GUIDELINES FOR THE DEVELOPMENT OF AN ETHICAL CODE FOR CLINICAL PSYCHOLOGISTS IN SOUTH AFRICA

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ABSTRACT

The aim of this thesis is to propose guidelines for the development of an ethical code for South African clinical psychologists. A discussion of the philosophical basis of ethical codes and a critical examination of the most developed and useful existing ethical code for psychologists - the APA code - serve as background information for identifying the essential elements of a code for clinical psychologists in this country. It is concluded that such a code should consist of three levels - an ethical theory, ethical principles and rules for specific situations. The application of this structure to practical situations in which the clinical psychologist functions is illustrated in the final section of the thesis with particular reference to psychotherapy, psychological assessment, research and professional conduct and relationships. The particular circumstances of South African society which may complicate ethical issues in these areas are considered, and procedural recommendations are made concerning the establishment of an ethical code which will have specific relevance to the practise of clinical psychology in South Africa.

INTRODUCTION

INTRODUCTION

The development of a code of ethics is an essential aspect of the general establishment and development of any autonomous profession which serves the public.

The South African Institute for Clinical Psychology has recently expressed concern over the lack of adequate ethical regulation of the profession in this country. It was felt that in order for South African clinical psychologists to fulfill their functions adequately, a code should be developed which would address the specific ethical issues important to clinical psychologists in South Africa. The aim of this thesis is to present some proposals for the development of such an ethical code. In order to achieve this aim it was felt that a three stage development of the thesis would be appropriate, and the arguments contained within the thesis are therefore presented in three major sections.

The first section is concerned with the philosophical background to the study of ethics and provides an introduction to the philosophical structure of ethical codes in general. The particular functions of professional ethical codes are also discussed in this section.

In the second section, the development and application of ethical codes within the profession of psychology are considered. On the basis of the arguments presented here, this section culminates in a set of proposals for the process by which an ethical code could be developed which will be specifically relevant to the functioning of clinical psychologists in South Africa.

The final section of the thesis serves as an illustration of how the concepts and principles discussed in the previous sections have relevance to four major areas of general functioning of clinical psychologists, and of how an ethical code such as the one proposed in section two would be useful to South African clinical psychologists in approaching ethically problematic situations within these areas. This section also considers special issues pertinent to South African society which may have significance for the ethical practise of clinical psychology in this country.

SECTION ONE

PHILOSOPHICAL BASIS OF ETHICAL CODES

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The study of ethics is concerned with issues such as the definition of "good" and "bad" and is essentially philosophical in nature. For this reason, before exploring the requirements for an adequate ethical code for South African clinical psychologists in more detail, some discussion of the philosophical study of ethics and the philosophical basis of ethical codes seems necessary. This section will therefore be concerned with the structure of ethical codes and the components - ethical theories, ethical principles and rules - which make up this structure. The development of ethical codes for application in professional practise constitutes a special branch of the study of ethics and will also be briefly considered within this section.

CHAPTER ONE

THE STUDY OF ETHICS

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The aim of this chapter is to provide a brief outline of the philosophical approach to ethics and the philosophical basis of ethical codes. Two major types of ethical theories - i.e. utilitarian and deontological theories - and the four ethical principles of autonomy, nonmaleficence, beneficence and justice which may be encompassed within either of these theories will be discussed. Following this, the nature of rules and the origins of ethical dilemmas will be reviewed. Finally, the specific nature of professional ethics as a specialized branch of the general field of ethics will be considered.

1.1 MORALITY AND ETHICS

The concepts of morality and ethics are closely related, both being concerned with the definition of human conduct as "good" or "bad". A standard dictionary definition of ethics is: "the science of morals, that branch of philosophy which is concerned with human character and conduct: a system of morals, rules of behaviour". (Chambers 20th Century dictionary). Individual moral judgements in specific situations therefore imply a more basic system of definitions of general moral norms or values which system constitutes an ethical theory. The philosophical basis of ethical codes, according to Beauchamp and Childress (1979), consists of such a basic ethical theory which encompasses certain ethical principles out of which rules for conduct in specific situations may be derived. In this chapter, consideration will be given to the nature of two

major ethical theories, four ethical principles which may be encompassed within these theories and the nature of rules which may be derived from these principles.

1.2 ETHICAL THEORIES

Beauchamp and Childress (1979) have listed four requirements for a valid ethical theory:

1) Internal consistency and coherency

2) Completeness and comprehensiveness

3) Simplicity

4) Sufficient complexity to account for the whole range of moral experience, including ordinary moral judgements.

In recent years, the types of ethical theory which have received the most attention have been utilitarian and deontological theories (Beauchamp and Childress, 1979; Moore, 1967; Jones, Sartag, Beckner and Fogelin, 1977; Sidgwick, 1967). It is not within the scope of this thesis to provide a detailed critique of the philosophical validity of either of these theories. Consequently, they will be accepted at face value and an attempt will be made to outline the most important features and assumptions of each theory.

1.2.1 Utilitarianism

Broadly speaking, this theory asserts that the only basic principle in ethics is that of utility, which implies that

in all circumstances one must produce the greatest possible balance of value over disvalue for all persons affected and that human actions are to be assessed in terms of their production of maximal nonmoral value. While there has been much argument amongst theorists working within this model as to what constitutes "the good" or "maximal nonmoral value", in recent times the most popular definition is that "the good" relates to the preference of the individual in specific situations. Maximising the good would therefore involve maximising the potential for the greatest number of individuals to realise their preference. A further tenet of this theory is that values which are intrinsically good should be pursued before these which are extrinsically good. An intrinsic value would be something which is assumed to be good in itself (e.g. life), while an extrinsic value is good as a means to something else, which may itself be an intrinsic value (e.g. money). Within the utilitarian position there is a further distinction between act and rule utilitarianism. In act utilitarianism the consequences of each particular act are considered, whereas the rule utilitarian considers the consequences of generally observing a rule which has itself been derived from the basic principle of utility. Thus the rule utilitarian would adhere to the principle "you should not break a promise" because in the past this rule proved to generally produce maximal utility, while the act utilitarian would be prepared to break a promise in particular situations where he perceived this as the most beneficial course to take. Because such situations do arise, act utilitarians suggest that rule utilitarians violate the demands of the principle of utility. Rule utilitarians, on the other hand, argue that

the utility of whole codes or systems of rules, rather than individual rules, should be considered, pointing out that the overall utility of adhering to such codes outweighs the individual values that could be gained in a ruleless society.

1.2.2 Deontological Theories

As opposed to utilitarian theories in which the consequences of an act determine its morality, deontological theories hold that features of some acts other than their consequences make them right or wrong. Deontologists maintain that there are one or more basic rules or principles - such as universalisability, fidelity, beneficence and justice - from which one can derive all other rules or judgements.

As in utilitarianism, there is also a distinction between act and rule deontology. Act deontology is relatively rare - it involves acting by individual conscience or intuition, or by immediate and direct perception of God's will. This position is rarely defended as it is so obviously open to distortion due to self-interest. Rule deontology, on the other hand, asserts a set of principles and rules that identify classes of acts which are right or wrong, obligatory or prohibited, regardless of their consequences.

There are four basic points on which utilitarianism and deontology differ: (Beauchamp and Childress, 1979).

1. Utilitarianism argues in terms of means to ends whereas deontology asserts that we lack the capacity to predict and control the future in

the way utilitarianism implies. In addition, responsibilities to others are more varied and specific than the responsibility to promote good.

2. Utilitarians agree that there is only one significant moral relationship between people, which is that of benefactor and beneficiary, while deontologists maintain that people are related in various ways according to their own previous acts. The relationship of one man to his wife, his son, his lawyer and his own clients are all morally different in terms of the obligations incurred by both parties within the relationship.

3. There is considerable disagreement concerning the role of past actions in moral assessments. For utilitarians, the past is of little or no significance, whereas for the deontologists, acts performed in the past (such as making a promise) are a determining factor for present actions.

4. Deontologists argue that in some cases, particularly act utilitarianism can lead to morally unacceptable conclusions. If, for example, acts A and B have identical consequences, but act A involves lying while B does not, act utilitarians would maintain that both actions were equally justifiable. This would in fact conflict with the requirement of an ethical theory that it be congruent with the ordinary

moral convictions of most people.

If called upon to make a choice between the theories described above, the difficulties inherent in both act utilitarianism and act deontology are immediately apparent. However few differences are to be found between rule utilitarianism and rule deontology in terms of the tests of consistency and coherence, simplicity, completeness and comprehensiveness and capacity to account for moral experience. From both standpoints it is possible to defend and assign the same weight to the same rules. In addition, the same issues have to be faced within each theory, the most prominent of these issues being the problem of ethical dilemmas.

1.3 ETHICAL PRINCIPLES

Ethical principles can be seen as general ethical statements which give rise to specific rules and can be encompassed within a broader ethical theory. Beauchamp and Childress (1979) have outlined four basic ethical principles, which could be encompassed within either the rule-utilitarian or rule-deontological theory, and which have relevance for the practise of psychology. These principles are those of Autonomy, Nonmaleficence, Beneficience, and Justice. They will be discussed in general here, while their specific relevance and application to areas of functioning of clinical psychologists will be explored in later chapters.

1.3.1 Principle of Autonomy

The concept of autonomy owes its development to two philosophers

of different schools - the deontologist, Kant, who understood autonomy as meaning freedom of the will; and the utilitarian, Mill, who was concerned with autonomy as freedom of action. According to Kant, freedom of will is the choosing on the basis of reason (rather than desire) one's own moral principles subject to only one condition which is that these principles should be universalisable (i.e. can be willed to be valid for everyone). Mill's understanding of freedom of action involves the freedom of all people to act on their convictions as long as such action does not interfere with the freedom of others to do the same.

A synthesis of these two understandings into a unitary view of autonomy would dictate that people should be free to act according to their own self-formulated principles, while showing respect for the autonomy of others by acknowledging their right to similar beliefs and actions. Kant describes a moral relation as one in which two autonomous agents have respect for one another's autonomy.

An important concept which arises out of the principle of autonomy and which is relevant to the practise of clinical psychology is that of informed consent. The basic idea behind this concept is that in order for people to make truly autonomous decisions they must do so on the basis of all the relevant information about what the decision would involve, what its consequences might be and what alternative decisions are open to them in particular situations. It will be seen in further chapters that it is often the psychologist's

responsibility to ensure that all this information is available to clients so that they may participate autonomously in their own treatment.

An important proviso of the principle of autonomy is that it applies only to people who are capable of making an autonomous choice, and not to those whose decision-making is hampered by environmental or psychological restrictions. Thus, prison and mental hospital inmates may not be autonomous agents by virtue of the external environmental constraints put upon their ability to choose autonomously, while the decision of a severely depressed patient to commit suicide may not be regarded as an autonomous choice because the psychological disability of depression may be hampering his ability to make a rational moral decision. In such cases it is the responsibility of some other person - frequently somebody who has a degree of authority over the non-autonomous agent - to make decisions for them which they would presumably have made themselves, were they in a position to do so.

The relationship between the concepts of autonomy and authority is also one of some complexity as they are apparently contradictory, with some theorists going so far as to say that an autonomous agent makes decisions totally unimpeded by any authority's influence. However, the adequate functioning of society is obviously impossible without the allocation of authority to certain people in different areas, whether this authority is administrative or based on particular skills possessed by the person in authority. However within most nondictatorial social

systems authority is autonomously accepted and sometimes allocated by the members of the society and therefore the two concepts need not necessarily be incompatible. The complex interplay between the authority held by psychologists and the rights to autonomy of their clients as this occurs in various areas of psychological functioning will be discussed in the remainder of the thesis.

1.3.2 Principle of Nonmaleficence

This principle has as its basic axiom the directive to "do no harm". The definition of harm seems to vary from a narrow one of specifically physical and mental suffering and injury to a broad one which includes injury to reputation, property and liberty. Within the field of psychology the broader definition is probably more relevant as some psychological procedures may carry attendent risks of harm to at least the reputation and liberty of clients besides to their mental and physical well-being.

Both intentional harm and the risk of harm are included under this principle, with the former being in all cases prohibited and the latter being permitted only when the goals of an action are sufficiently important to justify the risk of harm arising out of such an action. This process of weighing the importance of the outcome against the degree of risk involved is known as detriment-benefit analysis, which demands that at all times agents should act carefully and with due consideration for the possible consequences of an action. In other words agents should at all times act with "due care" and where such "due care" has not been taken the person responsible may be

justifiably accused of violating the principle of nonmaleficence through negligence.

A final important concept to be considered here is that of "double-effect", in which a harmful effect constitutes an indirect foreseen consequence of an action. Such harm does not necessarily constitute a violation of the principle of nonmaleficence as long as the effect is indirect and not the intended direct effect of the action. If, for example, it was decided to undertake some research because of its possible wide-ranging beneficial effects despite a degree of mental suffering which would be caused by some of its procedures, the harm constituted by the mental distress would fall under the principle of double effect. If, however, the aim of the research was to investigate the best way of inducing distress and had no other aim, then the mental distress would be a direct effect of the research procedure and would violate the principle of nonmaleficence.

1.3.3 Principle of Beneficence

Closely related to the principle of nonmaleficence, this principle asserts that a duty exists to actively contribute to others' health and welfare in a positive way through prevention of harm, removal of harmful conditions and positive benefitting of others. Two types of actions are encompassed within this principle - positive beneficence, which refers to the conferring of benefits and active prevention and removal of harms; and balancing the good which involves weighting the good an action will possibly produce against the harm that might result from doing or not doing the good.

Positive beneficence involves the production of positive benefits for society as for example is the purpose in community mental health programmes. Some philosophers call this positive benefitting a duty on the basis of the reciprocal relationship in society - i.e. I receive benefits from society and therefore owe society something in return. However, most agree that while positive beneficence is a virtue it cannot be seen as an absolute duty. For example, leaving one's lucrative private practice to work in a deprived community for little or no financial gain is morally admirable, but not a moral requirement.

The best means of providing benefit for the majority of people falls under the principle of balancing benefits and potential harms, or cost-benefit analysis. The chosen beneficial action is arrived at through such analysis as being the one which provides the most benefit for the least cost, where cost is seen in terms of the risk of harm involved in an action. This type of analysis implies a quantifying model and often, especially in the psychological field, poses many difficulties as it is problematic to talk about potential benefits and harms here in quantitative terms. Often a non-quantitative approach must be used. There is no easy solution to the problems inherent in this, but possibly an ethical code for clinical psychology would need to incorporate some weighting of the kinds of benefits and harms commonly arising out of psychological procedures and methods.

1.3.4 Principle of Justice

The basic idea underlying the principle of justice is that of fairness, which dictates that people should be given what they deserve or can legitimately claim. Comparative justice involves the determining of what one person deserves by weighing the competing claims of other people against his claim, while noncomparative justice is concerned with judging deserving by a standard independent of other's claims. Although both forms of justice can be seen as applicable to clinical psychology and its functions, it is in cases of comparative justice that most ethical problems are encountered.

An example of the application of noncomparative justice occurs when there is scarcity of an amenity (such as psychological treatment) and therefore competition for the benefits arising out of this amenity. The allocation of these scarce resources is known as distributive justice. The question then arises as to how these resources are to be distributed in a just way.

Formal principles of justice propose a basis for the distribution of goods, but do not specify the mechanics of doing so. A popular example of such a principle first proposed by Aristotle, is that equals should be treated equally and unequals unequally, without specifying the relevant ways in which people should be judged as equal or unequal, or the kind of differential treatment unequals should receive. This task falls within the range of material principles of justice, which generate lists of valid criteria by which people's claims can be judged. A popular list includes the following principles:

1) to each person an equal share

2) to each person according to individual need

3) to each person according to individual effort

4) to each person according to societal contributions

5) to each person according to merit.

Differing philosophical and social theories differ as to which of these principles takes priority in the administration of justice. Professional ethics generally rate the client's interests and claims as being more valid and important than the claims of any non-client, but within the client population there must still be some guiding principle as to which clients will receive the benefit of scarce treatment resources and here, once again, theories differ as to which principle will be used. Utilitarian approaches would emphasize a mixed use of these criteria so that public and private utility could be maximised. Once again, difficulties arise in the practical application of this principle in that concepts such as "need" and "merit" are difficult both to define adequately and to weigh against one another, and an ethical code must take some account of this problem.

1.4 THE NATURE OF RULES

In previous sections the drawbacks of both act utilitarianism and act deontological theories were briefly discussed and the value of rules within both ethical theories was outlined. Beauchamp and Childress (1979) distinguish between situation ethics (practised in the act variation of both theories) and

ethics in which rules are applied. In situation ethics, although rules may be partially recognized, they are viewed primarily as "rules of thumb" and therefore expendable in particular situations. This is in contrast to absolute rules such as "be caring", "be conscientious" or "you must not murder", which may never be overruled in any situation. Rules which include all possible exceptions can also be absolute. The debate about whether some rules can be absolute hinges, according to Beauchamp and Childress on the definition of the moral terms included in them - such as "murder" - and that these definitions may lead to problems in their application and justification.

Ross (quoted in Beauchamp and Childress) proposes a third way of seeing rules as neither "rules of thumb" nor absolute. He proposes that rules should be seen as prima facie binding and has distinguished between prima facie duties and actual duties, saying that one's actual duty in a situation can be determined by examining the weighting of all the competing prima facie duties (as expressed in rules). Prima facie duties "constitute strong moral reasons for performing the acts in question", but do not necessarily prevail over other prima facie duties and may therefore be over-ridden in particular situations.

This way of conceptualizing the nature of rules may assist psychologists in confronting situations in which two different rules seem equally applicable. These types of situations are known as ethical dilemmas.

Ethical dilemmas arise, even with the most adequate ethical theories, when practitioners are confronted with situations where accepted rules came into conflict. For example, the rules "You must not betray a confidence" and "You must not lie" - both of which may be encompassed within the same ethical theory - come into conflict when to tell the truth would be to betray a confidence. While conceptualization of rules as prima facie duties rather than absolute duties would mean that one of these rules could prevail over the other in a specific situation, some basis for deciding which rule should prevail needs to be derived. Without such a basis, there is no standard, ethical way of approaching such difficult and ethically conflictual situations. This crucial issue will be central to much discussion in this thesis.

1.5 PROFESSIONAL ETHICS

There has been much dispute amongst sociologists about the definition of a profession and which occupations "qualify" as professions, with definitions ranging from the broad and general to the specific incorporating well defined criteria. Talcott Parsons (1954) defines a profession as "a cluster of occupational roles, that is, roles in which the encumbents perform certain functions valued in the society in general, and by these activities, typically earn a living at a full-time job", a definition which would seem to incorporate a wide-ranging variety of occupations.

More recent theories (Sundberg and Tyler, 1963, Beauchamp and Childress, 1979), stress the following characteristics:

1) High standards of training

2) Controlled entry into the profession by certifying that candidates have developed the requisite body of skills and knowledge

3) Autonomy in performing its functions, which are valued by society

4) Autonomy to pursue creatively the problems which fall in its domain

5) Independence in regard to policy-making, including specification and enforcement of responsibilities and obligations, so that those who enter into a relationship with a member of the profession may trust them.

Part of the policy-making mentioned in the final point would involve the development and implementation of a professional code of ethics, the functions of which may now be considered.

Beauchamp and Childress (1979) define a professional code as "an articulated statement of the role morality as seen by members of the profession" and specify the function of such a code as being "to facilitate relationships of trust and confidence that permit and encourage certain activities to be performed for socially valued ends". Downie (1980) proposes that a professional code should embody three main components:

1) Standards of professional competence

2) Standards of professional integrity

3) Accepted professional procedures

to which could be added a fourth component in the form of effective mechanisms for ensuring that these standards are maintained by individual practitioners. It is obvious that such codes should promote trust in professions amongst the community in that they provide protection and security for members of society who have dealings with professionals. A further function of these codes is, however, to ensure the autonomy of the profession itself by protecting it from the interference of outside agencies, such as the State. An adequately self-regulating profession provides assurances to the agencies responsible for protecting members of society by guaranteeing the welfare of its clients. With absence of external constraints, a profession may freely develop and refine its range of functions. Individual practitioners are protected in certain respects too from external prosecution by recourse to a professional ethical code.

In summary, codes of professional ethics specify and enforce accepted limits of expertise, behaviour and integrity of members of the profession, thereby protecting members of society from exploitation and ensuring a climate within which the profession can function independently and autonomously.

The question may arise as to the essential differences between societal ethics and professional ethics. Societal ethics is that set of principles and rules, embodying generally accepted values, to which all members of a society, including those who are professionals, are expected to adhere. Naturally, no professional ethical code can establish rules which violate the general ethical standards of the community and, for this

reason, there are many similarities between societal ethics and professional ethics. The differences appear to lie in "the priorities, emphases, intensities and applications" of the agreed-upon principles (Loewenberg and Dolgoff, 1982). These differences are especially evident in the principles governing the relationship between two people. Although both societal and professional ethics stress the principle of equality, in professional ethics the client's interests are given priority above the interests of others. Frequently, this leads to the kind of ethical dilemma discussed previously, when the interests of a particular client clash directly with the interests of society as embodied particularly in the law. Thus, there may be conflicts not only within an ethical system but also between differing ethical systems, which need to be resolved by practising professionals. Sieghart (1982) proposes that these conflicts are, in fact, the very subject matter of ethics, writing: "Its central field of study is how people behave when they are faced with a conflict between two or more moral principles to which they subscribe... without such conflicts there are no moral problems". Thus, an adequate professional ethical code, such as is considered in this thesis, should not only identify possible conflict areas but should attempt the far more difficult task of proposing some means of resolution for the practitioner who is confronted with them. For, as Sieghart maintains, "professional codes, if they are to be worth anything, cannot merely confine themselves to asserting that there is a problem, and leaving it at that - let alone leaving it to individual

members of the profession to solve the dilemma as best they can, after consulting their unguided conscience and perhaps a few respected colleagues. At the least, such a code must say something about how to approach this kind of problem. And nothing I have yet seen begins to do anything of the kind".

An adequate professional code of ethics for psychology must therefore fulfill all the general requirements for a professional code, but must also, following on Sieghart's last point, take account of the possibility of ethical dilemmas and provide some approach to these situations. In the following section the profession of psychology will be considered in general and the adequacy of one of the most developed codes of ethics for the profession will be discussed both in terms of its general utility and in terms of its adequacy in accounting for and guiding psychologists in dealing with ethical dilemmas.

SECTION TWO

ETHICAL CODES IN CLINICAL PSYCHOLOGY

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In the previous section, the philosophical basis of ethical codes and the particular functions of such codes within professions were discussed. This section considers the development and application of ethical codes specifically within the profession of clinical psychology. It begins with a description of the profession and the areas of functioning of clinical psychologists which require ethical regulation and then examines in some detail the development and adequacy of the current ethical code for American psychologists. The reasons why this particular code has been chosen for such examination is that it currently constitutes the most comprehensive and detailed ethical code in the field of psychology and is generally regarded as having relevance and utility for guiding American clinical psychologists in ethical conduct. Consideration of its strengths and limitations may therefore be useful in developing such a code for South African clinical psychologists. With discussion of the American code as background, the current situation in South Africa as regards ethical regulations is critically examined and proposals are made for the development of a more adequate ethical code for clinical psychologists in this country.

CHAPTER TWO

THE DEVELOPMENT OF CLINICAL PSYCHOLOGY AS A PROFESSION

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Having considered the nature and functions of professional codes of ethics in relation to the broader field of the study of ethics, it may be useful at this point to describe the development of the field of clinical psychology from its academic beginnings, to the point where it developed into a profession in the true sense of offering a range of services to the public. The nature of these services, which are briefly described in this chapter, necessitated professional organization in order to ensure the competence of practising clinical psychologists and along with professional organization and autonomy came the need for a professional ethical code to regulate the conduct of these practitioners. At present, the American Psychological Association's Ethical Standards for Psychologists represents the most comprehensive set of guidelines for ethical practise in clinical psychology and for this reason some discussion of this ethical code will be pertinent to the aims of this thesis. This chapter will conclude with an outline of the process by which the American code was developed, while in the following chapter the structure and contents of the code will be considered in more detail.

2.1 THE HISTORY OF CLINICAL PSYCHOLOGY

Two major fields of study which emerged during the 19th century may be seen as forming the roots of clinical psychology as a profession. These were, firstly, the study of abnormal behaviour undertaken primarily by European physicians such as Charcot and Kraepelin and, later, by the American Lightner Witmer, and, secondly, the study of individual differences in which the English Scientist Galton was the major figure.

Research in these two fields gave rise to early interest in the possibility of assessing mental handicap, with the term "mental test" being coined in 1890 by Cattell. The following two decades saw the appearance of numerous books and articles on the study and assessment of human abilities, culminating in Binet's development of the first intelligence test in 1905, a test which constituted the first objective psychological instrument for the diagnosis of mental abnormality. This was a landmark in the history of clinical psychology as it provided the impetus for the development of numerous further tests and made the clinical psychologist a valuable staff member in institutions and clinics established to deal with problems of mental abnormality.

Until the outbreak of World War II, the role of the Clinical Psychologists within such institutions was largely confined to psychological testing and making recommendations on the basis of test results. Most of their work centred on problems of children and was conducted in university and community clinics (the first of which was established at the University of Pennsylvania in 1892 by Witner) and institutions for mentally retarded or delinquent children. Towards the end of the 1930s, emphasis on personality testing of adults in mental institutions began increasing, but the primary focus remained the testing of mental ability and deficiency.

The situation changed significantly with the advent of World War II, a change which Rotter (1964) attributes partly to the large-scale migration of European psychologists and psychiatrists, many of whom were psychoanalytically trained, to America. Their

influence was to reduce the emphasis on intelligence testing and to increase the emphasis on tests of personality and deviant personality characteristics. This movement was simultaneously reinforced by the large number of psychiatric war casualties, which led to greater public concern with the prevention and treatment of mental disorders. Psychologists and their testing techniques and skills proved extremely valuable in predicting susceptibility to the stresses of war in psychologically vulnerable recruits.

The number of men requiring psychiatric treatment at this time proved too large for the relatively small number of psychiatrists qualified to offer this treatment and psychologists were called upon to assist, with short training courses being established to equip them for this task. This trend persisted in the postwar years with psychologists becoming increasingly involved in working with adults with "personality breakdowns" or problems, and official sanction for this new role was established at the 1949 Colorado Conference on the training of clinical psychologists, in which the United States Public Health Service strongly supported the training of clinical psychologists as psychotherapists. The range of employment possibilities for psychologists now expanded to include State Hospitals, Universities, Private Practice and Industrial Consulting firms.

Concurrent with the growth of the field of clinical psychology has been the establishment of professional organizations, particularly in the United States. In 1892, the American Psychological Association (APA) was founded with its aim being the promotion

of psychology as a science, and as early as 1917 the American Association of Clinical Psychologists was created. These two organizations remained separate until the postwar period when they amalgamated, with the latter becoming the Clinical Section of the former. At this time the APA was asked to specify standards of training and competence, and to set up boards and committees to develop criteria and methods of assessment of clinical psychological practice. Accompanied as it was by the increasing trend of psychologists towards private practice in which they exercised a wide range of skills, this development firmly established clinical psychology as a profession in its own right.

2.2 THE ROLES AND FUNCTIONS OF CLINICAL PSYCHOLOGISTS

As is apparent from discussion in the previous section, the roles and functions of clinical psychologists have developed and diversified considerably since the beginnings of the profession in the 1890s. Clinical psychologists are currently employed in a wide variety of settings and work in collaboration with numerous other professionals such as psychiatrists, social workers and psychiatric nurses in mental institutions and community health services, teachers in schools and businessmen in industry. The functions which they are expected to perform in these varying settings may be classified as follows:

2.2.1 Psychological Assessment

The earliest developed field of expertise, this range of skills remains the exclusive domain of clinical psychologists who alone

are qualified to administer, interpret and make recommendations on the basis of the vast range of psychological tests which have been devised to date. The psychological assessment procedure requires highly developed interviewing and observational skills which complement the data obtained from psychological tests. The following categories of tests are most commonly administered:

a) aptitude tests which provide some indication of the client's abilities and potential in specific areas of functioning.

b) achievement tests which assess clients' success or otherwise in attaining certain expected levels of competence.

c) intelligence tests which measure overall cognitive capability.

d) personality tests, both projective and objective, indicating the existence of and relationship between particular personality traits, as well as the complex intrapsychic components underlying manifest personality, and

e) specific diagnostic tests designed to elicit symptomatology of psychiatric syndromes.

