UNIVERSITY OF GHANA

A QUALITATIVE STUDY ON THE ETHICAL DILEMMAS FACED BY
PRACTICING CLINICAL PSYCHOLOGISTS IN GHANA

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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN
PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MPHIL
CLINICAL PSYCHOLOGY DEGREE

JULY, 2014
DECLARATION

I hereby declare that, except for references to other people’s work, which have been acknowledged, this thesis is the result of my own research work carried out in the department of psychology under the supervision of Dr. Joseph Osafo and Prof. Angela Ofori-Atta.

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DEDICATION

I dedicate this piece of work to my husband Eric and children; Nana, Akosua and Naana for their understanding and support throughout my training.
ACKNOWLEDGEMENT

I thank the Almighty God for His grace and favour which saw me through the completion of this dissertation. I really want to express my gratitude to my wonderful, able and trustworthy supervisors namely; Prof. Angela Ofori-Atta and Dr. Joseph Osafo for their contributions, suggestions and guidance which have seen me through a successful completion of this work.

I also thank all the clinical psychologists who took part in the interview during the data collection process. I hope that the findings of this work will benefit them immensely.

I would like to specifically thank Dr. Maxwell Asumeng and Mr. Nortey Dua who contributed in diverse ways to this work and my graduate training in general. To all my colleagues in clinical psychology class, I say thank you so much. May the good Lord reward you all, AMEN.

And finally, last but not the least; I earnestly appreciate the emotional and financial support of my husband, Mr. Eric Adomako Dapaah.
ABSTRACT

The purpose of this study was to investigate ethical dilemmas experienced by 20 clinical psychologists in Ghana and the various measures they employ in the resolution of these dilemmas. The qualitative method using a semi structured interview guide and two vignettes were used to investigate ethical dilemmas faced in professional practice. The main dilemmas include those arising from third party and privacy interferences, dual relationships, fees, motive as against moral issues, policies and practices that conflict with ethical guidelines, competence and client expectations, manipulation of the therapist and cultural competence. Likewise, when resolving ethical dilemmas, professionals draw on several sources including their professionalism, bricolage of values and consultation. Using the above resolution dynamics, they encountered some facilitating factors and impediments. The study observes that these dilemmas and the dynamics of resolving them are expressed within the general cultural context of Ghana and the professional culture within which the psychologist is socialized. Recommendations to assist clinical psychologists in dealing with the various dilemmas are presented from the context-specific ethical issues found from the study such as; to develop legally binding code of ethics and training psychologists and other health professionals to be culturally sensitive. It is concluded that this work could inform the development of ethical regulations in Ghana.
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<td>APA</td>
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<td>AMA</td>
<td>AMERICAN MEDICAL ASSOCIATION</td>
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<td>BPS</td>
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CHAPTER ONE

INTRODUCTION

1.0 Background of the study

The ethical basis of psychological practice has received increasing attention (Lindsay & Colley, 1995). The constant changes in expectation of patients’ wellbeing and societal expectation has led to new and increased awareness of the ethical dimension of psychology and its impact on the delivery of high-quality care (Coverston & Rogers, 2000). In their daily practice, psychologists are constantly confronted with decision-making that is ethical in nature. Thus, in a study of ethical decision-making, Raines (2000) found that psychologists averagely, experience thirty-two (32) different types of ethical dilemmas during a 1-year period, with many of these events taking place on a daily basis. From these experiences, the most frequently cited dilemmas dealt with pain management, cost containment issues and quality-of-life and other decisions relating to a patient’s best interest (Raines 2000). Underlying the scientific literature is the understanding that ethical dilemmas are going to exist therefore requiring the ability to respond to these unanticipated events (Birbeck & Drummond, 2005). A corollary of this is that in the postmodern healthcare climate of rapid change and growing complexity, Psychologists will increasingly be confronted with ethical dilemmas.

A study of available scientific literature showed that there were two broad kinds of ethical dilemma in existence. The first consisted of dilemmas that fitted the traditional form of ethical codes for professionals such as psychologists (e.g. confidentiality). A second category concerned tensions between the psychologist’s preferred practice, and
constraints imposed by the organization within which the psychologist works (e.g. the National Health Service) (Lindsay & Colley, 1995). Inferred from this, ethical dilemmas are likely to be influenced by many other factors that may wax and wane over time and space.

The ethical apprehension for a patient’s well-being is fundamental to the ethical demand that inspires psychological practice (Bishop & Scudder, 1990; Gastmans et al., 1998). Thus, psychologists not only have to show how their (evidence-based) practice can be both clinically and cost effective, but also that this care contributes to the full appreciation of the patient as a human being (Kitson, 1996). In clinical practice, as well as in the literature worldwide, there is a growing concern about implementing ethical psychological practice. Quite unfortunately, ethical practice seems most problematic in daily ethical dilemmas, arising from situations that involve conflicting values or beliefs about what is the right or best course of action (Ham, 2004).

In comparison with justice and other universal principles, patient wellbeing is proposed to be a fundamental criterion of judgment in ethical dilemmas (Dierckx de Casterle’ et al. 1998). It is however important for healthcare professionals and individuals to recognize and explore the presence of these ethical dilemmas, since it acts as catalyst for the entire ethical decision-making process (Hunt & Vasquez-Parraga, 1993). This is so because ethical decision-making criteria will not be employed if the existence of ethical dilemma is unrecognized (Jones, 1991). Moreover, as the general theory of ethics (Hunt & Vitell, 1986) states, it is vital to study ethical dilemmas and ethical reasoning, since this will consequently lead to ethical actions and perhaps inactions.
According to Zydziunaite et al. (2010), there is a lack of scientific literature in general and in health care research specifically with the focus on ethical dilemmas concerning decision-making within health care leadership. There is ample evidence to suggest most psychological ethics literature focuses on external and contextual barriers to ethical psychological practice. Little is however known about how psychologists involve themselves in ethical decision-making and action (McAlpine, Kristjanson & Poroch 1997; Doane, Brown & McPherson 2004). This implies that Psychologists’ ethical practice is not yet well-understood. Promoting ethical practice among Psychologists requires better understanding of the difficulties they experience when they use ethical values and principles to guide their care decisions, and of course the impact these difficulties may have on Psychologists practice.

Writing extensively on ethical conducts, Wassenaar (1998) suggests that in order to develop a code of ethics to guide their care decisions, it is important to examine the ethical difficulties that psychologists experience and are faced with. In this regard, undertaking this research will be essential as it will provide an avenue to explore the ethical difficulties confronting the Ghanaian psychologists as a means of contributing to research on ethics and possible influence on policy and practice.

The American Psychological Association's (2002) "Ethical Principles of Psychologists" and the Code of Conduct of the; American Medical Association, (2006), are but two examples of professional codes of ethical conduct. However, virtually all professions have codes of ethics as keystone documents (Bersoff and Koeppl, 1993).
Even though the American Psychological Association (APA) has a documented ethical code (Fisher, 2009); Ghana psychological association does not have legally backing ethical codes yet that are purely contextualized to guide ethical decisions in Ghana. This means that the Ghanaian clinical psychologist may have to rely on non-contextual ethical codes and values to guide their decision making. A corollary of this is that ethics is essentially affected by our culture and shapes the way we react and assess situations in our environment. This brings to attention what Africans consider morally right or wrong. Neil (2009) presents a conceptual distinction between morality and ethics in the following quote:

“Morality is the sense and view of what is right and wrong and that which constitutes an absolute reference for character and behavior. It is an authoritative code of conduct in matters of right and wrong. It is usually seen in a broader sense than “ethics”. However, “Ethics” refers to the acts of human behavior informed by the moral principles of good and evil (right and wrong). Ethical principles of conduct relate to absolute values that condition human behavior, and in this sense it may correlate with moral assumptions of good and evil.” (Nel, 2009:35).

There are two schools of thoughts regarding the basis of African morality. Whilst others think African morality is essentially driven by religious values, others think it is essentially based on social ethics. For those who hold on to the religious perspectives (e.g., Mbiti, 1989) African morality is predicated on religion so that the moral values of good and bad or right and wrong derive from the commands of some supernatural beings and that their moral beliefs and principles can be justified only by reference to religious
beliefs and doctrines. Thus to an African, morality and religion are inseparable (Mbiti 1989). A decision which dwells on morality may therefore be made on the basis of the religious values of the decision maker.

However, Gyekye, (1996) disagrees, arguing that the religious view as the basis of African moral values is erroneous. He points out that African morality is a social phenomenon like any other society which lends itself to rational and logical rigorous analysis (unlike faith or religion which may not lend itself to rationality). Ikuenobe (1998) and Gyekye (1996) however, do not negate the role of religion in African moral thought. They believe that although morality is not based on religion, religion to a greater extent influences moral thoughts and behaviors in Africa. This reveals one of the main characteristics of African morality which is, it is heavily influenced by religious values. That is African peoples’ moral decisions and expressions are infused with religious values and considerations.

Secondly, African morality is socially oriented. A person is viewed moral not on the basis of the metaphysical qualities as a human being such as his reasoning abilities or autonomy but rather what he does in relation to a group (Mbiti, 1989; Ikuenobe, 2006). African morality has unrelenting preoccupation with human welfare. Unlike Western cultures where morality is predominantly individualistic (i.e. justice morality), African morality lies within what promotes social welfare, harmony in social relationship and solidarity.

Another characteristic is the orientation towards fulfilling responsibilities rather than individual rights (Gyekye, 1996). This is a caring attitude or conducts that one feels one
ought to adopt with respect to the well-being of another person. In a traditional African society, the whole socialization process is premised on communal welfare. That is ethic of responsibility rather than the ethic of individual rights. This is inculcated in the African child from the onset. However, their individual human rights are not ignored, but communal welfare always comes first (Ibid).

Furthermore, African morality is seen as normative. This means that it is rooted in what the whole group considers as acceptable. The moral rules of the community or group therefore provide the evaluative standard for specific behaviors as good or bad (Ikuenobe 2006). For an individual to make decisions, he considers what is socially accepted by the entire community, but not what he personally considers as the right course of action in his opinion.

The final characteristic, but not the least based on the discussion in this paper is the tendency of relativism. In African morality (unlike western morality which is viewed in Kantian terms on the basis of absolutes, objectivity, rationality and universality) the view of what is right or wrong is different. Actions that may help sustain social equilibrium regardless of its consequences may be seen as more socially acceptable than those that cause disequilibrium in society (Osafo, 2012).

Based on the discussion, an African’s view of morality and ethical decisions may be completely different from that of western morality. The way in which indigenous / African people know what is morally right may not correlate with the way in which Western religious people know what is right (Nel, 2008). It would be inappropriate, therefore, to adapt for instance, APA code and values of ethics without assessing our own
cultural presuppositions that enter into and influence our ethical thinking in ways we are not entirely aware of (Behnke, 2006). There is therefore the need to develop and document ethical code for clinical psychologists in Ghana that must stem from the cultural influence of specific customs that may affect the delivery of services by clinical psychologists in Ghana.

Currently, Ghanaian clinical psychologists practice within the framework of western ethical assumptions and expose graduate clinical psychology students to ethics which are predominantly western. The Ghana Psychological Association (GPA) will therefore be doing a great disservice to its members if for example the APA or the British Psychological Association’s code of ethics is adopted in its entirety without considering the setting of the Ghanaian clinical psychologist.

Following from the preceding discussion, empirical research in ethics among clinical psychologists in Ghana also has a great gap that needs to be filled. This study hopes to generate contextual ethical dilemmas/issues that could inform the development of ethical regulations in Ghana and examine the various ethical challenges facing the Ghanaian clinical psychologists and evaluate practical solutions adopted in dealing with the difficulties.

1.1 Research questions

The study seeks to find answers to the following central questions underpinning the subject matter.

1. What are some of the ethical dilemmas faced by practicing clinical psychologists in Ghana?
2. What are the factors that significantly impact ethical decision making among practicing clinical psychologists in Ghana?

3. How do practicing clinical psychologists confront these ethical dilemmas in their course of duty?

1.2 Objectives of the study

The main aim of the study is to document ethical dilemmas faced by psychologists in Ghana. Specifically, the study will be guided by the following objectives:

1. To document ethical dilemmas faced by practicing clinical psychologists in Ghana
2. To determine, and analyze practical solutions employed by practicing clinical psychologists in Ghana as to how ethical dilemmas are resolved.
3. To identify the possible barriers to ethical decision making in Ghana.
4. To provide a template for discussing ethical codes for psychologists in Ghana

1.3 Significance of the study

This research will primarily, help document some of the common ethical dilemmas faced by practicing psychologists and how they are able to solve them in a Ghanaian context. Hence in order to provide excellent patient/client services, the psychologist needs to have clear cut guidelines suitable to the Ghanaian culture. It is therefore important to document these dilemmas in the professional context.

Secondly, it is expected to bring out unique and practicable solutions to ethical dilemmas with emphasis on the Ghanaian culture even before the establishment of the ethical codes.
At the same time help lay more emphasis on the factors which pertains exclusively to Ghanaian society when constructing the ethical codes for the Ghana Psychological Association (GPA).

Furthermore, the research findings can form a basis in the establishment of the ethical codes and also be used as a teaching aid for graduate students as a guide to the potential ethical dilemmas they are likely to face in their future carriers and how to resolve them. Lastly, this research would also provide a basis for future research on ethical dilemmas and provide direction for policy, programmes and practice.

1.4 Organization of the Study

The report is organized into five chapters. The first chapter deals with the background issues and general introduction of the study. It also covers aspects such as the research problem, research questions and objectives of the study, significance and justification. The second chapter provides the theoretical scope of the study by reviewing various theories on ethics. The literature review also looks into global perspectives on ethical dilemmas and the various practical ways in which such difficulties are resolved. Chapter three provides a detailed methodology. Chapter four presents the results emerging from the study. The last section, chapter five provides the discussion, conclusion, summary of findings and policy recommendations.
CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

This chapter specifically presents a review and discussion of relevant literature on the topic. In the field of psychological counseling, it can be seen that the concepts of ethics, values, morals, law and professionalism are used interchangeably (Akfert, 2012). It is necessary therefore to unpack and examine current discourse within the academic literature. According to Gill and Johnson (2002) any research project will necessitate reading what has been written on the subject and gathering it together in a critical review which demonstrates some awareness of the current state of knowledge on the subject, its limitations and how the proposed research aims to add to what is known.

The literature review is in five parts. Section one provides definitional and conceptual issues regarding ethics. This is followed by how ethical dilemmas are conceptualized when applied to health professionals. A short review of various ethics theories is provided. The next section reviews literature on dimensions of ethical dilemmas confronting health professionals by drawing on research from various countries of the world. The last part reviews the barriers to ethical decision making and resolutions to ethical dilemmas.

2.1 Ethics: Definitional and Conceptual Issues

The word, “ethics”, was coined from the ancient Greek expression “ethos”, which essentially connotes “character”, so that an ethical person is deemed simply as one who has character (Ehrich, n.d.). Beyond that, the understanding of “character” is most likely
to be broadly interpreted. Therefore, it is not at all surprising that ethical principles have been subjected to much debate and contestation. Drawing on the early works of Greek philosophers, Plato and Aristotle state that ethics can be understood as “what we ought to do” (Freakley & Burgh, 2000:97). It thus requires that there ought to be sound judgment and reasoning in decision making that raise questions regarding what is right, wrong, good or bad conduct, fair or just. In other words, Singer (1994:4) describes ethics to mean a “set of rules, principles or ways of thinking that guide, or claim authority to guide, the actions of a particular group.”

