU-NATAL

2nd February 2006

Dear Colleague

A Study of Ethical Decision- Making IN HIV-Related Psychotherapy

The attached questionnaire forms part of a research study for the requirements in respect of a Masters degree in Clinical Psychology. It is hoped that the information obtained will contribute to our understanding of the work associated with HIV-positive clients who are engaging in high risk sexual behaviour with a partner who is unaware of the client's HIV status.

Your participation in this study is voluntary. I would however be grateful if you would complete the attached questionnaire. The questionnaire should not take longer than ten minutes to complete. A stamped addressed return envelope is provided.

Your responses are anonymous and you are not required to supply your name. Data analysis will identify common themes and will not reflect any individual submissions.

Ethics approval for the research has been obtained and was granted in December 2005.

If you are unable to complete the questionnaire I would nevertheless be grateful if you would return the blank questionnaire and simply mark it "incomplete".

Your contribution for the study will be much appreciated. **Please return the questionnaire before the 31st March 2006.**

Thanking you
Yours sincerely,

Ms. K. Maharaj (Clinical Psychology Masters Student)

Contact Number 033 3914710 (after hours)
E-mail Address 201505560@ukzn.ac.za

Supervised by

D.R. Wassenaar PhD
Clinical Psychologist
Associate Professor

Appendix B

* **"I understand the nature and purpose of this study and participate freely and voluntarily. I understand that by completing the questionnaire below I indicate my consent to participate".**

Questionnaire:

1. Demographic details: (Tick which applies)

Gender	Male	Female
Age		

2. Qualifications

Highest Degree obtained	
Year obtained	
Name of University	
HPCSA Registration Category	

3. Primary therapeutic orientation:
Tick (√) where applicable

Psychodynamic	
Systemic	
Cognitive-behavioural	
Client- centered	
Eclectic-integrative	
Other	

4. Primary work setting
Tick (√) where applicable

Private practice	
Community setting	
Hospital – Provincial or Govt.	
Hospital - Private	
College Counseling Centre	
Other	

5. HIV/AIDS Education

Have you received any training in HIV/AIDS Education? Tick (√) where applicable

YES	NO

If Yes, please complete the table below

Where?	
Duration?	

6. HIV/AIDS Clinical Experience. Tick (√) where applicable

None	
Minimal up to 10 cases	
Extensive more than 10 cases	

Case Vignette

You have been seeing Mr. X in therapy for the past three months. Mr. X is 33 years old and has been married for the past six years. He has two children a boy and a girl, ages 5 and 3 respectively.

Mr. X recently admitted to you in the course of a psychotherapy session that he had an affair with a work colleague. His wife never found out about the affair, which lasted for about two years. He recently found out that the person with whom he had an affair had died of HIV /AIDS related illnesses. This prompted Mr. X to have an HIV test, the results of which were positive. Mr. X told you that he has no intentions of telling his wife about the test results. He becomes very emotional as he imagines her hurt feelings and the shame it would bring to the family. He is also afraid that his wife will keep the children away from him.

1. How dangerous do you assess this patient to be in terms of HIV/AIDS risk to his wife? **Tick(√) where applicable**

No Danger	
Little Danger	
Very dangerous	

2. What do you consider to be the primary goal in Psychotherapy for this case? **Tick (√) where applicable**

To guide the client to disclose his HIV status to his wife.	
To guide the client not to disclose his HIV status to his wife.	
Ignore HIV status as it is unrelated to the Psychotherapy.	
Advise the client to be 100% compliant with condom use.	

3a. If the client refused to consider informing his wife, would you breach confidentiality by contacting Mrs. X? **Tick (√) where applicable**

Yes	
No	

3b. Motivate your answer briefly

4. Rate the importance of referring to the HPCSA Professional Board for Psychology ethical guidelines as part of your intervention in this case: **Tick (√) where applicable**

Extremely Important	
Very Important	
Relevant but not important	
Unimportant	

5. Are you familiar with the foundational ethical principles to clarify the ethical issues in respect of this case? **Tick (√) where applicable**

Yes	
No	

6. List the five foundational ethical principles or as many as you can recall.

7. Are you familiar with the HPCSA guidelines about informing the client's sexual partner about her risk? **Tick (√) where applicable**

Yes	
No	

8. If the client refuses to disclose, what management plan would you consider? **Tick (√) where applicable**

Terminate therapy with the client	
Contact the wife and inform her about the client's decision	
Address the issues that discourage disclosure	
Respect the client's wish and continue with psychotherapy	
Other (please specify)	