2.2.2 Psychotherapy

This area of functioning is generally shared by all members of the mental health professions, most notably psychiatric nurses,

clinical social workers, psychiatrists and clinical psychologists. Three major types of psychotherapy are practised today - individual therapy, group therapy, and marital and family therapy.

a) Individual Therapy

Originally practised only by psychiatrists, the first form of individual therapy was psychoanalysis, an activity which required considerable investments of time and money by the client. Currently, analysis or "dynamic" therapy is also practised by other professionals, but the influence of the involvement of these others, particularly clinical psychologists, has been the development of and growing interest in other methods of treatment which are more time and money efficient and require less rigorous training for practitioners. The most prominent of these new developments are Rogerian "non-directive" therapy, Gestalt therapy and behaviour therapy, with the development of the latter being heavily influenced by the work of clinical psychologists who have particular training in learning theory. The aims of individual therapy may be divided into two approaches: Traditional long-term dynamic approaches claim to result in "personality restructuring", whereas the modern, more short-term approaches have as their aim the resolution of problems in areas of current functioning.

b) Group Therapy

An increasingly popular method of therapy, group therapy focusses on the relief of problems through the exploration and modification of interpersonal relationship skills of the client. Interventions of therapists are primarily related to

the processes within the group and the patterns of relationship occurring between group members, with the aim of assisting individual members to recognize and modify destructive patterns which they repeat in their private lives, and to cultivate constructive patterns which they observe and experience within the group. As in individual therapy, the therapist may be directive or essentially inactive and may employ varying techniques depending on his or her basic theoretical orientation. Groups may take many forms and have differing aims - e.g. experiential groups for essentially normal people wishing to maximise their relationship potential, groups of psychiatric patients sharing and assisting one another in their experiences of difficulties in adjusting to society, or professional groups within organizations wishing to improve their occupational functioning by ironing out interpersonal difficulties.

c) Marital and Family Therapy

Often regarded as a special form of group therapy, family therapy is based on the assumption that personal problems arise within a wider system of dysfunctional relationships and roles, the most immediate of which is the family. Essentially directive in approach, the therapist in this model, removes the cause of the problem by manipulating the patterns of interaction between members of the family system. Once again, differing techniques are dictated by different theoretical schools of thought.

2.2.3 Research

Traditionally an important area of functioning in psychology, professional organizations such as the APA and many institutions employing clinical psychologists, such as state mental hospitals and universities, encourage clinical psychologists to engage in research as one of their major activities. Because of their numerous other responsibilities it is difficult for many practitioners to devote much time to this activity and those in private practise are hampered by a lack of facilities and equipment. For these reasons, clinical psychologists generally engage in far less research than the psychologists registered in other categories (APA monitor). Nevertheless, with their particular training in research methodology and assessment techniques, clinical psychologists, of all mental health professionals, are probably the best equipped to engage in research into what remains an underdeveloped field of knowledge - the causation, treatment and prevention of emotional and behavioural disorder. In this rapidly expanding field, research therefore remains one of the most important functions of the modern clinical psychologist.

2.2.4 Community Mental Health Programmes

Growing awareness of the role of societal and economic circumstances in the etiology of psychiatric disturbance has led to a recent emphasis on preventative measures in the form of community mental health programmes. In this context, clinical psychologists must relinquish their traditional roles of diagnostician and therapist in a direct service relationship and must redefine themselves as operating in a consulting

capacity. The important function here is to apply principles of action, diagnosis and treatment to ppoblematic situations, analyzing these and proposing solutions on the basis of current knowledge of common factors underlying emotional and behavioural disturbance. Rather than acting as a direct agent of change, the clinical psychologist involved in such a programme motivates and directs members of specific communities and of the broader society to effect reforms which will lessen the probability of psychiatric problems being generated.

2.2.5 Legal Involvement

Increasingly, as clinical psychologists' expanding roles bring them into contact with a wider range of human concerns, the necessity for co-operation with the legal system, traditionally the guardian of the best interests of all members of society, increases. Clinical psychologists may be required to assist in the assessment of criminal responsibility or fitness to stand trial in criminal cases. They are also frequently assessors in compensation claims resulting out of physical or emotional injury, and in custody disputes. A third form of involvement may arise when clinical psychologists are required to give evidence in cases involving a client who is in therapy with them.

2.3 THE DEVELOPMENT OF ETHICAL CODES IN CLINICAL PSYCHOLOGY

The need for professional codes of ethics has been outlined in chapter one. This section describes the process of development of such a code for clinical psychologists, specifically focussing on this process as it occurred in the United States of America, for the reasons stated earlier in this chapter.

The growth of the American Psychological Association has been briefly described earlier in this chapter. This is a powerful body with a large proportion of its membership (approximately thirty seven per cent according to Sundberg and Tyler (1963)) being clinical psychologists. Up until the immediate post war period, the ethical codes applied to psychologists had been largely bound by existing codes of other professions, most notably medicine (Wolman, 1965), a situation which proved unsatisfactory as these codes lacked authenticity and relevance, failing to provide adequate guidelines for psychologists who, in their professional capacities, were faced with particular kinds of ethical problems, which could not be accommodated by the principles embodied in the ethical codes of other professions. It was for this reason that, under the direction of the United States Public Health Service, the APA undertook in 1948, to derive a code of ethics specifically for clinical psychologists.

The strength of the resulting code arises out of the method by which it was derived. Rather than working from general ethical principles towards specific rules, the council adopted an empirical, inductive approach to the problem, inviting all of its members to submit examples of situations which they felt had ethical signicance. On the basis of these examples, major problem areas were defined and principles derived. The result was the booklet entitled Ethical Standards of Psychologists, published in 1953. The code embodied in this booklet was supported by a casebook of illustrative examples providing direction for practitioners faced with ethically problematic situations, and

was greeted with widespread approval by American psychologists.

Wolman (1965) writes: "To be effective the psychologist's code of ethics must be continually revised andbrought up to date". This is particularly true of clinical psychology in which research and practise are continually expanding the areas of functioning within which practitioners operate. In 1974, the APA set about this process of review and attempted to update their existing standards. They submitted successive drafts (of which there were at least eight) to the scrutiny of APA members and finally adopted the revised Ethical Standards of Psychologists in 1977. Following this revision, it became apparent that psychologists registered within different categories were working in differing settings and employing different methods and therefore required more specific guidelines for work within their respective fields. In 1980, after three years of research this problem was solved by the adoption of the "Speciality Guidelines for the Delivery of Services Provided by (Clinical, School, Counselling, Industrial/Organizational) Psychologists", which serve as an adjunct to the more general standards. Enforcement of the standards embodied in the APA code is entrusted to the Committee on Scientific and Professional Conduct, which was established to assess and adjudicate claims of malpractice by psychologists. They operate within specific procedures which guide them in deciding on the validity of claims and the punitive measures to be taken against transgressors.

This chapter has reviewed the development of professional psychology and the various ways in which members of the profession may come into contact with members of the public and other professionals. The extent of this involvement makes an ethical

code to regulate this contact obviously essential and the methods used to develop such a code in the United States of America have been described. At this point some discussion of the adequacy of this code must occur.

CHAPTER THREE

A CRITIQUE OF THE 'APA' ETHICAL STANDARDS

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A CRITIQUE OF THE APA "ETHICAL STANDARDS"

Numerous papers have been written since the publication of the APA's Ethical Standards on the topic of the many ethically problematic situations still confronted by psychologists. This is testimony to the fact that, although generally acknowledged as a practical and relevant guideline to ethical decision-making, the code as it stands has certain limitations. This chapter begins with a description of the content and structure of the code, proceeds on to a discussion of its major shortcomings and ends with a proposal for revision of the code, which may assist in alleviating some of its major drawbacks.

3.1 STRUCTURE AND CONTENTS OF THE APA CODE

The method by which the Ethical Standards were derived have been described in Chapter Two. Problematic situations submitted by psychologists to the committee responsible for devising the code were seen as falling into nine major categories and rules for conduct were set up under each of these categories.

The code begins with a general statement of the values and responsibilities of psychologists. Called the preamble to the standards, it reads as follows:

> "Psychologists respect the dignity and worth of the individual and honour the preservation and protection of fundamental human rights. They are committed to increasing knowledge of human behaviour, of people's understanding of themselves

and others and to the utilization of such knowledge for the promotion of human welfare. While pursuing these endeavours, they make every effort to protect the welfare of those who seek their services or of any human being or animal that may be the object of study. They use their skills only for purposes consistent with these values and do not knowingly permit their misuse by others. While demanding for themselves freedom of inquiry and communication, psychologists accept the responsibility this freedom requires, competence, objectivity in the application of skills and concern for the best interests of clients, colleagues and society in general. In the pursuit of these ideals, psychologists subscribe to principles in the following areas:

1) Responsibility,
2) Competence,
3) Moral and legal standards,
4) Public Statements,
5) Confidentiality,
6) Welfare of the Consumer,
7) Professional Relationships,
8) Utilization of Assessment Techniques, and
9) Pursuit of Research Activities"

(APA Ethical Standards of Psychologists (1971), p.1).

The nine areas mentioned in the preamble are then expanded upon, with each consisting of a generally stated principle followed

by a set of rules and guidelines for practise. The principles and briefly summarized rules are presented below:

Principle 1, Responsibility.

> "In their commitment to the understanding of human behaviour, psychologists value objectivity and integrity, and in providing services they maintain the highest standards of their profession. They accept responsibility for the consequences of their work and make every effort to ensure that their services are used appropriately." (p.1).

In this first section, the rules refer to the duties of psychologists as researchers, employees of government or private institutions, teachers, practitioners and supervisors. They outline the necessity for careful consideration by psychologists of the methods and techniques they employ and of the possible consequences - especially abuse by others - of the results of their work. Willingness to reveal all facts about methods and results to interested parties is demanded and it is stated that the psychologist has a responsibility to ensure that institutional practises which may be to the detriment of individual clients or society as a whole are exposed and reformed.

Principle 2, Competence.

> "The maintenance of high standards of professional competence is a responsibility shared by all psychologists in the interest of the public and

> the profession as a whole. Psychologists recognize the boundaries of their competence and the limitations of their techniques and only provide services, use techniques or offer opinions as professionals that meet recognized standards. Psychologists maintain knowledge of current scientific and professional information related to the services they render." (p.2).

In this section the duty of psychologists to accurately represent their abilities to clients and to re-educate themselves constantly in order to develop and expand these abilities is described. The necessity to be aware of and avoid the possibility of personal problems interfering with effectiveness as practitioners is emphasized. Finally, the propagation of inaccurate knowledge through insufficient preparation by teachers is indicated as a problematic area requiring attention.

Principle 3, Moral and Legal Standards

> "Psychologists' moral, ethical and legal standards of behaviour are a personal matter to the same degree as they are for any other citizen, except as these may compromise the fulfillment of their professional affiliations and functions or reduce the trust in psychology or psychologists held by the general public. Regarding their own behaviour, psychologists should be aware of the prevailing community standards and of the possible impact upon the quality of professional services provided by their conformity to or deviation from

these standards. Psychologists are also aware of the possible impact of their public behavior upon the ability of colleagues to perform their professional duties." (p.2).

Here, the psychologist's duty to uphold the rights of members of the public by opposing institutional practises that involve discrimination on the basis of race, sex, age, religion or national origin and by avoiding in their own practise actions which diminish the civil or legal rights of their clients. They are also directed to be aware of state legislation which may have implications for the conducting of their practise and are specifically directed to develop legal and quasi-legal regulations which best serve the interests of the public and to work towards changing existing regulations which are not beneficial to public and professional interest.

Principle 4, Public Statements.

"Public statements, announcements of services, and promotional activities of psychologists serve the purpose of providing sufficient information to aid the consumer public in making informed judgements and choices. Psychologists represent accurately and objectively their professional qualifications, affiliations, and functions, as well as those of the institutions and organizations with which they or the statements may be associated. In public statements providing psychological information or

> professional opinions or providing information about the availability of psychological products and services, psychologists take full account of the limits and uncertainties of present psychological knowledge and techniques." (p.3).

Advertising procedures as such are considered unethical within the APA code, with public statements being largely limited to a statement of the practitioner's name and qualifications. No description of services offered or mention of the psychologist's employer is allowed unless the latter is directly supervising the services offered. Psychologists are expressly forbidden to endorse any product themselves and may not use members of the public to endorse their services. The psychologist concerned is directed to correct public statements made by other members of the public which violate these standards.

Principle 5, Confidentiality.

> "Safeguarding information about an individual that has been obtained by the psychologist in the course of his teaching, practice or investigation is a primary obligation of the psychologist. Such information is not communicated to others unless important conditions are met." (p.4).

Rules within this section state the psychologist's responsibility to inform the client of the limits of confidentiality and to safeguard confidential records, releasing confidential information only when the client has given express permission for

this release, there is clear and imminent danger to the individual or society, or the investigation has been requested by another professional who, in this case, is the only person to whom the information may be communicated.

Principle 6, Welfare of the Consumer.

> "Psychologists respect the integrity and protect the welfare of the people and groups with whom they work. When there is a conflict of interest between the client and the psychologist's employing institution, psychologists clarify the nature and direction of their loyalties and responsibilities and keep all parties informed of their commitments. Psychologists fully inform consumers as to the purpose and nature of an evaluative, treatment, educational or training procedure, and they freely acknowledge that clients, students or participants in research have freedom of choice with regard to participation." (p.4).

Here, the psychologist's duty to ensure that activities and relationships with clients are always beneficial is specified. Where this is not the case, the relationship must be terminated. Dual relationships with clients are labelled as detrimental and sexual intimacies are specifically mentioned as being unethical. Psychologists are directed to keep payment for services in accordance with professional standards and to devote a certain proportion of their time to societally beneficial activities for which they receive little or no remuneration.

Principle 7, Professional Relationships.

> "Psychologists act with due regard for the needs, special competencies and obligations of their colleagues in psychology and other professions. Psychologists respect the prerogatives and obligations of the institutions with which they are associated." (p.5).

Psychologists are directed to recognize the possible contributions of other professionals to the maximal well-being of their clients and to co-operate with these others in providing services. The responsibility of psychologists to attempt to rectify malpractice within institutions or by professional colleagues is outlined, but it is stated as necessary to do this within professionally recognized channels, with public exposure being used only as a last resort. Acknowledgement of major contributors to publications via the assignment of publication credit is also included in this section.

Principle 8, Utilization of Assessment Techniques.

> "In the development, publication and utilization of psychological assessment techniques, psychologists observe relevant APA standards. Persons examined have the right to know the results, the interpretations made, and, where appropriate, the original data on which final judgements were based. Test users avoid imparting unnecessary information which would compromise test security, but they provide requested information that explains the basis for decisions that may adversely affect

that person or that person's dependents." (p.6).

Under this heading, the psychologist is allocated the responsibility of using understandable, non-technical language in explaining the purposes, results and implications of these results to the client. In scoring and interpreting tests, the necessity of taking into account possible limitations and reservations about results is outlined as is the psychologist's responsibility to prevent misuse of these results. In developing tests, the psychologist is directed to state clearly methods of administration and interpretation and the nature of the standardization sample in order that the above conditions may be met.

Principle 9, Pursuit of Research Activities.

> "The decision to undertake research should rest upon a considered judgement by the individual psychologist about how best to contribute to psychological science and to human welfare. Psychologists carry out their investigations with respect for the people who participate and with concern for their dignity and welfare." (p.6).

The major emphasis in this section is on the protection of human subjects involved in research by avoiding unnecessary physical or emotional distress and fully informing participants of the methods, possible deleterious effects and relative responsibilities of experimenter and subject embodied in the research procedure. Confidentiality of participants' identities is regarded as an important protective measure.

3.2 LIMITATIONS OF THE CODE

Criticisms of the APA's Ethical Standards appear to fall into two broad categories, which are related but may be discussed separately. The first of these concerns the failure of the code to emphasize sufficiently the societal responsibilities of psychologists, while the second is concerned with conflicts within the code leading to ethical dilemmas for which the code itself provides no method of resolution.

3.2.1 Societal Responsibilities of Psychologists

Zemlick (1980) claims that the existing ethical standards in practice serve more as "cosmetics for the face of the profession" than as a protection for members of society from malpractises. He attributes this to inadequate policing of the standards, selection of trainees and faculty staff who are unlikely to challenge the status quo, and inadequate training in ethics, warning that these are resulting in increasingly restrictive external legislation which is threatening the integrity of the profession.

Other writers (Beck (1971), Kelly (1972), Simon (1974) and Sundberg and Tyler (1963)) assert that this failure to adequately protect members of society has a more fundamental cause than the mere failure to adhere to the existing standards. Rather, they demand that the standards themselves should more specifically demand the active involvement of psychologists in altering environmental, social and political circumstances which adversely affect the functioning and growth of the individual members of society who constitute the psychologist's clientele. This is expressed by Sundberg and Tyler (1963) as follows:

> "Psychologists not only need to be loyal to the highest ethical standards, but they must plan how they should relate themselves to the political forces which will decide just how psychology is to be utilized. In a democratic society, psychologists should be as committed to the development of independent thinking as the physician is to the preservation of life." (p.487).

These critics are reacting to what they perceive as the essentially conservative nature of the existing standards. They suggest that psychologists should be as concerned with wider positive social change and reform as they are with positive change in their individual clients, and, further, that this concern should not be the choice of the individual psychologist but should be part of the essence of the profession and should therefore be explicitly reinforced through the Ethical Standards.

There is some mention of the psychologist's responsibility to change state legislation which is not in the best interests of the public made under principle 3 of the Ethical Standards, but these authors maintain that this point is not made strongly enough, nor emphasized in the preamble to the code.

3.2.2 Conflicts generated by the Standards

Talbutt (1981) states: "On one hand there are conflicts within the standards. On the other, there are legal and ethical issues not covered by the standards." (p.110). The example he quotes

of an internal conflict is that between the responsibility of the psychologist to his client and his simultaneous responsibility to his employing institution, claiming that the code provides no guide-lines for action when these two responsibilities came into conflict, as when the demands of the institution are at variance with the client's needs. Legal and ethical issues not covered by the code cause dilemmas when the specific duties of the psychologist as outlined in the code came into conflict with the laws of the State. Once again, no guidelines are provided as to which of his duties - that to his client or that to the State - should be given priority by the practitioner.

Talbutt's reservations are echoed by Hobbs (in Wolman, 1965) and Michels (1976), with the latter including the profession - therapist - patient triad as a potential source of conflict, expressing concern that the tendency (and duty) of the profession to protect its members against public condemnation may make it easier for therapists to capitulate to the demands of larger more powerful bodies such as the State or employing institution than to support the client against these bodies.

In summary, then, there are two kinds of ethical conflicts, of which the APA code does not seem to take adequate account. The first are conflicts within the code itself, that is, rules contained within the code may conflict in specific situations, while the second kind of conflict is conflict between the rules contained within the psychologist's ethical code and rules which are enforced by the legal structure of the society. One

of the major criticisms which can be levelled at the APA code as it stands is, therefore, that it provides no guidelines for psychologists as to how to approach such ethically conflictual situations.

3.3 PROPOSED APPROACH TO THE LIMITATIONS OF THE APA CODE

As was indicated in Chapter One, there is no possible ethical code which will not give rise to the kinds of conflicts and objections described in the previous section. No code can account for all possible ethically problematic situations in which individual practitioners may find themselves. However, it is proposed in this section that further development of the existing AP A code could provide psychologists with a guide to the kind of approach which could be taken in making difficult ethical decisions.

In Chapter One the essential structure and development of an adequate ethical code was mentioned briefly. At this point it will be useful to review this structure, which can be conceptualized as consisting of four levels. These levels are diagrammatically represented in Figure 1.

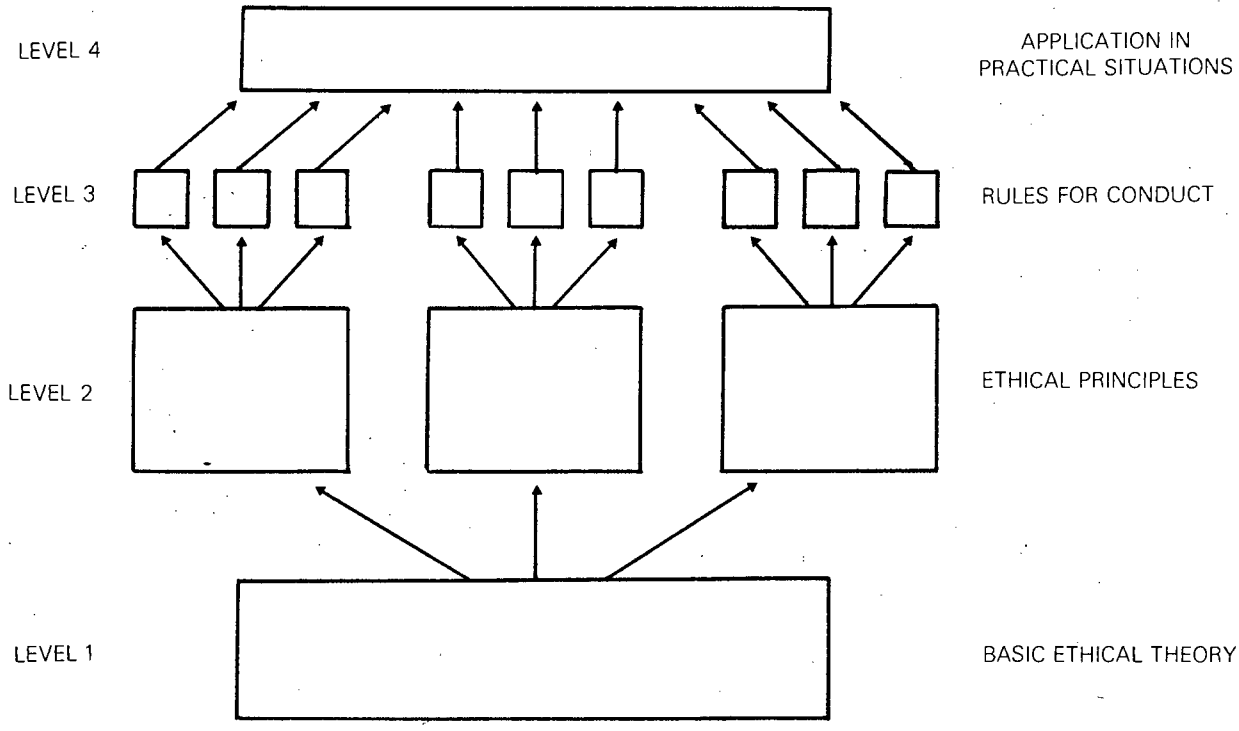

FIG 1: ETHICAL THEORIES GIVE RISE TO ETHICAL PRINCIPLES UPON WHICH RULES FOR CONDUCT ARE DERIVED. THESE RULES ARE THEN APPLIED IN PRACTICAL SITUATIONS.

In their construction of the Ethical Standards, the APA in fact worked in reverse order, starting inductively with reports of ethically significant situations from which they derived rules for conduct.

Working backwards from these rules they proposed that these seemed to fall into 9 distinct categories which the Ethical Standards refer to as principles, but which could perhaps more accurately be termed "practical principles", to distinguish them from the "ethical principles" referred to in the above diagram.

While this method of deriving the standards had the advantage of resulting in rules which are practical and relevant to real situations,

their system lacks an explicit coherent ethical basis, which, had it been present, would have placed the rules within a broader ethical perspective. It is apparent that, in constructing the code, the rules derived for different situations must have been grounded in some more basic ethical assumptions and principles, but these basic principles and the ethical theory from which they derive have not been made explicit in the body of the code. As the system exists, the rules stand by themselves with no justification apart from their practical relevance and consistency with the broad values outlined in the preamble. This is problematic in that in all situations all rules can be seen as carrying equal weight and it is therefore difficult, if not impossible, to make an ethically justifiable choice as to which rule to follow in situations where one or more rules conflict.

A solution to this problem may be to explicitly relate the practical principles and rules outlined in the body of the standards to more basic ethical principles, which in turn would be derived from the central tenet of one of the ethical theories described in Chapter One. In problematic situations where rules conflict it would then be possible to appeal to these more basic principles or, if necessary, to the ethical theory itself in deciding which action to take. The chosen action would then be the one which best fulfills the demands of the ethical principle or of the central tenet itself.

A commonly encountered ethical dilemma occurs when psychologists are requested to reveal confidential information about a client in the context of a legal investigation, in which case it is

difficult to decide which duty takes priority - the duty of confidentiality or the duty towards the legal standards of the society. When placed within the context of an ethical system defined according to the outline in the previous paragraph, this conflictual situation is depicted in figure 2.

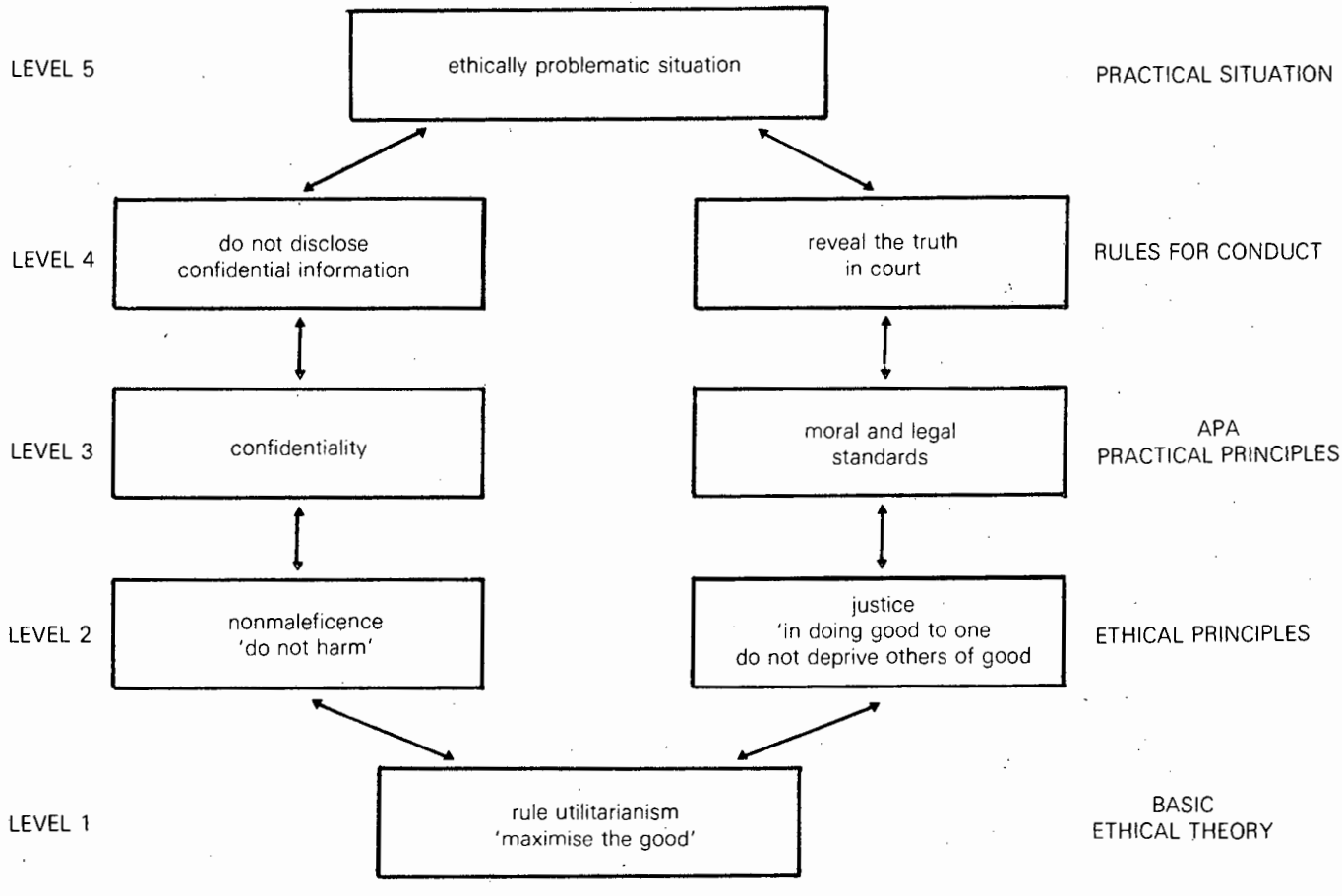

FIG 2: THE STRUCTURE UNDERLYING AN ETHICALLY CONFLICTUAL SITUATION

It can immediately be seen that, at the level of rules, there can be no resolution as both rules have equal weight although they demand opposing behaviours of the psychologists. This problem continues to exist at the level of practical principles, which is the most basic level encompassed by the APA code.