Whilst the “concept of ‘ethics’ is a complex construct, it has largely been infused with certain values and beliefs that influence how we approach decision making” (Graham & Fitzgerald, 2010:134). Kitchener (2000: 3) provides a good starting point for examining ethical decision making by defining ethics as “a branch of philosophy that addresses questions of how people ought to act toward each other, that pronounces judgments of value about actions and that develops rules of ethical justification”. She adds that ethical issues come into play when professionals are “faced with deciding between competing moral obligations or between competing claims about what is ‘right’”. Thus, Gallagher (2009:11) aptly notes that ethics are simply “principles of right and wrong conduct”. Therefore they are broadly conceived as “a set of moral principles and rules of conduct” (Morrow & Richards, 1996:90). On this subject of “Ethics”, the views of other scholars such as Edwards and Mauthner (2002) cited in Gorin, et al. (2008: 278) briefly notes that “ethics is about how to deal with conflict, disagreement and ambivalence rather than in attempting to eliminate it”.

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Broadly defined, the term Ethical dilemma is described as “a situation which is caused by the chaos between two values in a decision-requiring circumstance” or “in circumstances when two or more options are encountered and there is a difficulty in deciding about which one is better; as a result of which the existing necessities cannot be met by present alternatives” (Lindsay & Clarkson, 1999; Noureddine, 2001).

Inherent in a wide range of academic literature, is the appreciation that ethical dilemmas are situational and will invariably exist, necessitating that professionals assume ways of responding to unanticipated happenings (Birbeck & Drummond, 2005). Based on this premise, critical views have asserted that ethical dilemmas are most likely to confront many professionals as they endeavour to opt amongst competing sets of principles, values and beliefs in decision making (Ehrich, n.d.).

Arguing independently but along the same line, Badaracco (1992:66) refers to these competing sets of principles as “spheres of responsibility” that have the potential to “pull professionals in different directions” and thus create ethical dilemmas for them. On this account, an ethical dilemma can thus be termed to connote a decision that requires a choice among competing sets of principles, often in complex and value laden contexts. Similarly, Kidder (1995:16) underscores the role of ethical dilemmas in decision making and aptly argues that “many of the ethical dilemmas facing professionals and leaders don’t just hover around right versus wrong but can equally involve right versus right”. On this account, ethical dilemmas can arise from equally attractive options that could be justified as being 'right' relative to peculiar situations (Duignan & Collins, 2003: 83). In their conceptualization of ethics, Buelow et al. (2010) assert that ethical dilemmas are experienced by all individuals, but are especially prevalent among healthcare
professionals. For instance, in the views of Buelow et al. (2010), as the US healthcare system struggles to provide high quality services to its diverse populations, healthcare professionals experience relatively new and increasing numbers of ethical dilemmas. These dilemmas have a profound impact not only on clients receiving (or not receiving) care, but also on the healthcare workforce (Swetz, Crowley, Hook, & Mueller, 2007).

I contend that within complex contexts and circumstances of ethical dilemmas, it may not be so easy to discern what the ‘right’ option might be and what the ‘wrong’ option might be or whether the action is ethical or unethical. The next part of the discussion alludes to several ethical decision-making models that have emerged in literature in recent years.

2.2 Ethical Decision Making: Theoretical Perspectives

Understanding how we make and follow through on ethical decisions is the first step to making better choices. Slowther (2004) is of the view that, in considering what is the right course of action/treatment in any healthcare situation, health professionals tend to initially think about the consequences arising from the different options. Indeed, there are many and varied theories guiding ethical decision making. However, the basic models that have been theorized to govern ethical decision-making include among others, the constructivist, rational and the virtue ethics model (Forester-Miller & Davis, 1995; Jordan & Meara, 1995).

For the purposes of this study, the constructivist/constructivism theory is adopted as the principal theory guiding psychological ethical decision making. The theory posits that knowledge is not passively obtained from the world or from authoritative sources but constructed by individuals or groups making sense of their experiential grounds.
(Maclellan and Soden 2004). In this direction, constructivism advances meaning-making and knowledge construction as its foremost principles (Crotty 1998; Fosnot 1996; Phillips 1995). It thus views knowledge as temporary, nonobjective, internally constructed, developmental, socially and culturally mediated (Fosnot 1996). From these views, it can be inferred that individual psychologists in their health care practice are assumed to construct their own meanings and understandings of the ethical dilemmas they face and this process is believed to occur as interplay between existing knowledge and beliefs and new knowledge and experiences of the practitioner (Richardson 1997, 2003; Schunk, 2004). Within the domains of constructivism, the theory is not a single or unified theory; rather, it is characterized by plurality and multiple perspectives. On this account, the constructivist school of thought provides this theoretical framework for understanding how varied theoretical orientations (Phillips, 1995) explicate such different facets of constructivism as cognitive development, social aspects, and the role of context. Many theorists and scholars place all forms of constructivism in three distinct categories: (1) sociological, (2) psychological, and (3) radical constructivism. All three categories share the epistemological assumption that knowledge or meaning is not discovered but constructed by the human mind (Richardson 2003).

Phillips (2000:6) has also attempted to define and explain the attributes of social and psychological constructivism; according to him, the social constructivism/constructionism theory upholds that bodies of knowledge or disciplines are built up as a result of human constructs, and that the form that this knowledge takes is predetermined by such things as politics, ideologies, values, the exertion of power and the preservation of status, religious beliefs, and economic self-interest. Additionally, he
expounded on psychological constructivism which relates to a developmental or learning theory that suggests that individual learners actively construct the meaning around phenomena, and that these constructions are idiosyncratic, depending in part on the learners’ background knowledge. The development of meaning may take place within a social group that affords its individual members the opportunity to share and provide warrant for these meanings. If the individuals within the group come to an agreement about the nature and warrant of a description of a phenomenon or its relationship to others, these meanings become formal knowledge. According to Cottone (2004), social constructivism theory as described above comes as an intellectual movement that allows for a biological and social conception of human understanding.

Relative to the social constructivist theory, Maturana (1978) provided a biological basis for understanding that knowledge derives from the connection between biology i.e. how people are physiologically structured to perceive and the social context (what he described as the “social domain”). In his theory, Maturana upholds that humans are biologically organized in such a way that allows for simultaneous perceptual and social perturbation; organization that literally allows for a communicational context at the time of perception. In other words, all behaviour can be viewed as biologically affected and manifested through social relationships. Premised on these arguments, it is sufficient to point out that what appears to be ethical decision-making is simply an action taken within the context of biological and social forces. Consequently, ethical and unethical actions are always biologically and socially compelled. Thus, it can be argued that the predicaments of ethical dilemmas within which psychologists find themselves can
emanate from the biological and social forces that were operative at the time actions were taken. Helping to define those forces is however, a critical aspect of the ethical decision-making process (Cottone, 2004).

Constructivism helps in understanding the event where rationalist theories fall short. According to Kitchener (1984), a rational model is based primarily on principle ethics. Under this model, professionals faced with a dilemma first identify the principles in conflict, and then choose the best course of action based on a rational evaluation of the advantages and disadvantages of choosing one ethical principle over another (Bersoff, 1996).

To the other extreme, the virtue ethics model relies largely on personal characteristics and professional wisdom involved in making an appropriate ethical decision (Jordan & Meara, 1995). Subsequently, the virtue ethics model or theory has been identified as a modern revival and revision of Aristotle's ethical thinking. Aristotle’s ethics, while not generally thought of as consequentialist, is certainly teleological (Slowther, 2004). To him, the telos, or purpose, of a human life is to live according to reason leading to ‘happiness’ in the sense of human flourishing. This flourishing is achieved by the habitual practice of moral and intellectual excellences, or ‘virtues’. Commenting on the virtues model, Slowther (2004) opines that modern virtue ethics sets itself the task of discerning the virtues for our time. Other virtues mentioned under this model include integrity, prudence, discretion, perseverance, courage, benevolence, humility, and hope. Arguing along the same line, Freeman (2000) adds that virtues such as self-
understanding, openness, honesty, and prudent judgment should also be an integral part of this model.

Beyond these two models, other theories have been propounded by scholars in the literature. These include the consequentialist and the deontological theories. Recognizing the consequentialist theory as one sub class of teleological moral theory, proponents’ believe that morality is the moral value of an act whose rule or policy is to be found in its consequences and, not in intentions or motives (Slowther, 2004; Gumus & Gumus, 2010). The theory dates back to days of Jeremy Bentham in the late 18th century and John Stuart Mill in the 19th century. Such ‘hedonistic’ utilitarians argue that the principle to judge our moral thinking is utility, that is, the maximization of happiness, in the sense of pleasure and the minimization of suffering, in the sense of pain. In any situation the morally right thing to do is the action that promotes the greatest happiness for the greatest number of people (Slowther, 2004).

A critique that has been leveled against the consequentialist theory is that it is so concerned with ends; that it may overlook the moral importance of means; the ways in which the ends or goals are achieved. It is upon this criticism that the deontological theory emerged (Gumus & Gumus, 2010). The deontological theory states that people should adhere to their obligations and duties when analyzing an ethical dilemma. Unlike the consequentialist, deontological theory uses rules rather than consequences to justify an action or policy. The best-known deontological theory is that of Immanuel Kant in the 18th century. ‘Kantianism’ is a modern term, referring to a Kant-like emphasis on duties
and rules. Kant defended rules such as ‘do not lie’, ‘keep promises’, ‘do not kill’ on what he claimed were rational grounds. To him, a set of rules should comply with the categorical imperative. Though the deontology theory is clothed with many positive characteristics, some critical voices have registered their reservations (criticisms) against it. Key among the criticisms leveled against the theory is that there is no rationale or logical basis for deciding an individual's duties. For instance, businessman may decide that it is his duty to always be on time to meetings. Although this appears to be a noble duty we do not know why the person chose to make this his duty (Ridley, 1998).

Similarly, other criticism against deontology theory is the fact that sometimes a person's duties conflict and that deontology theory is not concerned with the welfare of others. For example, if the deontologist who must be on time to meetings is running late, how is he supposed to drive? Is the deontologist supposed to speed, breaking his duty to society to uphold the law, or is the deontologist supposed to arrive at his meeting late, breaking his duty to be on time? This scenario of conflicting obligations does not lead us to a clear ethically correct resolution nor does it protect the welfare of others from the deontologist's decision. Since deontology is not based on the context of each situation, it does not provide any guidance when one enters a complex situation in which there are conflicting obligations (Penslar, 1995).

The categorical imperative holds that moral rules should be universalizable i.e. applied to all rational, moral members of the community rather than to a selected few. Significantly too, he adds that all persons should be treated not only as means but also always as ends
in themselves, Members of the moral community should take a hand in making the laws as well as living by them (Slowther, 2004).

The theories identified and reviewed above remain important in the ethics scholarship, There has however been a push towards principlism among ethics writers today such as Beauchamp and Childress (2001) who set out four normative principles in ethical decision making especially in the health profession. Beauchamp and Childress’ (2001) approach to ethics provide a general guide and leave considerable room for judgment in specific cases. These principles are as follows:

• Respect for autonomy: respecting the decision-making capacities of autonomous persons; enabling individuals to make reasoned informed choices. The moral basis of the principle of autonomy is based on the principle of respect for persons, which holds that individual persons have right to make their own choices and develop their own life plan (Garrett et al., 1993). The principle of autonomy which is a general indicator of health recognizes the rights of individuals to self-determination. This is rooted in society's respect for individuals' ability to make informed decisions about personal matters. Thus, autonomy has become more and more important just as social values have shifted to define medical quality in terms of outcomes that are important to the patient rather than medical professionals. For example, the increasing importance of autonomy can be seen in the social reaction to a "paternalistic" tradition within healthcare (Beauchamp and Childress, 2001). Arguing independently but along the same lines, Pollard (1993) makes a point that respect for autonomy is the basis for informed consent and advance directives so that by considering autonomy as a gauge parameter for (self) health care, the medical and ethical perspective both benefit from the implied reference to health. For instance
psychiatrists and clinical psychologists are often asked to evaluate a patient's capacity for making life-and-death decisions at the end of life.

• Beneficence: Beauchamp and Childress in their work, Principle of Biomedical Ethics (1978) identify beneficence as one of the core values governing healthcare ethics. The principle of beneficence requires us, among other things, to do good, or what will put patient’s interest first; this must reflect in the utility of treatment against the risks and costs; thus the healthcare professional should act in a way that benefits the patient. In other words, the principle of beneficence according to them entails actions that advance the collective well-being of others. In medical context however, this means taking actions that serve the best interests of patients. The first is the positive requirement to further the patient’s interest.

• Non maleficence: avoiding causing harm; the healthcare professional should not harm the patient. The principle of non-maleficence to them requires us, other things being equal; to avoid harm to the patient, or what would be against the patient’s interests. Essentially, the principle rests on the fundamental importance of what interests the patient and that it is imperative for health care professionals to avoid the causation of harm. It is important however to note that the principle of non-maleficence is a requirement to refrain from doing what damages the patient’s interest.

• Justice: respect for justice takes several forms including distribution of a fair share of benefits, legal justice - doing what the law says, Rights based justice, which deals in the language, and perhaps the rhetoric, of claimed human rights, and hence goes beyond, though it includes, legal rights (Beauchamp and Childress, 2001). The formal principle of
justice requires that a health care practitioners and society in general treat equal cases equally. In other words, the principle is premised on the need to distribute and rationally allocate scarce healthcare resources, and the decision of who gets what treatment in all fairness and equality. For example, two patients with the same medical condition ought not to be treated differently (Beauchamp and Childress, 1994). It is important to note that this principle, though crucial, does not tell us what we need or which needs are most important so that they are put first on the scale of preference as priority needs.

Slowther (2004) was quick to add that these principles are prima facie – that is, each to be followed unless it conflicts with one or more of the others - and non-hierarchical i.e. one is not ranked higher than another. In recent years however, respect for patient autonomy has assumed great significance in the context of patient choice, underpinned by the requirement to provide the patient with sufficient information to put him or her in a position to choose (Beauchamp and Childress, 2001).

2.3 Ethical Dilemmas Facing Health Professionals: A Review

Recognizing the existence or presence of ethical dilemmas in the health profession is essential as it may act as catalyst for the entire resolution and decision-making process (Hunt & Vasquez-Parraga, 1993). This is so because ethical decision-making criteria will not be employed if the existence of ethical dilemma is unrecognized (Jones, 1991). Scholarship on the interface between ethics and the health profession agree that although the experience of ethical difficulty itself is certainly expected in clinical practice everywhere, the types of difficulties encountered, how difficult they are considered to be and the perception that ethics support services can be of help may vary considerably in
different countries (Gracia, 1993; Mino, 2001). This conception is premised on three main reasons. In the first place, it is argued that when faced by an ethical difficulty, reaching a decision that is ethically justified and acceptable to all concerned may be a complex process, making variation likely both within and between countries. The second is that differences in cultural constructs of health, disease, death or how medicine ought to be practiced may affect the experience of ethical difficulties and of the usefulness of help in different countries (Brody, 1997, Tangwa, 1996). Nevertheless, nationality does not subsume culture, it is usually considered to be one of the circles within which some degree of culturally shared elements is contained. The third reason is that healthcare services themselves vary to such a degree that the European Commission recently renounced the project of centralized regulation (Szeremeta et al, 2001).

In the same piece, there is a growing body of research in recent times which has turned attention to exploring the various dimensions of ethical dilemmas confronting health professionals although such evidence is limited in the Ghanaian context, necessitating the need for this study. In one extensive cross country study in Europe covering four countries including the United Kingdom, Switzerland, Norway and Italy, Hurst et al (2007) found that ethical difficulties existed in clinical practice in all surveyed countries, with important differences among countries regarding both the frequency of different kinds of dilemma and their perceived difficulty. They reported that, generally, the ethical dilemmas that confronted Doctors (psychologists) in all the surveyed countries included uncertain or impaired decision-making capacity, disagreement among caregivers and limitation of treatment at the end of life. Although these dilemmas were the major concern, the types of difficulties most frequently described as the most difficult were
requests for euthanasia or doctor assisted suicide, disagreement among caregivers, impaired or uncertain decision-making capacity and uncertainty about whether to disclose the diagnosis to the patient (Hurst et al, 2007).