9. Have you dealt with a case similar to this in your practice? **Tick (√) where applicable**

Yes	
No	

10. If **Yes** what did you do? **Tick (√) where applicable**

Consult supervisor/ colleague	
Consult a decision making model	
Consult the HPCSA guidelines	
Refer to another professional	
Other	
Ignore the issue	

Additional Comments

*** THANK YOU FOR YOUR VALUED ASSISTANCE. KINDLY RETURN THE QUESTIONNAIRE IN THE SELF ADDRESSED STAMPED ENVELOPE TO:**

Ms. K. Maharaj
School of Psychology (PMB)
UKZN
Private Bag X01
Scottsville 3209

Appendix C

Least square differences indicate the differences with regard to the perceived danger of the client's sexual behaviour and work setting which relate to section 7.3.3 of this study.

Multiple Comparisons of the perceived danger of the client's sexual behaviour and work setting.

Work setting	Comparisons of setting	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
private practice	community setting	.0000	.06082	1.000	-.1219	.1219
	hospital-Provincial or Govt	.2500(*)	.06082	.000	.1281	.3719
	Hospital-Private	.0000	.06954	1.000	-.1394	.1394
	College counselling centre	.0000	.08431	1.000	-.1690	.1690
community setting	private practice	.0000	.06082	1.000	-.1219	.1219
	hospital-Provincial or Govt	.2500(*)	.08257	.004	.0845	.4155
	Hospital-Private	.0000	.08919	1.000	-.1787	.1787
	College counselling centre	.0000	.10113	1.000	-.2027	.2027
hospital-Provincial or Govt	private practice	-.2500(*)	.06082	.000	-.3719	-.1281
	community setting	-.2500(*)	.08257	.004	-.4155	-.0845
	Hospital-Private	-.2500(*)	.08919	.007	-.4287	-.0713
	College counselling centre	-.2500(*)	.10113	.017	-.4527	-.0473
Hospital-Private	private practice	.0000	.06954	1.000	-.1394	.1394
	community setting	.0000	.08919	1.000	-.1787	.1787
	hospital-Provincial or Govt	.2500(*)	.08919	.007	.0713	.4287
	College counselling centre	.0000	.10660	1.000	-.2136	.2136
College counselling centre	private practice	.0000	.08431	1.000	-.1690	.1690
	community setting	.0000	.10113	1.000	-.2027	.2027
	hospital-Provincial or Govt	.2500(*)	.10113	.017	.0473	.4527
	Hospital-Private	.0000	.10660	1.000	-.2136	.2136

- The mean difference is significant at the .05 level.

Appendix D

Least square differences indicate the differences with regard to the perceived likelihood of disclosure and work setting which relate to section 7.4.3 of this study.

Multiple Comparisons with regard to the perceived likelihood of disclosure and work setting.

Setting	Comparison of setting	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
private practice	community setting	.0000	.05153	1.000	-.1028	.1028
	hospital-Provincial or Govt	.0000	.05153	1.000	-.1028	.1028
	Hospital-Private	-1.6667(*)	.05893	.000	-1.7843	-1.5491
	College counselling centre	-2.0000(*)	.07146	.000	-2.1426	-1.8574
	Other	-2.0000(*)	.03096	.000	-2.0618	-1.9382
Community setting	private practice	.0000	.05153	1.000	-.1028	.1028
	hospital-Provincial or Govt	.0000	.07001	1.000	-.1397	.1397
	Hospital-Private	-1.6667(*)	.07562	.000	-1.8176	-1.5158
	College counselling centre	-2.0000(*)	.08575	.000	-2.1711	-1.8289
	Other	-2.0000(*)	.05661	.000	-2.1130	-1.8870
hospital-Provincial or Govt	private practice	.0000	.05153	1.000	-.1028	.1028
	community setting	.0000	.07001	1.000	-.1397	.1397
	Hospital-Private	-1.6667(*)	.07562	.000	-1.8176	-1.5158
	College counselling centre	-2.0000(*)	.08575	.000	-2.1711	-1.8289
	Other	-2.0000(*)	.05661	.000	-2.1130	-1.8870
Hospital-Private	private practice	1.6667(*)	.05893	.000	1.5491	1.7843
	community setting	1.6667(*)	.07562	.000	1.5158	1.8176
	hospital-Provincial or Govt	1.6667(*)	.07562	.000	1.5158	1.8176
	College counselling centre	-.3333(*)	.09039	.000	-.5137	-.1530
	Other	-.3333(*)	.06342	.000	-.4599	-.2068
College counselling centre	private practice	2.0000(*)	.07146	.000	1.8574	2.1426
	community setting	2.0000(*)	.08575	.000	1.8289	2.1711
	hospital-Provincial or Govt	2.0000(*)	.08575	.000	1.8289	2.1711
	Hospital-Private	.3333(*)	.09039	.000	.1530	.5137
	Other	.0000	.07521	1.000	-.1501	.1501
Other	private practice	2.0000(*)	.03096	.000	1.9382	2.0618
	community setting	2.0000(*)	.05661	.000	1.8870	2.1130
	hospital-Provincial or Govt	2.0000(*)	.05661	.000	1.8870	2.1130
	Hospital-Private	.3333(*)	.06342	.000	.2068	.4599
	College counselling centre	.0000	.07521	1.000	-.1501	.1501