Thus, in this situation, the contents of the code are inadequate in providing guidelines for ethical decision-making. Reference to the more basic ethical principles is still not sufficient as the rules derive out of different principles having equal importance within the system. However, by referring to the most basic axiom of the ethical theory on which the system is based, some guide to decision-making is possible. Here, the decision can be based on which of the two possible courses of action would best satisfy the directive to "maximize the good". This judgement needs to be based on a careful evaluation of all the relevant environmental factors operating in the situation and would seldom be an easy task, but the resulting decision would be less likely to be arbitrary or possibly based on the psychologist's self-interest. It would be an ethically informed choice and one which could be publicly justified on the basis of the psychologist's accepted ethical position. If such a system were in operation, not only would ethically based choices be easier to make in cases of ethical dilemmas, but the psychologists could be held accountable by his profession and by the broader society in the event of his failing to make such a decision.

Besides addressing the problem of the resolution of such ethical dilemmas, the development of such a system may well go some way towards answering the question of the extent of the psychologist's societal and political responsibility. For example, if the rule utilitarian theory were adopted as the basis of the ethical code, the clinical psychologist could be viewed as having a duty towards effecting societal and political reform, where this would be the best method of maximising the good. This duty could be comfortably encompassed and emphasized within a code based on a fundamental

directive of this nature.

It is not suggested that psychologists working within such a system would inevitably make choices which would have the best possible outcomes. It is seldom possible to be fully aware of all the possible variables operating within a particular situation or to accurately predict the future consequences of any action. Weighing "the good" is also in essence an extremely difficult task. However, the evaluation of an action lies not so much in its consequences as in the intentions which underlie it. If it can be proved that an individual psychologist made a decision which to the best of his knowledge was consistent with the ethical system within which he was operating, then his resulting action cannot be judged as unethical. Other problems arise when, within particular social systems, an action which is not unethical may well prove to be illegal, but this is an area which will be discussed at a later stage of this thesis.

CHAPTER FOUR

PROPOSALS FOR THE DEVELOPMENT OF AN ETHICAL CODE

FOR SOUTH AFRICAN CLINICAL PSYCHOLOGISTS

CHAPTER FOUR

PROPOSALS FOR THE DEVELOPMENT OF AN ETHICAL CODE FOR SOUTH AFRICAN PSYCHOLOGISTS

This chapter has two major aims. The first is to critically review the existing legislation concerning ethical standards for South African psychologists, while the second is to propose ways in which a more adequate code may be developed. As background to this discussion the professional organization of psychology in South Africa will initially receive consideration.

4.1 PROFESSIONAL ORGANIZATION OF PSYCHOLOGY IN SOUTH AFRICA

In South Africa, psychologists are registered with the South African Medical and Dental Council and therefore fall under the jurisdiction of this body. Although carrying ultimate authority over the regulation of the profession, the council delegates most of the responsibility for matters directly relating to psychology to the Professional Board for Psychology. The powers assigned this board are specified in the Government Gazette of December 1976 (R232) - as follows:

The Professional Board may -

1) make to, or through the council, representation for the making, amendment or withdrawal of any regulation or rule which applies to the professional board to psychology.

2) inquire into any complaint, charge or allegation against any person registered under section 18 or section 25 as a psychologist or psychotechnician, of

improper or disgraceful conduct or conduct which, when regard is had to such person's profession is improper or disgraceful;

3) hold an inquiry, under the provisions of section 51 of the Act, in respect of a person registered as a psychologist or psychotechnician under section 18, or section 32 of the Act.

The composition of the Professional Board for Psychology is laid down in the Government Gazette of March 1979 (R437).

The Professional Board shall consist of ten persons and shall be constituted as follows:

1) Two persons, designated by the council, who shall be members of the council

2) Six persons, who shall be registered psychologists, elected by the persons whose names appear on the register of psychologists under Section 18 of the Act.

3) One person, who shall be a registered psychotechnician, elected by the persons whose names appear on the register of psychotechnicians kept in terms of Section 32 of the Act.

4) One person, designated by the council, who shall be a medical practitioner or dentist and who shall have a special knowledge of psychology.

The election in terms of subregulations 2 and 3 shall be conducted by the council and members shall be

elected for a period of five years, at the end of which period they shall vacate office. Provided that such members are eligible for re-election.

The Medical and Dental Council itself consists of 28 members, all of whom are medical practitioners. While there is a directive that one of these members must be the chairman of a Professional Board, at present this person is also a medical practitioner.

4.2 EXISTING ETHICAL REGULATIONS IN SOUTH AFRICA

At present these regulations are contained within the Government Gazette of September 1977 (R1856) and are listed as "Rules specifying the acts or omissions in respect of which disciplinary steps may be taken by the Professional Board for Psychology and the Council".

While there have been other sets of guidelines for ethical conduct which have been developed by non-statutory professional organisations such as the now defunct SAPA (South African Psychological Association) and PIRSA (Psychological Institute of Republic of South Africa), these guidelines have borrowed heavily from the American code and therefore suffer from the limitations of this code discussed in chapter three. The most serious drawback of these codes is, however, that they were developed by bodies of which membership was voluntary and which have no legislative powers within the profession. Thus, the rules set out in the Government Gazette of September 1977

will be regarded as the official set of ethical regulations for South African psychologists. These rules are listed in the Gazette as follows:

1) Advertising

A set of very specific rules are listed, outlining the extent and manner in which psychologists may publicize their services.

2) Business Advertisement

An extension of the rules on advertising, these rules refer to the prohibition of public association of the psychologist's name with any test material or institution.

3) Name Plates

Once again concerned with advertising, rules regarding the exact nature and position permitted for psychologists' name-plates are specified.

4) Visits by a psychologist to a place other than that at which he resides or practices

Secondary practises are disallowed unless they correspondend exactly in terms of time allocation and costs of services to the primary practise.

5) Letter-heads and Account Forms

Again concerned with advertising. Precise information listed on the above documents is limited by these rules.

6) Canvassing and Touting

These are prohibited.

7) Fees and Commission

Receiving and paying commission and sharing of fees are prohibited.

8) Covering

All locums must be registered psychologists. Consultation with any person not registered with the council is disallowed.

9) Clubs, Societies, etc.

A psychologist may not hold financial interest in an advertising psychological clinic or association.

10) Association with charitable institutions

No organization falsely purporting to be charitable in nature may be joined by a psychologist.

11) Tendering

This is prohibited.

12) Supersession

Taking over a case which has not terminated services with a previous psychologist is disallowed.

13) Improperly impeding a patient or client

Clients must not be prevented from obtaining a second opinion.

14) Professional reputation of colleagues and other registered persons.

False or unjustifiable criticism of the reputation, skill, knowledge, service or qualifications of any other registered person is prohibited.

15) Professional secrecy

Divulging of confidential information about a client is only permissable with the client's consent.

16) Certificates

Certificates issued to clients must be based on personal observations or carry the words "as I am informed...".

17) Professional Appointments other than appointments made under the Public Service Act

The conditions under which psychologists may accept appointments are noted.

18) Secret remedies, etc.

No form of testing, treatment, procedure, apparatus, or technical process may be kept secret by the psychologist.

19) Consulting Rooms

These may not be shared with persons not registered as psychologists without the board's approval.

20) Council's statutory duties

Psychologists may not impede the council in carrying out these duties.

21) Performance of professional acts by psychologists

Psychologists are neither permitted to perform services for which they are not adequately trained, nor to undertake treatment under improper conditions, except in emergencies. They are not allowed to undertake intensive long-term therapy unless the client has been referred by a medical practitioner or to diagnose a person's illness or prescribe medicine or surgery except in collaboration with a medical practitioner.

22) Performance of professional acts by psychotechnicians

The limits of the permitted functions of psycho-technicians are outlined.

23) Restriction in Practice of Psychologists

Psychologists may only practice within the category under which they are registered and may not be in partnership with or employ psychologists registered in other categories.

24) Exploitation

Psychologists must prevent exploitation of their services which are detrimental to public or professional interest.

Criticism of these regulations may be made in two areas - the method by which the rules were derived and the format and content of the set of regulations.

The essential difference between the American and South African systems at this level lies in the fact that while the APA (which constitutes the regulating body in America) is independent and composed entirely of psychologists, this is not the case in South Africa. The Professional Board for Psychology falls under

the direct jurisdiction of the South African Medical and Dental Council and must have at least two medical practitioners amongst its members, while the council itself is composed entirely of medical practitioners and its primary aim must be the furthering of the interests of medical practitioners and dentists. It is proposed that there are disadvantages inherent in this system. The primary disadvantage is that it is difficult for members of another profession, however closely related to psychology in values and aims, to fully understand the particular needs and problems of practising psychologists. Legislation approved by such other professionals may therefore not be as relevant to the specific requirements of psychology as could legislation determined entirely and solely by registered psychologists. Further, it is understandable, and perhaps expected, that the primary concern of these other professionals would be for the promotion and development of their own profession which, for them, may take priority over support for the interests of the profession of psychology. While it is not suggested that this is the case, it is possible that this fact could make the medical practitioners who constitute the Medical and Dental Council reluctant to amend or create new legislation which would promote the development of psychology where they may perceive such development as occurring at the possible expense of their own profession.

For these reasons, it is possible that the interests of psychology as a profession may be served better by the establishment of an independent regulatory body in which

psychologists would determine and enforce their own present and future professional standards. As has been described in previous chapters, over the years psychology has developed its own distinct professional identity and it seems inappropriate for this profession to be subsumed under an organisation established to regulate another profession which differs from psychology in many respects. In fact, referring back to the definition of a profession proposed in chapter one, it would appear that because of psychology's lack of autonomy and independence in South Africa, it does not fulfill the requirements of this definition and therefore cannot be fully regarded as a profession in this country.

4.2.1 The Development of the Current Regulations

Possibly due in part to the absence of an independent statutory professional body there has been no attempt to conduct extensive research into the particular problems faced by psychologists in South Africa. The current regulations appear to be heavily influenced by the regulations applying to medical practitioners with perhaps some detectable derivations from the APA code. In Chapter Two the problems inherent in transferring an ethical code from one profession to another have already been noted. These problems centre on the lack of authenticity and specific relevance arising out of such a transferral. Similar criticisms apply to the transferral of codes from one country to another, in that, as will be elaborated upon later, the particular kinds of ethical dilemma faced by psychologists must of necessity differ between countries with differing social, economic and political circumstances. The South African regulations appear

to be based on two kinds of transferral - cross-profession and cross-country - and therefore must inevitably suffer from certain shortcomings.

4.2.2 The format and content of the existing regulations

Hobbs (in Wolman, 1965) writes:

> "(ethical standards) must be more than a compendium of approved and disapproved ways of handling fees, referrals, advertising and countertransference". (pp.1507-1508).

The first criticism to be made here is that the existing regulations in South Africa are not only not more than the compendium quoted by Hobbs, but in fact less than this. The list of regulations reproduced earlier are merely a list of disapproved activities of psychologists and make no mention of approved actions in any situation. Psychologists are therefore left with no guidelines as to what constitutes ethical behaviour within their practise.

A lack of organization of these prohibited behaviours into logical categories makes them difficult to assimilate and apply, but this is an aesthetic objection and minor in relation to a far more serious objection which seems to be a result of the method by which the regulations were derived. Probably because there has been no investigation of the difficulties encountered by South African psychologists, there is a detectable discrepancy between the content and extent of the regulations and that of the psychologist's every day functioning.

This means that a disproportionate emphasis is placed on relatively minor areas of concern such as advertising, whereas concerns more intrinsic to the psychologist's roles and functions, such as ensuring the welfare of clients and furthering knowledge through research, are largely neglected.

At present, there is also no statement of the essential values and ethical attitudes to be held by psychologists, such as is presented in the preamble to the APA standards, and in the light of this, it is barely possible to call the existing list of rules an ethical code in any meaningful sense. In essence, the situation in South Africa may be compared with that existing in America prior to the publication of the original Ethical Standards in 1953.

It is unacceptable that a profession which has been established in South Africa for many years and which has an ever increasing number of members does not have an adequate ethical code. If psychology in South Africa is to adequately fulfil its functions, it is essential that this situation should be remedied.

4.3 PROPOSALS FOR THE DEVELOPMENT OF AN ADEQUATE ETHICAL CODE FOR SOUTH AFRICAN CLINICAL PSYCHOLOGISTS

An adequate ethical code for practising clinical psychologists should be relevant to practical situations and should take account of ethical dilemmas, providing psychologists with some guidance as to how to approach these ethically conflictual situations. The APA code, as was illustrated in Chapter three,

fulfills the first criterion, but does not fare as well in dealing with the problem of ethical dilemmas. It is suggested that in developing an ethical code for South Africa which fulfills both of these criteria, the practical relevance and utility of the APA code be retained, but some attempt should be made to meet the limitations of this code in addressing ethical dilemmas. In this section the ways in which these aims may be achieved will be considered with reference to firstly the structure of the code and secondly its contents.

4.3.1 Structure of an adequate ethical code.

The philosophical basis of an ethical code - that is, its roots in a specific ethical theory and the ethical principles encompassed within this theory - was outlined in Chapter one, while in Chapter three it was seen that the limitations of the APA code appear to arise out of its lack of a specific grounding in such a theory and principles. For this reason, it seems that in order to avoid the same limitations, an ethical code developed for South African clinical psychologists should be explicitly based in one of the major ethical theories discussed in Chapter one. The central tenets of this theory and the basic relevant ethical principles of autonomy, nonmaleficence, beneficence and justice should be concisely and clearly stated in an introductory statement contained within the body of the ethical code. To be maximally helpful, the introduction to such a code should outline how the rules for conduct in specific situations derive from the basic principles. It has been seen

that one of the major functions of an ethical code should be to provide an approach to the resolution of ethical dilemmas. It would therefore be desirable to describe the nature of these dilemmas and the process by which they may be resolved via reference to the ethical dilemmas, and, if necessary, to the underlying ethical theory within this introductory section of the code.

The question arises as to which of the two ethical theories - rule-utilitarianism or rule-deontological theories - would be most appropriate in forming the basis of an ethical code for clinical psychologists. Beauchamp and Childress (1979) argue that the same four ethical principles may be encompassed within both theories, and if this argument is accepted without further philosophical consideration, it appears that on this theoretical level there is little to choose between the two theories. However, psychologists are concerned with choosing a theory which will have maximal practical relevance and utility in guiding them in situations which are ethically conflicted, and at this point it may be useful to consider each of the ethical theories in the light of their potential usefulness in these kinds of situations.

Referring back to Ross's conceptualization of rules as prima facie duties outlined in Chapter one, it will be remembered that one's actual duty in a situation may be determined by the relative weighting of prima facie duties encompassed within this situation. The question arises as to how this relative weighting is to be assigned. Within a rule-utilitarian theory

the weighting assigned to prima facie duties or rules would be based on an assessment of the likelihood of each rule accomplishing the basic aim outlined in utilitarianism, which is to maximise the good. The chosen action in this situation would be to follow the rule which would result in more good relative to the other rules. In deontological theory, however, it will be remembered that rules arise out of more basic principles which are absolute in themselves and therefore equal to one another in importance. Using this latter theory, it would be necessary to choose between rules by devising, on the basis of these absolute principles, a hierarchical ordering of the rules to determine which would take priority. It is conceivable that across different situations in which different rules and environmental factors are operating this hierarchy would need to change in content and structure.

Psychologists, in their day-to-day functioning are confronted by a wide variety of situations encompassing differing demands in which their decisions may have widely varying consequences. To devise a different hierarchy of rules for each of these specific situations would be an impossible task, and, for this reason, on the level of practical application, the rule-utilitarian theory may constitute the best basis to be adopted for an ethical code for psychologists, providing, as it does, a standard approach to the evaluation of actions dictated by conflicting rules in working situations. It must be noted that the choice of rule-utilitarianism as a basic ethical theory is not based upon a detailed critical review of each of the ethical theories and their philosophical compatibility with the ethical principles,

as such a review has not been within the scope of this thesis. It is possible that in the light of more detailed consideration, a deontological theory may possibly prove to be preferable. However, accepting at face value the rule utilitarian theorists' assertion that these ethical principles may be encompassed within their theory, the above arguments are valid. For this reason, for the purposes of this thesis, rule-utilitarianism will be regarded as the most useful ethical theory on which to base an ethical code for South African clinical psychologists.

In summary, the structure of an adequate ethical code which can account for and suggest an approach to the resolution of ethical dilemmas in the practise of clinical psychology must conform with the following format:

1) A basic ethical theory. This may be either rule-utilitarianism or a deontological theory, although on the basis of the arguments presented in this thesis rule-utilitarianism is proposed.

2) Ethical principles encompassed within the ethical theory. These are the four principles of autonomy, nonmaleficence, beneficence and justice.

3) Rules for conduct in specific situations. It would be made explicit within the code that these rules are based on the ethical principles as outlined.

The specific areas of functioning which should be covered by these rules will be discussed in the following section.

4.3.2 Contents of an adequate ethical code for South African clinical psychologists

The rules contained within the body of an ethical code for South African clinical psychologists must fulfill the first criterion of an adequate ethical code - that is, they must be relevant to practical situations encountered by psychologists and they must be comprehensive, covering all areas of functioning within which ethically problematic situations may arise.

The areas of functioning of clinical psychologists were identified in Chapter two as being psychological assessment, psychotherapy, research, community work and medico-legal work. Rules contained in an ethical code must regulate the psychologist's conduct and provide guidelines for approaching ethical dilemmas in all these areas of functioning and must also account for more general issues of professional conduct, such as the ways in which psychologists make themselves known to the public, the ways in which professional relationships are conducted and maintained, and the ways in which psychologists as professionals may receive remuneration.

It has also been noted that the kinds of ethical dilemmas which may arise within each of these areas will differ across different countries with different societal structures. For this reason, it can be expected that while there will be commonalities between ethical codes in different countries, the details of the regulations may differ according to the particular needs and difficulties of differing societies.

In order to ensure that the regulations contained within an ethical code for clinical psychological practising in South Africa are sufficiently comprehensive and relevant to the particular social circumstances of this country, it would seem that an empirical study similar to that on which the APA Ethical Standards are based should be conducted to ascertain which areas of functioning present difficulties for psychologists in this country and what the nature of these difficulties are. These difficulties could then be taken account of by devising rules applicable in this situation, which rules, it must be remembered, would be based on the ethical principles which underline the code as a whole.

SUMMARY

The current situation in South Africa as regards professional organization of the profession of psychology and ethical standards for psychologists which are currently operative, has been critically reviewed, and suggestions have been made as to how this situation could be improved. These suggestions include the reorganization of the profession so that it has independence and autonomy in policy decisions, and the development of an ethical code which would be adequate in guiding psychologists in ethical decision making within all their areas of functioning. It was proposed that such a code should have a structure which is explicitly grounded in an ethical theory and ethical principles and therefore allows a standard approach to the resolution of ethical conflicts. In addition, it was argued that the content of the regulations should cover all potentially

problematic situations in the country and that the nature of these situations should be ascertained via an empirical study similar to that conducted by the APA in the development of their Ethical Standards.

SECTION THREE

PRACTICAL APPLICATIONS

OF

ETHICAL PRINCIPLES

SECTION THREE

PRACTICAL APPLICATIONS OF ETHICAL PRINCIPLES

In previous sections the philosophical basis of ethical codes and proposals for the development of an adequate ethical code for South African clinical psychologists were discussed. It was seen that such an ethical code should be constituted of at least three levels - that is, an underlying ethical theory, the four ethical principles of autonomy, nonmaleficence, beneficence and justice, and rules for conduct in specific situations. It was noted that the nature of the specific situations which require ethical regulation should be ascertained via an empirical study of the actual ethically problematic situations encountered by South African psychologists. This section is intended to provide an overview of the possible ethical difficulties encountered in some of the major areas of functioning of the clinical psychologist, and to demonstrate how ethical principles may be applied to these situations in order to derive guidelines for ethical conduct. This section is intended to be illustrative rather than exhaustive. It is not within the scope of this thesis to consider in detail all the major areas of functioning in which ethical dilemmas may be encountered by clinical psychologists, and for this reason it was decided to examine one major area - that is, psychotherapy - in depth and to highlight the major ethical issues in three other areas, namely research, assessment, and professional conduct and relationships. The reason for choosing psychotherapy as the area to receive the most attention is that it is on this area that the bulk of the literature on ethics in clinical psychology

has centred, which suggests that this area contains the most ethical complexities. Although not covered in this section, the areas of community work and medico-legal involvement would also require regulation within a fully comprehensive ethical code.

The section concludes with a consideration of the particular socio-political context of South Africa and the additional compexities which this may contribute to ethical conduct of South African clinical psychologists in many of the areas of functioning considered.

CHAPTER FIVE

ETHICS IN PSYCHOTHERAPY

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The definition of the roles and responsibilities, and the related issue of what constitutes ethical and unethical behaviour, of clinical psychologists as psychotherapists, has given rise to many conflicting arguments in the literature on the practise of psychotherapy. Opinions differ not only between differing schools of psychotherapy but also between individual practitioners within each school. Many of these conflicts seem at present irresolvable, with each opinion being supported by theoretical and empirical data. The aim of this chapter is therefore not to propose a resolution of all these conflicts, but to outline the kinds of arguments which have been put forward and to review some of the suggestions which have been made in the literature concerning ways in which the therapist can deal with commonly encountered ethical dilemmas.

The major areas in which ethical dilemmas are encountered in psychotherapy will be discussed in this chapter under the sub-sections of the societal role of psychotherapists, values and goals in psychotherapy, the psychotherapist's responsibility towards clients, and methods and techniques of psychotherapy.

Finally, the value of the rule-utilitarian ethical theory in providing an approach to these problems will be considered.

5.1 THE SOCIETAL ROLE OF PSYCHOTHERAPISTS

This constitutes one of the central issues which has engendered

disagreement amongst psychotherapy practitioners. Classical theoretical writings on psychotherapy appear to make little or no mention of the broader societal role of psychotherapists, focussing on the responsibility of therapists towards the individual client. This has given rise to the widely-held view that therapists should not concern themselves with broader social values and should concentrate on developing the capabilities of the individual client. In other words, these theorists see the psychotherapist's role as encompassing only responsibility towards their clients, and the particular pathology of these clients. The welfare of the individual client should therefore be their only concern. Engelhardt (1973), Breggin (1971) and Kennedy (1973) argue that this implies that psychotherapists should be "value-neutral" and that the process of psychotherapy is therefore "not telling the patient what the good is, but allowing the patient to choose the good".

This view is not unanimously held by psychotherapists, some of whom argue that by virtue of being members of society, therapists inevitably also have their own conceptualization of what "the good" is . (A commonly held view is put forward in Lederer's (1971) argument: "'good' is that which, in the overall and in the long run, furthers the survival of the human community" (p.83). This means that there is a body of psychotherapists who advocate that therapists should guide their patients in the direction of "good" behaviour. For example, Smith and Peterson (1977): "We need to guard against emphasizing individual autonomy at the expense of the community" (p.316); Graham (1980): "I do not think we ever convince our patients that we are neutral observers or that we

are devoid of moral judgement. I think a patient can and must be informed at times that his/her behaviour is odious" (p.371); and Garfield (1974): "the therapist has to make a decision that he can not only 'help' the client, that is, move towards the client's goal, but also that the goal is a 'desirable' one" (p.202).

Critics of this conceptualization of psychotherapy (most notably Szasz, 1960, 1961 and 1967) argue that this leads the process of therapy into becoming a means of social control in that the therapist's values are frequently identical with society's values, as the professions of psychiatry and psychology are created and maintained by society. These writers argue that many emotional problems are directly or indirectly caused by the values of the society and the restrictive roles it assigns to various of its members. Psychotherapy in the form described in the previous paragraph may therefore be seen as a self-defeating activity because it "accepts the society which established it and by enabling the society to maintain itself, perpetuates the problems it was planned to abolish" (Statman (1970), p.15). Even where therapists do not advocate directly advising clients as to what constitutes desirable or undesirable behaviour, it is felt by some writers that the inherent emphasis on the pathology of the individual client may indirectly be a mechanism of social control in that, as Hurvitz (1973) argues, "it trains the individual in continuing introspection and in the interpretation of people, processes and events by methods associated with investigation of the unconscious and away from the social causes of self-defeating behaviour" (p.233) and thereby, "makes personal problems of political issues" (p.235). Bugental (1971) argues against this viewpoint, asserting that methods of psychotherapy which espouse humanistic values such as

autonomy and responsibility automatically foster in clients a concern with broader societal issues and, furthermore, provide clients with the ability to tackle these issues and become involved in social reform. There has been no research which has investigated whether clients become more or less socially conscious and involved after therapy and until such research has been conducted, there will be no way of verifying the validity of either of these two opposing opinions.

Halleck (1971) proposes the viewpoint, supported by Strupp and Hadley (1977) that the diagnosis of maladaption or mental illness is made with reference to societal norms and that one of the implicit goals of psychotherapy contained within its explicit goal of "curing" mental illness, is therefore helping clients to adapt to these norms, rather than to challenge them. Halleck attributes this emphasis in psychotherapy to a reluctance on the part of therapists "to criticize institutions that have brought them to positions of relative affluence and power that they wish to retain, and they are concerned over whether it is ethical for a "politically neutral" healer to fight for reform" (p.34). However, he argues against the popular assertion that psychotherapy <u>is</u> politically neutral, writing: "By reinforcing the positions of those who hold power, the psychiatrist is committing a political act, whether he intends it or not" (p.32). In the light of this inevitable political involvement, Halleck goes on to suggest that therapists should work towards changing societal conditions which are not conducive to mental health. This can be achieved by treatment which encourages clients to examine and confront their environment, thus making the individual client an agent of social reform, but Halleck feels

that this may not be sufficient in view of the fact that therapy clients constitute a small minority of people who are "miserable enough or fortunate enough to obtain psychiatric help". Rather, the therapist should become actively involved in confronting those societal institutions which are oppressive and restrict the autonomous functioning of individual members of society. Halleck states further that, in fact, psychotherapists have more of an obligation to do this than ordinary citizens by virtue of their specialized knowledge which enables them to identify the specific factors in society which cause mental distress.

There will be no attempt in this thesis to suggest a resolution of this particular issue, which appears to be primarily related to the role-definition of psychotherapists, and thus an issue of professional policy. It is possible that through the process of the evolution of psychologists' conceptualization of themselves as professionals, some clearer stance may be adopted as to whether an aspect of the psychologist's role should involve active involvement in social reform. Until such time, this must remain a contentious issue.

Despite the continuing conflict of opinions over the precise nature of the therapist's responsibilities towards society, there is general agreement that the psychotherapist cannot ignore the demands of society completely. Promotion of the client's welfare (which is encompassed by the professional values of the therapist) is on occasion challenged by and must be tempered with the therapist's general responsibility towards the society in

which he lives and works (in other words, the responsibilities which he holds in common with all other members of society as opposed to his specific professional responsibilities). The ways in which conflicts between professional and societal responsibilities arise, the nature of these, and suggestions for ethical management of such conflicts, constitute the body of this chapter.

5.2 VALUES AND GOALS IN PSYCHOTHERAPY

The issue of the psychotherapist's values and the effects that these have on the process of psychotherapy is one which is frequently considered in the literature. As was briefly discussed in the previous section, many practitioners (e.g. Breggin (1971), Engelhardt (1973), Kennedy (1973), Strupp (1980) and Will (1981)) argue that the most important guiding principle is autonomy which implies that the therapist's obligation is to ensure that, through the exploration and understanding of the client's past and present conflicts, the client will eventually arrive at a position where he can "evaluate and select the ethics by which he wishes to conduct his life" (Breggin (1971), p.60). The "personal freedom" of clients to make their own choices regarding values and to choose values which may be different from those of the therapist is therefore held to be essential. Even therapeutic models which concentrate on "symptom-removal" rather than exploration of intrapsychic factors maintain that they are upholding the principle of autonomy in that they are removing symptoms which impair the client's ability to function autonomously.