Akfert (2012), using purposive and maximum diversity sampling method conducted 40 psychological counselors through a semi structured interview and identified among other things the common ethical dilemmas experienced in all institutions as limitations to privacy, entering into multiple relations, conduct of colleagues, transfer of competence and values (that is most faculty members stated if they have to lecture in areas which are not their expertise, they experience dilemmas. Others stated that they will include their own values when giving ethical decisions in legal procedures). In the same bases, he discovered that in resolving dilemmas, psychologists take ethical rules into consideration, trying to stay in the legal process, receiving help and engaging a counselor in the process. The obstacles which affect the resolution of these dilemmas were also political and institutional, lack of competence in resolution of the dilemma and personal reasons. Are these the same dilemmas the Ghanaian psychologists face and do they consider the same factors in their resolution?

Koocher and Keith-Spiegel (1998) and Korkut, Muderrisoglu and Tanik (2006) concluded in a study that one of the most important reasons for ethical violations conducted by those who work in the psychological counseling profession is lack of sufficient knowledge in ethical related subjects. In another study it was established that psychologists utilize formal rules and codes of ethics when considering what one should do when presented with an ethical dilemma. However, they also relied on personal values.
and practical considerations in order to determine what they would actually do given the same situation.

Haas, Malouf, and Mayerson (1988) explored how the personal characteristics of practicing psychologists influence their ethical decision making. They presented 294 randomly selected psychologists with ten potential ethical dilemmas and asked them how they would resolve each and provide reasons for their choices. They found out that the professionals were more similar than different in the resolution of the dilemmas. However, responses were affected by particular theoretical orientation, years of experience and sex. Significantly too, they learnt that a willingness to adhere to codified ethical guidelines was related to willingness to take direct action to resolve ethical issues. Consequently, their study demonstrated the importance of having ethical guidelines to regulate professional ethical conduct. However, methodologically, the dilemmas in this study were hypothetical and might generate different action in real practice.

A study which deals with situational factors impacting ethical decisions by professionals (Roberts, Battaglia & Epstein, 1999) noted that certain characteristics seem to magnify ethical dilemmas dealing with overlapping relationships, conflicting roles and challenges to maintaining client confidentiality. This is instructive because it cautions professionals to be mindful of the institutional arrangements or set up within which they work in order to facilitate ethical decision making. It also points to a need to be cautious about the impact of cultural factors on institutional arrangements.

Ethical dilemmas facing health professionals with emphasis on clinical psychologists in the Ghanaian context have marginally been explored by researchers. Up till now the only
extensive study in Ghana addressing this is the one by Ofori-Atta and Jack (2013) who examined the dilemmas of healthcare professionals in Ghana. For a class assignment, 153 medical students at the university of Ghana medical school interviewed health care professionals about their most difficult ethical dilemma and how these were resolved. The data covered 122 physicians, 17 nurses, 8 residents, 1 pharmacist, 1 dentist, 1 medical assistant and 1 medical student. The results of the study indicated that professionals face dilemmas about; determining appropriate use of authority, making decisions about resource allocation, ensuring standards of quality of care and questioning the role or scope of the health care professional. This preliminary small scale study highlights the importance of family in the ethical decision process and the need for ethics education among medical professionals. This recommendation is because of the communal nature of the Ghanaian society and lack of ethical knowledge among the medical professional. Though the study advanced knowledge in science, there was variation in the ways that the dilemmas were collected and reported because different students collected each dilemma. The sample used was not representative of all medical providers in Ghana and also, since it was not specific to psychologists and was limited as to the range of dilemmas it investigated, there is the need to research further and established whether there are other dilemmas which are peculiar to the Ghanaian psychologist and other factors which may also contribute to the obstacles to ethical dilemma resolution.

Summarizing, relevant literature indicates that the most common ethical dilemmas encountered by psychologists are privacy, blurriness of boundaries, fuzzy, multiple or conflicting relationships, academic environment, teaching/educational dilemmas and
conduct of colleagues (Capuzzi, 2002; Davis and Mickelson, 2003, Knapp and VandeCreek, 2010). Others include uncertain or impaired decision-making capacity, disagreement among caregivers and limitation of treatment at the end of life, euthanasia or doctor assisted suicide, determining appropriate use of authority, making decisions about resource allocation, ensuring standards of quality of care and questioning the role or scope of the health care professional. So to what extend do these identified ethical dilemmas fit within the context of clinical psychologists in Ghana. This study attempts to amplify the literature from a Ghanaian perspective on the ethical dilemmas facing practicing clinical psychologists.

2.3.1 Ethical Dilemma most frequently experienced by Clinical Psychologists

A review of literature reveals that there are some ethical dilemmas that are frequently experienced by psychological counselors. In this section the most frequently reported dilemma are discussed briefly. This will cover issues such as confidentiality, dual relationship and conduct of colleagues.

Confidentiality

Confidentiality is one of the most frequently experienced ethical dilemmas among clinicians. Akfert (2012) found that the most common dilemmas experienced by psychological counselors are those related to boundaries of confidentiality. Other researchers (Bodenhon, 2006; Erdur-Barker & Centinkaya, 2007) also found that confidentiality is the most experienced source of dilemma among psychotherapists in their various studies. These findings which are related to the boundaries of confidentiality
show the universal nature of this ethical dilemma. Take for instance Linden and Radestrom (1999) assertion that the most common ethical dilemma experienced among psychotherapists in Sweden is related to confidentiality. In their study, a majority (30%) of the participants noted that they were confronted by issues related to confidentiality. Even though confidentiality appears to be universal among nations surveyed by different researchers, cultural and geographical factors, among others, may affect the situation in Ghana. This present study finds out whether ethical dilemmas faced by psychologists in Ghana are related to the boundaries of confidentiality considering the communal nature of society and the role of family.

_Dual/multiple Relationship_

Dual relationship is another significant source of ethical dilemma most clinicians experience. In some studies on ethical dilemma, most researchers have ranked this the second most experienced dilemma among psychotherapists (Lindsay & Clarkson, 1999; Linden & Radestrom, 1999) even without including dual relations involving sexual behaviour. This means that it could have ranked highest among other sources of dilemma in psychotherapy. Lindsay and Clarkson (1999) identified two main types of dual relationship related dilemma: 1) social relations with clients which create a situation where a former client is encountered in social setting. This type becomes prominent especially when practicing in small communities; 2) working with two separate clients who are in a kind of relationship. In their study, Lindsay and Clarkson (1999) reported that there have been several situations in which participants worked with two separate clients who happened to have both professional and personal relationships. In this case,
the psychologist needs to be free working with each client without divulging of information (Hart & Crawford-Wright, 1999). Dual relationship as a source of ethical dilemma has not been adequately explored and this is a focus of this present study.

**Conduct of Colleagues**

This has to do with the recognition of other colleagues’ unethical behavior in a therapeutic relation with a client; and the difficulties these colleagues face (Linden & Radestrom 1999). Lindsay and Clarkson (1999) reported that a total of 9% of dilemmas their participants encountered could be put under conduct of colleagues as compared to 7% in the Society sample. In their study, Lindsay and Clarkson (1999) noted that the most common incident regarding colleagues concerns sexual behavior. Others include professional competence—where it is not always clear when a psychotherapist is not competent; unprofessional comments, professional conflicts regarding referrals, concerns over fee charging and inappropriate disclosure. This present study finds out if this is a major source of ethical dilemma experienced among clinicians in Ghana.

2.4 Ethics, Morality and Religion

In reality, a plethora of religions are said to have some inherent ethical component which is quite often derived from purported supernatural revelation or guidance. However, according to Blackburn (2001), for many people, ethics is not only tied up with religion, but is completely settled by it. Such people do not need to think too much about ethics, because there is an authoritative code of instructions, that is a handbook of how to live. For example, Christianity is a striking example of a perfect harmony, a strong mutual affinity, and almost a unity of a great religion and great ethics (Alija, 2012).
Thus to Singer (1993), ethics, is a major aspect of philosophy which encompasses what is right conduct and good life. It is significantly broader than the common conception of analyzing right and wrong.

Many scholars assert that religion is necessary to live ethically. For instance, Blackburn (2001) makes a point that, there are many people who would say that we can only flourish under the umbrella of a strong social order, concreted by common adherence to a particular religious tradition or belief. Therefore, a central aspect of ethics is "the good life", the life worth living or life that is simply satisfying, which is held by many philosophers to be more important than traditional moral conduct (Singer, 1993).

Morality and religion on the other hand is simply the relationship between religious views and morals. Many religions have value frameworks governing personal behavior meant to guide adherents in determining between right and wrong (Esptein, 2010).

From the inception of western thought, the concepts of morality and religion have been closely intertwined (Hare, 2010). This has also raised a lot of debates within ethical decision making. Morality refers to the human propensity to judge certain forms of behavior as good and deserving of admiration, encouragement and reward, and to judge other forms of behavior as bad, not to be imitated, and worthy of punishment. Morality also includes the systems of rules which particular societies develop to codify these judgments. These systems of rules are developed gradually over many generations and represent the judgment of many individuals about exactly what sorts of behaviours are right and what sorts of behaviour are wrong (Irons, 1996). Geertz's (1966:4) defines religion as "a system of symbols which act to establish powerful, pervasive and long-
lasting moods and motivations in men [and of course women] by formulating conceptions of a general order of existence and clothing these conceptions with an aura of factuality such that the moods and motivations seem uniquely realistic."

Certainly it has been argued that religion and morality are not synonymous. This implies that morality does not depend upon religion although this has been an almost spontaneous assumption (Rachels & Rachels, 2011). According to The Westminster Dictionary of Christian Ethics, religion and morality "are to be defined differently and have no definitional connections with each other. Conceptually and in principle, morality and religious value systems are two distinct kinds of value systems or action guides (Childress, Macquarrie & John, 1986). However, it is also important to note that morality is an active process which is, at the very least, the effort to guide one's conduct by reason-while giving equal consideration to the interests of all those affected by what one does (Rachels & Rachels, 2011).

Corollary to the views held by those who believe that there is an association between religion and morality, Gaukroger (2012), reiterate that in the 17th century, there was the believe that religion provided the unique basis for morality, and that without religion, there could be no morality. Nevertheless, this view slowly changed over time. Therefore, in the 1690s, Pierre Bayle asserted that religion "is neither necessary nor sufficient for morality (Gaukroger, 2012). Critical voices have attempted to separate the two concepts. For example, The Westminster Dictionary of Christian Ethics illustrated that, for many religious people, morality and religion are the same or inseparable; for them either morality is part of religion or their religion is their morality. For others, especially for nonreligious people, morality and religion are distinct and separable; religion may be
immoral or non-moral, and morality may or should be nonreligious. Even for some religious people the two are different and separable; they may hold that religion should be moral and morality should be religion, but they agree that they may not be (Childress and Macquarrie, 1986).

From the research literature, there is evidence to suggest that several schools of thought are divided as to whether religion and morality are related. For example some schools of thought have argued that morality can only be based on religion, but morality and religion are not one. They posit that in principle, morality does not exist without religion even though morality as a practice and a particular case of behaviour is not dependent directly on religiousness (Alija, 2012).

To the other extreme, some scholars are of the view that indeed there is a connection between religiosity and morality. According to (Dixon, 2008), religious beliefs are necessary to provide moral guidance and standards of virtuous conduct in an otherwise for example corrupt, materialistic, and degenerated world. In the same vein, Christian theologian Ron Rhodes has remarked that it is impossible to distinguish evil from good unless one has an infinite reference point which is absolutely good. On this account, Dixon (2008) therefore asserts that religion certainly does provide a moral framework within which people can learn the difference between right and wrong.

Arguing independently but along the same line, Esptein (2010), concurs maintaining that numerous religions have value frameworks regarding personal behavior meant to guide adherents in determining between right and wrong. These include the Triple Jems of Jainism, Judaism's Halacha, Islam's Sharia, Catholicism's Canon Law, Buddhism's
Eightfold Path, and Zoroastrianism's "good thoughts, good words, and good deeds" concept, among others. These frameworks are outlined and interpreted by various sources such as holy books, oral and written traditions, and religious leaders. Many of these share tenets with secular value frameworks such as consequentialism, free thought, and utilitarianism.

It seems important to also note that religion is not always positively associated with morality (Barna, 2008); but sure enough, religions provide many different ways of dealing with moral dilemmas. For example, there is no absolute prohibition on killing in Hinduism, and this point to the fact that it may be inevitable and indeed necessary in certain circumstances (Werner, 2007). This is sufficient to point out that when moral values are in conflict, the result may be an ethical dilemma or crisis.

To those who believe that morality is independent of religion; they have claimed that moral truths can always be adequately discerned through reason, conscience, or moral intuition. In view these group of people who hold a general view that religion is the basis of morality are often confronted with the following dilemma: If the commands issued by God are morally obligatory, then that is because either: (1) they express independently justified moral values, or (2) God’s commands are necessarily morally good. If alternative 1 is true, then morality is independent of religion. If alternative 2 is true, then what is morally good seems to depend implausibly on God’s whim.

Inferred from the discussions above, it can be recognized that there is a certain inner consistency between religion and morality that is not automatic, mathematical, or logical but rather practical; apparently, divergences are possible but sooner or later the
dependence is reestablished. Atheism, after all, ends up as a negation of morality, and every true moral transformation starts with a religious renewal. Morality is thus a religion transformed into rules of behavior. This shows both the interdependence of religion and morality as well as their independence of each other.

2.5 Resolution to Ethical Dilemmas

In the field of clinical practice, it has been noted that ethical difficulties and barriers to ethical decision making largely exist in almost every country, although there are important differences among countries regarding both the frequency of different kinds of dilemma and their perceived difficulty as well as how to address such difficulties (Hutton et al 2007). This is largely attributed to the ideals of culture and the diverse socio-economic circumstances in countries. Thus the element of culture and cultural differences has been noted as one factor that confronts health professionals in making ethical decisions. This coalesces with the views of Hunt and Vitell (1986:10) in their general theory of marketing ethics arguing that ‘cultural norms affect perceived ethical situations, perceived alternatives, perceived consequences, deontological norms, probabilities of consequences, desirability of consequences and important stakeholders although they did not offer specifically how cultural norms may affect ethical decision making.

In addressing the difficulties in the ethical dimensions among health professionals, scholars in ethics and related fields have been exploring the theoretical foundations of public health ethics, to enrich our ideas about the common good and to offer frameworks that enumerate and balance communal values with the individual interests that seem to dominate political and legal system (Gostin, 2002; Roberts & Reich, 2002). Much of this
work is at an early stage of development, with some ethical concepts and methods still “largely undefined,” and public health values unspecified. Complicating the analyses is the fact that public health is an enormously complex phenomenon (Kass, 2001).

2.6 Ethics Codes

Indeed, one way in which individuals can support ethical conduct is to develop a code of ethics that can support a professional’s efforts to make ethical decisions. In connection with this, Corning (2005) sees professional codes of ethics as a body of rules, principles, and standards, which govern the conduct of its members. Each profession may adopt a code of ethics to self-regulate the conduct of its members. Furthermore, a code of ethics establishes the group as a profession, and promotes a certain image of that profession to the public. In this way, Psychologists, Physicians, Nurses, Respiratory Care Practitioners, and many other professional healthcare providers have adopted their own code of ethics (Corning, 2005).