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

Appendix E

Cross tabulation of clinical experience as a function of the psychologists' active intervention using least square differences which relate to section 7.5 of this study.

(I) REDO6	(J) REDO6	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
None	minimal up to 10 cases	.0000	.14646	1.000	-.2932	.2932
	extensive more than 10 cases	-.5000(*)	.15951	.003	-.8193	-.1807
Minimal up to 10 cases	None	.0000	.14646	1.000	-.2932	.2932
	extensive more than 10 cases	-.5000(*)	.14126	.001	-.7828	-.2172
Extensive more than 10 cases	None	.5000(*)	.15951	.003	.1807	.8193
	minimal up to 10 cases	.5000(*)	.14126	.001	.2172	.7828

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

Appendix F

Least square differences indicate the differences with regard to psychologists' theoretical orientation and the individual's right to confidentiality which relates to section 7.6 of this study.

Multiple Comparisons with regard to the psychologists' theoretical orientation and the individual's right to confidentiality.

Theoretical orientation	comparisons	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Psychodynamic	Systemic	-.9167(*)	.11278	.000	-1.1406	-.6928
	Cognitive behavioural	-1.7500(*)	.09208	.000	-1.9328	-1.5672
	Client centred	-2.9167(*)	.10112	.000	-3.1174	-2.7159
	Eclectic integrative	-3.4167(*)	.09946	.000	-3.6141	-3.2192
	Other	-3.9167(*)	.14560	.000	-4.2057	-3.6276
Systemic	Psychodynamic	.9167(*)	.11278	.000	.6928	1.1406
	Cognitive behavioural	-.8333(*)	.11278	.000	-1.0572	-.6094
	Client centred	-2.0000(*)	.12027	.000	-2.2388	-1.7612
	Eclectic integrative	-2.5000(*)	.11888	.000	-2.7360	-2.2640
	Other	-3.0000(*)	.15949	.000	-3.3166	-2.6834
Cognitive behavioural	Psychodynamic	1.7500(*)	.09208	.000	1.5672	1.9328
	Systemic	.8333(*)	.11278	.000	.6094	1.0572
	Client centred	-1.1667(*)	.10112	.000	-1.3674	-.9659
	Eclectic integrative	-1.6667(*)	.09946	.000	-1.8641	-1.4692
	Other	-2.1667(*)	.14560	.000	-2.4557	-1.8776
Client centred	Psychodynamic	2.9167(*)	.10112	.000	2.7159	3.1174
	Systemic	2.0000(*)	.12027	.000	1.7612	2.2388
	Cognitive behavioural	1.1667(*)	.10112	.000	.9659	1.3674
	Eclectic integrative	-.5000(*)	.10788	.000	-.7142	-.2858
	Other	-1.0000(*)	.15147	.000	-1.3007	-.6993
Eclectic integrative	Psychodynamic	3.4167(*)	.09946	.000	3.2192	3.6141
	Systemic	2.5000(*)	.11888	.000	2.2640	2.7360
	Cognitive behavioural	1.6667(*)	.09946	.000	1.4692	1.8641
	Client centred	.5000(*)	.10788	.000	.2858	.7142
	Other	-.5000(*)	.15037	.001	-.7985	-.2015
Other	Psychodynamic	3.9167(*)	.14560	.000	3.6276	4.2057
	Systemic	3.0000(*)	.15949	.000	2.6834	3.3166
	Cognitive behavioural	2.1667(*)	.14560	.000	1.8776	2.4557
	Client centred	1.0000(*)	.15147	.000	.6993	1.3007
	Eclectic integrative	.5000(*)	.15037	.001	.2015	.7985

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