The therapeutic values regarded as essential within this framework have been summarized by Strupp (1980) as follows:

"1) People have the right to personal freedom and independence

2) They have rights and privileges but they also have responsibilities towards others

3) People should be responsible for conducting their own lives without undue dependence on others

4) People are responsible for their actions but not their feelings, fantasies, etc.

5) People's individuality should be fully respected and they should not be controlled, dominated, manipulated, coerced or indoctrinated.

6) People are entitled to make their own mistakes and to learn from their life experiences" (pp.397-398).

Will (1981) expands on these, emphasizing the autonomy of the individual client within the therapeutic relationship as well as in his outside life, writing: "The patient's freedom is a matter of great concern. He is to have freedom of choice about the form of therapy, the selection of therapist, and his ways of expressing himself within the limits of safety, public acceptance, and the necessity to preserve the treatment process itself; he is free to live in ways that may not be congenial to the therapist" (p.209). Strupp (1980) expresses the basic tenet of this group of practitioners thus"...what is unique about the enterprise of psychotherapy is the basic

belief that...people will search for and find their own solutions to basic life problems" (p.400).

Although the approach suggested by the above authors may be the ideal approach, several writers have questioned the possibility of its practical application. Weisskopf-Joelson (1980) questions the possibility of the therapist maintaining a value-free neutrality in therapy, writing: "values are bound to be disseminated during the therapeutic process regardless of the therapist's intentions. The therapist's appearance and clothing as well as the appearance of his/her office communicate values. Even a noncommittal 'mmm' or a Rogerian reflection might, by its timing, suggest to the client what the therapist values as important" (p.462). Even the process of diagnosis, theoretically based on objectively observed symptomatology, appears to be heavily influenced by the therapist's own values. Research conducted by Braginsky and Braginsky (1973) showed that when dummy "patients" expressed political views which differed radically from those of the therapist they were judged as far more disturbed than patients who presented with the same symptoms, but expressed political views consistent with the therapist's. Further, this "worsening" of pathology was also noted when patients made critical comments about mental health professionals rather than flattering comments.

There has been some empirical evidence to support the notion that therapist's values are communicated to the client during therapy and that this has some influence on value changes in the client. Beutler (1979) quotes several research studies, including his own, which have revealed three relevant facts:

1) patients tend to evaluate the success of therapy on the basis of the therapist's initial goals rather than their own,

2) they acquire the "interest" patterns of their therapist, and

3) patients acquire their own therapist's values while concomitantly moving away from the value patterns of similarly trained therapists.

It would appear from this, that, while consciously attempting to avoid imposing their values on clients, therapists are unconsciously communicating their own values and reinforcing clients for adopting these values. In the light of these facts, it seems necessary for therapists to be continually aware of their own values and the extent to which these differ from those of the client and it may in fact be preferable for therapists to make their own values explicit while simultaneously reassuring the client that he has a right to disagree with these. This may avoid the seemingly inevitable implicit transmission of these values and the unconscious coercion of clients into adopting them.

Decisions as to the goals of psychotherapy are closely related to the issue of differing values of therapist and client. The writers reviewed earlier in this section seem to assert that there should be only one goal common to all therapy which is the ultimate autonomous functioning of the client, unhampered by intrapsychic conflict or debilitating psychiatric symptoms. The goal of adaptation to societal norms, criticized in the first section, is devalued by these writers who feel that the goal of

autonomy implies that the choice of whether or not to conform to society's demands is in the hands of the client and is not the therapist's decision. However, even within this model conflicts over goals may arise. For example, a client may come into therapy with the specific aim of adapting to a restrictive environmental situation. To take a hypothetical case: A woman who feels depressed and dissatisfied with her life due to pressures on her to conform to the traditional societal role assigned to women may request therapy with the specific aim of being able to accept this role without feeling depressed. The goal of the therapist whom she consults may, on the other hand, be the development of autonomy in this client, after the achievement of which she may well choose not to conform to this societally defined role. In other words, the client's goal is acceptance of and adaptation to these externally-imposed pressures, while the therapist's goal for the client is freedom from these same pressures. The question arises as to whether the therapist has the right to pressure the client to become autonomous when in fact what she wants to do is adapt.

The same conflicts are more obviously present in the types of therapies previously discussed in which the therapist feels that the client should work towards a "desirable" goal. The principle of autonomy as outlined in Chapter one asserts that clients have the right to decide on their own present and future actions as long as these do not affect the ability of others to do the same. Thus, where the client's goal is freedom from guilt so that he can continue to physically assault or even kill others, there is no conflict. Apart from this extreme example, though, there are many imaginable instances in which the goal which the

client perceives as "desirable" is not seen this way by the therapist. A possible approach to such conflict situations is suggested at a later stage in this chapter.

Another potentially difficult situation may arise when the therapist realises that the agreed-upon goal of therapy may require the client to sacrifice other aspects of his or her life which are valued in themselves. A well-known case reported by Cohen and Smith (1976) and discussed at some length in the literature (e.g. Coyne (1976), McLemore and Court (1977)) provides a good example of this kind of situation. In this case, the therapists felt that the cause of the patient's subjective distress and obsessional symptoms was the restrictions imposed on her by virtue of her religious affiliation (which was Christian Science). Therapeutic outcome was regarded as successful, but, as had been predicted by the therapists, but never made explicit to the client, this outcome involved some challenging of her religious beliefs which eventuated in her renunciation of her religion. As a result of this, her marriage became conflicted, in that her husband remained a staunch Christian Scientist, and she eventually obtained a divorce. The issue here was that the client, on entering therapy, had no intention of changing her religion or of obtaining a divorce and was not aware that working towards her goal of relief from distress would possibly involve these losses. Had she been aware of this possibility, she may well have decided not to engage in therapy. Such indirect effects of therapy are frequently recognized by psychotherapists and the question arises as to whether a client's decision to begin therapy can be fully autonomous unless he or she is aware of the possibility of these

effects and can weigh the benefits of achieving the therapeutic goal against the possible losses which may be involved. This weighting should arguably not be the therapist's task as he can never be fully aware of the value which the client assigns to the various factors involved.

5.3 RESPONSIBILITIES TOWARDS THE CLIENT

There is considerable agreement in the literature as to the range of responsibilities which the therapist incurs in relation to the client. These responsibilities can be seen as concerning issues of confidentiality, competence, dual relationships with clients, and involuntary hospitalization and the right to treatment. The nature of these responsibilities and their ethical justification in terms of the principles of autonomy, nonmaleficence, beneficence and justice will be discussed. Despite general agreement as to the nature of these responsibilities there are arguments within the literature as to the specific ways in which these responsibilities are realised within practical situations. These arguments will also be presented in this section. There will also be some consideration of the ways in which responsibilities towards the client commonly conflict with the therapist's more general societal responsibilities, but proposals for ways in which to approach these conflicts will be left for discussion in a later section of this chapter.

5.3.1 Confidentiality

Numerous authors have discussed the issue of confidentiality in psychotherapy (Dubey (1974); Plaut (1974); Lowental (1974);

Teichner (1975); Denkowski and Denkowski (1982); Mariner (1967)). The rationale for the ensuring of therapeutic confidentiality is based on the principles of autonomy (the client should be able to choose which information he wishes to reveal to which persons); beneficence (the client will be unable to reap the full benefits of therapy without a trusting relationship with the therapist); and nonmaleficence (the client may be harmed by the release of private information to other sources). Denkowski and Denkowski (1982) question the necessity for absolute confidentiality in non-psychoanalytic therapy, but still maintain that in order to protect patients from potential harm, it is essential to respect confidentiality. Several factors, especially in the United States, are making the maintenance of confidentiality increasingly problematic for therapists. The major difficulties appear to derive from the increased subsidisation of therapy fees by third parties such as medical aid associations, the increasing use of computer storage for confidential material, the nature of therapeutic work in institutions or mental health agencies and several recent legal rulings which appear to reduce the patient's rights to confidentiality and emphasize the demands on the therapist to breach confidentiality in certain circumstances.

Insurance companies in the United States who are increasingly bearing the financial burden of many clients' therapy payments are naturally concerned about the nature and effectiveness of the services for which they are paying and this has led to their increasing demands on therapists for information regarding the diagnosis, treatment plans and therapeutic progress of

individual clients. Many therapists are concerned about the release of this information to such bodies particularly where the client's employer may also have access to it.

Increasingly, large institutions and therapeutic agencies are making use of computer storage systems for confidential data. While this facilitates the efficient organization of the institution, it also provides easier access to confidential information by many potentially interested parties. There is special concern over the fact that many government agencies can gain access to such information by putting their own computers directly on-line to an institutions system and, through this so-called "computer rape" obtain confidential data without the institution's knowledge. Therapists are therefore encouraged to carefully monitor the nature of the information programmed into such systems, maintaining it at a minimum level.

Demands on the therapist working within such an institution are also frequently not conducive to maintenance of confidentiality. The sharing of information with other members of a therapeutic team via case conferences immediately diffuses the responsibility to maintain confidentiality and the release of information therefore becomes more difficult to maintain and control. In addition, the established tradition of "co-operation between agencies" means that therapists within such institutions are frequently requested to reveal information to other agencies who have some interest in the client. Dubey (1974) argues that this policy deprives the client of the right to confidentiality and, particularly where the client refuses to release such information, the therapist should run the risk of being labelled "unco-

operative" by his employing institution and also refuse to divulge such data. He argues that despite the potential extra expense, such other agencies should employ their own independent psychologists to evaluate the particular aspects of the client in which they are interested, pointing out that, as soon as information is released by an individual therapist to a third party, the therapist loses control over the further dissemination of this data and the client's rights may be more easily further eroded.

The major recent area of concern has been the legal injunction on therapists to breach confidentiality when the client is perceived to be dangerous to himself or others. Here, "dangerousness" has not been clearly defined and appears to encompass any form of criminal act. Robinson (1974) has argued against this broad definition and recommended that the concept of dangerousness be limited to private harm as in many societies activities which do not involve private harm, such as political activism, are also frequently defined as criminal acts. However, no legal ruling has as yet been made on this. According to the APA code the therapist is obliged in the case of dangerousness to inform "appropriate professional workers or public authorities", however, in the United States the much publicized "Tarasoff" case (1974) has raised doubt as to whether this limited breach of confidentiality is regarded as sufficient in the eyes of the law. This case highlights the conflicting loyalties that therapists feel towards their clients and towards society and has given rise to conflicting arguments in the literature. The circumstances of the case were that the psychotherapist was informed by his client of the client's intention to kill his girlfriend. Satisfied that

this was a serious threat, the therapist, in conformity with APA standards, informed the campus police at the client's university and requested that the client be detained. He was duly arrested by the police who questioned him and thereafter felt that further detention was not justified. Two months later the client killed his girlfriend whose parents then sued the therapist for negligence. The therapist was initially acquitted, but on appeal the Supreme Court ruled that he had not taken adequate enough precautions to ensure the safety of the woman as he had failed to warn her directly of the threat to her life. The judge in this case recognized the necessity for confidentiality, but ruled that "the protective privilege ends where the public peril begins". While this latter statement is generally accepted by psychotherapists, the extent of the responsibility to warn potential victims of danger is regarded with apprehension. Dubey (1974) and Bersoff (1976) amongst others point out that, firstly, "dangerousness" is notoriously difficult to predict beyond reasonable doubt, and, secondly, several ill-effects can arise out of direct warning to the potential victim, for which the therapist may be held responsible by the client. Dubey argues that in the event of such a warning, it is possible that the potential victim may "get at" the client first. Bersoff writes that, more commonly, "knowledge by the putatively potential victim may lead to abrupt disruption of the relationship between client and third party in instances where such disruption would not, in fact, be warranted" (p. 2-3). The therapist may, as a result of such consequences, be vulnerable to defamation of character law suits or be considered liable for the assault on the client or disruption of his relationships.

At this point it is important to note that the privilege of confidentiality is considered to be the client's privilege and not the therapist's, and therefore if the client gives consent for the release of certain kinds of information, the therapist is generally regarded as being under obligation to comply in revealing the information. Dubey (1974) presents several arguments for making the privilege of therapeutic confidentiality the therapist's as well as the client's.

Firstly, clients are frequently unaware of the possible consequences of giving consent for the release of confidential information and may be unwittingly compromising their position by so doing in certain circumstances.

Secondly, in some situations clients may be coerced into giving this consent. For example, in applying for employment, clients are frequently asked whether they are or have been in therapy. If they are honest and reply affirmatively to this question they are then asked to give permission for the potential employer to contact the therapist and ask questions about the client's condition and progress. If the client were to refuse to grant this permission his application would undoubtedly be jeopardised and he has little choice but to consent.

Finally, in cases where the revealing of confidential therapeutic information would benefit the client in some way (for example, in gaining exemption from military service), Dubey argues that the therapist's compliance in supplying the information reinforces

the secondary gain which the client derives from his symptomatology. This situation would be antithetical to the goals of the therapeutic process.

Thus, Dubey argues for a form of absolute confidentiality in which the therapist refuses to reveal confidential information about the client to any third party no matter what the purposes of the request for information and regardless of whether the client has given consent or not. Obviously where the therapist is required by law to reveal such information a dilemma arises, but Dubey suggests that all agencies which commonly request such information from therapists, including the courts, should employ independent professionals who are trained in eliciting the kind of information which the agency requires. He maintains that wherever possible, the therapeutic treatment of the client and evaluation of the client for other purposes should be separate tasks performed by separate professionals.

Laudable as this suggestion may be in maximising the welfare of the client, many practical problems may be encountered in its implementation including wastage of both time and money resources and it therefore seems unlikely that such a system will be implemented in the near future. Psychotherapists will therefore continue to be faced with many conflicts over the issue of confidentiality for some time to come. Proposed approaches to the resolution of these conflicts will be outlined in the final section of this chapter.

5.3.2 Competence

Clients who consult psychotherapists do so with the expectation that the therapist will be able to assist them in resolving their difficulties. The principles of non-maleficence and beneficence dictate that, in undertaking psychotherapy with a client, the therapist will possess the necessary competence to perform services which will not harm the client and which will have some beneficial result. Clients are frequently poorly informed as to the competence of therapists and the ensurance of competency must therefore lie in the hands of the therapists themselves and the professional organizations responsible for ensuring professional standards of practice. Several factors appear to be important in assessing and maintaining the competence of clinical psychologists as psychotherapists.

a) Basic Training and Professional Qualifications:

Most countries have an agreed upon set of academic qualifications without which the potential clinical psychologist may not become registered and may therefore not practise psychotherapy. Due to the relatively short time period of these basic training courses, frequently they provide only a broad introduction to the various modes and models of psychotherapy or else emphasize the practise of only one model, while affording other models only a cursory examination or neglecting them completely. In addition, it could be argued that it is only through experience in psychotherapy that an adequate level of competence is eventually attained. It is doubtful that there is sufficient time during the duration of the basic training course to gain enough experience to achieve this level. Therefore, although psychologists are theoretically

academically qualified to engage in any model of psychotherapy of their choice upon graduation from such a training course, their competence is of necessity initially limited due to their limited exposure to both the theoretical and practical aspects of many of these models. The differences between training programmes at differing universities both in terms of the focus and the intensity of training in psychotherapy produces extra complications in that psychologists who initially embark on careers as psychotherapists do not have a standardised minimal level of competence in any aspects of psychotherapy. Although it would not be practical or even desirable to standardise the main focus or preferred models of all psychotherapeutic training programmes, it may be helpful to set certain basic minimal standards for these programmes so that the public may be assured of some basic level of competence in novice therapists.

In order to achieve the desired level of competence in psychotherapy with the minimum risk of harm to clients it appears necessary then to advocate some post-graduate in-practice training for newly graduated therapists in the form of advanced training programmes in particular models and techniques and/or regular required supervision by more experienced practitioners for a stipulated time period.

b) Continuing Training and the maintenance of Competence

Singer (1980) points out that: "psychotherapy is best understood as an application of available scientific knowledge" (p.372). Because "available scientific knowledge" is constantly expanding and revealing new facts and relationships between facts, Singer

asserts that in order to maintain an optimum level of competence, psychotherapists must regularly scan scientific journals in order to modify both their theoretical understanding and practical applications of psychotherapeutic methods in order to benefit their clients maximally.

It could be argued that to adhere tenaciously to one model of therapy and apply it in the treatment of all clients, even where it is obviously not maximally beneficial may constitute incompetence in psychotherapists. In such cases, therapists must be prepared to refer such clients to more appropriate sources of help, or remain alert to the possibilities of other methods, especially those newly developed which may be of more benefit. Continuing training and education in such new techniques and methods even for experienced therapists would then be desirable to ensure competence. This aspect will be discussed further in the section on methods and techniques in psychotherapy. In any event, it remains essential for therapists to be aware of new developments and discoveries within their preferred model and not to assume that their basic training and years of experience make them sufficiently competent to continue practising within that model.

c) Personal needs of the therapist

Conflicts and problems within the therapist himself frequently interfere with the competent delivery of psychotherapeutic services. Such difficulties may obscure the therapist's understanding of the client's situation and may also lead him into using the process of psychotherapy to fulfill his own needs. In his discussion of the major causes of unethical practice, Schwebel (1955) identifies the therapist's self-interest as one of the major factors to be considered. He lists three main types of

self-interest: 1) personal profit motive - clients may be engaged inappropriately or the therapeutic process itself artificially prolonged because of the therapist's reliance on a regular clientele for his livelihood. 2) need for self-enhancement - inappropriate dependence in clients may be fostered as a means of validating the therapist's conceptualization of himself as an expert and helpful person. 3) need to maintain security and status - the limitations of the therapeutic relationship and the possible failure of the therapeutic endeavour may not be recognized by the therapist who needs his role as therapist to gain social status and security.

Brown (1980) in his discussion of the various forms of usuriousness in psychotherapy agrees with the points raised by Schwebel and in addition mentions "those instances wherein the patient is used to continue to work out the therapist's personal dynamics in relationship" (p.422).

The therapist needs to be constantly aware of the possibility of such personal problems and needs interfering in the psychotherapeutic process, and where he has identified such difficulties should consult with peers, or a supervisor, and if necessary, enter therapy himself in order to resolve these problems.

d) Recognition of Limitations

Although clients frequently feel that therapy will be the panacea for all their problems, it is widely recognized that all therapeutic models and methods have limited effectiveness. It is the therapist's responsibility to recognize these limitations and, where therapy is no longer beneficial to the client, to

terminate the process and refer the client to alternative sources of help.

Apart from these technical limitations, the therapist's personal limitations need to be considered. Some of these were considered in the previous section, but, in addition, many therapists find that because of personal factors, they prefer working with some clients and find it very difficult to work with others. As the therapist's personal feelings towards the client undoubtedly affect his competence in offering adequate therapy, these types of personal limitations also need to be recognized. Many personal needs of therapists obscure their recognition of limitations whether technical or personal, and this must be detrimental to clients who are consequently denied the opportunity for more successful treatment elsewhere. This situation is aggravated by the fact that the more inexperienced a therapist is, the more inadequate and insecure he feels in his role and consequently the less willing he is to admit to these kinds of limitations. This means that the more incompetent therapists are in fact the least likely to recognize their limitations, and highlights the need for monitoring through supervision, especially for novice therapists.

In summary, the ethical psychotherapist ensures his competence by ongoing training and supervision, caution in the practise of new or unfamiliar methods, recognition of technical and personal factors which limit his competence with particular clients. He consciously attempts to resolve these latter limitations by adequate supervision or by himself entering psychotherapy.

5.3.3 Dual Relationships with Clients

The APA code outlines the responsibility of psychotherapists to avoid engaging in dual relationships with clients which could be detrimental, specifically identifying sexual relationships with clients as unethical. It is primarily the principle of nonmaleficence from which these injunctions appear to be derived. This section will look at the theoretical and ethical arguments against such dual relationships, firstly in general and then specifically with regard to sexual relationships. Some suggestions for ameliorating the negative effects of dual relationships other than sexual ones (which are always ill advised) will also be considered.

Roll and Millen (1981) discuss the negative effects of dual relationship with clients, where the client is a friend or acquaintance of the therapist. They identify the following negative effects:

a) Loss of the friendship:

Because of the particular restrictions and roles inherent in the practice of psychotherapy, new stresses are introduced into the relationship which may lead to the end of the friendship.

b) Complication of the transference:

The client who knows the therapist in another context will experience difficulties in establishing a therapeutic transference relationship. Interpretation of transference will also be more complicated in that the therapist cannot be

sure whether the client's reactions to him are based in the therapeutic relationship or on the client's perception of him outside the relationship. This increases the complexity of an already difficult aspect of therapy and may impede the client's therapeutic progress.

c) Support of grandiosity

The inevitable disequilibrium of power and the relative powerfulness of the therapist may well extend back into the previously established relationship and, should the therapist be susceptible to this kind of inflation of his role, his professional competence and standards in general may be eroded.

Despite these contra-indications, Roll and Millin (1981) recognize that in some cases, particularly in relatively small communities, the therapist will not be able to avoid treating some patients with whom they also have some extra-therapeutic contact. The client may be a friend, a student or even a professional such as the doctor or dentist of the therapist. In the light of this, they provide some guidelines for dealing with such cases which minimize the potential negative effects.

a) "Don't do it" - it is re-emphasized that, wherever possible, such relationships should be avoided by referring acquaintances to professional colleagues or alternative sources of help.

b) "The transference relationship is real and the 'real' relationship is real" - two temptations may arise in these cases. One is to treat all reactions of the acquaintance-client as transference and the other is to ignore the transference and concentrate on the real relationship. Therapists are advised to discuss the problems of the dual relationship with the client early in therapy, and to continue to interpret the transference. Failure to do so may contaminate the extra-therapeutic relationship with the unresolved transference reactions of the client.

c) "Corollary to above : get supervision or consultation". Supervision is an aid to distinguishing transference and countertransference reactions from the transactions which derive out of the original relationship.

d) "Rigidify". The negative effects of overlap between the therapeutic relationship and outside relationship may be minimized by more than usually strict adherence to the limits of therapy (especially time limits) and by specifically requesting that issues raised in therapy not be carried over to the outside context.

e) "Organize a hierarchy of values"
Some decision about the relative importance and dominance of each relationship appears to be necessary. Because special obligations are incurred

by the therapist towards the client which are qualitatively different from those in relationships with friends and acquaintances, it is suggested that the therapeutic relationship should always be given priority as long as the dual relationship continues.

f) "Be prepared to lose the friendship"

Not only must the therapist be prepared to lose the friendship of his client in the interests of therapeutic progress, but where the client is a close friend or a relation of a friend of the therapist, the therapist must be prepared to forfeit this friendship as well. Where he is not prepared to lose the friendship, the therapeutic endeavour should not be undertaken.

g) "Avoid discussing case material"

This advice seems to apply not only when the client is a friend, but also where there is the danger that the people to whom the material is being presented may be friends or relations of the client.

h) "Know when to stop"

Because of the increased danger of the therapeutic relationship with an acquaintance becoming complicated and possibly even pathological, the therapist should be more than usually alert to the point where therapy is becoming destructive so that the therapy may be terminated and the client referred.

i) "Be gratified"

The danger of gratifying personal needs through therapy with a client who is also a friend, is greatly increased. The therapist must be especially sensitive to this possibility and take active steps to ensure that his own life is sufficiently gratifying.

Roll and Millin confined their discussion to therapy with clients with whom the therapist has an already established relationship. The establishment of friendships or other extra-therapeutic relationships with clients already in therapy is always regarded as anti-therapeutic (Chipman, (1978)). By far the largest proportion of writings in this area are devoted to the negative effects of sexual relationships established during the process of therapy with clients (e.g. Kardener (1974), Hare-Mustin (1974), Finney (1976), Stone (1976), Davidson (1977), Barnhouse (1978) Hays (1980) and Serban (1981)).

Barnhouse (1978) presents a primarily theoretical argument against therapist-client sex arguing that, particularly in psychodynamic therapy, it is detrimental to the client for three major reasons. Firstly, within the transference relationship the client almost invariably enters into a type of parent-child relationship with the therapist and therapist-client sex can therefore be seen as having incenstuous overtones. Particularly where oedipal problems are involved, this metaphorical violation of the incest taboo may have very detrimental effects on the client whose ego strengths are poor. Kardener (1974) supports

this particular argument against therapist-patient sex. Barnhouse's second reason is that an important part of therapy is frequently the interpretation and understanding of the client's sexual fantasies, particularly where these involve the therapist. Where these are acted out, the opportunity for interpretation is lost. Finally, the argument is frequently put forward that clients voluntarily and autonomously enter into sexual relationships with their therapists, but Barnhouse considers this invalid because of the relatively greater power of the therapist in the relationship which means that the client is frequently not in a position psychologically to refuse to engage in a sexual relationship.

Finney (1976) supports this final point and suggests that even after the therapeutic relationship has officially terminated, the same objections to a subsequent sexual relationship of this nature may be made. He quotes the case of a woman who was sexually propositioned by her ex-therapist two years after terminating therapy. She felt betrayed by the therapist, expressing her feelings thus: "A psychotherapist should not ask his patient to go to bed with him. It's taking unfair, personal advantage of knowledge that he gained in a relationship of professional trust and confidence" (p.595). Finney also warns that seduction by a client may be an unconscious expression of hostility towards the therapist, perhaps in an attempt to equalize the perceived power imbalance. Serban (1981) supports this viewpoint and adds that should the therapist end the sexual relationship, the client's anger and hostility is exacerbated and frequently leads to law-suits against the therapist. If these possible unconscious motivations of the client are not perceived and dealt with in

therapy in a constructive way, rather than acted upon, the therapist may be said to have failed in his therapeutic task.

Sexual relationships with clients are frequently justified by therapists as being beneficial for the client and therefore in some ways perhaps an acceptable therapeutic technique. Hare-Mustin (1974) strongly challenges this assertion, maintaining that, on ethical grounds, therapist-patient sex is not an acceptable therapeutic technique despite the beneficial effects it may have for some clients. She writes: "How can it be determined if sexual contact is indicated and the treatment of choice? And, is the therapist the most competent person to provide such treatment?" And further, "If the therapist does feel competent to offer sexual contact to the patient...the obvious next question would be, does the "competent" therapist offer sexual relations to all his patients who could benefit from it, rather than just young attractive patients of the opposite sex? For example, would a male therapist be equally ready to offer himself in this technique to an old unattractive female, or male for that matter?" (p.308). She goes further to show that not only is therapist-patient sex theoretically unsound, but also violates both principles 3 and 8 of the APA Ethical Standards. Principle 3 states that the therapist should display "sensible regard for the moral and legal standards of the community in which he works. Hare-Mustin maintains that most communities would regard client-therapist sex as immoral, particularly as the client could be regarded as paying for the sexual relationship. Principle 8 directs the therapist to inform the client of important aspects of the therapeutic relationship which may affect the client's decision to enter therapy. The use of sexual intercourse as a therapeutic

technique could well be classed as such an important aspect, but most sexual relationships with clients are formed at a point in therapy where the client has developed an involvement in and dependency on the therapeutic process and the therapist himself and is therefore no longer in a position to refuse the relationship as easily as prior to beginning therapy.

Thus, several authors have demonstrated that there is no justification for therapist-client sex which may be condemned on both theoretical and ethical grounds. Kardener (1974) feels that it is the therapist's unresolved needs combined with the powerful position he holds in relation to the client which may propel him into such relationships against his better judgement. Once again, the need for awareness of such needs, and safe-guarding against their fulfillment in the therapeutic context, through consultation and supervision are advised.

5.3.4 Involuntary Hospitalization and the Right to Treatment

In this section the ethical principles of autonomy, nonmaleficence, beneficence and justice all come into play. Involuntary hospitalization in itself immediately violates the principles of autonomy and nonmaleficence, and protecting the rights of patients whose freedom has been restricted in this way means that therapists must ensure more fully that patients benefit in some way from this action (beneficence) through the provision of adequate treatment which caters for their needs (justice). In this section we will consider the process of involuntary hospitalization and the issues involved in respecting the rights of involuntarily hospitalized patients.