Recognizing the importance of code of ethics in resolving ethical dilemmas, public health practitioners have in recent decades been actively engaged through professional associations in formulating a Code of Ethics that sets out basic public health values to serve as source for practitioners facing ethical questions in their day-to-day jobs (Thomas, Sage, Dillenberg & Guillory, 2002). Some researchers in the field of ethics have increasingly argued that professionals, especially those in the health profession, should thoughtfully identify their personal values to inform the development of such a code of ethics (Kitchener, 2000; Shapiro & Stefkovich, 2001). In this regard, Ethicists have argued that professionals follow a hierarchical sequence of ethical reasoning that
builds upon their personal values (Kitchener, 2000; Shapiro & Stefkovich, 2001). When faced with an ethical problem, the first line of defence for professionals is their professional standards or code of conduct (Kitchener, 2000; Shapiro & Stefkovich, 2001). For instance under the American Bar Association (2006), an attorney faced with ethical dilemma can refer to the “Model Rules of Professional Conduct”. Similarly, for medical practitioners the first source for resolving their dilemmas is to refer to the AMA Medical Code of Ethics that is provided by the American Medical Association (2001). In effect, referring to the code of ethics of the particular profession largely serves as one major pathway through which professionals could resolve any ethical dilemma that they are confronted with.

Hurst et al. (2007) in their cross country study in UK, Switzerland, Italy and Norway to explore the ethical difficulties in clinical practice, also identified some resolution measures that were identified by their participants (health professionals). Their study demonstrated that the preferred types of help namely, professional reassurance that the decision was correct, someone capable of providing specific advice, help in weighing outcomes and clarification of the issues seem to have an underlying model in common: that of calling on an expert to solve a puzzle. The authors showed in their study that the types of help that imply a stronger component of self-engagement in the process of solving an ethical difficulty are less often preferred. Furthermore, despite the diversity in the types of difficulties encountered, the kinds of help perceived as useful were strikingly similar. Even though different sensitivities to ethical problems are evident in the four countries that the authors surveyed, the health professionals had a common perception of the help they needed. Additionally, they showed that although sensitivity to local cultural
elements is likely to be an indispensable component of ethics consultation, general structure of ethics support services would not have to be radically changed to suit cultural variations, at least among the surveyed countries (Hurst et al 2007).
CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents the research methods for the study. This will cover aspects such as the research design, sample size & sampling method, research setting, target population with inclusion criteria, data gathering procedure, data analysis techniques. Other sections include research rigour; which has to do with the application of precise and exact standards in conducting research, ethical consideration and concludes with a brief outlook on pilot study which is to ensure validity and reliability of the interview guides.

3.1 Research Design

The study employed the qualitative research design. The choice of qualitative research design was premised on the fact that it was an exploratory and descriptive inductive approach that would allow for the discovery and/or expansion of sufficient knowledge on the subject matter being studied which are ethical dilemmas confronting psychologists in Ghana, given that so little research has been done in this field. The approach is in-depth in that it involves detailed examination of the participant’s world; it attempts to explore personal experience and was concerned with an individual’s personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object or event itself (Clarke, 2010: Smith & Osborn, 2003). This explorative design was chosen because it a more practical and appropriate approach that rigorously investigates the full nature of phenomenon rather than simply observing and explaining the phenomenon. Essentially, it provides a comprehensive insight on issues and situations
that were relevant to the subject matter (Polit et. al., 2001). In essence, the study of ethics in Ghana today had to be exploratory.

3.2 Sampling Technique

Jensen and Shumway (2010) refer to sampling as the process used to select a portion of the population for a study (as cited in Gomez & Jones, 2010). The study employed the non-probability (purposive) sampling technique in selecting the participants for the study. The purposive sampling technique is a sampling method in which decisions concerning the individuals to be included in the sample are taken by the researcher based upon a variety of criteria which include specialist knowledge of the research issue, or capacity and willingness of participants to partake in the research (Creswell, 2009). On this account, purposive sampling was found to be the most appropriate method for selecting participants in this study because of the focus on practicing clinical psychologists and the ethical dilemmas they are confronted with.

3.3 Target Population

The target population studied comprised all practicing clinical psychologists in Ghana. Clinical psychologists were purposively selected because they deal most with psychological health and are therefore likely to be confronted with numerous ethical dilemmas. Secondly, clinical psychologists were chosen because there is as yet no code of ethics for them and knowledge of dilemmas faced is a precursor to writing a code of ethics for them.
3.4 Inclusion Criteria

The criteria for inclusion were: 1) the participant must be a trained psychologist (MPhil or PHD) practicing in Ghana; 2) must have practiced clinical psychology for a year or more; 3) the person must also be willing to participate. Those who did not wish to participate were excluded.

3.5 Sample Size and Sampling Method

Conventionally, with most qualitative studies (Mason, 2010), the sample size is not predetermined but rather reflects the saturation point of the study. That is the point where no new themes were emerging. Within any research area, different participants can have diverse opinions. Qualitative samples must be large enough to ensure that most or all of the perceptions that might be important are uncovered, but at the same time if the sample is too large data becomes repetitive and, eventually, superfluous, (Glaser & Strauss, 1967) when the collection of new data does not shed further light on the issue under investigation.(Mason, 2010).

In order to ensure generalization and fair representation of the target population, a total sample size of twenty (20) practicing psychologists were used for the study owing to the fact that there are approximately forty (40) to fifty (50) practicing clinical psychologists in Ghana and also, no new themes were emerging.

3.6 Data Collection Procedure

Selected participants were reached whilst in their offices. They were then informed about the study and if they agreed to participate, they are scheduled for an interview that was at
their convenience. Having identified and informed target participants, and gone through an informed consent with them, the semi-structured interview guide was administered through face-to-face interactions in accordance with the survey interview questions. The interview questions were in two sections; the first section covered aspects of demographic information of the participants (age, sex, qualification, religion and years of practice) whilst the second part was made up of open ended questions and two vignettes that solicited participants opinion on the scenario. The two vignettes used were to help bring out other dilemmas which may not have been willingly expressed by participants. During the interview, the researcher probed for complete understanding of themes whenever key information needed was not forthcoming. Each interview lasted 25-45 minutes. With participant’s consent and permission, the interview was audio recorded and assurance of privacy given. Participants were asked to answer a ten item religiousity scale called the religious commitment inventory-10. From the recorded information, all relevant information gathered was transcribed for further analysis and interpretation. The recording only included the pre assigned code for the subject, with no other identifiers.

3.6.1 The religious commitment inventory-10 (RCI-10)

The Religious Commitment Inventory-10 (RCI-10) is a brief 10-item screening assessment of the level of one's religious commitment using a 5-point Likert rating scale from 1 ('Not at all true of me') to 5 ('Totally true of me'). It is a measure of the extent to which an individual adheres to his or her religious beliefs, values, and practices and whether he/she utilizes them in everyday living. RCI-10 examines intrapersonal religious commitment (6 items) and interpersonal commitment (4 items). Religious commitment
refers to how much an individual is involved in his or her religion (Koenig et al., 2001). More precisely, a religiously committed person is supposed to “adhere to his or her religious values, beliefs, and practices and use them in daily living” (Worthington et al., 2003, p. 85). The Religious Commitment Inventory-10 (RCI-10) is a valid instrument that aims to capture the interpersonal and intrapersonal commitment levels of the individual.

This instrument has strong internal consistency, 3-week and 5-month test-retest reliability, construct validity and discriminant validity. The RCI-10 measures motivational and behavioural commitment to a religious value system, irrespective of the content of beliefs in that faith system and has been validated across different samples (Worthington, et al., 2003).

There is no scoring manual. The scoring is straightforward. Add the scores on each item. If you want to use the two subscale scores separately (Items 1, 3, 4, 5, 7, and 8 make up the Intrapersonal Religious Commitment subscale; items 2, 6, 9, and 10 make up the Interpersonal Religious Commitment subscale), add the items on each subscale. (No reverse scoring is needed).

3.7 Data Analysis Procedure

Relevant data gathered from the field were analyzed using the principles of thematic analysis. Thematic analysis, like content analysis, is a qualitative method of data analysis that seeks to identify, analyze and report themes or patterns within data. It thus, organizes and describes qualitative research data in rich and comprehensive detail (Braun & Clarke, 2008). According to Taylor and Ussher (2001), thematic analysis requires the active
Involvement of the researcher in order to discover the overriding themes inherent in the data in which research participants meaningfully define their experiences as well as how the world at large shapes those meanings, taking into account the focus of the data and the constraints imposed by reality. More importantly, thematic analysis focuses on identification of themes and patterns in data and grouping similar ideas together for comprehensive analysis (Constas, 1992).

In this study, the researcher read through the entire interview transcripts several times in order to be well acquainted with all aspects of the data gathered. This was followed by identification of similar answers, ideas or patterns which were lumped together in sub-themes. The next stage was to identify all relevant data that are related to the classified patterns. The identified patterns were categorized so that all data fall under one such identified grouping. Associated patterns were then combined and catalogued into sub-themes. Having done this, the results were analyzed, interpreted and synthesized with reference to theory, literature and within the context of psychological practice from which implications were drawn. (Braun & Clarke, 2008).

3.8 Research Rigour

The study adopted a qualitative research rigour which encompasses credibility, transferability, dependability and confirmability. Credibility comprises activities that upsurge the probability that, credible results and findings will be produced (Carpenter & Spiziale, 2007). The most appropriate way to confirm credibility of findings in research was to ascertain whether participants found that the results and findings of the study were true reflections of their experiences. In view of this, transcripts were discussed with the
research supervisors to enhance interpretation of participant’s views. More so, transcripts of data of the interview (study) were made available to participants on one on one basis regarding preliminary findings and interpretations to ensure true reflection of their experiences.

Transferability according to Creswell, (2009) broadly refers to the likelihood that the study findings have implication to others in similar circumstances. Also called fitness, transferability determines whether findings can suitably fit well in or are transferable to related conditions. To accomplish transferability in this study, a clear description of procedure for participant’s selection, as well as detailed presentations of the process of data collection and analysis is adequately provided in this report.

To Graneheim and Lundman (2004), dependability of a study is the extent to which judgments about similarities and differences of content are consistent with time. To ensure dependability in this research, all participants were interviewed using the same interview guide with similar process. It was an open dialogue between the researcher and practicing clinical psychologists to ensure that results obtained were replicable elsewhere. A detailed description and recording of all stages and methods in the research process were provided so that other researchers who want to replicate the study elsewhere could follow suit.

Lastly, confirmability in research was described to mean the degree to which the results and findings could be confirmed or substantiated by others. If a study demonstrates credibility and fitness, the study was said to possess confirmability. To achieve confirmability under this study, there is a comprehensive audit trail of interviews and
transcripts as well as drafts of the final report. Thus, a systematic collection of documents and recordings of activities that allowed an independent auditor to come to similar conclusions about the data. (Creswell, 2009).

3.9 Pilot Study

A pilot survey was conducted in order to ensure validity and reliability of items on the interview guide. This was to allow for avoidance of inconsistencies in the interview process as well as enhance the interviewing skill and experience of the researcher. Three senior MPhil clinical psychology students were interviewed for the pilot study. However, participants were given free will to opt out of the pilot study at any given time.

3.10 Ethical consideration

Ethical principles were strictly adhered to in carrying out this study. In the first place, ethical approval was sought from the institutional review board of the Institute of Statistical, Social and Economic Research (ISSER) at the University of Ghana before the commencement of the study. Added to that, an introductory letter and request for permission for the study was obtained from the department of psychology at the University of Ghana.

The ethical considerations in this study included issues of confidentiality, informed consent and respect for autonomy. Confidentiality is an essential part of any ethical psychology research. Participants need to be guaranteed that obtained information and individual responses would not be shared with anyone who was not involved in the study. Participants in psychological research have a right to expect that information they provide
is treated with strict confidence and, if published, could not be identified as theirs. In the event that confidentiality and/or anonymity could not be guaranteed, the participant is warned of this in advance of agreeing to participate.

Informed consent on the other hand is a prerequisite for all research involving human beings. It involves the process by which an individual may choose whether or not to participate in a study. The researcher’s task is to ensure that participants have a complete understanding of the purpose and methods used in the study, the risks involved, and the demands placed upon them as a participant (Best & Kahn, 2006; Jones & Kottler, 2006). The participant also is made to understand that he or she has the right to withdraw from the study at any time. From a legal standpoint (Drew & Hardman, 2007), informed consent involves three elements: capacity, information, and voluntariness. All three elements must be present for consent to be effective. Lastly autonomy means that each person should be given the respect, time, and opportunity necessary to make his or her own decisions. Prospective participants must be given the information and free will they will need to decide whether or not to participate in a study. In view of this participants were not pressurized or coerced to participate in the study against their will. Essentially, the principle of autonomy requires that protection be given to potentially vulnerable populations such as children, the elderly, the mentally ill, or prisoners. Individuals in these groups may be incapable of understanding information that would enable them to make an informed decision about study participation. Consequently, careful consideration of their situation and needs is required and extra care must be taken to protect them.

By all possible means these ethical considerations were used to protect the anonymity and confidentiality of research participants during data collection, analysis and
dissemination by avoiding leading traces in the report which may lead to identification of participants and also in the dissemination of results, names of participants in the research were not disclosed. The aims, benefits and potential harm of the study were explained to each participant and a consent form was signed to indicate understanding of the nature of the research and also as an indication of agreeing to participate. Finally, no coercion was used to push or force people to be participants in the research whether through incentives or physical force.
CHAPTER FOUR

DATA ANALYSIS

4.0 Introduction

This chapter presents the demographic characteristics of participants and the qualitative analysis of interviews from the study as well as analysis of responses to two vignettes included in the interview guide.

4.1 Demographic Characteristics of Participants

A sample of twenty (20) psychologists participated in the study. The average age of participants was forty-five (45) years with the youngest being thirty-two (32) years and the oldest seventy-two (72) years. The average years of clinical practice was thirteen (13) years with the least being two (2) years and the highest being forty-five (45) years.

Gender wise, analysis of results indicated that the number of females outnumbered the males. Out of the total sample of 20 respondents, twelve (12) were females with the remaining eight (8) being males. The gender distribution of the participants may suggest that in clinical psychology, women dominate the field.

All the participants sampled in this survey had attained at least a master’s degree. Fourteen (14) of the participants had a master of philosophy (Mphil) degree in clinical psychology, and the rest held a doctor of philosophy (PHD) degree in clinical or health psychology. In terms of religion, all participants interviewed were Christians. (See table 4.1 for details).
Table: 1 Demographic Characteristic of Participants

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<tr>
<th>MEAN AGE</th>
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<th>NUMBER OF MALE</th>
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4.2 Qualitative Analysis

A thematic analysis of the interviews centered on two major categories; ethical dilemmas and resolution dynamics. From these two general categories various themes emerged. Under the Ethical Dilemmas 8 major themes with sub-themes emerged, namely 1) Third-Parties and Privacy (with sub themes: therapy with minors, marital disclosures, source of referral and duty to warn), 2) Policies, Practices and Ethical realities 3) Dual relationship (with superior and subordinate relationship, collegial relationship) 4) Motive vs. morality, 5) Competency and client’s expectations, 6) Manipulation of the therapist, 7) Fees and 8) Cultural competence

Under Resolution dynamics four (4) themes emerged; 1) Bricolage of values 2) Professionalism 3) Consultations. 4) Opportunities and challenges.