In considering the moral and legal justifications for involuntary hospitalization, the concept of dangerousness once again becomes important because it is on the grounds of imminent danger to self or others that people may be committed to mental institutions without their consent. Shah (1975) expresses concern about these grounds pointing to the difficulties of accurately predicting dangerousness and to the discrepancy between the grounds for detention of potentially dangerous criminals and those for the detention of mental patients. Even a habitual criminal who has committed numerous violent crimes in the past may not be detained on the basis of potential dangerousness alone, but must actually have committed a new criminal act. Mental patients are not protected in this way and there is no substantial evidence to suggest that they are any more dangerous than so-called mentally healthy people. Shah ventures to suggest that in fact mental patients could be proved to be far less potentially dnagerous than people who engage in drunken driving and questions whether the loss of liberty and other undesirable consequences of hospitalization are justifiable in the light of these difficulties and inaccuracies in the prediction of dangerousness in mental patients, particularly where the patient has never before displayed violent behaviour. The social stigmatization attached to mental patients is undoubtedly aggravated by this conceptualization of them as dangerous. Shah proposes that, rather than basing the hospitalization of the mentally ill on medical judgements of dangerousness, this should be a legal procedure in which the principle of proof "beyond reasonable doubt" would be required before people are hospitalized on the grounds of their potential dangerousness.

The issues involved in protecting the rights of individuals whose freedom has been curtailed by involuntary hospitalization have been extensively debated in the literature (e.g. Schwitzgebel (1975), Rachlin, Pam and Milton (1975), Miller and Burt (1977), White and White (1981) and Cahn (1982). The right to treatment of such patients is an issue which was highlighted in the recent Donaldson vs. O'Connor case in the United States (discussed by Kopolow (1976)), in which a mental patient successfully sued the mental institution where he had been involuntarily committed for fifteen years. He claimed that during this time he had not received adequate treatment and his claims that he was neither insane nor dangerous were rejected by the hospital authorities without an adequate assessment of their validity. The Court rules that all mental hospital inmates have a basic right to adequate treatment during their period of hospitalization.

Difficulties inherent in the provision of adequate treatment in these cases include one which was brought up in discussion of the Donaldson case (1976) in the literature, namely the chronic shortage of staff and treatment facilities which make adequate treatment of all inmates a well-nigh impossible task at many mental institutions. The responsibility of the state to provide funding and resources necessary to correct these inadequacies was emphasized to avoid placing therapists in the impossible position of having to satisfy the state by treating all mental patients while being denied the state resources which would make it possible to do so.

Other difficulties highlighted by Cahn (1982) involve the fact that frequently effective treatment of a patient's disorder is not available. In addition, the court has ruled that the least restrictive treatment alternative be the treatment of choice, but in many cases the most effective treatment is also the most restrictive (e.g. pharmacotherapy). The therapist in the mental hospital therefore has a difficult task in providing treatment which is "adequate" (i.e. effective) and simultaneously providing the least restrictive treatment.

A corollary to the patient's right to treatment is the simultaneous legally upheld right of patients to refuse treatment (a right which is based on the principle of autonomy). Here, one of the most pressing issues is that of the patient's competence to make such a decision regarding his treatment. Mental health professionals frequently treat mental patients involuntarily with the justification that by virtue of the patient's mental state he is not able to act autonomously in making such decisions. White and White (1981) point to the potential abuses inherent in this system and assert that the judgement of incompetence should be essentially a legal one and not one to be made by treating professionals. Cahn (1982) discusses the legal ruling that treatment against a patient's will may only be administered in "emergency" situations to prevent death or serious deterioration in the condition of the patient. He points out that the concept of emergency is however not legally defined and this presents problems for therapists in deciding what constitutes an emergency and therefore also in deciding when the emergency is over.

Several suggestions have been made as to the ways in which some of the patient's rights may be respected. Schwitzgebel (1975) proposes a contractual model for treatment decisions in which therapist and patient collaborate in drawing up a contract, specifying the goals and methods of the treatment programme, after the patient has been informed of the relative effectiveness and potential side-effects of the available treatment opinions. While this may be a part-solution to the problem, it is difficult to imagine how a psychotic patient would be able to participate in such a task and there therefore must remain instances in which the patient does not partipate in this way. In these cases, it is recommended that the therapist consult with some third party, such as relations, who have an interest in the wellbeing of the patient, and that these people be informed of, and possibly participate in treatment decisions.

It is apparent that this particular aspect of the therapist's functioning is fraught with many potentially conflictual situations. Possible approaches to be adopted in such situations will be considered in the final section of this chapter.

5.4 METHODS AND TECHNIQUES OF PSYCHOTHERAPY

The principles of nonmaleficence and beneficence dictate that the chosen method and techniques of treatment in psychotherapy must firstly not harm the patient and secondly must benefit the patient in objectively verifiable ways. Recently there has been concern expressed about the extent to which psychotherapy does benefit clients and whether in some cases the client

may end therapy in a worse position than when he started. This section examines some of the attempts that have been made to assess therapeutic effectiveness, to highlight the potential dangers inherent in psychotherapy and to determine what factors guide the therapist in deciding on his therapeutic approach. Some suggestions as to ways in which therapeutic efficiency may be maximised and the outcome of therapy may be more successfully measured are also considered here.

In a review of the outcome studies to date which have been attempted to determine which of the therapeutic methods and techniques are more effective, Bergin (1975) states that there is some evidence that therapy is more beneficial for clients than no treatment at all. A well controlled study showed that 65% of therapy clients showed some improvement over a certain period of time as opposed to 50% of untreated controls. However, only 5% of the control group showed deterioration over this period, while 10% of the therapy clients deteriorated. Outcome of therapy did not seem to be related to the particular methods and techniques employed by therapists, but rather to the personal style of the therapist. Truax and Mitchell* found that therapists who showed high levels of empathy, warmth and genuine concern during therapy sessions produced better results, while in a similar study, Yalom et al* related deterioration in therapy to therapists who were impatient and authoritarian in nature or intrusive and aggressive in their approach to clients. Thus, no specific method of therapy has been identified by these studies as being more or less beneficial than any other method in any significant way.

*quoted in Bergin (1975)

This failure to identify differences between approaches which relate to outcome may not be so much a reflection on the absence of these differences as of the methodological difficulties which have characterized much of the research. The primary difficulty is in devising objective criteria of successful outcome. Kisch and Kroll (1980) write about the distinction between effectiveness and meaningfulness in therapy, defining "effectiveness" as the achievement of explicit goals as measured by objective, operationally-defined criteria, and "meaningfulness" as the client's subjective experience of the success of therapy. Kisch and Kroll assert that, by its nature, therapy frequently cannot identify explicit goals and the outcome of therapy should therefore be measured in terms of its meaningfulness to the client. Strupp (1975) argues against this professed inability to specify therapeutic goals. He states that the failure to specify goals not only makes the assessment of therapeutic outcome impossible, which may in turn allow the continuing use of therapeutic methods which are useless or even harmful, but this failure may be unethical from the client's point of view in that "if the therapist is not clearly aware of the nature of the client's problems, the treatment objectives and the kinds of outcome by which therapeutic change can be judged, he is asking the client to engage in a journey that might lead somewhere or nowhere, a venture that is time-consuming, expensive, and demanding" (p.40). Strupp maintains that, even in types of therapy which have broadly stated objectives such as self-realization or personality growth, it may still be possible to identify the desired therapeutic outcome against which actual outcome can be measured. Strupp developed these ideas further in conjunction with Hadley (Strupp and Hadley,(1977)) into a "tripartite model of mental health and

therapeutic outcomes". In this model it is argued that there is no consensus on the definition of what constitutes mental health, and therefore no consensus on the definition of successful therapeutic outcome. Three major participants in the dispute over these definitions may be identified as being society, the client and the therapist.

1) Society defines mental aberration largely as the basis of observed behaviour, which differs significantly from society's norms. Therefore success in therapy is measured in terms of observable behaviour change.

2) The client's indicator of mental disturbance is subjective emotional distress or discomfort and his aim for therapy is the relief of this distress.

3) The therapist bases his judgement of mental illness on the basis of some theoretical model of ideal personality structure and his gain in therapy is to change the intrapsychic processes and/or behaviour of the client which deprive him of such a healthy personality.

The outcome of any particular therapeutic process will therefore be judged differently according to which perspective is adopted in evaluation. Strupp and Hadley therefore suggest that all three of these sets of criteria be used in outcome studies, and that therapeutic outcome should not be seen as a unitary concept but as one which may be seen from differing perspectives. The model makes no evaluative comparisons of the relative merits of

the three differing aims of psychotherapy. The point is that the choice of methods of therapy for particular clients will vary according to the desired goals which could be behaviour change, relief from distress, personality change, or a combination of any of these. If therapeutic methods are evaluated in terms of this model, therapists will be able to choose between one or another in terms of their relative effectiveness in each of these three areas. Application of this model in outcome studies, which does not yet appear to have occurred, could help to determine the validity of the claims that psychodynamic therapy, aimed at personality change, will also automatically result in relief of subjective distress and behaviour change, or the claims that behaviour therapy aimed at behaviour change may result in relief of distress and personality change. The degree to which different types of therapy are effective in each of these areas could also be clarified; and totally ineffective, or relatively ineffective therapeutic methods could be discarded.

In the absence of such objective grounds for preferring one treatment method over another, the question arises as to the basis upon which therapists currently decide on which method to adopt. Barron (1978) suggests that it is the personality variables, such as particular attitudes and values, of the therapist which determine this decision. This suggestion is confirmed by Reiss, Costell and Almond (1976), who examined the technical preferences of staff at mental hospitals and found that "technical preferences are an indication of kinds of personal needs an individual wishes to satisfy in an organizational

setting" (p.796). The implications of this are that therapists may tend to practise a particular method of psychotherapy more for the personal gratification which they derive out of it than for its proved effectiveness in satisfying the needs of the client and that therapy may therefore become for the therapist an end in itself rather than a means to an end. The danger of this is that the chosen method of therapy may be inappropriate for some clients and that therapy may be artificially prolonged by the therapist beyond the point at which it is benefitting the client. These factors may be underlying some of the negative effects leading to the deterioration in some clients reported by Bergin (1975).

The nature of the possible negative effects of psychotherapy are rarely examined. Robitscher (1978) suggests that the direct negative effects may include the following: 1) exacerbation of presenting symptoms; 2) appearance of new symptoms; 3) the client's abuse or misuse of therapy (e.g. developing a sustained dependency on the therapy or the therapist); 4) the client "overreaching" himself (e.g. undertaking life tasks prematurely; undertaking tasks requiring resources beyond these of the client, or in other ways putting excessive strain on the psychological resources of the client) and 5) disillusionment with therapy and/or the therapist (through the wasting of the client's resources that may have been better expended elsewhere which may lead to the hardening of attitudes towards other sources of help; or loss of confidence in the therapist which may extend to other human relationships). Robitscher notes that temporary negative effects may be necessary in the course of any successful treatment and

that long-term negative effects cannot be definitively related to the treatment or treatment mistakes, but it appears that more sound outcome research may well determine whether the "temporary negative effects" are outbalanced by the potential benefit to the client in the long run, and whether certain kinds of treatment and treatment mistakes generally have negative effects.

Graziano and Fink (1973) discuss what they term "second-order" negative effects in therapy which may derive out of the process of therapy regardless of which techniques or methods employ and which they have grouped as follows:

1) failure to complete the therapeutic process - i.e. "dropouts" from therapy,

2) implicit labelling and the client's self-evaluation, and

3) treatment system demands of fees and scheduled appointments.

1) "Dropouts" from therapy

Clients who fail to complete the process of therapy fail to derive the full benefits of the treatment and, in some cases, may experience negative effects in terms of feeling that perhaps they cannot be helped at all or disillusionment with the process of therapy. The reasons why clients may terminate therapy prematurely are encompassed within the following two sections.

2) Labelling and the "sick" role

The implicit labelling of therapy clients as sick or

in some way inadequate may have serious consequences for their self-concept and may lead them to adopt the "sick" role actively, unrealistically underestimating their coping capacities. The social stigma attached to being in therapy may disrupt important relationships of the client in that friends and relations may also perceive the client as sick, inadequate and in need of "special" treatment by them. Besides this, the client's family's functioning may also be disrupted, by the stigma attached to having produced a "mentally ill" member.

3) Demands imposed by the professional system : fees and schedules. Especially for lower socio-economic class clients, the difficulties of meeting the demands for payment and attendance in therapy may result in particular kinds of negative side-effects. Fees constitute new demands on the family's financial resources and may have to be met by curtailing other expenditures, depletion of savings and going into financial and possibly concomitant psychological debt through borrowing money from the extended family or other resources. This may increase the emotional strain between family members and particularly between the rest of the family and the client for whose benefit the sacrifices are being made. Time schedule demands lead to disruption of normal scheduling which may

include taking time off work and consequent loss of pay and loss of status at work.

Graziano and Fink maintain that therapists are frequently unaware of these kinds of difficulties encountered by the client and that where these are sufficiently great the client may harbour resentful feelings towards therapy and the therapist which unless recognized and dealt with in therapy, may hamper therapeutic progress or lead to premature termination by the client.

In assessing the effectiveness of therapy, both the beneficial and potentially negative effects of therapy for particular clients must therefore be considered. Ellis (1980b) introduces another element when he points out that in recent times, when economic resources are becoming scarce, there is increasing pressure on therapists to provide therapy that is efficient in terms of time and money as well as effective. He proposes that in order to be efficient, therapy should preferably be brief, depth-centred, extensive, thoroughgoing and preventative. The rationale for these characteristics is that besides brevity, which ensures minimum expense in terms of both time and money, therapy which is maximally efficient should also ensure that therapeutic progress is maintained once the actual process of therapy has ended. Therapies which concentrate on symptom-removal, although brief and effective, may not necessarily be the most efficient in these terms unless they also equip the client with more adequate coping mechanisms which will prevent the re-emergence of problems in future difficult situations.

It has been seen that in choosing a particular method of

psychotherapy the therapist needs to balance the possibility of negative effects against the potential benefits to the client and must also ensure that the method is maximally efficient. The question arises as to whether there are any existing methods of therapy involving techniques which make them immediately unethical in these terms. Some - such as aversive techniques in behaviour therapy - involve harm to the patient which forms an essential part of the process of treatment. It is generally accepted by behaviour therapists that such techniques should be employed only where other less harmful techniques have failed to achieve the desired results and that the degree of benefit which would result from the use of such techniques should outweigh the harm involved. In other methods, the dangers of harm are less obvious and frequently underplayed by the proponents of these methods. Examples of such techniques are those involving "deception" of the client as in paradoxical techniques and certain strategies in family therapy where the therapist consciously deceives or lies to the client in order to achieve a desired result. Haley (1977) writes: "If it is essential for the cure that deceit be used, it might be justified on that basis. However, one must also be concerned about the long-term effect of a person experiencing an expert as an untrustworthy person, which may be more harmful than the continuation of the symptom" (p.203). Annitto and Kass (1979) discuss the deception involved in administering placebos in pharmacotherapy saying that therapeutic deception "is not conscious lying, manipulative deceit, or dishonest chicanery; rather it is an example of the expression of the conscious

decisions made during psychotherapy" (p.552). Thus, in some cases where benefit to the client may definitely be expected to result out of deception and where the therapist's motivation for deceiving the patient is entirely based on the desire for and expectation of this benefit, conscious and deliberate deception in therapy may be a valid and useful technique. However, as Haley asserts, it is necessary to be constantly aware of the balance between the benefit to be derived and the possible harm which could arise if the client realises that he is being deceived.

The most ethical concern has been expressed regarding therapeutic techniques which involve the "intrusion" of the therapist onto the body of the individual and the attendant risks of physical and emotional harm in these techniques. Examples are certain types of encounter groups and "body therapy" techniques, which may involve bodily stress and pain. The necessity of exercising "due care" in the execution of such techniques is emphasized by Leland (1976), but recent rulings in American courts reported by Foster (1977) and Pope, Simpson and Werner (1978) suggest that certain of these techniques fall below professional standards and are inherently negligent regardless of whether "due care" is exercised during their performance. So that even if it could be proved that these techniques benefited some clients, the likelihood of physical and emotional harm and the degree of intrusion which is involved invariably outweigh the potential benefits and thereby render the techniques unethical. An example of such a technique is one developed by Zaslow in the United States, known as "Z therapy", in which the patient is tickled until an extreme emotional reaction is evoked.

A difficult ethical situation arises when new therapeutic techniques are being developed. Initially, in such a process, the therapist cannot be sure that the new technique which he feels may benefit clients will in fact do so or will not produce concomitant negative effects. In addition, when practising such techniques the therapist cannot claim to be competent in this practise. Obviously then there are attendant risks in the initial implementation of any new therapeutic method and as such methods develop primarily through practice, some clients will inevitably be exposed to these risks. Advancement in the practice of psychotherapy necessitates the continuous re-evaluation of old methods and experimentation with alternative methods, but it is suggested that, in order to minimize the risk, these innovations be based on sound theoretical judgement and that the first clients who serve as the "guinea pigs" for such innovations be regarded as research subjects. The ethical considerations applicable to research, which will be discussed in a later chapter, should then also be applicable in these situations.

This section has highlighted the dearth of definitive research on the relative efficacy of various psychotherapeutic methods and techniques and emphasized the need for such research in order to allow therapists to make treatment decisions on other than purely subjective criteria. The nature and causes of negative effects in therapy have been examined and it is emphasized that in deciding on a treatment method the possibility of such effects should be continually weighed against the potential benefit of the treatment process. The ethical validity of certain existing

types of therapeutic methods has been briefly considered and, finally, the ethical problems inherent in the innovation of new techniques were examined. The major ethical problem in this area appears to revolve around the careful cost-benefit analysis (described in Chapter one) of treatment methods. At present, in the light of the lack of satisfactory research into the effects of therapy, this remains a difficult task which each individual therapist must tackle within his own sphere. The major need which is identified in this area is, therefore, the need to conduct further, more adequate research into therapeutic outcome and the relative efficacy of existing techniques.

5.5 PROPOSED APPROACHES TO ETHICAL DILEMMAS IN PSYCHOTHERAPY

Some suggestions have been made in the literature as to ways in which the kinds of ethical dilemmas described in this chapter may be approached by psychotherapists to minimize the negative effects which may arise out of these situations. Because of its particular significance in many areas of the psychotherapist's functioning the concept and assessment of dangerousness and suggested approaches to dealing with potentially dangerous clients will be examined first. Secondly, the concept of informed consent which was briefly described in Chapter one has been proposed by many writers as a useful approach in the resolution of many conflict situations in psychotherapy. The mechanics of the application of this concept in various areas will be examined.

In the first part of this thesis it was suggested that the rule

utilitarian ethical theory may be a valid basis for an ethical code for clinical psychologists and that the basic tenet of this theory may be applied in approaches to ethical conflicts. The final portion of this chapter will be devoted to examining the application of this approach to conflicts arising in the practice of psychotherapy.

5.5.1 The concept of dangerousness

It has been seen that the determination of dangerousness is crucial in many psychotherapeutic decisions, especially those involving involuntary hospitalization and the revealing of confidential information. The difficulties of assessing potential dangerousness, especially where there has been no previous history of violent behaviour, have been briefly mentioned. In addition there exists no agreement as to the definition of dangerousness - i.e. which behaviours are sufficiently threatening to society to be defined as dangerous. Shah (1975) asserts that because of the undesirable publicity attracted by the release of or failure to detain a mental patient who subsequently engages in dangerous or criminal behaviour, psychiatrists and other mental health professionals tend to "overpredict dangerousness to an extraordinary degree" (p.504). Shah quotes Rosen's (1954) estimate that for every one correct prediction of dangerousness there would be between 50 and 99 false positives. Lane and Spruill (1980) also highlight the inaccuracy of prediction of dangerousness and the necessity for "a set of criteria that at least represent a consensus of the factors that increase the probability of dangerousness in the individual" (p.204).

In the light of the current lack of such a consensus, the therapist needs to exercise special care in the prediction of dangerousness. Lane and Spruill suggest that some checks on the power of therapists to make far-reaching decisions on the basis of demonstrably inaccurate predictions of dangerousness should be developed and suggest that these checks could take the following forms: 1) the therapist faced with a potentially dangerous client should obtain several independent professional opinions regarding the possibility of danger, 2) existing ethical committees should be used for consultation regarding both the prediction of dangerousness and the appropriate intervention; 3) alternatively, one or two representative practitioners who would be available for consultation in these cases should be appointed by the State.

Once the therapist is satisfied that the client is dangerous the policy of "least restrictive alternative" normally applied to choice of treatment should be applied to the decision as to the appropriate intervention. Lane and Spruill suggest a hierarchy of options to guide therapists in making this decision.

1) Attempt to talk the client out of it

2) Change the client's environment - e.g. turning in weapons to Police, taking a vacation.

3) Enlist the help of family members and other social support systems.

4) Chemical restraint in the form of pharmacotherapy, the administration of which could be monitored through daily appointments.

5) Continuous monitoring or surveillance of the client with the co-operation of family and friends.

6) Warn the victim via consultation with Police authorities.

7) Voluntary or involuntary hospitalization.

The progressive attempting of each of these options reduces the likelihood of unjustified hospitalization and provides the opportunity for the therapist to assess more accurately the extent of the potential danger.

5.5.2 Informed Consent

It was seen in Chapter one that the concept of informed consent derives from the principle of autonomy and involves the person's right to participate in decisions involving his future. The concept and application of informed consent may be particularly important in the practise of psychotherapy where the power imbalance between therapist and client may provide fertile ground for exploitation of the client in order to fulfill the therapist's own needs for control. Karasu (1980) refers to "one of the most prominent negative effects in the traditional therapeutic relationship; its insufficient regard for the patient's intentionality or will" (p.1503). It is suggested by several authors that informed consent by the client to all aspects of the therapeutic process may constitute an approach to the resolution of this problematic situation (e.g. Ayllon and Skuban (1973); Bastinsen (1974); Sadoff (1974); Schwitzgebel (1975); Strupp (1975); Coyne (1976); Noll (1976); Robitscher (1978); Coyne and Widiger (1978); and Hare-Mustin et al. (1979)).

The nature of informed consent implies that the client must be fully informed by the therapist, in clear and understandable terms, of all the possible factors involved in the process of therapy which may affect the client's decision to enter therapy. Without such information the client will not be in a position to make an autonomous decision regarding his own treatment.

In this section, the application of the principle of informed consent will be considered with reference to the areas of the goals of therapy, including both direct and indirect effects of the treatment process; the competence of the therapist; the issue of confidentiality, and the proposed methods and techniques involved in the process of therapy. Finally, general principles and problems of the application of informed consent will be considered.

1) Goals of Psychotherapy

The importance of setting goals in therapy and the difficulties which may arise when the therapist's and client's goals differ have already been outlined. The principle of informed consent implies that the therapist must carefully describe to the client the goals which he feels are desirable and take account of the client's desired goals. Some negotiation must then occur until both therapist and client agree on what would constitute the actual goals of the therapeutic transaction. During this process of negotiation, the therapist is obliged to explain to the client the limits of his expertise as well as

the possible benefits that may accrue from therapy and correct the client's misapprehension about the ability of therapy to change certain aspects of his life.

As Karasu (1980) says: "Although some degree of positive expectation and hope is regarded as a requisite for producing therapeutic effects in all psychotherapies, the patient may get the erroneous impression that therapy and the therapist can solve everything. This can perpetuate unrealistic expectations and goals that are deleterious to the patient" (p.1505).

Besides the therapist's and the method of therapy's limitations, the client's limitations, whether these be intellectual or practical need to be taken into account in negotiating appropriate goals. For example, setting the goal of personality structuring for a client who does not have the financial resources to engage in intensive, long term therapy is obviously inappropriate.

Hare-Mustin et al (1979) and Coyne and Widiger (1978) emphasize that, in setting treatment goals, the possible indirect effects on other aspects of the client's life, such as his values and relationships, must be made explicit to the client. If the value of the threatened relationships or beliefs outweigh the potential benefits the client feels he will gain from achieving a specific goal, he may well choose not to engage in therapy. Failure to inform clients of these aspects may be seen as "tricking" the client into a position where his previously held values are challenged and changed. Where the client has no

objections to having his values challenged this does not represent a problem but the choice must remain the client's and not the therapist's.

Frequently, during the process of therapy, either therapist or client may perceive the possibility of working towards new goals or changing the existing goals. At this point the changes in perception must be discussed and the goals for therapy renegotiated in a similar way as were the original goals.

1) Competence of the therapist

> Hare-Mustin et al (1979) write that clients are usually uncertain about the specialities and training of various professionals. An example is the frequently mistaken understanding of the training and qualifications of clinical psychologists as opposed to psychiatrists. They suggest that a short description of the qualifications and relevant experience of the therapist may help to dispell clients' unrealistic expectations.

It is particularly important for therapists-in-training to inform clients of this fact, with the reassurance that they are under the supervision of a qualified and experienced therapist. Robitscher (1978) acknowledges the danger of this information operating in the service of the resistance of the client, thus impeding therapeutic progress to a certain extent, but nevertheless maintains that the client's right to choosing his therapist on an informed basis outweighs the

potential negative effects of imparting such information.

3) Confidentiality

From previous discussion, it is apparent that the assurance of absolute therapeutic confidentiality is frequently one which cannot honestly be made in view of the kinds of pressures therapists may experience to breach confidentiality. The therapist therefore incurs the responsibility to inform clients of the limits of confidentiality before undertaking therapy.

In institutions and agencies, clients must be informed of the therapist's intention to share case material with other staff members through case presentations. Where other agencies request information on the client which has been gained during the course of therapy, the client's express permission for such revelation must be obtained.

The societal responsibilities of the therapist have been demonstrated to have particular consequences as regards the issue of confidentiality. These must also be explained to the client, pointing out that, while violent feelings and thoughts are acceptable and indeed need to be expressed during the therapeutic process in order to facilitate therapeutic progress, at the point where the client actually intends to harm another person and informs the therapist of this intention, the therapist will be obliged to breach confidentiality and inform the relevant authorities.

In order for the client's decision to be fully informed as regards giving consent for the release of confidential information, the therapist must ensure that the client fully understands both what

the consequences of such consent may be, as well as the implications of refusing to reveal such information.

4) Methods and Techniques:

Before beginning therapy, the client must be informed of and consent to the type of treatment which the therapist is able to offer and the demands that will be made of the client in the context of this treatment. Some estimate of the cost of treatment in both time and money must be given, and frequently a "trial period" may be agreed upon, during which the therapist may guage more accurately the possible length of treatment and the client may decide whether he finds the style of treatment congenial.

Robitscher (1978) emphasizes the importance of informing the client of potentially harmful side effects of treatment, whether these involve emotional distress or physical discomfort. All forms of therapy, even the essentially non-intrusive "talking therapies", involve some degree of emotional distress due to the uncovering of emotionally painful material, and this must be explained to the client who may then make an autonomous decision as to whether the benefits to be derived from therapy outweigh the distress involved in the process.

The therapist also has an obligation to inform clients of alternatives to the type of treatment he can offer, such as other therapeutic methods or even nontherapeutic support systems in the community. These alternatives must be presented in the most objective possible way with reference to their relative

effectiveness and the kinds of demands they make on the client in terms of time and money. The client may then decide on the basis of his own personal needs and limitations which of these procedures he prefers.

In order for the principle of informed consent to be applied in a way which maximises the achievement of its main aim of protecting the autonomy of the client several issues must be considered. These are mainly concerned with the nature of the consent which is requested by the therapist and the degree of freedom to refuse consent experienced by the client.

It is the practise in some kinds of agencies to ask clients to sign "blanket" consent forms which place decisions regarding treatment and the release of confidential information entirely in the hands of the agency. This violates the principle of informed consent in that clients are almost invariably unaware of the implications of signing such blanket consent forms. Some authors (e.g. Ayllon and Skuban (1973); Coyne and Widiger (1978) and Schwitzgebel (1975)) refer to the lack of clarity and confusion that may arise in situations where such blanket consent is obtained. They believe that this lack of clarity may even extend to verbal agreements between therapist and client and suggest that one resolution of this situation may be the use of written contracts, signed by both client and therapist, which clearly specify the relevant aspects of the therapy to which the client is consenting. Such contracts may be renegotiated and revised at any point in therapy at which any one or more of its elements are no longer relevant.

It has been suggested that some clients may give consent for various aspects because they are in need of help and fear that, should they refuse to give such consent, they will be refused treatment. Rosen (1977) confirmed this through research which demonstrated that when clients applying for treatment at a psychotherapeutic agency were not told that they had the right to refuse consent there was 100% compliance. However, when they were informed of this right, only 20% complied. In this sense, clients are coerced into signing consent forms - a situation which defeats the purpose of obtaining informed consent at all. Thus, clients should be informed that their choice is fully autonomous and that the provision of treatment will not be affected by their refusal to consent to certain aspects of the treatment.

Objections to the application of informed consent in psychotherapy arise out of therapists' fears that if confronted by all the possible difficulties and negative effects of psychotherapy patients' may lose confidence in the treatment before being able to experience its positive aspects, and may be "scared off" therapy or else may be so cautious of the therapeutic process that progress will be impeded. Epstein (1978) argues that, while this may be true in some cases, there is the danger inherent in some therapies of a subtle authoritarianism emerging in which the client is seen as child-like and helpless, unable to make his own decisions regarding his preferences and in need of the wiser, parent-like therapist to make these choices for him. Epstein believes that "It could be a boon for therapeutic efficacy to appreciate what is positive about

a patient, and to recognize that an individual makes choices and takes action quite freely with responsibility for these choices and actions" (p. 87).

Indeed it is difficult to understand how the therapeutic aim of developing the client's autonomy can be helped by robbing the client of all autonomy in decisions regarding the important aspects of the therapeutic process.

5.5.3 Rule Utilitarianism and Ethics in Therapy

The concept of informed consent has been seen to be based on the principle of autonomy, in that it encourages the independent informed decisions of clients regarding their own future. In the course of this chapter the way in which certain directives in therapy may be derived from one or more of the four basic principles has been indicated. It appears then that ethics in psychotherapy are compatible with the basic ethical model proposed in Chapter one. In the light of this, it appears that the rule-utilitarian model put forward may be useful in providing an approach to the resolution of some of the ethical conflicts described in this chapter. Examples of the way in which rule-utilitarianism can be applied in each of the potentially conflictual areas described earlier may be useful to consider.

a) Values and Goals

Many ethical principles may come into play in this area of concern, but the example to be considered here involves a conflict between the principle of autonomy which dictates that

patients should be allowed to choose their own therapeutic goals and the principle of beneficence which asserts that therapy should be of benefit to the client. To take a hypothetical and admittedly somewhat farfetched and simplistic example: suppose a client requested therapy because in his job as a teacher he felt the use of frequent corporal punishment was necessary to control a class of particularly unruly scholars. He experienced this as a difficult aspect of his occupation in that his pupils resented him as a result and he himself felt guilty and unhappy about seeing himself in this punitive role, in that he felt himself to be an essentially gentle and amiable person. However, he also felt duty-bound to fulfill his teaching duties. If he requested therapy in order to be able to rid himself of his guilt and unhappiness so that he could fulfill what he saw as his occupational duty, the therapist may well be faced with a dilemma in that while the principle of autonomy dictates that it is the client's goals rather than the therapist's which should constitute the aim of therapy, the principle of beneficence would dictate that therapy should be of benefit to the client. The therapist may well feel that helping the client find alternative means of discipline and control in the classroom would be of more benefit to the client, not to mention his pupils, than would the client's goal. Applying the rule utilitarian approach to this problem would mean that the therapist should make a decision, which would maximize the good. In deciding what will achieve this, the therapist would need to take into account the client's feelings and environmental circumstances and those of others who would be affected by the decision. Depending on the

circumstances in this case, the therapist may well decide that the ethical choice would be to work towards his goal rather than that of his client's. This could be explained to the client, along with the reasons for it, upon which the client may decide to go along with the therapist's aims. If he did not, the therapist should then decide to refer the case rather than participate in a therapeutic endeavour which, in terms of the rule utilitarian approach, would appear to be essentially unethical.

b) Methods and Techniques

One of the most common conflicts here arises out of the conflict between the principles of nonmaleficence and beneficence. Techniques which are potentially beneficial may have attendant risks of harm, either emotional or physical. Here the rule utilitarian approach can be applied in a fairly straightforward way. Not only must the benefit of a particular method outweigh its potential negative effects, but in terms of the directive to maximize the good, the benefits of a potentially harmful method must also outweigh the benefits of alternative techniques which do not involve the same degree of risk.

c) Competence

The relevant principles here may again be those of nonmaleficence and beneficence. These may be especially important where a recently developed therapeutic style or technique is being proposed as the treatment of choice. In such cases, there are rarely any therapists who can claim to be fully competent and experienced in the use of the technique. In other words, the

therapist's competence is of necessity limited. Although the therapist may feel that his use of this technique may benefit the client, he should also be aware that his own relative incompetence may reduce this benefit or even render the technique harmful. The particular needs of the client should be carefully weighed in such cases and the benefits of alternative techniques in which the therapist is competent need to be taken into account as well. Only when these considerations have been made and when the new technique still appears to be the one most likely to be beneficial despite the therapist's lack of competence should the technique be used.

d) Confidentiality

Frequently the most problematical area in psychotherapy, many kinds of conflict can arise out of the issue of confidentiality. Two kinds of conflict will be considered here. The first concerns the conflict frequently referred to in this chapter in which the therapist is obliged by law to breach confidentiality in cases where the client has committed or may intend to commit a criminal act. Here the conflict could be understood as one between the principles of nonmaleficence (which requires that confidentiality be upheld in order to do no harm to the patient) and justice (in the broad societal sense in which protecting one person from harm should not result in harm to others). Assessing the approach which would maximize the good is frequently difficult in such cases. Some examples of the kinds of factors which would need to be considered are:

1) the nature of the actual or intended criminal act and the harm that this would cause to society,

2) the consequences for the client of breaching confidentiality,

3) the consequences for the profession of psychology and the trust that society invests in this profession, of breaching confidentiality,

4) the consequences for the professional of refusing to reveal confidential information (which may include a prison sentence) and the effects on others connected with the therapist such as his other clients should he accept these consequences.

Only when these factors have been considered as carefully as possible is the therapist in a position to make an ethical decision in such cases.

The second type of dilemma to be considered here is where there is the possibility of two types of action, both of which are derived from the principle of beneficence. The therapist may be asked to reveal confidential information which would benefit the client in some way. For example, the therapist may be asked by the client to support a job application. In cases where the information revealed by the therapist would constitute solid support for such an application, a dilemma may arise. Do the benefits of maintaining confidentiality in terms of the client's trust in the therapist and need for the assurance of confidentiality for therapeutic progress outweigh the benefits to the client involved in obtaining the employment? Dubey (1974) argues that

this is always the case, but this is by no means a definitive opinion. Once again, the particular circumstances of the case need to be carefully considered, such as the importance to the client of the potential employment, and the degree of centrality which will be accorded the therapist's report in the employer's decision. Where the therapist's report will make the essential difference to the client's employment and where the client has, for example, been unemployed for some months and desperately requires the money, the therapist may well decide that the benefits inherent in writing the report outweigh the benefits for the client of being assured of absolute confidentiality. The directive maximizing the good could in such cases involve revealing the confidential information.

e) Dual Relationships

It has been seen that there is general agreement that sexual relationships between client and therapist are always unethical in that the potential harmful effects cannot be seen to outbalance the potential good which may arise out of such relationships. However, some problems for the therapist may arise when he is approached for therapy by a friend or acquaintance. This type of therapeutic alliance has been shown to have certain attendant risks of harm. The conflict here would again be between the principles of nonmaleficence and beneficence. What the therapist would need to consider in such cases may include the need of the client for his help, the possibility of obtaining comparable help from other sources, the extent of the damage to the previous relationship which could arise from therapy and the extent to which

the therapist feels he is competent to deal with the complications which may arise out of such a therapeutic relationship. Where the client is in dire need of help and the therapist is the only available source, the benefits of treatment may well outweigh the possible harm and the rule-utilitarian approach would dictate that the therapy should be attempted. In fact, it may well be unethical in such cases to refuse to treat the client.

f) Involuntary Hospitalization and the Right to Treatment

This area of concern involves all four ethical principles - autonomy, nonmaleficence, beneficence and justice - and conflicts may arise between any of these. Frequently in resolving such conflicts the interests of the client need to be balanced against the interests of many other people including the client's family and friends, the broader society and the professionals who work within the institution. Involuntary commitment of a patient to a mental hospital immediately violates the principles of autonomy and nonmaleficence and the decision to do so must therefore always be to maximize the good. The principle of justice then dictates that the needs of such a person must be met via adequate treatment within the institution. The principles of autonomy and beneficence and nonmaleficence are all relevant when a client refuses treatment, the patient may not only not benefit but may be harmed in that his condition may deteriorate; an eventuality which will not only cause distress to himself but also to others who are connected with him. This dilemma appears to be particularly difficult because whereas

"maximizing the good" would involve giving treatment involuntarily to such a patient, this action would immediately further violate the principle of autonomy. As the rules which arise out of the principle of autonomy also indirectly arise out of rule-utilitarianism as a basic orientation, and as rule-utilitarianism dictates that rules must be obeyed, it would appear that in such cases therapists are ethically obliged to allow patients to refuse treatment unless they have sufficient objective grounds on which to assert that the patient is incapable of making a truly autonomous decision with regard to his treatment.

CONCLUSION

This chapter has examined the major areas of concern in the practice of psychotherapy and has reviewed what constitutes ethical behaviour in each of these areas with reference to the guiding ethical principles discussed in Chapter one. The potential for ethical conflicts in these areas has also been discussed and the concept of informed consent as a possible means of resolving some of these conflicts was reviewed. Finally, the rule-utilitarian approach to the problem of ethical dilemmas in psychotherapy was outlined. It appears that this approach may well be useful in addressing problematic situations commonly confronted by the psychotherapist. However, the resolution of some areas of conflict is particularly difficult and arises out of basic disagreements regarding the definition of the role of the psychologist. Such a conflict is the degree to which psychotherapists should be actively and directly involved in social

reform. There has been no attempt to suggest a resolution of this particular issue, as it appears that such a resolution will only occur with the evolution of psychologists' conceptualisation of themselves as professionals and the roles which they should accept as such professionals. In other words, such issues appear to be more ones of professional policy than of ethical behaviour and therefore do not fall within the range of this thesis.

CHAPTER SIX

ETHICS IN PSYCHOLOGICAL ASSESSMENT

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ETHICS IN PSYCHOLOGICAL ASSESSMENT

It has been noted in Chapter two that psychological assessment is the psychologist's one exclusive domain of expertise. For this reason, it is especially important for psychologists to maintain the highest possible standards in their execution of this role. This chapter outlines the standards of ethical behaviour required to maximise the usefulness of psychological assessment procedures (beneficence), to minimize the abuse of such procedures (nonmaleficence) and to simultaneously maintain the autonomy of the individual subjected to such procedures. These standards will be discussed with reference to the goals of assessment, the available assessment methods and techniques, competence of the psychologist, the maintenance of confidentiality, and the issue of informed consent as it relates to psychological assessment.

6.1 GOALS OF ASSESSMENT

Psychological assessment may be requested by a variety of interested parties for a number of different purposes. These may be broadly categorized as follows:

a) Aptitude testing - an individual may refer himself for assessment to guide him in choosing a suitable occupation.

b) Employment - individuals may be referred by potential employers in order to assess their suitability for positions in their organization.

c) Legal assessments - courts may require the assessment of individuals i) to judge criminal responsibility or ability to stand trial, ii) to assess the degree of loss of functioning in, for example, compensation claims due to head injuries resulting from accidents, iii) to assess the suitability of parents disputing custody.

d) Scholastic assessment - children may be referred for investigation of their failure to attain normal educational standards or to assess children for special class placement.

e) Diagnostic assessment - other mental health professionals may request assessment to help determine the diagnosis of a patient.

f) Therapy assessment - this may be required to asses the suitability of a patient for a particular mode of therapy or to provide further insight into the types of intrapsychic conflicts which may need to be explored during the course of therapy.

It is apparent that the results of psychological assessment may have far-reaching implications for the future of the individual being assessed. A clear definition of the exact goals of the assessment procedure is therefore important in order to ensure that the information gained from assessment

will be relevant, complete and accurate.

Besides ensuring that the goal is clearly defined and understood both by himself and by the referral agent, the psychologist may frequently be required to judge whether a particular goal is appropriate and whether his participation in assisting in this goal is ethical or not. A useful guideline in deciding on this is to consider the ethical principles of beneficence and non-malificence. That is, the goal of assessment should be concerned with the wellbeing of the client and not constitute potential danger to the client. In most cases this is easy to determine. Even where an individual may be refused a job due to the results of psychological assessment it could be argued that it would not be in his best interests to occupy a position with which he would not be able to cope psychologically. The major difficulty that arises in this area is where the interests of society conflict with the interests of the individual being assessed. This is particularly apparent in legal assessments of individuals standing trial for criminal behaviour where the psychologist's assessment may result in imprisonment or commitment to a mental institution. In these cases, the psychologist's participation is justified on the basis that society must be protected from dangerous or potentially dangerous individuals and therefore assessment of such cases falls within the range of ethical behaviour. A more problematic situation is exemplified in the frequently quoted case where a psychologist was employed by the United States Defence Force to assess the psychological suitability of soldiers to return to the battlefield after suffering psychological disturbance during the Vietnam war.

The dilemma experienced by the psychologist was that the men he was assessing were not willing to return to the war and in no way could the results of the assessment be beneficial if it was determined that there were no objective psychological reasons to keep them away from the battlefield. The high risk of being killed as a result of returning in fact meant that the psychologist's recommendation would constitute recommending that the men be placed in situations where the potential harm to the men was great, thus violating the principle of non-maleficence. In addition, the psychologist himself was ethically opposed to the war, seeing it as unjust. The psychologist's eventual decision was that he would not participate in the assessment process.

Further consideration of this case may shed some light on the ethical approach to this situation and those that are similar. Firstly, the Vietnam war involved no direct attack on American society as a whole - in other words, by refusing to participate, the psychologist was not directly endangering the lives of American citizens. Thus, the war in Vietnam was conducted on the instigation of the government in power at the time and justified on the basis of the state's interest. The psychologist is under no obligation to protect the interests of the current government of the state at the possible cost of the individual client. What this means is that the protective function which the psychologist must serve towards other members of society by preventing violent action of a client, does not extend to protection of instituions of the state. It appears then that where there is no direct threat of violence or danger to society

members, the psychologist is under no obligation to support the government where such support may damage the image of the psychologist in making him an agent of the state rather than of the client and may constitute unethical behaviour where the goals of assessment violate the principles of autonomy, beneficence, maleficence or justice in relation to an individual client.

A further consideration in determining the goals of assessment concerns the right of the referral agent to have access to particular information about a client. It can be argued that in order to ensure the client's autonomy to a maximal extent, the psychologist must release to referral agents such information as is directly relevant to the agents concerns and the concerns of the client in relation to the agent. For example, an employer who requests the assessment of a job applicant needs only such information as would be pertinent to their decision on job allocation. An employer does not have the right of access to private information about the client such as his marital difficulties or intrapsychic conflicts where these would not affect his performance of any job-related tasks. Although the psychologist may acquire such information during the course of assessment it would be inappropriate for him to release this even if requested to do so by the employer.

Finally, in determing the goals of assessment the principle of nonmaleficence dictates that the psychologist must also consider the indirect consequences of achieving these goals and where possible minimize the negative elements of these consequences. For

example, when assessing schoolchildren for potential special-class placement, the psychologist must not only consider whether the child's intelligence is not sufficient for normal schooling, but also what the consequences of such placement would be in terms of the inevitable stigmatization, the child's loss of self-esteem and the family's reactions to the decision. As part of the assessment procedure the psychologist should consider the strengths of the child and the family and ways in which these may be mobilized in order to minimize the negative side-effects of such a decision, even where, overall, the decision could be considered as being in the best interests of the child.

It is apparent from the above discussion that the clinical psychologist's role in psychological assessment extends far beyond the unquestioning conducting of an assessment procedure at the request of any referral agent. Defining the goals of psychological assessment involves decisions as to whether the goals themselves are ethically justifiable, determining the appropriateness of requests by particular referral agents for psychological assessment, and conscious attempts to ameliorate the indirect negative effects of assessment procedures and the consequences of them.

6.2 METHODS AND TECHNIQUES OF ASSESSMENT

The two major components of any psychological assessment procedure are interviewing strategies and the administration of psychological tests. Although texts on psychological assessment have traditionally emphasized the latter strategy,

the importance of conducting a concise interview with the client in order to gain historical data as well as data on current functioning is emphasized by Maloney and Ward (1976): "A well-documented history gives a context in which the client's current problematic performance can be viewed in perspective. In fact, case history data are crucial to adequate assessment of many problems" (p.7). Anastasi (1976) also states that test scores cannot not be adequately interpreted without other pertinent information about the individual.

In deciding what information needs to be gathered and which tests need to be administered it is important for the psychologist to consider both the goals of the assessment procedure and the individual who is being assessed. Methods and technique need to be selected on the basis of their appropriateness both to these goals and to the individual in question.

6.2.1 Goal Appropriateness

A wide variety of tests exist measuring many different aspects of psychological functioning. The two crucial considerations here are those of validity (does the test measure what it purports to measure?) and reliability (does the test measure the same function consistently over time?). Before tests are made available for general use it is assumed that the designers have taken precautions to ensure that it is both valid and reliable, but it is the responsibility of the individual psychologist to ascertain by reference to the test manual that this has in fact been adequately ensured.

In addition, the psychologist must determine the exact nature of the test's purpose. Many tests measure only one particular aspect of an area of psychological functioning - for example Test A may measure immediate recall of visual material, while Test B may measure delayed recall of auditory stimuli. Although both tests A and B are measuring memory the two aspects with which they are concerned are different in many respects, and total memory functioning cannot be assessed by using only one or the other.

Thus, bearing in mind the eventual goal of the assessment procedure, the psychologist must isolate the particular areas of psychological functioning which would be pertinent to the overall ability of the individual which needs to be gauged, and must then select tests which are appropriate to those specific areas of functioning.

6.2.2 Individual Appropriateness

In deciding whether it is appropriate to administer a particular test to the referred individual, the concept of standardization becomes important. Before a test is released for use, standardization studies must have been conducted to provide norms against which an individual's functioning on that test may be compared. These studies must be reported in the test manual and it is important that the psychologist ensure that the standardization sample which produced the norms constitutes an appropriate comparison group for the individual. For example, the norms of a test standardized on white, American college students may not be appropriate in assessing a Nigerian labourer who left school at the age of 12.

The issue of test bias becomes important here. It has been widely argued in the United States that intelligence tests based on the American cultural tradition unfairly discriminate against lower-class black Americans, and that, on the basis of their lowered scores, they are denied employment and other opportunities for advancement. Anastasi (1976) agrees that certain types of cultural background have an effect on test performance and may therefore lower test results. She argues however that this is not in itself an undesirable outcome. What is important is the interpretation that is put on these lowered scores. For example, if intelligence tests are regarded as definitive measures of basic intelligence, "culturally disadvantaged" people may well be discriminated against by virtue of being seen as less intelligent. Anastasi asserts that such tests should rather be seen merely as "behaviour samples" and that performance of these behaviours may be affected by a wide range of individual factors, including cultural background. She writes: "Every psychological test measures a behaviour sample. Insofar as culture affects behaviour, its influence will and should be detected by tests. If we rule out all cultural differentials from a test, we may thereby lower its validity as a measure of the behaviour domain it was designed to assess" (p.58). However, Anastasi recognises two major sources of cultural bias in testing. One is where cultural factors affect performance of the tasks which the test is designed to assess and the other concerns cultural bias which is "built in" to the test design and content.

a) Cultural bias in task performance

Performance on particular tests may be affected by factors which arise out of the individual's cultural background. These may include unfamiliarity with test-taking procedures, low test-taking motivation, poor educational background leading to reading difficulty or inadequate knowledge of arithmetic and hostility towards authority figures of which the psychologist is representative. It is therefore important in the interpretation of test results that such facts are taken into account in order to differentiate between those whose poor test performance results from an inherent deficit in performing certain tasks and these whose performance is affected by extraneous culturally-related variables. Another way of approaching the problems is to avoid comparisons across cultural groups by developing subgroup norms, so that the individual is evaluated according to the general functioning of the cultural group to which he belongs.

b) Within-test Cultural Bias

Test content which discriminates against members of particular cultural groups includes the use of names or pictures of objects unfamiliar in a particular cultural milieu and stories or pictures depicting life situations in one subgroup, which may lead to feelings of alienation in members of other groups (e.g. the exclusive representation of members of one racial group in illustrations). Until such time as tests are developed which eliminate these sources of test bias their negative effect must be considered in the interpretation of test results.

In summary, assessment procedures, in order to be effective, need to be carefully selected bearing in mind the particular functions of test materials, their validity and reliability, the standardization sample with which the test was developed and possible further sources of test bias particularly when assessing members of other cultural groups. Where fully appropriate tests are unavailable, test results must be interpreted cautiously in the light of the above.

6.3 COMPETENCE OF THE PSYCHOLOGIST

The distribution of tests and test materials are universally restricted to qualified test users. In South Africa at present there are two categories of test users - psychometricians who have an honours degree in psychology, and qualified psychologists who have a masters degree in psychology. Both of these groups are registered with the South African Medical and Dental Council. Psychological tests are classified into A, B and C group tests, with A group tests comprising of elementary aptitude tests and ability tests, B group tests being group intelligence tests and aptitude tests and C group tests being personality tests and individual intelligence tests. Psychometricians may not administer C group tests and may only administer B group tests under the direct supervision of a qualified clinical psychologist.

Although clinical psychologists are legally recognized as being competent to administer and interpret any psychological test, the restrictions of current training programmes mean that it is

impossible for a trainee to have exposure to all the available tests, although most training programmes incorporate training in at least one major test in each of the test categories. For this reason, it is the responsibility of the individual psychologist to ensure that, when administering a test which is unfamiliar to him, he familiarizes himself fully with the test's purposes, materials and methods of administration by careful study of the test manual. In addition, in both administering and interpretation of an unfamiliar test, the psychologist should, if possible, consult a colleague who has had experience with the test and who is aware of its practical uses and limitations.

Anastasi (1976) asserts that, besides familiarity with the tests themselves, clinical psychologists also need to be constantly aware of the latest developments in research into subjects such as learning, child development, individual differences and behaviour genetics, as "test scores can be properly interpreted only in the light of all available knowledge regarding the behaviour that the tests are designed to measure" (p.46). As in the practice of psychotherapy, clinical psychologists can therefore only be competent test administrators and interpreters if they continue their own education beyond the point of qualification by continued review of the latest developments in research.

In summary, competence in psychological assessment may be seen as incorporating all of the following factors:

1) knowledge of all available tests, including newly introduced tests, and their range of intent;

2) selection of appropriate tests to be administered according to the goals of the assessment procedure;

3) meticulous administration of the test according to the instructions given in the test manual;

4) careful interpretation of test results taking into account all other relevant data, including information about the client's cultural background and life history, and recent research findings relevant to the behaviour being assessed.

It has already been made clear that the consequences for the client of recommendations made by psychologists on the basis of psychologists' assessment procedures may be far-reaching. It is the psychologist's ethical responsibility to fulfill all the criteria for competence in this area in order to ensure that these consequences are appropriate and just.

6.4 CONFIDENTIALITY

The major problem that arises here is to whom test results are to be communicated and the form that such communication should take. There are generally three types of interested parties who may request such information - the client himself; in the case of children, the parents or legal guardians of the child; and third parties who may or may not have been the referral agent. The need of these parties to know the results must be balanced against maintaining the security of test content and the risk of misunderstanding test scores.

It is increasingly felt that no matter the source of the referral, the client himself has a right to know the results of any psychological assessment procedures. In America it is regarded as necessary to show the client the test report so that he can comment on its contents and if necessary clarify or correct any factual information contained within it. (Anastasi 1976, p.53). Where the client is a child, the parents are regarded as having similar rights of access to this information.

Solomon, Kleeman and Curran (1971) consider cases where the assessment has been requested by agencies such as potential employers and emphasize the need to explain to the client prior to the assessment, the kind of information which will be communicated to these agencies. They also emphasize the importance of keeping confidential any information gathered during the interview which is not directly relevant to the purposes of the referral agent; stating that "redundancy, unnecessary details, and extraneous matter can often be omitted without weakening the report" (p.1568).

In all cases where the results of assessments are requested by third parties who were not the referral agent, the client's permission must be obtained before any information is released. It is apparent that the results of psychological assessment may be communicated to any number of interested parties and, especially if it is assumed that the client will also have access to the assessment report, it is obvious that the way in which test results are communicated is of central importance. The risk of misinterpretation of test scores is especially important and it appears necessary to avoid reporting raw scores. For example, in reporting on IQ testing, the client's actual IQ score should not be reported

and discussion of abilities should be limited to ranges of ability rather than fixed scores. The raw scores should be stored in a separate file which would only be available to clinical psychologists who are qualified to interpret them adequately. In addition, interpretations of test material should be present in a clear, understandable way without the use of technical jargon, and limited to the immediate objectives of the assessment procedure. Test protocols and their content should also be kept in a confidential file and reported on only where they illuminate an important finding of the procedure.

The strict confidentiality of test protocols is an obvious necessity in the light of the above, and these should not be stored in a file which is readily available to anybody other than the psychologist who is concerned with the case. In all cases, no information on the capabilities of a client should be released without the client's knowledge of and consent to this release.

6.5 INFORMED CONSENT AND PSYCHOLOGICAL ASSESSMENT

Psychological assessment procedures frequently involve, sometimes of necessity, revelation of characteristics without the client being aware that he is doing so. For example, the projective tests of personality would not be effective in many cases if the client were fully aware of the methods by which his responses are interpreted. There is therefore an element of deception involved in some assessment techniques, which raises ethical issues for the clinical psychologist. It must also be borne in mind that any observation of the client or routine history-taking will reveal to the astute clinician information which the client is unaware of

communicating. The responsibility of the psychologist to preserve as far as possible the autonomy and privacy of the client is therefore extensive.

As in the practise of psychotherapy, obtaining the informed consent of the client for participation in assessment procedures may be useful in minimizing the degree of invasion of privacy which is frequently involved. In assessment, the client should therefore always be aware of the general aims of the procedure and should consent to participation in procedures with these goals. Related to this is the necessity to inform the client which parties will have access to the information gained during assessment.

Prior to the procedure the client must be informed that he may inadvertently communicate information to the examiner regarding his general functioning with the assurance that the examiner will use this information only in ways which will be relevant to the general purposes of the assessment. Prior to administering each test, there should be some general statement of the broad purposes of the technique and it is in this area that the psychologist needs to exercise special care to ensure that the client has enough information to make an informed decision as to whether or not to participate while simultaneously avoiding reducing the validity of the test by evoking defensiveness and resistance in the client. The amount of information which can be communicated will therefore vary according to the nature of the test.

Although some psychologists feel that obtaining informed consent from clients may increase their resistance and reduce the number of clients who agree to participate in assessment procedures

this has not in fact been found to be the case. Fink and Butcher (1972) assert that "the number of respondents who feel that a personality inventory represents an invasion of privacy or who consider some of the items offensive is significantly reduced when the test is preceded by a simple and forthright explanation of how items were selected and how scores will be interpreted... such an explanation did not affect the mean profile of scores on the personality inventories" (p.638).

Thus, it appears that applying the principle of informed consent in psychological assessment, far from reducing the number of clients who agree to participate may in fact provide the necessary reassurance for the client to feel free to participate.

CONCLUSION

This chapter has examined the ways in which the ethical principles relevant to psychology may be applied in psychological assessment. Competent and ethical behaviour in this field comprises of a careful and clear definition of the goals of assessment, selection of tests appropriate to both these goals and the particular characteristics and needs of the client and accurate interpretation of results on the basis of these same characteristics. The rights of the client are to be protected by maintaining the confidentiality of test results and by obtaining the informed consent of the client before any assessment procedures are initiated.

CHAPTER SEVEN

ETHICS IN RESEARCH

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ETHICS IN RESEARCH

Psychological research involves many complex ethical issues, some of which are common to research in all fields of scientific endeavour but many of which arise out of the inevitable use of human subjects in research in psychology. The ethical dilemmas confronted by clinical psychologists in conducting research will be examined in this chapter mainly with reference to the goals and methods of research. These two issues will be discussed separately although it will become apparent that they are mutually interdependent with the goals dictating the methods and the methods frequently being evaluated in terms of the ultimate goals.