4.2.1 Ethical Dilemmas

Third-Parties and Privacy

This theme examines the views about confidentiality and how much information can be given to a third party concerning issues raised during therapist-client interactions. About 95% of participants in the study had in one way or the other dealt with issues that bordered on how much information could be relayed outside the therapeutic relationship. Various dilemmas discussed raised confidentiality issues that cut across varying degrees
of cases. This is discussed under the following sub themes; therapy with minors, marital disclosures, source of referral and duty to warn.

**Therapy with Minors**

Majority of participants had to deal with issues concerning minors where information relayed to the therapist was supposed to be kept confidential because disclosing them would mean betraying the trust of the child. This is illustrated in the voice below:

“The mother wanted to be told about everything that was discussed in therapy and it was clear to me that if I did that the teenage daughter, would not talk. Why would she talk if everything was going to be told her mother? She could tell her mother herself. So the dilemma was, understanding that the mother needed to know that her daughter was okay but also the need for me to keep the confidentiality of the child and what would happen if really there were issues she needed to know about? You know, so how was I going to balance this?” (Psychologist-3).

A closer look at the latter part of the voice illustrates the clear dilemma the therapist experiences- how to get the mother engaged in the provision of support in treating the child and maintaining the trust the child has reposed in the therapist. Obviously, keeping the mother engaged in the process might compromise confidentiality as the therapist rhetorically expressed. The voice below corroborates the above:

“That dilemma, I still struggle with it. It is about minors. When a minor is your client and they want some things not told and you realize that they would need
their parent’s help and they don’t want it told and you think that it is better for their parents to know. To tell or not to tell?” (Psychologist-8).

The above voice illustrates that this particular dilemma is very difficult to deal with. The therapist is torn between how much she can disclose without infringing on confidentiality issues with the client:

“So here the child is not your immediate client but then you are getting some information that you are not sure whether to divulge to your original client or the one who has become your client. This is where the parent does not even want you to refer, then it becomes a bit of a dilemma.” (Psychologist-18).

**Marital Disclosures**

Another area most participants had ethical dilemmas with, was dealing with disclosures in marital counseling. Where information entrusted to the therapist, if revealed, could either break the marriage or could be helpful in the management of the marital crisis. The psychologist is then torn between the two decisions. This is illustrated by the voice below:

“I am forced if possible to tell the husband but because of ethical reasons, confidentiality, how could I? So I have to intensify my treatment with this girl without telling the husband”. (Psychologist-6).
Other participants perceived themselves as being gate keepers for such information and also found it a personal difficulty if they had to reveal such information. Furthermore others psychologists were bothered what the other partner might think with regards to secrets he/she may be holding in confidence for the patient’s spouse:

“What is that person thinking of you or this professional may keep my secrets away from my wife; will he do the same for her? What does he know about her and he is not telling me on the other side?” (Psychologist-5)

“During a marital therapy, and you realize that one partner has been unfaithful and so what do you do? If you took one person out of therapy, it means the person could tell you one-on-one what exactly is happening. You become the repository of that information. Do you then give that information to the other partner or not? And should you? Now that you know for sure because you’ve been told how ethical is it not to let the other person know.” (Psychologist-3).

The participant presents a scenario where information divulged during therapy appears to have a negative moral implication for the marriage. In this regard, as a repository of such sensitive information, the dilemma that occurs is rooted in a clash between 1) a commitment to keep client’s information and 2) a moral duty to inform the concerned third party- client’s partner.

Furthermore other participants were bothered about what the other partner may think with regards to secrets the therapist may be keeping in confidence for their spouse as illustrated:
“Bringing up in therapy, ‘guess what? Your wife is having an affair and not only an affair but got pregnant,’ ok. And this is something with a great deal of personal difficulty. Eh.., I could not bring into the process, right?” (Psychologist-5).

What is important to note here is that, although the therapist wants to help the couple, being the gate keeper or at times knowing the basis of the misunderstanding between the couple but not being able to disclose openly puts the psychologist in an ethical dilemma.

**Source of Referral**

A considerable number of participants raised issues concerning the extent to which they had to release information to agencies and agents who referred clients and often who paid for therapy; i.e. third party. They were normally torn between how much information they could report and what they needed to conceal as expressed below:

“Now here I am caught between who my client is. Truthfully because my client originally was, the organization, and it is the organization that is paying for me to attend to the gentleman. The gentleman is my primary objective in all of this.” (Psychologist-9).

“There are times when it’s not quite clear cut; there are times when the line blurs, so you’re not sure whether or not you’re required to report and how much you’re required to report.” (Psychologist-16).
In some instances the therapist is also torn between whom to listen to with regards to the direction of therapy, whether to treat to please the one who referred the client or please the client who is receiving treatment. As by the voice below:

“So I could see where the parent was coming from but like I said it’s always the person who comes to you who is your client. Who are you trying to help? Are you trying to relieve the stress of the parent or you are trying to help the child? So that is where you usually have the dilemma.” (Psychologist-18).

**Duty to Warn**

Confidentiality issues especially with regards to HIV disclosures were also one of the difficult dilemmas participants recounted. Most of them felt an obligation to warn a partner in the event where the client refused to disclose. However they were also confronted with issues of confidentiality with regards to who their clients were and therefore to whom they owed allegiance. This is illustrated by the voices below:

“Professionally, you know and you are trained to know that people disclose when they are ready but there are situations when they are not ready but there are significant others who should be informed and this places significant challenge” (Psychologist-5).

“……..because I feel somebody’s life is at risk on the other one hand and my patient I owe confidentiality to for professional reasons. So it becomes, do I break my professional codes and tell the person or do I allow the person to be at risk of
their lives because they are having unprotected sex with someone who is infected?”(Psychologist-8).

**Responses to vignette on third party disclosures**

In a vignette presented to participants, where a psychopath client had intention of abusing his sibling, in their responses, all the participants without hesitation were ready to break confidentiality although a blank confidentiality was promised to the client in that particular scenario. They all felt they had a duty to warn and about 90% referred to the Tarasoff\(^1\) case. These were some of the responses:

“Because if he went and he harmed that person, your duty to warn is eh…an American term, you know that comes out of the Tarasoff case because if you don’t you cannot protect who you know who is of sound mind better than they can. If that sister knows that or that sibling knows that Mr. (what is his name?) is coming to harm her/him, she/he can make his decisions to protect herself/himself”(Psychologist-3).

“It used not to be but after that the Tarasoff….confidentiality breaks down when the welfare of another person is at stake. You know in this case he is going to sexually abuse her. Isn’t it?”(Psychologist-8).

\(^1\) **Tarasoff v. Regents of the University of California** was a case in which the Supreme Court of California held that mental health professionals have a duty to protect individuals who are being threatened with bodily harm by a patient. The original 1974 decision mandated warning the threatened individual, but a 1976 rehearing of the case by the California Supreme Court called for a “duty to protect” the intended victim.
“Duty to warn comes in immediately. Harm has been suggested to somebody else and that is where my confidentiality ceases. I mean I wouldn’t think twice about it.” (Psychologist-18).

One participant however felt that aside from the fact that you needed to protect somebody’s life, if you continue to shield dubious information given by client, it may reinforce psychopathic behavior. This is also illustrated by the voice below:

“Sometimes it can even be a test, ok. Because if you don’t do that you might end up becoming first of all, a repository of a lot of negative fantasies, first of all and that is in-itself a way of actually enabling the negative psychopathic practices that you are trying to curb. You may wake up one day and you will become the person’s alter ego.” (Psychologist-19).

It is thus evident that even though almost all participants, held client confidentiality paramount; they were not willing to compromise where another human life was at stake.

**Policies and Practices**

This theme addresses dilemmas which come about as a result of certain institutional policies and ethical principles that in reality may not work as effectively as expected hence creates a dilemma for the psychologist. It pertains to institutional policies, cultural expectations, resources and so forth which may clash with ethical principles the psychologist is expected to adhere to. This is illustrated by the voice below:
“So the dilemma was, here we were, we had a hospital policy of depopulating, she was well enough to go home. She wanted to go home but her relatives didn’t want her at home. (Psychologist-3).

Judging from the voice above, institutions may have their policies, however in reality it may be difficult to implement those policies because of other psychosocial factors that come into play. Additionally, our cultural sensitization also puts the psychologist in an ethical dilemma. Although he/she may know what is ethically right, following it may cause a displeasure considering the cultural setting within which he is operating. This is also illustrated with the voice below:

“Eh… in Ghana if I’m not over generalizing, you know people, eh… usually like to show their appreciation for whatever you’ve done for them or you intend doing for them. So you are likely to see somebody coming with an envelope maybe some money or some food stuff or something. ‘oh help me’. Or he meets you somewhere and thinks he’s obliged to do something for you no matter how you try to turn it down...Trying to make them understand that it is unacceptable is very difficult because culturally it’s been ingrained in us to show appreciation for whatever is done so if you do that the person does not understand fully” (Psychologist-15)
“I discussed it with my supervisor, my supervisor was eh…, it’s a cultural thing. If you don’t accept, the people feel hurt; you know that you are not accepting the things that they have...” (Psychologist-20).

**Dual Relationships**

Quite a number reported that they faced challenges that hovered around relationships aside from the therapeutic one which in effect created discomfort and presented as an ethical challenge. This theme therefore encompasses the various types of relationships that participants were confronted with aside from the primary therapeutic relationship. This will be discussed under the following sub-themes; collegial relationship, and superior-subordinate relationship.

**Collegial Relationships (Same Power Level)**

Some of the participants interviewed expressed that they found themselves in a situation where they had to attend to a colleague as their client. Although they all found it ethically challenging, some felt it was an area which is clearly out of bounds considering the professional training they had received where as others felt regardless of what the ethical principles says, they had to attend to their patient for pragmatic reasons citing the low number of psychologists in Ghana and the social arrangement of interdependency that pervades in Ghanaian society with-in which they practice. This is illustrated below:

“I thought that was one of those instances where I needed to stay away. This is a colleague, yes but this is a colleague’s personal problem not like a referral of a case or consultation of a case. You know, I felt that I was too close to them to be
objective especially when it comes to marital and sexual issues and the relationship of people you know, it’s not easy. (Psychologist-18)

The above voice indicates that the participant felt he / she may be biased when dealing with a colleague in same profession. This fear of possible subjectivity therefore, creates a dilemma for the therapist.

“you know the ten commandments of your profession as far as ethical issues are concerned, but the person recognizes that so far as we are friends errrrr… we are both this….”I have an issue I think you can help” how do we negotiate the relationship?”(Psychologist-11).

Here although both the therapist and client who is also a colleague knows the rules governing their profession, they may overlook this and still go ahead and enter into a therapeutic relationship because the therapist may have a certain specialty which makes him/her a perfect person for the job. The dilemma therefore arises when the boundaries of the two relationships cannot be clearly defined.

_Superior-Subordinate Relationship (Unequal Power Level)_

This sub-theme also addresses other relationships expressed voluntarily by participants as some of the dilemmas that have confronted them in the course of their work and also opinions on a hypothetical case (vignette) presented to participants. These are when they are obliged to enter into multiple roles such as a student being a client or a client being a customer etc. They reported that these kinds of relationships compromise the therapeutic
relationship hence may affect their primary role as therapist. Others also thought that because of the interdependent social arrangements, certain dual relationships are quite difficult to avoid. This creates a dilemma as expressed below:

“Because some of the decision you might have to take from the problem may affect the student down the line. Or some of the decision you have to take as a teacher or as a lecturer, if the person or the student is not doing their assignments and you need to give them a zero or whatever, it creates distrust, it creates some animosity, so that if the person comes into therapy, they may not be able to open up the way they need to, you know. So that’s, that can be a problem.” (Psychologist-16)

“Your client is not your friend, and what we are taught is the APA one, we are not supposed to give a lift to the person. But in our culture, you are driving and it’s raining, you can’t drive past the person.”(Psychologist-14)

From the above narratives it is evident that most of these relationships may compromise the fiduciary duties of the therapist hence pose as an ethical challenge. The cultural non-specificity of the ethical codes being adhered to (currently the ethical codes used by clinical psychologists in Ghana is western based.) also aid in the dilemma experienced by the latter narrative presented above.

The following narratives illustrate the various views expressed by participants on a hypothetical case where a psychologist treating a client decided to have an intimate/amorous relationship concurrent with the normal therapeutic relationship and
other situations where they had to deal with intimate relationship issues. Here, although most participants felt it was wrong to have such relationship while still attending to the client, there were a few who had divergent views about it. Below are few examples:

“I think this is a very dangerous position for the psychologist. Now, as a psychologist, so far as I am aware, dual relationship is not acceptable, alright. Now, even if you’ve seen the patient, the last time you saw the patient was five years ago, it’s not acceptable to enter into a relationship with the patient. I remember this came up years ago and we said it’s a no go area because you never know what will come up so is a no go area.” (Psychologist-7).

“I think that like we were told, ethically you are not supposed to have any such relationship with your client. So on an ethical front it is wrong but then again we all meet our partners at different places and that’s how they were meant to meet then there isn’t much I could fault them for even though on the ethical front it may sound wrong. So that’s what I think.” (Psychologist-17).

When asked what they would actually do if they were the psychologist in the scenario, there were divergent views. Participants stipulated different appropriate elapsed periods after therapy that they felt would be appropriate prior to the start of an amorous relationship with the former client. These were some of the responses:

“It says that even if your student or your patient is falling in love with you, you have to treat the student to graduate and the period you can get involved, 7 years.
You can marry her. That is a patient or students involved but allow 7 years before.”(Psychologist-8).

“So I probably would suggest to the person that they see another therapist for let’s say, some two months or a little bit and ensure that what their feeling is genuine before we consider having any other kind of relationship”(Psychologist-16).

“The lady, she is been dumped so she is also single and they’ve expressed interest in each other. I would have had this dilemma. Should I, should I not? But at the end of the day if I think that if the sort of person fits my bill I would have gone ahead with that person.”(Psychologist-17).

“……..have a discussion and then I would have referred them to another psychologist so that if I want to have the relationship I can continue to have a relationship with the person as a fiancée but not as a therapist. You can’t have both but what I would have rather advised the therapist, is to finish with the person and if the person is that sure about you after two, three years and you feel the relationship is still there, the affection is still there, you can take it to somewhere else”(psychologist-1).

From the narratives above, the participants have varying duration that they think a therapist can be a life partner to a former client. However there were others too who felt there was no need for a duration what so ever but clearly not a relationship worth pursuing at all.
“Be assertive enough to tell the patient no!” (Psychologist-7)

“It definitely, as spelt out in the scenario, is very wrong. My other comments on the scenario, you are treating somebody for something. That is the purpose.” (Psychologist-6)

Other participants also had to deal with real life situations where there are dilemmas created as a result of clients and family making advances towards the therapist. This is illustrated below;

“Another issue is that sometimes the patients make sexual advances at you. Sometimes is not the patient but the parents. “Can I take you out for lunch”, etc. sometimes, it makes you feel uncomfortable.” (Psychologist-10).

**Motive and Morality**

Some participants had dilemmas associated with certain decisions they had to take. Although the reason for taking that decision appeared right to the participants, there is also another part of them that viewed it differently considering the moral issues at play. There is therefore that dilemma between the two decisions. Whether to go ahead with that decision because their intentions are clear or to consider the moral implications enshrined in there. This is illustrated below:

“When sometimes you are presented eh, with a case of a couple that are fighting so violently and you know that somebody’s life is at risk or somebody’s health is seriously at risk but growing up as a psychologist, being trained as a therapist, one
of the things that we were taught, unless it’s absolutely necessary, as much as possible, you as a therapist, you are not supposed to advice a couple to break, sometimes sincerely you are confronted with cases where at a certain point you believe that there is so much confusion and the best thing to do will be to end it but not the kind of suggestion any psychologist can do easily, yea”(psychologist-20)

“Another is when you have a couple with sexual issue and then some of the techniques that are known to work have been beyond my religious eh……religiosity, whatever. So there were instances where I have to really think about what comes first, the best thing for the client or my own feelings about it”(psychologist-18).