7.1 GOALS OF RESEARCH

The primary role and duty of any scientist is to expand human knowledge through research. The basic assumption has been that knowledge is a value in itself. In terms of the principle of autonomy, all research which expands human knowledge is ethical because it provides humans with greater understanding of and therefore control over the environment. However, some theorists assert that the question of whether some kinds of research are ethical or not should extend further than the question of whether this research would expand human knowledge. Parker (1974) writes that one should ask the question "Is the knowledge one wishes to acquire valuable or not, in an ethical sense? Ought one to know it?" (p.209). His justification for asking this is that the

acquisition of knowledge cannot be seen as separate from the application of this knowledge, and where knowledge may be applied in unethical ways to the detriment of society or groups within society, it may be better not to acquire the knowledge in the first place.

An example of such ethically questionable application is the development of nuclear weapons which was made possible by research into the possibility of splitting the atom. In psychology, Jensen's studies of race and IQ could be seen as ethically questionable from this viewpoint because of the potential for increased discrimination against blacks on the basis of the results of the research. These considerations have led Parker to assert that "Both the facts and the possible applications are dependent upon the aims of and goals of the inquiry; therefore, beforehand the aims and methods of the inquiry should be examined and an ethical choice made about the knowledge to be gained" (p.209).

The argument against this assertion is that it may impede the development of science and therefore the progress of the human race. The APA in their "Ethical Standards for Research with Human Subjects" (1972) point out that "it is rarely possible to predict the uses to which scientific knowledge can be put" (p.2) and in the light of this, "the scientist cannot appropriately be asked to limit research to topics that appear to have immediate relevance to human and social problems. Nor should every research scientist be held responsible for making research applications" (p.2). The APA therefore supports the contention that research and the resultant gains in knowledge are values in themselves and states further that "for a psychologist, the decision not to do research is itself an ethically questionable

solution, since it is one of his obligations to use his research skills to extend knowledge for the sake of ultimate human betterment" (p.2).

In attempting to clarify this dilemma, it may be useful to distinguish between "pure" research and "applied" research. In the field of psychology, "pure" research may be seen as research which attempts to answer questions about human behaviour such as "how do humans react when placed in a situation such as X?". "Applied" research, on the other hand, would ask questions such as "how can we manipulate the environment (or the person) so that person X will behave in this way?". It can be seen that in the former type of research, the researcher is concerned merely with gaining knowledge, whereas in the latter, the application of particular types of knowledge is investigated. It is apparent that fewer ethical difficulties arise with "pure" research than with "applied" research in that it is in the application of knowledge that the potential for harm may arise. It seems inappropriate to insist that "pure" researchers should be concerned with the application to which the results of their experiments may be put in that, as has been stated, it is frequently almost impossible to predict what these applications may be. In fact, both good and bad applications may arise out of the same basic research findings. The Jensen study, for example, may also give rise to new approaches to the measurement of IQ, or at least a revised look at the interpretation and validity of standard IQ tests - a development which could only be seen as a positive advancement.

Thus, it is at the level of applied research that the goals of research may be more accurately judged according to their ethicality. Here, the principles of beneficence and nonmaleficence become important yardsticks in that the goals of research should be beneficial to human society and should not cause harm. This still remains a complex area in that, as has been pointed out in previous chapters, the definition of good and harm vary according to who evaluates the outcome. Thus, the development of nuclear weapons may be seen as unethical because the direct goal of such research is the manufacture of mechanisms which will most effectively kill large numbers of people, but such research is justified by governments in terms of these weapons' role in protecting the members of a particular society. The decision to continue with such research depends on the beneficial effect (i.e. the protective function of weaponry) being seen as more important than the potential harmful effect (the destructive function of these same weapons).

It is apparent, therefore, that in evaluating the goals of research, both the intended beneficial consequences and the possible harmful consequences need to be taken into account, and weighed against one another before such research is conducted. While it is obvious that research conducted purely with a harmful aim is unethical, psychologists must be aware of the possibilities of the usage of results of research with a beneficent goal being used for harmful ends. Thus, while it is apparent that research into the best means for continuing discrimination against a group of people is unethical, it is not so obvious that research into the best ways of relieving discrimination may achieve the same harmful results, by highlighting the most powerful discriminative mechanisms within a society. Where the possible indirect negative results of research outweigh the intended positive results, it may be argued that such research

should not be conducted and where the research is conducted despite possible negative usages, psychologists incur an obligation to minimize the potential for such harmful consequences by reporting and interpretation of research results with all due care and qualification.

7.2 METHODS OF RESEARCH

The primary ethical conflict in this area is that between the psychologist's duty to conduct research in order to improve the welfare of society as a whole and his simultaneous duty to protect the welfare of the individuals who participate as subjects in his research. As will be seen, the mechanism by which such conflicts are resolved frequently involves a form of costs-benefits analysis in which the costs are the potential physical or emotional distress experienced by research subjects and the benefits are the improvements or gains which may be made by society as a result of the research.

The forms of harm that subjects of psychological research may experience may arise out of the necessity to place subjects in situations in which they may experience failure, frustration, embarrassment, boredom and aggression, and may also force them to realise aspects of themselves about which they were previously unaware and which they find unpleasant - for example they may find themselves conforming blindly or cheating as a result of the experimental environment. It is important for the experimenter to be aware of the possible emotional effects of his research methodology in his subjects and where possible to minimize these. Where the goals of the research necessitate inducing any of these negative experiences, the researcher must have satisfied himself that the

benefits of the research outweigh these negative effects. In addition, the APA in their "Ethical Standards for Research with Human Subjects" (1972) propose some further steps to ensure the autonomy and well-being of research subjects. These will be discussed in the remainder of this section, along with the major criticisms which have been levelled against them by other writers.

7.2.1 Costs-Benefits Analysis

In deciding whether the costs of a research project are worth its potential benefits, the APA recommend that the researcher reduce his own biases contaminating his decision to proceed with the research via three methods. Firstly, he should bear in mind that costs may differ "as they appear to the investigator, as they would consensually judged by his colleagues, as members of the general public might see them, and as they are seen by the research participant himself" (p.3). They emphasize that all these differing points of view must be taken into account by the investigator when he attempts to evaluate the potential costs of his research. The second means of reducing the bias of the researcher in conducting such analysis is to obtain the advice of colleagues who will not be directly involved in the research project. This advice should be focussed directly on the ethical issues which will relate to the research participants. Finally, the APA recommend that pilot studies be conducted in which the main emphasis would be on gauging the subject's reactions to the research procedures, and where these are anxiety provoking or dehumanizing, attempts should be made to modify the procedures

to minimize these negative effects. The APA conclude by emphasizing that no matter what precautionary measures have been taken or what advice has been received by the researcher, he remains solely responsible for the conducting of the research and for any negative effects on participants which may arise out of his procedures. Thus, the mere fact of having taken such measures does not release the researcher from ultimate ethical responsibility. It is therefore also important for researchers to ensure that all other professionals, such as research assistants, who are involved in conducting the research are aware of the ethical issues involved.

7.2.2 Informed Consent

The APA's Ethical Standards emphasize the necessity to obtain informed consent from all potential research subjects for participation in the research project, stating this requirement as follows: "The investigator should inform the participant of all features of the research that reasonably might be expected to influence willingness to participate. In addition the investigator should explain all other aspects of the research about which the participant inquires" (p.6). In terms of this directive, the researcher needs to explain both the goals of the research and all negative consequences for the participants that may arise out of the research procedure.

It is this aspect of the Ethical Standards that has given rise to the most extensive debates in the literature on research in psychology. The major reason for this debate is that much research in psychology necessitates deception of the research

subjects in one form or another. Eisner (1977) identifies two forms of deception - instances where the subject is given misleading or erroneous information, and instances where the subject is given incomplete information. In both cases the subject is not given the opportunity to give informed consent for participation in the research procedures, which Eisner views as a negative factor in that the participant thereby loses his freedom of choice. The further negative effects of the use of deception are seen as follows by Eisner: "using deception may make the subject feel foolish or embarrassed, alter his psychological state, particularly his self-esteem, and lead to a feeling of mistrust and cynicism" (p.234). She goes further to state that this latter feeling of mistrust has generalized in America to the point where many people are immediately suspicious of psychological research, expecting an element of deception to be involved. As it has been shown that suspicious subjects do not behave in the same way as naive subjects during experiments, Eisner maintains that the traditional use of deception in research has led to a situation where experimental results may be slanted anyway because of this developing suspicion, and that the use of deception is therefore self-defeating.

The counter arguments to this position have been put forward by writers such as Resnick and Schwartz (1973) and Helmchen and Muller (1975) who argue that in order to avoid perceived-demand effects in research, the actual goal of any research must of necessity be hidden from research participants. An example of such situations in psychological research is the use of placebo treatment in order to measure the efficacy of new techniques of

psychotherapy. It is argued that it would be impossible to measure the effects of such techniques without such placebo groups which could be compared with both no-treatment control groups and the treatment group. To inform subjects that they may receive a placebo would influence their expectations and contaminate the results of the research. Even where placebo research is not involved, Resnick and Schwartz (1973) have demonstrated that fully-informed subjects behave significantly differently from deceived subjects in research and that the application of informed consent in research settings therefore makes certain kinds of research difficult, if not impossible.

Rugg (1975) has attempted to shed more light on this conflicted area by investigating the attitudes of potential research subjects towards the use of deception in research. His results showed that, where no stress was involved deception was generally regarded as acceptable, but stressful research procedures which involved deception were rejected. Thus in a straightforward verbal conditioning experiment, deception would not be objectionable, but an experiment such as Milgram's where the subjects experienced high levels of anxiety and subjective distress would be regarded as unethical by the groups consulted by Rugg. Possible ameliorative measures in research involving deception were also investigated in this paper, and it was found that, where subjects were aware that they were involved in research but unaware of its exact purposes, careful post-research debriefing of the subjects had some ameliorative effects on the distress of the subjects.

It appears, then, that the issue of informed consent by research participants conflicts directly with the use of deception in

some research procedures. The main objections to the use of deception is that it may result in negative consequences for the participants which are additional to the distress which arises out of other experimental procedures, while the major argument for the uses of deception is that in some cases it may be impossible to achieve the desired results with any other design. What can be concluded from the above arguments is that while the use of deception is not the optimum ethical choice of research design it is occasionally necessary. In the light of the above, the following steps could be suggested as ways of evaluating research in which deception appears a desirable option. According to Rugg (1975), where the research procedure does not involve stressful circumstances for the participants, the use of deception may be more justifiable, but nevertheless it must be accepted that, ethically, fully informed consent by participants is the optimum choice and therefore where possible the use of deception should be avoided or minimized.

1) Consideration of alternatives to deception

Eisner (1977) suggests the use of simple observational techniques and "simulation" research in which participants are placed in simulated environments for extended periods of time, as alternatives to the traditional deception design, while O'Leary and Berkovec (1978) suggest a number of alternatives to the use of placebo groups, including "best available" comparisons, component control comparisons, neutral expectancy and counter-demand manipulation. Where a viable alternative exists to the proposed "deception" design, this alternative would be suggested as the ethical choice.

2) Costs-benefits analysis

Where deception appears to be the only available option, the researcher must satisfy himself that the value of the research goal outweighs the disadvantages of the use of deception. This decision should be reached after consultation with colleagues uninvolved in the research project.

3) Debriefing of subjects

Rugg (1975) suggests debriefing subjects as the actual purposes of the research and the necessity to use deception as part of the design. This would presumably help to ameliorate any feelings of resentment that the subjects may feel towards being unwittingly forced to reveal aspects of their behaviour.

In summary, wherever possible subjects should be fully informed of the factors operating in research procedures which may affect their emotional state or self-esteem and their consent to participate should be gained, but where the nature of the research requires some form of deception, researchers should ensure that the autonomy and well-being of their subjects are protected as far as possible by taking the precautions listed above.

7.2.3 Withholding treatment and control groups

Much psychological research, especially that which involves researching new forms of treatment necessitates the use of untreated control groups against whom the efficacy of the new treatment can be compared. However, as the Working Group in current Medical/Ethical Problems (1977) points out: "Any clinical research which is not directly for the benefit of the

patients on whom it is performed poses certain ethical questions" (p.14). Subjects who constitute control groups are not directly benefitting from the research procedures and concern has therefore been expressed about the ethicality of withholding treatment from such groups for the purposes of research. Such withholding could be seen as violating the principle of beneficence.

This dilemma can be approached in a number of ways. Firstly, if the treatment being developed is in an area in which there has previously been no means of treatment, the control group could arguably be seen as being no worse off than before if no treatment is administered. If the experimental treatment proved to be successful after the research, such control groups could be assured the treatment once the research had run its course. Secondly, where treatment is available it does not seem unfeasible to compare the new treatment to the previous treatment which would be administered to the control group. The only justification for introducing a new treatment is where it is superior to previous methods on one or more dimensions. In such cases it does not seem necessary to deprive the control group of treatment in order to demonstrate the superiority of a new method. Finally, in all cases where a control group is being used, the subjects who constitute this group should give consent to participate on the understanding that they would operate as controls and as such not receive the potential benefits of a newly-developed treatment method until these benefits had been conclusively demonstrated through the research.

7.2.4 Confidentiality

One of the most important ways of ensuring the welfare and protection of research subjects, emphasized by the APA, is the assurance of absolute confidentiality by researchers. Because of the sometimes distressing nature of what subjects reveal during research, this assurance, important in all areas of psychological functioning, is especially important here. Subjects must be informed that in reporting research results, all names and possible identifying data will be omitted. All records of research findings should be similarly censored and, for computer storage, it is preferable that the subjects be assigned numbers. Where subjects are inmates of an institution, research data should not be kept in their general files, although there should be some record kept that they have been involved in a research project, because of the tendency to use the same institutional subjects in repeated research projects Access to the original research data should be restricted to the researcher and this data should not be released to other researchers without the permission of the individual participants. All research assistants should be made aware of the importance of maintaining the confidentiality of data recorded during research.

CONCLUSION

It is apparent from the discussion in this chapter that the psychologist who wishes to conduct research must be constantly alert to the ethical issues that are involved not only in the goals of his research but also in the methods by which he intends to achieve these goals. A process of careful balancing is necessitated throughout the process of research. In considering the goals of research the

balancing process involves weighing the anticipated beneficial uses of the research against the potential harmful uses, while in designing methodology the protection of the welfare of the human subjects becomes important with the balancing process involving evaluating the extent of the potential harm to the subjects and weighing this against the beneficial outcome of the research as a whole.

CHAPTER EIGHT

PROFESSIONAL CONDUCT

AND

PROFESSIONAL RELATIONSHIPS

CHAPTER EIGHT

PROFESSIONAL CONDUCT AND PROFESSIONAL RELATIONSHIPS

In the discussion of professional codes of ethics in Chapter one, it was pointed out that one of the functions of such codes is to promote public trust and confidence in the profession by regulating the conduct of the members of the profession. The ethical justification for this function of professional codes is that without such confidence in the profession, members of the public who are in need of the services of the profession would be less likely to seek and acquire professional aid.

It seems necessary, then, that in an ethical code for clinical psychologists a certain proportion of the regulations should be concerned with establishing a particular public image of clinical psychologists as professionals which would inspire confidence in members of the public who may require psychological treatment. While many of the directives discussed in previous chapters, particularly those of confidentiality and informed consent, may contribute significantly towards establishing and maintaining such an image, there are other areas of the psychologist's functioning not directly related to treatment of clients, such as the administration of the psychologist's practise and the way in which psychological services are made known to the public, which must also be regulated in order to protect this public image. It is with these issues that this chapter will be concerned.

Before discussing the particular kinds of regulations which seem

appropriate in order to create and maintain a public image of the profession of clinical psychology which will inspire the necessary trust and confidence, it is necessary to consider briefly what would constitute such a desirable public image for psychology. The two primary factors which need to be communicated seem to be firstly the profession's primary concern with the psychological wellbeing of the community within which it operates and, secondly, its competence to promote this well-being.

With regard to the first issue, the profession as a whole and individual clinical psychologists must be seen as holding the client's welfare as of primary importance and not be seen to promote their own self-interests at the expense of the interests of their clients. For this reason, the profession must avoid being viewed as in any way exploitative, either materially or emotionally of the public who may at some time constitute its clientele, and must be seen as willing to co-operate with other related professions where this would be in the best interests of individual clients.

The second issue relating to competence of the profession as a whole to achieve its aims and adequately fulfill its service functions implies that the profession must make public the standards of competence it requires of its members and must be seen to take appropriate steps to ensure that these standards are maintained. It is essential that the public believe that any individual member of the profession whom they consult will be competent to assist them and it is the profession's responsibility to ensure that this belief is not only widely held, but justified.

Thus, a professional code for clinical psychologists must regulate against exploitation of the public by individual professionals and must ensure that the behaviour of practitioners does not in any way bring the competence of the profession as a whole into question. A significant proportion of the regulations in both the APA and the South African ethical codes is concerned with these issues. These regulations and their justification will be considered under the two major headings of exploitation and competence in the remainder of this chapter.

8.1 EXPLOITATION

In this section, in which regulations aimed at preventing the exploitation of the public will be discussed, three major areas in which potential exploitation may occur, will be considered. These are: remuneration for services, public statements, and co-operation with other professions.

8.1.1 Remuneration for Services

While it is obvious that psychologists like any other professionals, depend on remuneration for their services for their livelihood, it is important that they are not and do not appear to be primarily concerned with personal material gain. Therefore, there need to be regulations which are primarily concerned with both the legitimate services for which remuneration may be received and the extent of this remuneration.

As a general rule, clinical psychologists should be remunerated, in their professional capacity, solely for those acts which are

directly beneficial to an individual client or clients. A broad range of services may be offered, including psychotherapy, psychological assessment, supervision of professional colleagues, assessment and expert advice in legal proceedings, and professional consultation. The extent of the remuneration which may be received for each of these services should be determined by the regulating professional body and individual practitioners should not exceed these limits. Clients should be informed in advance of the fees for services to be offered and the APA code recommends that "Psychologists willingly contribute a portion of their services to work for which they receive little or no financial return" (Principle 6(d)).

Both the American and South African codes prohibit both the receipt of commission for the recommendation of particular services or wares and the payment of commission to agencies or individuals for the referral of clients to their services. In addition, the South African code does not permit tendering for an appointment by a psychologist.

These regulations are all aimed towards reducing financial competition between clinical psychologists, in order to maintain the image of the profession of clinical psychology as being non-exploitative and concerned primarily with the welfare of the client.

8.1.2 Public Statements by Clinical Psychologists

The manner by which psychologists make themselves known to the public is obviously extremely important in creating and maintaining

a particular public image. In both the South African and American codes there are very specific regulations as to the manner in which this may be done although these regulations differ in some respects.

The common factor in both codes is the prohibition of advertising which consists of any statement about the quality of services to be offered or of any endorsement of services by clients or agencies. The justification for such prohibitions is firstly that such advertising is by its nature potentially exploitative, particularly as it would be aimed at an audience whose psychological resistance is low and therefore very susceptible to suggestions about quick and effective cures for their distress. Secondly, such advertising by individual practitioners is obviously aimed at personal gain for the practitioner by acquiring more clients and therefore undermines the image of the psychologist as being concerned more with the client's interests than with his own.

The points where the two codes differ are in the specific forms of advertisement that are prohibited. In America, psychologists may publicly announce their services where such an announcement is limited to the psychologist's name, qualification, address and telephone number and types of services offered - e.g. psychotherapy, group therapy, marital counselling, etc. However, in South Africa, all such public announcements are prohibited and when beginning practice the psychologist is limited to informing only other professionals who are registered with the Medical and Dental Council and institutions and agencies which offer psychological services. A psychologist's name may not be listed along with his qualification in any public arena including newspapers, and

magazines, so that he as an individual is not made directly known to the public. In addition, nameplates outside the offices where a psychologist practises are restricted in terms of size and location so that they do not attract the attention of the general public and thereby constitute advertising.

While these latter regulations are understandable and justified in that they prevent competition amongst psychologists to be interviewed in the media and develop extravagant signs and notices advertising their services, which would again undermine the desirable image the profession wishes to maintain, it does not seem that merely announcing services to the public through the means of, for example, a newspaper, would necessarily constitute advertising. As in the American system, such announcements could be viewed as merely one way of providing information to the public as to the kinds of services which are available, and where they are located. As an alternative to the use of newspapers, a booklet could be produced by the professional body which would provide a list of psychologists available, the services they offer, and the areas in which they are located and this could be distributed to be displayed in places such as doctor's waiting rooms and the waiting rooms in hospitals and other health institutions. While not excluding the possibility of recommendation of particular psychologists by other professionals, such a measure could increase the potential client's choice of psychologist by providing him with more complete information as to the services which are available than could an individual practitioner consulted by the client. A further advantage of such a booklet being produced by the professional body would be the possibility

of directly regulating the size and nature of each individual practitioner's announcement.

8.1.3 Co-operation with other Professionals

In order to provide the best possible service to the client the psychologist needs to be fully aware of the functions and competence of members of other related professions, and, where the services offered by such other professionals may contribute to the client's welfare, the client should be referred to these practitioners. Examples of professionals whose services may complement those of the psychologist include medical general practitioners, psychiatrists, social workers, occupational therapists and speech therapists. In order to maintain good working relationships with these other professionals, psychologists need to be aware of their traditions and practices and to respect these. It is unethical for a psychologist to publicly undermine the services or quality of services offered by other professionals whether this is done directly to enhance the status of his own profession or not. Where a client consults a psychologist while already receiving services from another professional, the psychologist must not offer his services until he has informed the other professional concerned of the referral and has come to an agreement regarding the case, and the responsibilities of each professional with regard to the case. In summary, cordial and respectful relationships with other professionals must be maintained by psychologists and not undermined in public, in order to provide the client with the best possible services.

8.2 COMPETENCE

It has already been indicated that one of the hallmarks of a profession is that it ensures the competence of its members by setting standards for basic qualifications and entrance into the profession and standards for ethical conduct by its practitioners. The maintenance of trust in the competence of its members is therefore one of the most important functions of a professional body. In order to maintain this trust, individual psychologists must be prohibited from undermining this and, for this reason, the American and South African ethical codes prohibit "casting reflection explicitly or implicitly upon the probity or professional reputation" of any other clinical psychologist (SA code, regulation 14). Where a psychologist becomes aware of unethical or unprofessional conduct on the part of a colleague, the APA code recommends that he first attempt to rectify the situation himself, and, where this does not succeed, then report the psychologist concerned to the professional regulating body (In South Africa this body would be the Professional Board for Psychology).

In addition, in order to ensure the optimal functioning of the profession as a whole, it is desirable that psychologists report any new procedure which they have developed and which appears to be effective, in the psychological literature so that the general standard of professional services may be advanced. No psychologist may therefore claim to have a "secret remedy" which he maintains for his exclusive use.

Finally, especially in reporting on research, the significant contribution of any colleague to one's own work must be acknowledged in the appropriate manner and all professional competition must be limited to the psychological literature. Public competition or professional jealousy undermines the general image of the profession because it frequently involves casting aspersions on the competence of individual practitioners within the profession.

SUMMARY

This chapter has considered the public image of the profession of psychology and the functions of an ethical code in promoting this image. It was proposed that the two major elements of a desirable public image for clinical psychology are the non-exploitative nature of the profession and its competence to fulfill the functions for which it was created. The regulations contained within both the American and South African ethical codes which are aimed at communicating this image were discussed in terms of their content and justification.

CHAPTER NINE.

THE SOUTH AFRICAN CONTEXT

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In chapter four, the major criticism levelled at the existing ethical regulations for South African psychologists was that, possibly due to the fact that psychologists must be registered with and accountable to the South African Medical and Dental Council, these regulations seem to be derived from the medical code of ethics and therefore inadequately account for many major areas of concern for psychologists. Other, more detailed, ethical codes adopted by the various psychological associations in the country were seen to be more applicable and useful to the profession but had no legal standing. In addition, it appears that these codes were based directly on the American Ethical Standards and, as such, were not always adequate to deal with specific ethical problems encountered by psychologists in South Africa.

It appears that, while the ethical principles to which psychologists should adhere are universally applicable, as are the functions which they are required to perform, the social milieu in which they are located will give rise to particular difficulties in fulfilling these functions in accordance with ethical principles. Thus it can be expected that, by virtue of the unique social structuring of South Africa, South African clinical psychologists will be confronted with difficulties which are different from those in other countries and the details of an ethical code derived for psychologists in a

different country such as America will not necessarily be adequate in guiding South African psychologists in ethical decision-making.

This chapter examines two of the major aspects of South Africa which distinguish it from other Western countries, and outlines some of the particular problems which are posed for psychologists by these aspects. The first to be considered is the socio-political structure of the country which is based on the principle of racial segregation, while the second concerns the composition of the population which consists of a minority of white Westernized people and a majority of black people, the bulk of whom originate from an indigenous, African cultural background considerably different from the Western cultural background. Initially these two aspects will be considered separately, but it is apparent that the effects that they have on the psychologist in his functioning must be interactive and for this reason, in the final section of the chapter, they are considered together.

9.1 THE SOCIO-POLITICAL CONTEXT

It has been noted at various points in this thesis that there exists an inevitable tension between the ethical principles of autonomy, nonmaleficence, beneficience and justice, to which psychologists are committed in their practice, and societal norms, values and customs which may not be consonant with these principles. Psychologists are constantly faced with the difficulty of developing the capacity for free choice and autonomous action in clients within societies in which practices such as discrimination on the basis of sex, race, religion and political ideals, mitigate against such individual autonomy. Whilst these difficulties are inherent in all societies to a certain extent, they are particularly pronounced in countries where discriminative practices are not merely customary, but lodged in the political and legal structures of the society and therefore less amenable to questioning and possible reform. In this section, the nature of the conflict between the psychologist's ethical principles and the South African socio-political system will be outlined and the types of difficulties confronted by South African psychologists as a result of this conflict will be discussed. It appears that the particular socio-political setting of South Africa has bearing on the psychologist in his professional functioning on two levels. Firstly, it has implications for the mental wellbeing of the inhabitants of the country (who may constitute the psychologist's clientele), and, secondly, it influences the psychologist's functioning in his relationships with the society as a whole, with the institutions within which he may

work and with individual clients. These implications will be further discussed in this chapter but it appears necessary first to outline briefly some salient features of the South African socio-political situation.

9.1.1 The Socio-political structure of South Africa

While a comprehensive analysis of the nature and origins of the complex socio-political structure of this country is impossible within the scope of this thesis, it may be possible to identify some of the major elements operative within the society which have relevance to the particular difficulties experienced by South African clinical psychologists. Many of these difficulties appear to arise out of the policy of racial segregation which has been operative in the country for over thirty years, and which influences almost all aspects of social interaction and development.

The development of this policy finds its roots in the colonial history of the country. The white colonists gained political dominance by conquest and were responsible for developing and controlling the economy, using black race groups as the labour base upon which the economy was founded. With the discovery of mineral wealth in the late nineteenth century, South Africa became a rapidly developing and industrializing country, but the colonial pattern of exclusive white control of the political and economic spheres was maintained. This pattern became legally enforced state policy in 1948 which ensured that white dominance in political and economic decision-making has persisted until the present day. The

distribution of labour and benefits within the country has therefore remained unequal and divided along racial lines. The cheap labour force on which the economy is dependent has been ensured by the development of the legally enforced black migrant labour system. Concomitantly, economic benefits are maintained largely within the white group with other groups receiving reduced services on all levels including housing, health services, education and welfare facilities. The entire system has been protected by enforcement through the legal apparatus and by the denial of effective political rights to other race groups, thus reducing potential threat to white domination and control in the economic sphere.

While the policy of social, political and economic separation between race groups in South Africa is founded upon the principle of separate development which is intended to ensure the autonomy of all the groups, it can be seen, in the light of the previous discussion that, in practice, this does not occur and that the system in fact undermines the principle of autonomy in several important ways. Firstly, it is apparent that the separation occurs within the context of a common economy which is controlled by the white group. This means that other race groups are not economically independent and can therefore not be seen as autonomous in any real sense. Secondly, the social segregation of race groups is achieved via a set of legal injunctions which influence almost all aspects of an individual's life including

where he may live, how and by whom he may be educated, whom he may marry and even with whom he may associate socially. Thus it is apparent that the individual choices which may be made by members of the society are significantly restricted and individual autonomous action is curtailed by legal prohibitions. With this admittedly cursory review as a basis, discussion may now proceed to a consideration of the ways in which the socio-political structure of South Africa may influence the mental health of members of South African Society and the implications that it has for psychologists in their role as promoters of mental health.