“……but that final great big capital letter D is something that is not done easily and there is also another reason, you see, if you start proposing divorce and the couple, I mean, it is dangerous actually and the couple later on, ok do decide to come together. You can have a case where sometimes, if the husband is the violent one, he can tell the wife I don’t want you to see that therapist anymore and the wife trying to be obedient will agree not to see you anymore.”(Psychologist-19).

The above narratives indicate that morality as inculcated by society does play a major role in the creation of ethical dilemmas among participants. Although professionally the decision taken may be right, their moral values blur the decision making process.
Competency and Client’s Expectations

Some participants expressed that they have dilemmas with regards to the boundaries of their professional abilities and what client’s expectations are. They felt some clients do not know the scope of the professional practice of the psychologist hence expect more than the psychologist may be able to provide. They believed psychologists have limitations and may not be able to meet all the client’s needs or expectations.

“I thought of limitations eh people would probably expect that you be a know all, you explain to them that, some initially find it strange some you know our system has been on the biomedical, we’ve used the biomedical approach for so long so it is not that easy for people to understand the concept of biopsychosocial.”(Psychologist-15)

For decades, health services in Ghana have always centered on the biomedical model, neglecting the psychosocial aspect of the management of diseases in the hospitals. Most clients have less knowledge about how this aspect of therapy is included into the healing process. They therefore expect to be given pharmacological agents when they visit anyone in the hospital premises. This therefore creates a dilemma for the psychotherapist because some clients do not appreciate the services rendered hence may decide not to return after the first few sessions. The narrative below emphasizes it:

“I did relaxation therapy for him, teaching him how to relax and after everything, he kept on asking me “will you give me medicine, and since then I think he came twice or three times and he didn’t come again. So sometimes, it makes me wonder if people appreciate what we are doing.”(Psychologist-10).
“I find a lot of people consult us without knowing really how we work, what we can do and what we can’t do……”(Psychologist-5).

The dilemma is therefore to do with how the psychologist can educate the client, how to stick to his/her own domain of practice in the biopsychosocial model of treatment and also how the therapist is able to maintain his/her competency in the eyes of the client.

Manipulation of the Therapist

This theme encapsulates all the dilemmas experienced by participants with regards to the client trying to exploit the professional knowledge of the therapists (herein the participant) to achieve their ends. They always saw an element of truth in there; however the evidence did not justify what the client’s demands were. Hence this created a dilemma for the psychologist. Below is a voice to further illustrate this:

“I hate to be conned and when I am put in a position where it’s like the person is trying to get away with something, yeah, I am caught between being able to tell them I don’t think you are doing the right thing. You should just go and read up your books and the professional part of me that says that you can’t really make a judgment that this person is capable just from your intuitive thing and there is no other way really that you can use to tell how badly because they are ready to mangle, you know, whatever it is that you are looking for so I guess that is why it is difficult.”(Psychologist-8)
“Somebody wants a psychological report so that that person will dodge national service placement or this or that or that, ok. These are all complex forms of dilemma where some people might do it. They will say well I’m doing this for you because eh.., there is a little strong claim of truth in there but it doesn’t warrant this.” (Psychologist-5)

In the above narratives, the psychologist has a feeling of being used by the client to his benefit however the psychologists cannot entirely rule out the fact that there is an amount of truth in there. Hence the dilemma is centered on two things: 1) To be able to determine how much of the client’s condition warrants such an action from the psychologist and 2) The psychologist’s feeling of being manipulated.

**Fees**

This theme includes some of the dilemmas associated with the charging of fees. Some participants in private practice had dilemmas related to how much a client could be charged for their professional services. They saw some clients as being unable to afford the fees charged hence may see it as expensive where as other clients may see the fees as relatively cheaper. It created a dilemma because they felt the perception of the client about the fees had implication on the client’s expectation of professional competence. They did not want to be viewed as “cheap psychologists or too expensive psychologists.”

“Eh.., I think one of my biggest ever, one of my biggest dilemmas eh, very specific to Ghanaian situation is to do with fees and yes, collection of fees because eh.., I mean for instance, I am a private practitioner and in as much as I have a challenge, I have a responsibility to help my clients which I do by trying to
charge fees as reasonable as possible. Eh..., sometimes, there are people who come and eh..., they cannot pay and yet they need help but you don’t want to send out the wrong message of helping people for free all the time. And there are also people who come and they are in a better position to pay a lot more but yet when your charges come across a little too low, you know, it sometimes raises questions about your competence, you know.” (Psychologist-19).

**Cultural Competence**

Some participants felt that due to the differences in what has been taught and what is actually practiced, they have dilemmas in applying them especially in areas of test administration and some psychotherapeutic methods. They felt it is not culturally friendly or compatible. It is western based hence does not suit the environment within which the participants operate.

“Our training is western based which to a large extent I learnt that some of the things don’t fit our culture” (Psychologist-14).

“Eh…, yes. First and foremost, even if you have the use of tools, the interpretation of tools. Because a tool should be reliable, valid, culture fair. So you look at some of the tools. Even the Beck that we use every day, Eh..., Bender, although it’s nonverbal and all the others. Although I use them, to me its counter intuitive.” (Psychologist-11).

“I know there are instances where the case was brought from out there, out there I mean from the western world you know from Europe and stuff like that. But I want to believe that over time we possibly have our own local examples you
know the reasons why I will prefer local examples is that you know if you are practicing within a certain jurisdiction, it’s important that you get to know the cultural dynamics of that particular place because that really has a big role to play. You know so if for example, we give examples of local cases then we can bring to bear our cultural thing.” (Psychologist-13).

The dilemma experienced here by participants is basically due to lack of culturally specific training, instruments/tools and case examples which are foreign to the culture where they operate. They feel such factors do not help in the effective management of clients but since they have limited options, it creates an ethical dilemma.

4.2.2 Resolution Dynamics

When the category, resolution dynamics was examined based on participants own dilemmas encountered, various themes evolved. These themes are 1). Bricolage of values 2). Professionalism 3). consultations, and 4). opportunities and challenges. These were the major considerations or factors most participants considered when they were faced with ethical dilemmas, as well as the challenges faced when dealing with the dilemma.

Bricolage of values

a. Religion

This theme covers a collection of values participants considered when addressing or resolving ethical dilemmas. Such as; religions, client centeredness, cluster of values and so on.
Although all participants professed to be Christians, the RCI-10 was used to ascertain how religiously committed they were and how this religiosity played a role in their ethical decisions. Please refer to table 2 below.

<table>
<thead>
<tr>
<th>SCORE</th>
<th>MALE %</th>
<th>FEMALE %</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>2</td>
<td>6</td>
<td>8 (40%)</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>4</td>
<td>5</td>
<td>9 (45%)</td>
</tr>
<tr>
<td>LOW</td>
<td>2</td>
<td>1</td>
<td>3 (15%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
<td><strong>12</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

Following, Worthington et al. (2003), respondents that scored at least one standard deviation higher than the mean score were classified as highly religious, those who scored one standard deviation below the mean score were classified as low religiosity, and those who scored in between were classified as moderate religiosity.

Using the religious commitment inventory (rci-10), 40% of participants had scores signifying that they were highly religious, 45% scored moderately religious and 15% scored low religiously.

For the highly religious sample, 60% of them had their religious values playing a major role in the resolution of some of the dilemmas that came up. They perceived religion as the back bone of their practice as psychologists hence all their actions and inactions with regards to decision making in therapy relied solely on it.

“…..But before that, let me say this about religion in Ghana; religion, religion permeates almost everything that the psychologist would do. Eh…, in trying to
help your clients you must understand their religion, you must understand their spirituality and number one, you use it to help the client and the same religion is also what defines the boundaries of what you can and cannot do with the client.” (Psychologist-19)

This narrative gives indication that religion helps the therapist to culturally appreciate the client’s interests and also provides a platform for ethical behavior. To him religion sets the standards as to what is allowed to be done and what is frowned upon. For him ethics is built on religion. This is also reinforced by the voice below:

“Well, like I said you know we are born into societies and depending what your religion dictates does sink in some way or somehow. Consciously or unconsciously, it has a role to play. So generally I would say yes, religion plays a paramount role in ethical decisions or ethical rules.” (Psychologist-17).

“It determines what I do, how I do even how I pride myself in society you see because you are looking at it in the sense that if you are not careful you might rather say things that would go against you in terms of your religious principles or do things that would make people point fingers at you and for me religion is very important. So I wouldn’t do things that would go against my religion and therefore my reputation and therefore my ethical ways of doing things.” (Psychologist-20)
This participant views adherence to religious decisions as means of societal acceptance. She feels making decisions against her religious beliefs which are what her society is built on, may affect her reputation as a psychologist in the society where she operates.

The remaining 40% of the highly religious participants felt although they are religious, they do not allow it to cloud their judgment. Sometimes their religious or moral values are in conflict with the patient’s interest. However, they try to satisfy the patient’s interest and deal with their own internal issues later.

“That was why I said I had dissonance at the end of one particular case. I felt I had given them too much when the couple walked away happy. I felt I had done my job as a psychologist but failed as a moral agent.”(Psychologist-18).

Of the remaining participants, the moderately religious and low religious emphatically reported that they do not allow their personal beliefs to affect their professional decisions. That is, they paid little attention to religion. They however thought if religion is considered in most cases then it might probably cause more harm than good. This voice below illustrates.

“For clinical psychologists, I don’t think religion plays much of a role, at least for us here; the ones that I know of. I don’t think religion plays much of a role.”(Psychologist-16).

“Religion, I don’t consider that in my practice at all.”(Psychologist-7).
b. **Client-centeredness as a value**;

Some participants saw the patient’s interest as the most paramount consideration when resolving ethical issues. They viewed the whole decision making process from the client’s perspective. It is the client who makes the decision and they are there to guide and support the client along the decision making path.

“….i think that for me it’s always… I put the patient first. You know, what would be the best outcome for the patient? That is the first one and then the second one is so when I ask myself what is the right thing to do. For me the right thing to do is always to do what is the best outcome of the patient.”(Psychologist-3).

“I keep reminding myself that it’s not about me, it’s about the client and for me that’s a motto that I run by. So I may not be pleased by the person’s decision but hey it was not about me. It’s mine just to guide the person to see so that they have informed-consent more or less. You are informed of what is at stake and you make your decisions.”(Psychologist-9).

c. **The real bricolage**

Other participants didn’t just consider any singular value but looked at a collection of values that comes into play when faced with ethical dilemmas. They consider personal values, their reputation, religion, client’s interest, ethical principles and situation specifics. They resolve the dilemmas holistically.

“You’ll definitely be looking at first of all, your patient’s wellbeing, what is it, what can we do or how do we resolve this problem, so that the patient’s outcome
is best or it’s at the optimum. You’ll also be looking at your job. You need to protect your profession, your career, so what can you do such that you do not compromise your career and your value as a clinician, not necessarily personal moral but as a profession, what we stand for and what we look to do. So that’s also a consideration. Morally, I will say that will often be outweighed by what is legal and what is ethical.” (Psychologist-16)

“Ooh! I think obviously we cannot resolve everything. How you deal with a dilemma depends on the dilemma you are dealing with. Eh... I don’t believe in one side fit all. Yes you need to have to have a broad guideline but every dilemma and the challenges it brings. So if you are going to just stick to a routine way, one side fit all approach, it’s doesn’t work for me. Am not very rigid, am very flexible. So I take issues as they come, so I consult, read and move on, move on.” (Psychologist-11)

**Professionalism**

This theme addresses professional image and professional training /ethics. Some participants were very particular about their professional image and that came out strongly as one of the factors they consider when resolving ethical dilemmas. They did not want to take decisions that may bring their personal as well as their entire profession into disrepute.

“The other thing you need to look at is your reputation. If something goes wrong, what do you do? You could be struck-off the register. Eh..., of course Ghana we don’t have that but elsewhere we have a register and you could be taken to
disciplinary committee. So you need to be very careful of what you do in practice.” (Psychologist-7)

The narrative above gives indication of the fear the participant has of facing social exclusion or ridicule when things go wrong. Therefore his professional image is the most important consideration and it may also influence the type of cases to which participants may choose to attend to. This is illustrated below:

“….. Therefore you don’t want to do anything that will taint your image you know. So to be very honest, those things will make me not attempt to handle virtually any case at all I mean just because there is going to be some financial reward, not at all. I won’t do that.” (Psychologist-13).

Most participants when confronted with an ethical dilemma, the most important factor they also considered was the principles enshrined in their professional training they have received before any other considerations regarded. Principles like beneficence, non-maleficence, utility and so on.

“I think I look at the situation’s specific, circumstances and by the ethics of my profession, what I’m supposed to be doing and try and make sure that I stick and remain to that.” (Psychologist-5)

“Yes also having the ethical things at the background, thus back grounding and foregrounding it. When I fall back I must fall into ethical safety net. When I lean
forward, I must fall into how we call it, what is the word, when I hit a stone, and I must fall into ethical....” (Psychologist-11).

Consultation

Most participants mentioned that they go back to their books and on the internet when faced with ethical dilemmas. They read about what others have done in similar situations and research and apply the acquired knowledge to the problem at hand.

“They are indispensable. As a psychologist, in trying to help people we tap into not only our training but we also tap into the total reservoir of all our knowledge base. So in other words, the more widely read, the more widely studied, the more widely researched a therapist is, the better you are in a position to help your client. So eh…, in trying to help our clients we always give out a little bit, in fact, we always give out a lot of ourselves.”(Psychologist-19).

“You do your own research and you come up with your own ideas on how to work with the person.”(Psychologist-18)

The voices above bring out the fact that to be a good therapist, continuous training, research and reviewing of current literature is very relevant. This helps in the successful resolution of most difficult ethical dilemmas.

Supervisor and colleague consultation was also one of the most popular ways participants found useful in resolving ethical dilemmas. Most were very emphatic on the point that
some colleagues and former supervisors have specialties which they do not have and they therefore were eager to consult them when the need arose.

“In such a situation what I did was to consult with a colleague for peer supervision and we ironed things out in the best possible way for the client. In the end, the client was actually admitted for observation. So that was one specific area” (psychologist-7).

“I eh……confer. I consult with my peers when the dilemma is so much for me to handle. When it’s too much of a dilemma, I would talk to one or two colleague clinical psychologists just to see how they would have tackled it before I proceed.”(Psychologist-18)

“In a typical dilemma, one the thing I tend to do is eh…, I discuss it with senior colleagues when I don’t know what to do, I tend to discuss it with senior colleagues and solicit advice from them and I realize that it helps a lot so if it’s really serious dilemma I will normally defer making a final decision on it until I have spoken to a more senior colleague” (Psychologist-2).

**Opportunities and Challenges**

Under this theme, two major sub themes emerged; impediments and enablers.

**Impediments**

This sub theme includes all the hindrances to the successful resolution of the dilemmas and which also in part facilitated the creation of the ethical dilemma in the first place.
Some participants saw non-availability of certain facilities and resources as a reason why they faced ethical challenges and also find ethical decisions very difficult to resolve. The resources indicated here include resources from clients and families as well as from governmental institutions as expressed:

“So if there had been a special place for autistic children like that maybe that would have been a better outcome.” (Psychologist-3).

Some said that the lack of legislation did not help psychologists to work within their stipulated scope hence made the resolution of the dilemmas difficult. Most psychologists’ acts are based on their own standards and since different people have different standards, how decisions are made are not uniform among psychologists.