9.1.2 Influences on Mental Health

Much debate continues to be concerned with the factors which constitute the set causes of the universal problem of "mental illness" or psychological maladjustment. While there is undoubtedly an organic basis to many types of mental illness, particularly in its extreme forms such as psychosis, it is also apparent that optimal psychological development and well-being is hampered by conditions that pertain within most human societies. Simply put, there is inevitably a conflict between the individual's desire to satisfy his basic needs and achieve his individual aspirations and the societal conditions and demands which impede this achievement. Of course, both individual aspirations and the impediments to the achievement of these aspirations differ across societies and the degree and nature of the resulting conflicts and frustrations within individuals will therefore also differ. However, Maslow has constructed a hierarchy of human needs

which he proposes as universal and therefore common to all societies. It may be useful therefore to employ his model as a framework within which to discuss some of the major factors operative in South African society which may hamper the development of optimal psychological wellbeing in all the members of this society.

Maslow's theory identifies nine categories of human needs and aspirations and arranges them in a hierarchical ordering. Individuals must satisfy the more basic needs before aspiring to the satisfaction of other higher order needs. Figure 3 illustrates the ranking of these needs and aspirations.

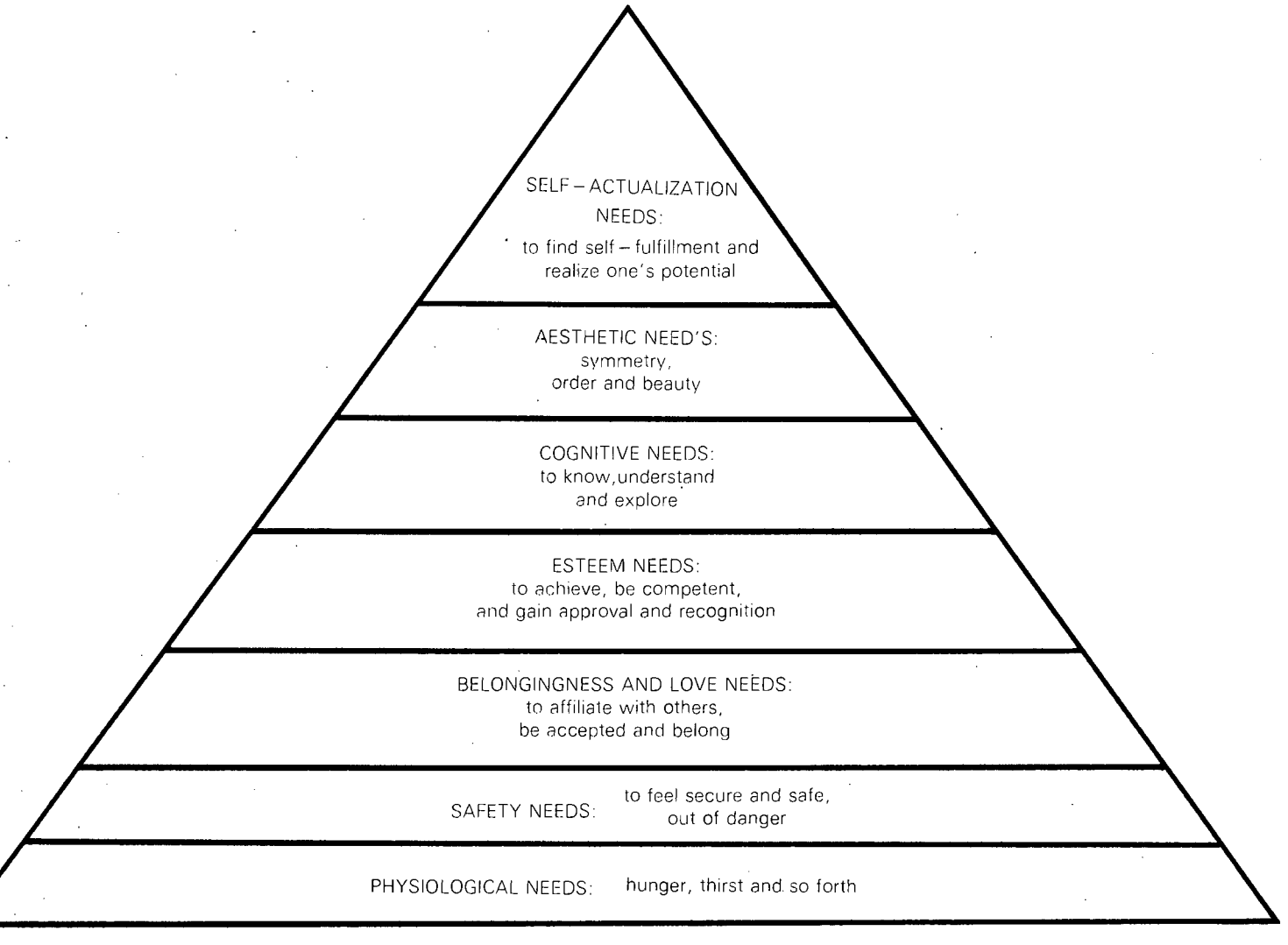

FIG 3 : MASLOW'S HIERARCHY OF NEEDS

In all societies, individual members will be located at different points of the hierarchy and will therefore have differing aspirations, with the degree of economic wealth, development and advancement of the society as a whole determining the level at which the majority of individuals are located. In South Africa, with the differential allocation of economic benefits the level at which the majority of the white population is located can be expected to be higher than the level of the other groups. Thus, for example, while the white population group generally has both its physiological and safety needs recognised, this is not necessarily the case for the other groups who are not similarly advantaged within the system. To discuss the effects of South African society on the fulfillment of individual needs as though all groups were located at the same level may, therefore, constitute a distortion of the social reality of the country. As the white population group, due to its access to superior facilities, enjoys a standard of living comparable to that of Western countries such as the United States of America and Great Britain, and as the autonomy of individual members of this group is consequently less restricted, the socio-political situation in this country may be seen as having fewer implications for the satisfaction of needs within this group. For this reason, discussion of the implications of this system for psychological wellbeing will be confined to the other population groups, who, it must also be remembered, constitute the majority of the inhabitants of the country.

Prior to this discussion, the effects of being unable to achieve aspirations at whatever level they are located should

be considered. Within Maslow's theory, full psychological development and well being can only be realised once all basic needs have been satisfied. In other words optimal mental and emotional functioning is possible only at the top end of the hierarchy. If an individual has been prevented at any level from moving upwards in the hierarchy one can expect a degree of psychological distress arising out of the frustration he must inevitably experience. This distress may take the form of a number of psychological symptoms including depression, anxiety and alcoholism. It can be expected, therefore, that the prevalence of psychological problems within a society is to some extent influenced by the degree to which individuals within the society are able to realise the aspirations of the level on which they are operating. The remaining part of this section will consider the hindrances to the realisation of these aspirations experienced by the black population of South Africa. It must be emphasized, of course, that not all individual black inhabitants of the country are located at the same levels of the hierarchy, but there are certain common difficulties experienced by individuals at each level which arise out of the societal context of the country. The hindrances at each level will therefore be discussed separately.

a) Physiological and Safety Needs

The needs of individuals at these levels may be broadly categorized as needs for adequate food, housing, health and material security. It is apparent that the satisfaction of these needs dependsupon the availability of employment which

can provide sufficient monetary gain to provide these necessities. In South Africa, such gainful employment is not ensured for all members of society with a high unemployment rate (the most recent estimate being 407,000 unemployed black people) and with many of those who are employed earning wages which are insufficient. In 1975 it was calculated that 30% of black families were earning below the poverty datum line (calculated at R.91 - 120 p.m.) and only 32% of black families had an income of over R.200 per month. Thus, the acquisition of adequate material security is problematic for many of the black population. Housing represents an additional problem, particularly in the urban areas where black families are restricted to allocated residential areas and are dependent on the state to provide adequate housing. The construction of housing has not kept pace with the demand and as a result there is chronic overcrowding in the urban areas with, for example, houses in Soweto built to accommodate 4 people found by a survey conducted in 1981 to be accommodating up to 17 people (Unterhalter, (1982)). The lack of privacy and consequent irritability and frustration arising out of such conditions can only be seen as psychologically deleterious.

b) Affiliation Needs

These needs are traditionally satisfied by an individual locating himself within his family and within a broader cohesive community. One of the significant aspects of South Africa- society which militates against such location is the

migrant labour system, which necessitates that labourers from rural areas leave their families and live in hostels in urban areas for periods of six months at a time. This disruption of family life has inevitable negative consequences both for the labourers and their families who must, in order to satisfy their basic physiological and safety needs, experience repeated separation from significant members of the family (normally the fathers and older sons). The labourers themselves experience isolation and alienation from supportive social groups, for, while the families remain within their original group, the transient nature of the labourers in the urban areas prevents the formation of satisfactory alternative affiliations and social support systems within this context.

The Group Areas Act which frequently gives rise to the removal of individuals and families from communities within which they have been established to newly constructed housing schemes is also disruptive to this necessary process of the establishment of mutually supportive community affiliations.

c) Esteem Needs

These needs are necessarily connected to the perception of approval and recognition by others, which gives the individual a measure by which to assign himself value. There appear to be two major factors which for the black person would undermine the development of self-esteem. Firstly, it has been noted that there is a high degree of social separation between race groups and that this separation is accompanied by the unequal distribution of social benefits. Particularly in urban areas

where there is a high degree of contact between members of different race groups, this differential allocation is patently obvious as is the fact that the facilities and services available to members of the white group are inevitably superior. Prolonged exposure to social situations in which one is allocated an apparently inferior status must interfere with the development of both group and individual self-esteem. This is possibly because rewards are traditionally allocated on the basis of value and worth and the reception of inferior rewards implies inferior value or worth within a society. The second major factor to be considered is that, in Westernised societies, social status is often associated with economic status and accorded on the basis of economic productivity and gains. Due to such factors as inferior education, job allocation and reluctance to train and employ black people as skilled members of the economy (because of the desire to maintain such positions for the white population whose employment would otherwise be jeopardised), it is difficult for many black workers to achieve such economic status and they are therefore restricted to some degree, to lower status employment and thereby to lower social status.

d) Cognitive Needs

In order to satisfy these relatively higher order needs, the major necessity is adequate educational facilities. Once again, the demand for these facilities amongst the black population exceeds the rate at which they are provided and education for the black population is therefore inferior and

conducted in inferior surroundings, with over-crowding and understaffing of schools. The inferior quality of the education received by blacks makes it difficult for many to cope with the high standard demanded at universities and thereby restricts the number of black people who manage to enter the professions to which they may aspire.

e) Aesthetic and self-actualization Needs

It is understood that the achievement of these needs depends on the satisfaction of the previously discussed more basic human needs and it will be apparent from the previous discussion that the number of black South Africans who can aspire to these is limited. Indeed, if it is assumed that these needs depend on the capacity for autonomous decision-making and action, it is doubtful that the number of South Africans of any race who can reach these levels is more than a small minority, but the denial of political and economic freedom experienced by the black population must imply that the proportion of this population which reaches these levels is significantly lower than that of the white population. The cumulative effect of these social impediments to psychological development in South Africa implies that there must be a significant degree of psychological stress within the black population. South African psychologists are therefore faced with a large number of people who potentially could benefit from their services. The obvious needs are for services which can both prevent the development of psychological problems and treat them when they do arise. However, in attempting to achieve both the prevention and cure of these problems, psychologists in South Africa are confronted by socio-political factors which are similar to these which have been

described as contributing to the cause of these problems. These factors will be discussed in the following section and will be considered from the points of view of the psychologist in relation to the society as a whole, to the mental health institutions within the country and to individual clients.

9.2 MULTI-CULTURAL COMPOSITION OF THE POPULATION

The development of particular individual values and attitudes is influenced by a variety of factors, one of the most significant being the cultural milieu within which the individual is located. Cultural background determines, amongst other things, the nature of social hierarchies, accepted social roles and channels of communication, and basic beliefs about the relationship between man and the environment. Important differences may therefore be expected to exist between individuals with differing cultural backgrounds.

The profession of psychology developed in the Western cultural system and therefore its basic assumptions about the nature of men, as well as the ethical principles which it holds as of primary importance are specifically Western in origin. As a result, psychologists may experience difficulties in understanding and working effectively with members of other cultural groups, whose assumptions and values may be significantly different. The nature of these difficulties and possible solutions to them should be areas of special concern for South African psychologists who, as has been pointed out, are working within a

multi-cultural society in which the majority of the population originate from indigenous African cultural backgrounds. In this section, the major aspects of the cultural diversity in South Africa which are potentially problematic for South African psychologists will be briefly considered, while the specific influences of these factors on the psychologist's work in mental institutions and with individual clients will be discussed in the following section.

The fundamental differences between the Western culture of the psychologist and traditional African cultures have been fairly well documented (Bührmann (1977, 1978 and 1979); Schweitzer and Bührmann (1978); Awanbor (1982); Fischer (1962); Cheetham and Griffiths (1981)). The major factor which has been identified by these authors as significant in determining differences in outlook and thereby constituting a potential barrier to accurate understanding of clients by the psychologist, is the difference in the interpretation of causality in these two cultures. While psychologists attribute the origins of psychological or behavioural maladjustment to essentially human factors, within traditional cultures these are attributed to factors which are non-human - normally the spirits of the ancestors. Thus, while the psychologist would concentrate on changing the individual's perception of and relationship to other people or the broader social environment, traditional healers advise their clients on how to placate the ancestors in order to restore equilibrium within the individual. In addition to this basic difference in orientation, the psychologist must also be aware of the social customs and norms existing in traditional cultural systems which determine the

ways in which the individual may express emotions or assert himself in relation to others. For example, what may be interpreted by a psychologist as unassertive behaviour may well be regarded as appropriately assertive within the individual's culture (eg Dowdall (1982)). It would be difficult, if not impossible, for psychologists to familiarize themselves with all the customs arising out of the traditional cultures in the country and, indeed, doing so may not be helpful in work with individual clients as particular customs vary between sub-groups within the same broad cultural group. However, sensitivity to the influence of customary practice on client's behaviour is essential.

In South Africa, the difficulties of working with members of other cultural groups are further complicated by the fact that the black population group may be seen as being in a process of transition, abandoning their traditional cultures and adopting the Western culture of the white population. This process can be attributed to the fact that, as is apparent from discussion in the previous section, the white group is dominant in all aspects of South African society and its cultural system has therefore also become dominant. Through the rapidly accelerating processes of urbanization and industrialization which have made a significant impact on all communities within the country, the western culture of the white group has concomitantly interfaced with and influenced the traditional cultures to the extent that at this point it is doubtful that any of these cultures have been preserved in their original form. Members of the black population group may therefore be seen as

ranging along a spectrum of Westernization from those, largely in the rural areas, on whom traditional beliefs and customs still exert a strong influence to those in the urban areas who may be regarded as primarily based in the Western culture. Thus, it may not be assumed that traditional customs and beliefs exert an equal influence on all black clients and to do so would be both simplistic and detrimental to effective work with these clients. Extra sensitivity is therefore required by psychologists as to the ways in which traditional cultural practises may influence black clients and the extent to which they in fact do influence each individual client.

A final point about the process of Westernization apart from the complications that it adds to the psychologist's attempts to understand black clients, is the potential effect that it has on the mental health of the members of the black population who are in this process of transition. These effects have been considered by, amongst others, Gijana and Louw (1980) and O'Connell (1980), who point out that the process of urbanization which exposes people to a completely different culture and forces them to live within this culture may lead to feelings of alienation and isolation as traditional practises are seen to be inappropriate and ineffective within a Western society. A period of adjustment is therefore inevitable and may involve conflict and psychological distress within the individual, which impairs his functioning in a highly demanding social situation. The higher incidence of mental disorder in urbanized

blacks is attributed to these difficulties in adjustment, but O'Connell points out that there has been a concomitantly higher incidence of "thwasa" (a Xhosa mental disorder, difficult to categorize within Western nosology) amongst rural Xhosa women who are exposed to higher stress as the men leave the rural areas to seek work in the towns.

The process of Westernization of the black population therefore both increases the likelihood of mental disorder in the black population and concomitantly complicates the understanding of this population by white psychologists who may view these people as neither entirely rooted within their traditional cultures nor as entirely Westernized.

9.3 INFLUENCES ON THE PRACTICE OF CLINICAL PSYCHOLOGY

9.3.1 The Psychologist and Society

In Chapter fiveit was seen that much debate still centres on the question of whether psychologists as professionals should be concerned not only with the treatment of mental disorder but also with its prevention by challenging the societal factors which cause psychological malfunctioning. This debate is not near resolution at the present time, but the issues involved in it need to be considered within the South African context. It has been pointed out that in all societies some degree of frustration of needs and resultant psychological distress exists and that some of the frustrating mechanisms are similar to those operating in South Africa. For example, the psychological negative effects of racial discrimination have long been a

source of concern to psychologists in America and there, as here, the question arises as to whether psychologists should actively oppose such discrimination. The crucial difference between the American and South African societies is, however, that in the former racial discrimination is a social custom whereas in the latter this discrimination constitutes state policy. Actively opposing this discrimination in South Africa therefore involves opposition to the state and can be construed as a political stand, whereas this is not necessarily the case elsewhere. There therefore exists a perhaps realistic fear that should one's opposition to the state policy of racial discrimination be perceived as too active and vigorous and thereby constitute a threat to the security of the current government, legal measures may be employed against one, whether or not this opposition was motivated by professional concern for the health of inhabitants of the country. However, this does not mean that such professional concern cannot be expressed and, in fact, if it is accepted that certain aspects of the state policy are detrimental to mental health, it may well be an ethical obligation of the South African clinical psychologist to bring this to the attention of the authorities by conducting research which will illuminate the extent of the detrimental influences and the implications that these have for the functioning of the society as a whole.

9.3.2 The Psychologist in Mental Health Institutions

The problems experienced by South African psychologists within mental hospitals may be seen as caused both by the socio-political dispensation within the country which negatively influences the quality of facilities and treatment available to black patients

and by language and cultural differences which complicate understanding and treatment of mental disorders in these patients.

While there are 9 954 beds in mental hospitals assigned to white patients, there are 9 068 beds assigned for black patients (Dept. of Constitutional Development and Planning (1980)). In view of the fact that the black population is four times larger than the white population, this allocation of beds means that black mental hospitals are frequently overcrowded and understaffed. This frequently results in premature discharge and a high turnover rate of patients which makes effective therapy and institution and management of therapeutic ward programmes a difficult task. As a result, the psychologists role within the institution is often confined to that of diagnostician with the emphasis being on pharmacological management of patients. It is in the area of accurate diagnosis that language and cultural differences became important in mental institutions. Cheetham and Griffiths (1981) and Bührmann (1976) have pointed to the disproportionate number of black atients who are diagnosed as schizophrenic within mental institutions. They suggest that this number may not in fact be reflective of the actual incidence of schizophrenia in this population but may reflect errors in diagnosis arising out of a failure to distinguish culturally determined communication and behaviour from symptoms of schizophrenia. This would suggest that extra care should be taken in diagnosing patients in whom language and cultural differences may create barriers to accurate understanding. The extra care necessary implies that more time should be spent with these patients

determining which aspects of their behaviour and communication are culturally based and which may be indicative of mental disorder but it is precisely this extra time which is not available within black mental hospitals due to the factors mentioned above. The result of overcrowding frequently means that black patients are allocated less time for diagnosis and assessment than are white patients and if this results as Cheetham and Griffiths suggest, in inaccurate diagnosis of these patients, they will be receiving incorrect treatment. In Chapter five it was pointed out that one of the basic rights of patients in mental hospitals, whose autonomy has been significantly curtailed, is the right to adequate treatment. All of the above discussion points to the problem that in many cases this basic right is not accorded to black patients.

The question arises as to what the psychologists in South Africa may do to alleviate this problem. The negative aspects of black mental hospitals are frequently attributed to the differential allocation of funds for health services for blacks and regarded as being a result of state policy and therefore beyond the powers of the individual psychologist to change. However, psychologists may achieve some gains in this area by pressing for reforms within the institutions in which they work. Research into the nature and degree of the inadequacies of the institution and the effects that these have upon the adequacy of mental health care may carry some weight, and reports on this research could be forwarded both to the authorities of the institution and to the political and bureaucratic authorities responsible for these institutions such as the Department of Health and Welfare. Sufficient concern expressed by a

significant number of mental health workers may result in the pressure necessary for reforms to be instituted by these authorities.

9.3.3 The Psychologist and individual Clients

The problem of working with clients who belong to different race groups and who therefore have a different cultural background and experience differential social benefits is certainly not unique to South Africa and has been a subject of concern to American psychologists as well (e.g Mizio (1972) and Kadushin (1972)). The difficulties inherent in working across race and cultural lines in psychotherapy can be roughly divided into difficulties in establishing an adequate therapeutic relationship and difficulties in defining and achieving therapeutic goals.

In establishing an effective therapeutic relationship, two major factors seem to be important. The first is a degree of trust in the therapist, while the second is a recognition that the task of achieving therapeutic goals is one which is shared equally by the therapist and client. Kruger (1980) writes: "Within this relationship the reality of the client as a person can emerge but the client's consciousness of his own reality is always co-constituted by the consciousness of his relationship with the therapist" (p.26). At this point it seems necessary to consider what aspects of the black client's relationship with the white therapist may be affected by the particular societal circumstances of South Africa. Firstly, as Kadushin (1972) points out, in societies where racism and its effects are prominent for the black person, the establishment of trust in

the therapist who as a white person may represent a feared and resented group of oppressors, presents immediate difficulties. Racial segregation fosters racial stereotypes in both participants and the therapist may have to be aware that what he may experience as resistance on the part of the client may reflect a more basic difficulty in accepting that the therapist is genuinely concerned with his wellbeing and has an interest in him as an autonomous person. Fibush and Turnquest (1970) adress this problem and suggest that one way to combat it is to introduce the question of race and the client's feelings and fantasies about the therapist as a member of the "opposite" race at an early point in the therapy. Through their research they found that tackling these issues early on in the therapeutic process made the establishment of a good relationship and, thereby, effective therapeutic work easier for both therapist and client.

The second issue inherent in the therapeutic relationship is the question of the balance of power. It has been seen that clients of any race frequently approach the therapist as an authority who will be able to remove their suffering by exercising his expertise. One of the initial tasks of therapy and one of the first steps on the road to autonomy within the client is to reduce this expectation and lead the client to take more responsibility for changing within the therapeutic process. In South Africa the superior status of the therapist as an expert is exacerbated by his superior social status by virtue of being a member of the white group. Many black clients will have been accustomed to assuming a passive inferior role in relation to

white people who they normally encounter in situations where the white person is an authority who makes all the decisions. The process of moving such clients towards a position where they are in a more equal relationship to the therapist is therefore made more problematic and it may be possible that the therapist will need to take a directive role for longer than usual, gradually allowing the client to assume more and more responsibility. This need to be initially directive may be especially important with clients who are strongly based in the traditional culture and are more familiar with traditional healers who assume a very powerful and directive role in relation to their clients.

The difficulties of defining and achieving therapeutic goals may also stem from both socio-political and cultural origins. Firstly, in many cases the psychological distress of the client may be seen as attributable to or at least aggravated by the circumstances outlined in the socio-political section of this chapter. It has been seen that these circumstances arise out of a complex legal structure and are therefore minimally amenable to change by either the therapist or the client. In many cases, therefore, the client may be prevented from making changes in his environment which would minimize the negative consequences he is experiencing. It has been seen that the purpose of therapy is not to help clients to adjust to adverse circumstances, but to remove the barriers which hamper autonomous action and thereby hamper the client's ability to change these circumstances. However, the fostering of the capacity for autonomous action in clients may have limited success in a society such as South Africa in which, as has been seen, certain types of autonomous action may be legally restricted.

In addition, the psychologist needs to be aware that the expression of autonomy may vary in different cultures and must avoid losing the client or causing unnecessary conflict within him by forcing upon him his own Western definition of autonomy. In Chapter five, the danger of imposing values and goals on a client was indicated and this is particularly important where the client's cultural background may determine that his value system is significantly different from that of the therapist. In working with black clients the therapist must be especially aware of the possibility that such basic differences exist and, where necessary, must be prepared to explore with the client what the significant aspects of his culture are and where the client perceives himself as an individual in relation to these aspects. This approach is not fundamentally different to the approach which should be taken with any client, but possibly more sensitivity is needed to this aspect of the therapeutic process and the therapist should more strongly guard against assuming commonality of values and attitudes where these may not exist.

CONCLUSION

In this chapter the particular social circumstances in South Africa which have bearing upon the efficient functioning of clinical psychologists within the country have been briefly analysed. While many of these circumstances are not unique to this country and problems of racial discrimination and cultural differences are common to most countries, both of these problems are exacerbated in South Africa by a legally

enforced policy of racial segregation. Although the problems of changing the system are considerable, it does seem, however, that psychologists as professionals may have a role to play in constantly alerting societal authorities to the negative effects that some practises have on the psychologist's area of concern, i.e. the healthy psychological development and functioning of all the members of society.

CONCLUDING COMMENTS

CONCLUDING COMMENTS

On the basis of discussion within this thesis the following features would seem to be necessary components of an adequate ethical code for South African clinical psychologists.

1) Explicit Philosophical Basis

It has been seen that one of the major difficulties in ethical practice is the resolution of ethical dilemmas and that, where ethical codes are not explicitly linked to or based on one of the basic philosophical ethical theories, such resolution may be difficult and is likely to be motivated more by personal interest than by careful consideration of the ethical issues. It is therefore suggested that an ethical code developed for South African clinical psychologists be based on one of the major ethical theories outlined in this thesis. In this dissertation, the rule-utilitarian theory has been preferred, but this choice is one which may still be open to further consideration. The chosen ethical theory should be briefly but clearly outlined in the introduction to the ethical code.

2) Ethical Principles of Psychologists

The four ethical principles which should underlie the practice of psychologists have been identified in this thesis as the principles of autonomy, nonmaleficience, beneficence and justice. These principles should be identified and explained in the body of the code and it should be made clear that the specific rules and guidelines contained within the code are based on these principles.

3) Specific Rules and Guidelines

It has been seen that the effectiveness of the APA Code derives to a large extent from its origins in an empirical study of the practical situations faced by American psychologists which required ethical regulation. It is suggested that in order to develop an equally effective code for South African clinical psychologists, a similar project should be undertaken. It would be expected that, should such a study be completed, the specific ways in which social circumstances unique to South Africa may affect ethical practice would be identified and regulations could be developed which would guide psychologists in this country in dealing with these especially problematic ethical situations. The rules and guidelines developed in this section should cover the major areas of functioning covered in this thesis - i.e. psychotherapy, psychological assessment and research - and should account for the particular aspects of each of these areas of functioning identified in this thesis as potentially ethically problematic.

It is apparent that in order for an ethical code to be maximally useful, it must be as concise as possible. At the same time it is apparent that the ethical issues inherent in the practise of clinical psychology are numerous and complex and may need more explanation than can be encompassed within a basic ethical code. In order to assist psychologists in understanding the many ethical issues of relevance to themselves as professionals and in order to assist them to make ethical decisions on the basis of all the necessary information, it may be desirable to accompany the ethical code with a handbook which explains and expands on some ofthe concepts within the code.

Thus, for example, while an ethical regulation may read, as in the APA code, that confidentiality must not be breached unless there is "clear and imminent danger to an individual or to society",(Principle 9(a)) within a handbook the concept of dangerousness and how this may be assessed could be explained more fully and in a way which would be useful to the psychologist in these situations.

Once an ethical code has been developed there must also be a mechanism by which the regulations within the code can be enforced. It is therefore recommended that a committee be created to adjudicate on complaints received about psychologists breaching any of these regulations. This committee could also be responsible for updating the ethical code at regular intervals and for ensuring that psychologists are sensitized to the importance of ethics in the profession by encouraging universities to include courses in ethics in their basic training programmes.

In conclusion, it must be noted that in order to develop and implement an ethical code which will be effective in regulating the conduct of South African psychologists, the profession of psychology in this country should be autonomous as regards policy-making and regulation of its members. As has been noted in chapter four this is not presently the case in South Africa as the profession of psychology is ultimately responsible to the South African Medical and Dental Council. It would perhaps be beneficial to both the profession and the public it serves should it develop into a profession in the true sense - that is, one which is autonomous and directly accountable to the public

for guaranteeing the professional competence and ethical conduct of its own members.

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