“The number one obstacle has to do with the fact that eh..., in Ghana, psychologists are not yet bound by law to do or not to do certain things and so it’s different from say the medical profession where there are clearly some things which you cannot do. Actually, the Ghana Psychological Council does have ethical codes but they are not yet legally binding and so too many of us are free to roam around.” (Psychologist-19).

Others felt lack of training makes them incapable of solving ethical dilemmas because their knowledge base had become old hence they needed further training in the form of workshops, seminars etc. to be able to be abreast with modern trends in the management of difficult ethical dilemmas.
“Lack of a culture of continuous training, we don’t do workshops. The Psychological Association doesn’t do workshops. We have very qualified experienced psychologists in the country and sometimes, they shouldn’t be afraid, they shouldn’t be shy that they have not taught in Legon but also, there are few others in Cape Coast, in Winneba and Tech who have different areas of competence. Some of them go outside and train in different things so when they come, they should organize the workshop, advertise it, let the members of the council know, let the information go round so that we the younger ones can patronize and then we are constantly refreshed otherwise without that we get stale and when we get stale that is when we start to commit all sort of unethical issues because really we don’t think it’s an ethical issue” (psychologist-19).

“Because every now and then newer things will come that is why it is important that the mother body from time to time will also possibly organize some refresher programs and you know stuff like that just to refresh.”(Psychologist-13).

Some participants felt working with other people from other professions at times poses as a difficulty. This is because each profession may have diverse ways of handling issues hence these diverse ways at a point may contradict each other and create a dilemma or make resolution of a dilemma very difficult.

“What is not helpful sometimes is the interdisciplinary working, working across disciplines say with nurses. You know, it’s good for the patient but nurses have a different ethic. You know the nurses focus on the physical not the psychological and so very often, many in fact, now that we are talking I’m remembering other
dilemmas that have come up in the past with nurses because they didn’t understand or they weren’t on the same……yes. You know, so in that case having to deal with a different ethic is always difficult. It has always been difficult.”(Psychologist-3).

“So the next major ethical dilemma I feel is gonna start happening very very soon especially, as now we are getting clinical psychologist into the public health sector. What I’m gonna start seeing, gonna happen in the next few years is cases where you are gonna have a lot of, you know, disagreement over diagnosis and assessment and now how are we gonna manage that?”(Psychologist-19).

“Working with social workers; is a team work and you have social workers, you have occupational therapists, you have nurses and all of that. You need to come to a consensus because some of the recommendations you make may not be acceptable by some of these professionals and then you have to stand on your ground to defend it, yea.”(Psychologist-7).

“It is a dilemma because, because it is a team work, we are supposed to agree on the same thing so that I can easily do my work. Do you understand? That is it prevents me from doing my work that is giving them palliative care. It prevents me from doing my work because the others are not in the same tune with you. That is the dilemma that I have.”(Psychologist-10).
From a closer view of narratives above it is evident that these hindrances which affects ethical dilemma resolution do not only emanate from the mother body; that is the GPA but also the working environment of the psychologist as well.

**Enablers**

This sub theme captures all the factors that have facilitated the resolution of ethical dilemmas.

Almost all participants saw peer consultation, former supervisor consultations as well as consulting people with specialized knowledge in certain fields in psychology as paramount in ethical decision making.

“I believe eh..., knowing your limitations, knowing what is expected of you, what you can do, what you cannot do, you know you also have people you can consult in times of difficulty and for me making sure that you are doing the best you can for humanity” (Psychologist-15).

“I think what every clinician must do is to have peer supervision. It’s extremely important. Elsewhere we call it special interest groups where you can go and actually discuss your issues and people may have experienced some of them and they can give you ideas. So supervision is important” (Psychologist-7).
“……absolutely. That’s why I like practicing in this milieu because I have my senior colleagues I can always talk to about it so yes, that’s very helpful.”(Psychologist-3).

Training received during graduate school was also adjudged one of the best instruments or strength that has helped in mitigating ethical issues in therapy. Continuous supervision during and after formal graduate school training, was also recounted among the best positive factors to ethical dilemmas resolution. This is illustrated below.

“What has been helpful is the quality of training that we have received from our supervisors. It has also been the level of supervision we got when we were doing our practicum and most importantly, constant continuous revision. Every therapist must nurture and cultivate eh..., an excellent relationship with a much more experienced psychologist, ok. And they must go to them as often as possible run their case list pass them, audit and you know, if they are doing the right thing, if they are on truck so that has helped.”(Psychologist-19)

Availability of certain facilities and institutions like the mental hospitals, general hospitals, and the police were also seen as very helpful in solving some ethical dilemmas.

“Well, having the Accra Psychiatric Hospital as a holding place for you know, that teenager. Who knows, without it, I mean if I were a private psychologist, I don’t know what would have been the solution to having the family kicked out of their home because of the “tyrant” teenager.”(Psychologist-3)

In summary, psychologists in Ghana, like all other psychologists worldwide face ethical dilemmas. The most common among these dilemmas are issues of confidentiality, dual
relationships, competency and client’s expectation, motive and morality, manipulation of the therapist, fees, policies and practices and cultural competence. However, cultural competence stood up as unique to the Ghanaian clinical psychologist. Professionalism, consultation and bricolage of values (religion stood out) were the main themes governing the resolution of dilemmas. Impediments and enabling factors were also found to be factors that affected the creation and resolution of ethical dilemmas in Ghana. This serves as a prelude to the discussion in the next chapter.
CHAPTER FIVE
DISCUSSION OF RESULTS

5.0 Introduction

This study seeks to: document ethical dilemmas faced by clinical psychologists, and analyze practical solutions employed by psychologists in Ghana as to how ethical dilemmas are resolved; identify the possible barriers to ethical decision making; and to provide a template for discussing ethical codes for psychologists in Ghana. This chapter presents a discussion of the key findings of this study under three major headings; 1) the context of practice in Ghana, 2) Therapeutic relationship, and 3) Resolution.

5.1 The Context of Practice in Ghana

The findings of the study do indicate that the cultural context within which psychologists practice in Ghana presents ethical dilemmas.

One of such dilemmas is other parties meddling in the private issues of the client. These dilemmas covered issues such as therapy with minors, marital disclosures, duty to warn and source of referral. It must be stated that all these dilemmas centered on the issue of confidentiality. Hurst et al., (2007) found that ethical difficulties existed in clinical practice in all surveyed countries, with important differences among countries regarding both the frequency of different kinds of dilemma and their perceived difficulty.

The issue of working with minors is one of such forms of third party interference. This indeed represents a major dimension of dilemma facing psychologists across the globe. Corning (2009) for instance, makes the point that in ethics, what one needs to bear in
mind is that, the confidentiality of the patient will be honored by members of the health professionals, except when required by principles of the practice, or by law. Thus it is only the client in question who may be provided with relevant information regarding his or her situation. Even if the third party is the parent or guardian or any close relation, practitioners by their ethical standards, must be cautious in terms of how much information they can relay and also the extent of involving any third party in the therapeutic process (Corning, 2009). In this regard keeping the third party in the therapeutic process would mean compromising confidentiality. This finding however, is not surprising since it is one of the most common ethical dilemmas encountered by psychologists elsewhere as indicated by previous research (Tabachnick, 1994; Tabachnick, Keith-Spiegel & Pope, 1991; Capuzzi, 2002; Davis & Mickelson, 2003; Knapp & VandeCreek, 2010). In her study of ethical dilemmas facing psychologists in the United Kingdom, Barnitt (1998) notes that practitioners in her survey were confronted with pressures from parents to disclose information regarding their children(main clients) especially in situations with regards to conditions that were life-threatening. She found that some parents sometimes even threatened to take legal action against the hospitals within which the psychologists were working, especially in situations where parents believed that the condition of their wards were life threatening and the psychologists increasingly remained adamant in not disclosing information (Barnitt, 1998).

Using a purposive and maximum diversity sampling method with 40 psychological counselors through a semi structured interview, Akfert (2012) identified the most common ethical dilemma experienced as limitations to privacy. He discovered that
clinical psychologists in the institutions he sampled had to deal with the issue of maintaining the trust in relation to not disclosing information related to their clients (children) although there were pressures from third party (relatives of clients to disclose such information).

Further to the issue of disclosure to third parties, is the risk of prosecution or other such harm to third parties. Lindsay and Clarkson (2000) reported that the issue of confidentiality remained the largest category of dilemma (scoring 31%) experienced by psychologists in Europe. This difficulty as reported by the authors covered diverse aspects with the main difficulty being risk to third parties of sexual abuse. Other dilemmas include disclosure of information related to child abuse and neglect, threatened violence, HIV and threatened suicide; to other parties particularly to medical agencies, other colleagues, close friends, relatives as well as careless or inappropriate disclosure by the psychotherapist or others (Lindsay & Clarkson, 2000).

Similar to the results reported from our Ghanaian psychologists, South African psychologists report confidentiality difficulties in the following areas: the legal obligation to release client records while at the same time maintaining client confidentiality, establishing confidentiality with underage clients when determining the degree of parental involvement in treatment, establishing limits of confidentiality in marital and family therapy, reporting child abuse and protecting third parties from threat and harm (Slack & Wassenaar, 1999)

It is important to mention here that maintaining confidentiality or not disclosing information could partly serve as an effective mechanism of ensuring trust and hence
effective psychotherapy and intervention while protecting the client and others from harm (Lindsay & Clarkson, 2000). In effect the finding that one of the most common dilemmas facing psychologists in Ghana and other countries in therapeutic relationships with minors has to do with whether to keep confidentiality with the minor or disclose to a third party; in this case, the parent. This can contextually be explained in terms of the interdependence of relationships in Ghanaian societies in particular. It is believed that when one member of the family morally deviates, it could affect the welfare of the lineage or family as a whole. (Assimeng, 1999). With this in mind, the welfare of each member remains very paramount to the entire family regardless of age or status. For instance, children continue to be regarded as minors and under strong parental influence even when they have constitutionally attained adulthood status in Ghana.

Another form of third party interference is in the area of marital privacy. Psychologists encountered ethical dilemmas when dealing with disclosures in marital counseling, where information entrusted to the therapist if revealed, could either break the marriage or could be helpful in the management of the marital crisis. This finding is consistent with what previous studies have reported. Research findings from the study by Lindsay and Clarkson (2000) indicate that many psychologists experience the difficulty with regards to how much information they could relay to husbands with respect to the therapeutic process of spouses. This is a clear case of impaired or uncertain decision-making capacity and privacy which other studies have identified (Capuzzi, 2002; Davis & Mickelson, 2003, Knapp & VandeCreek, 2010). These concerns are similar to those experienced by the psychologists reported by Lindsay and Clarkson (2000). This represents a major dilemma in a fundamental domain of practice for psychotherapists and psychologists.
working with clients namely, the need to reconcile the benefits of not disclosing marital issues to partners in order to maintain and ensure trust, keeping the marriage and hence effective psychotherapy and intervention, compared with the need to protect the client and others from harm (Lindsay & Clarkson, 2000). Indeed a common ethical dilemma experienced by psychologists involves the decision whether to break confidentiality with clients in the arena of marital disclosures (Sullivan, Ramirez, Rae, Razo & George, 2002; Jacob-Timm, 1999; Pope & Tabachnick, 1994; Tabachnick, Keith-Spiegel & Pope, 1991). Dalen (2006) studied ethically difficult situations that psychologists face in their daily work and the results showed that dilemmas concerning confidentiality and professional secrecy are most frequently reported.

It is important however to mention that confidentiality is not always guaranteed under certain situations. As noted by (Aube, 2011), psychologists working in a crowded refugee camp may find it difficult to maintain confidentiality as everyone in such camps is mostly aware of who may need particular assistance such as dealing with mental health. Additionally, Lindén and Rådeström (2012) states that, cooperation and contact with authorities such as the police, social welfare and school staff challenged the confidentiality of the Swedish psychologist in the study. This notwithstanding, it is unethical for psychologists to disclose information that may have the potential to break the marriage. It is therefore evident that maintaining confidentiality with respect to not disclosing information relating to marital issues represents a major dilemma faced by psychologists in Ghana and elsewhere.

This can partly be explained with regards to how the institution of marriage in Ghana is perceived. Individual privacy in marriage is hardly recognized especially with regards to
women and the man is always viewed as the head of the family or marriage hence all decisions that concerns each member of the family is the responsibility of the husband. As stated by Nukunya (2003:46) “in many Ghanaian societies the traditional position is that, women are never wholly independent”. Evidence from other African countries such as Congo suggests that female clients (wives) had to seek permission from their husbands before they could be allowed to consult therapists. Therapists were made to seek permission from husbands before engaging clients in a therapeutic relationship (Burke et al., 2006). Hiding the therapeutic relationship from the husband may mean the spouse does not trust the husband, thus threatening their union whiles seeking permission from the husband may also lead to compromising confidentiality. The critical issue here is should the therapist seek permission or not? This may lead to disclosures and hence invading privacy and compromising confidentiality (Burke et al., 2006; Bersoff, 2003). Indeed the decision to break confidentiality seems to be one of the most frequently encountered and serious ethical issues that psychologists face all over the world (Sullivan et al., 2002).

The issue of source of referral was another form of third party intervention that participants indicated as a source of dilemma. From the study, there were issues concerning the extent to which they had to release information to agencies and agents who referred clients to them. They are normally torn between how much information they can report on and what they have to conceal. Lindsay and Clarkson (2000) have found similar situations with respect to psychologists in the European context. They show that while some psychologists sought the client’s consent, others reported instances where there was no consent or where the client may not have been in a position to give informed
consent, when ‘a borderline person’s condition means disregarding their opinion and actually making a referral without their permission (Lindsay and Clarkson, 2000). This is the case described by other scholars as blurriness of boundaries (Capuzzi, 2002; Davis and Mickelson, 2003, Knapp and VandeCreek, 2010). With this dilemma, the Ghanaian context may not be very different from the European context since most agencies in Ghana, just like any other country, are interested in the feedback after referring a client for psychological management. It is therefore not surprising that it is a dilemma experienced universally.

The responsibility to warn third parties about potential harm that they could suffer from the client who might be in some way related to the third party was another source of dilemma. As Hurst et al. (2007) noted, this dilemma has to do with uncertain decision-making capacity which was faced by many participants (psychologists) in their study. However, in this particular study, they were also confronted with issues of confidentiality with regards to who their clients were and therefore to whom they owed allegiance. Psychologists in Ghana also encounter such dilemmas as fuzzy, privacy and blurriness of decision making (Capuzzi, 2002; Davis and Mickelson, 2003, Knapp and VandeCreek, 2010). It is however essential to state that many studies have largely not reported this dilemma related to the duty to warn. One other source of dilemma for practicing clinical psychologists in this study was how policies and practices within which they had been socialized as professionals clashed with the realities of the cultural context of Ghana. There are often certain psychosocial factors that must be considered in the healing process instead of as set or determined by institutional policies. Many studies have reported similar findings in other countries (Schwartz et al., 2010; Aude, 2011). Unlike in
the Ghanaian case, there have been cases in which health insurance schemes or governments decide whom the psychologist should engage in therapy and the duration of therapy, a situation that may be contrary to achieving good health outcomes for patients.

According to Meadows and Tylee., (2013), “In the UK, the delivery of public psychological treatments should fall within the founding principles of the National Health Service (NHS): meeting the needs of everyone, being free at the point of delivery and based on clinical need, not ability to pay.” (p.1).

The study further identified cultural expectations, resources and so forth which may clash with ethical principles and standards the psychologist is expected to adhere to as sources of dilemma. For instance, in the Ghanaian context, people usually show their appreciation for whatever is done for them or is intended to be done for them. Making the individual understand that it is unacceptable creates this dilemma. Culturally it is not unusual to show such appreciation in Ghana, however making a differentiation between such ‘gifts’ and corruption can be very difficult because the line blurs at a point.

It is however not surprising how Atoubi (2007) defines corruption. He indicates that one’s culture has influence on how corruption is perceived. Therefore corruption is culturally constructed and depends on the setting within which the psychologist operates. However this same cultural relativism in the perception of corruption may also favour few individuals who may use that to their benefit. As he contends:

“There is no universally agreed definition for corruption. The difficulty in coming up with a universally accepted definition is due to the fact that what constitutes an act of corruption differs from state to state and culture to culture. The most
acceptable definitions of corruption come from the legal realm. But legally-based universally accepted definitions of corruption have also been challenged on account of the fact that legal traditions also change over time, and are highly inter-related with the socio-political and cultural context. The danger in the lack of universalized but culture-relative definitions of corruption is the tendency for corrupt individuals to hide behind the cultural antics to perpetuate corrupt practices at the expense of society in general.” (Atoubi 2007:5)

Therefore the appropriate means of demarcating what is a gift from what corruption is, might be to draw a clear line in a legally backing document as to what a gift is and what a bribe or corruption is. It is noteworthy that even though this is universal, it is not a wide spread dilemma discovered in the study. This may be because psychologists are not usually found in positions where their core functions lead them into conflict of interest situations such as are rife in procurements, hiring and supervising of staff, etc

The result of this study shows that some therapists’ dilemmas were associated with certain decisions they had to take. Whether to go ahead with that decision because their intentions are clear or consider the moral implications enshrined in there. The decision therefore becomes blurred and fuzzy (Hurst et al., 2007). The few therapists who experienced this dilemma explained this in the light of marital issues.

To an African morality has unrelenting preoccupation with human welfare. Although the decision taken may be in accordance with the ethical standards of the profession but a Ghanaian psychologist may consider the general good such a decision may bring to the society as a whole. Unlike Western cultures where morality is predominantly
individualistic (i.e. justice morality). African morality tends to lie within what promotes social welfare, harmony in social relationship and solidarity. The implication of this finding suggests that Ghanaian psychologists’ views on morality may be indisputably different from that of the psychologist in the West (Nel, 2008).

The way in which indigenous / African psychologists know what is morally right may not correlate with the way in which Western psychologists know what is right (Nel, 2008). In this regard, Behnke (2008) opines that it would be suicidal to adapt or employ for instance the APA code of ethics in Ghana or African context without taking into consideration our own moral values or cultural presuppositions that enter into and influence our ethical thinking in ways we are not entirely aware of. There is therefore the need to develop and document ethical codes for clinical psychologists in Ghana stemming from the cultural influence of specific customs and ideations that may affect the delivery of services by clinical psychologists in Ghana.

The tension between respecting local customs and that of imposing foreign values can serve as a major dilemma for clinical psychologists especially those who are trained and practice in the African context. This is so especially when the local cultural values endorse unjust discrimination and the limitation of information for the purpose of gender or political control (Hunt, 2009; HAP and WHO, 2010).

One unique dilemma as unveiled by this study experienced by majority of the respondents relates to cultural competence. An overwhelming majority of the psychologists interviewed reported that they severally faced a clash between local cultural values and ethical principles in their practicing environments as they have been
taught. This finding is very important in this study because it brings to bear how the context of practice of the psychologist affects the dilemmas he/she is likely to encounter. In Europe, Sweden to be precise, Pettifor and Sawchuk (2006) found considerable agreement on the nature of dilemmas reported by psychologists from the different countries in the primary studies. The diversity between the countries appears to result from differences in clients, nature of practice and methods of payment more than cultural differences. This brings to the fore the fact that the element of culture may not be evident in some studies outside Ghanaian or African context. The critical question that needs to be asked is must the psychologists adhere to the professional training or must take into consideration the diversity with respect to his or her local circumstance? An examination of literature also indicates that this dilemma is more common in African context (Schwartz et al., 2010). In some other instances, some therapists faced dilemmas in which therapists were torn between advising clients who have been pregnant as a result of rape to cause abortion or not, knowing that the cultural group of the client frowns on abortion. This is similar to a case in Congo where abortion is illegal (Aude, 2011). This illustrates that multiculturalism will be a core competence for psychotherapists in a modern society like Ghana. It is becoming increasingly clear that in order to give the best of care as clinical psychologists in a multiethnic setting such as Ghana, we need to understand and appreciate many local cultures, be culturally competent and build strong alliances with different people from different cultural groups. If clinical psychologists lack sufficient training in multicultural counseling, there is the likelihood that they may also lack the skills to resolve ethical issues presented by clients with multicultural background.
5.2 Therapeutic Relationship

A group of dilemmas which faced clinical psychological practice in Ghana are those which evolved as a result of the therapeutic relationship between a client and a clinician. These included 1) Dual relationship (superior and subordinate relationship, collegial relationship) 2) Manipulation of the therapist, 3) Competency and client’s expectations 4) Fees

This present study identifies other types of relationship between the clinician and the client aside from that of the therapeutic one – social relationship (Lindsay & Clarkson, 1999). This social relationship includes collegial and superior-subordinate relationships. This finding is consistent with what previous studies have reported. In one study by Colnerud (1997), it was evident that after the issue of confidentiality, the second most frequently reported dilemma facing psychologists in Sweden concerned the issue of “blurred, dual, or conflictual relationships”, reported by 18% of psychologists. This category of dilemmas, as noted by the author, involved the relationship between the psychologist and the client or the parents to a child in therapy. However, Borys and Pope’s (1989) examination among psychologists, psychiatrists, and social workers’ attitudes and practices regarding dual professional roles indicate that many of the respondents had rarely or never engaged in dual role behaviors. Nevertheless, Borys and Pope’s finding does not obscure the point that dual relationship remains a major dimension of dilemma experienced by psychologists.

This study also identified other relationships (at an unequal power level). Under this category of dilemma some scholars have noted that problematic situations included having multiple roles as a psychologist, for example acting on behalf of different
authorities and at the same time caring for the client (Colnerud, 1997). This finding also involved conflicting obligations in dual professional roles and lack of guidance as to how to resolve dilemmas and difficulties in maintaining clear professional boundaries (Lindén & Rådeström, 2012).

This dilemma, according to Hurst et al. (2007), is experienced by many therapists and is consistent with the conclusions of other scholars (Erdur-Barker & Cetinkaya, 2007; Moleski & Kiselica, 2005), even though in these other studies the participants were psychological counselors in Schools and Universities. This explains why Akfert (2012) indicated in his study that psychologists working in different institutions can experience similar dilemmas.

It must be noted that this dual relationship finding has a spatial uniqueness. Although the current study was conducted in urban settings (Accra, Takoradi, Cape coast and Tema), findings from national surveys (Helbok et al., 2006; Campbell & Gordon, 2003; Schank & Skovholt, 1997) show that psychologists in rural areas appear to experience significantly greater difficulty involving dual relationships than psychologist in urban areas. In the same vein, Helbok et al. (2006) point out that rural psychologists are more often faced with questions about maintaining client confidentiality and issues concerning being visible in the community.

Psychologists practicing in rural and small communities experienced overlapping social relationships and business relationships. The psychologists knew the content of ethical codes but often struggled in choosing how to apply the codes in the best interests of clients (Schank and Skovholt, 1997). In effect although the current study discovered dual
relationship from an urban perspective, the evidence from the literature indicates that this finding is more common in rural areas. This may call for the need to conduct studies in rural and urban Ghana in the future (when there are enough clinical psychologists practicing in both rural and urban areas) to test the validity with respect to this dilemma whether it is applicable in our context.

Dilemmas related to the client manipulation of therapists and the therapeutic relationship, are similar to those reported by Akfert (2012) with respect to faculty members (participants) and students or close friends who present gifts. Lindsay and Clarkson (1999) identified similar dilemmas among their participants in their study of “Ethical dilemmas of psychotherapists” where employers put pressure on psychologists to conform to guidelines instead of following professional ethics.

The data also shows that the therapeutic relationship was challenged by dilemmas relating to the boundaries of clinicians’ professional abilities and what client’s expectations were. This finding, not reported widely in the present study, is however similar to that of Akfert (2012) and Tabachnick et al., (1991) that documented dilemmas related to feeling incompetent in ethics and lacking knowledge about the legal procedures in the early years of the counseling profession. With the above mentioned studies, the perception of incompetence was from the perspective of the psychologist. They viewed themselves as not being competent enough to handle certain cases or lectures. However, with this current study, the perception of incompetence is by the client with respect to the therapist. The psychologists felt clients may perceive them as incompetent. It is also consistent with the findings of Lindsay and Clarkson (1999) in their study of “Ethical dilemmas of psychotherapists”.
The therapeutic relationship was also challenged with the issues of fees. It can be seen that therapists, without focusing on their monetary gains and respecting the self-dignity of the clients would not want to charge fees that seem exorbitant to clients and prevent them from engaging the services of the therapists. To heighten the dilemma, ethical principles also forbid psychotherapists from discrimination against clients on the basis of their socio-economic status (Aude, 2011). The psychologist’s therapeutic relationship with the client may bring to light whether the client may be able to afford the fees or not. However as indicated above, if clients are allowed to pay based on their abilities to afford services, such discrimination may be ethically wrong and other clients may feel disappointed and exploited if they pay more for same services others may be paying less for. It is stated that:

Psychologists acknowledge that all persons have a right to have their innate worth as human beings appreciated and that this innate worth is not dependent on their culture, nationality, ethnicity, colour, race, religion, sex, gender, marital status, sexual orientation, physical or mental abilities, age, socioeconomic status, or any other preference or personal characteristics, condition or status (CPA, 2000, Principle I, values statement)

In Ghana psychological care is not covered by the national health insurance scheme (NHIS) and thus makes issues of appropriate fees a great challenge. How much is appropriate in relation to clients’ ability to pay is difficult to determine. The adoption of sliding scale of payment in a sensitive fashion is often an acceptable compromise.
5.3 Resolution

In resolving ethical dilemmas, clinicians drew upon two main sources: values and professional culture. However in the resolution of these dilemmas via the sources indicated, participants experienced certain facilitating factors as well as impediments in the process. These factors are discussed in detail below:

Participant’s religious values have also been identified as one of the factors that play a major role in the resolution of some of the dilemmas that confront therapists in Ghana. In this study, all the psychologists interviewed professed to be Christians. Most of them perceived religion as the back bone of their practice as psychologists and this greatly influenced all their actions and inactions with regards to decision making in therapy. This could probably explain why Alija, (2012) asserts that Christianity is a striking example of a perfect harmony, a strong mutual affinity, and almost a unity of a great religion and great ethics. This finding is consistent with Dixon’s (2008) study, which reported that religious beliefs are necessary to provide moral guidance and standards of virtuous conduct. One unique finding emerging from this study indicates that in resolving ethical dilemmas, religion represents a major factor of consideration. Thus religion plays a significant role in ethical dilemma resolution.

Mbiti 1989, recognizes the fact that morality and religion are inseparable in Africa. According to Ikuenobe (1998) and Gyekye (1996) African peoples’ ethical systems are fused with religious values and considerations. Thus although there are professional guidelines that may guide the ethical decision-making process, the tenets or ideals of religion may act as a major decisive factor in ethical decision making. Thus the element of religion may provide space for resolving a dilemma which has the potential to
influence happiness in society. For instance, religion, being used to encourage people to disclose their HIV status to partner and therefore help in reduction of new infections in the society. This finding also lends support to consequentialist theory (Slowther, 2004; Gumus & Gumus, 2010). Proponents of this theory argue that the principle to judge our moral thinking is utility, that is, the maximization of happiness, in the sense of pleasure and the minimization of suffering, in the sense of pain. Thus utilizing morality or religion in solving dilemmas even if it may have the potential to defy the professional ethical guidelines but may however lead to a sound resolution of ethical dilemma is the best option. In any situation the morally right thing to do is the action that promotes the greatest happiness for the greatest number of people (Slowther, 2004). This implies that the clinical psychologist has to find ways to know about various religious values that can be employed to speed up the therapy or make therapy more effective.

However some researchers have questioned African religion as the basis for making a moral thoughts or decision. Gyekye, (1996) for instance disagrees that religious view as the basis of African moral values is a decisive factor in ethical decision making, arguing that African morality is a social phenomenon like any other which lends itself to rational and logical rigorous analysis (unlike faith or religion which may not lend itself to rationality).

One other factor value consideration is where they view the whole decision-making process from the client’s perspective. This finding corroborates the view put forward by Evans as cited in Hersen, (2008). According to Evans the overriding ethical question is whether or not psychologists act professionally in the best interests of the clients, especially children. The link between assessment and treatment requires ethical decision-
making and the psychologist needs to be careful when assessing children as they cannot
easily refuse to be assessed and treated and they cannot usually advocate for themselves
or personally request an intervention. Therefore, professional ethics are closely related to
the clinical judgment of the psychologists (Evans cited in Hersen, 2008). In the review by
Pettifor and Sawchuk (2006) issues related to assessment were the fifth most frequently
reported dilemmas in all the studies.

Some ethical decisions/resolution to ethical issues made by participants in the study was
solely based on their professional culture. Professional training, ethics, professional
image and required duties like professional consultations which are inculcated right from
onset of graduate school training were paramount as to how certain ethical decisions were
reportedly made by participants in the study.

Most participants mentioned their professional training before any other considerations
Principles like beneficence, non-maleficence, utility and so on, were considered. This is
in line with the rationalism theory according to Kitchener (1984). A rational model is
based primarily on principle ethics. Under this model, professionals faced with a dilemma
first identify the principles in conflict, and then choose the best course of action based on
a rational evaluation of the advantages and disadvantages of choosing one ethical
principle over another (Bersoff, 1996). Yet, another important value discovered in this
study as a factor therapists consider when resolving ethical dilemmas is the professional
image. Most participants indicated that they did not want to take decisions that might
bring their personal as well as their entire profession into disrepute. Even though they
acknowledged the fact that there are no strict disciplinary actions taken against therapists
who tarnish the image of the profession as at now, they fear their personal images could
be tarnished. This finding however, is not a wide spread consideration in the resolution of ethical dilemmas in the study.

Most clinical psychologists, in their attempt to deal with ethical dilemmas, re-visit their books and other scholarly materials on similar situations on the internet and apply the acquired knowledge to the problem at hand. To them, these resources are indispensable as has always been the tradition in graduate school training. Supervisors and colleagues consultation when faced with dilemmas which are common among the participants are also not different from what is contained in the code of ethics and conduct of the British Psychological Society (BPS, 2009). They recognize the fact that some colleagues and former supervisors are more experienced to handle some kinds of ethical dilemmas than others and so they become certain that their suggestions flowing from professional experience and practice can help them address the situation. This peer supervision helps therapists iron things out in the best possible way. One important thing to note is that majority of those who consulted their colleagues did so with senior colleagues. This is in line with what the American Psychological Association (APA) code of ethics entreats its members to do.

5.4 Challenges and Opportunities

In resolving ethical dilemmas through values and professional culture as discussed above, the process was facilitated as well as hampered by certain factors.

To start with, the factors which hampered the process of resolving the dilemmas, the non-availability of certain facilities and resources, were mentioned. The resources indicated in this study include resources from clients and families of clients as well as from
governmental institutions. One example of logistics cited by some participants is a place for autistic children. Participants did not mention resources that families lack as a constraint to provision of services possibly because patients in need may not show up at all for services in the first place. Ofori-Atta et al (2004) documented resource limitations as a source of a variety of dilemmas experienced in the offering of services to patients. Akfert (2012) for example, also indicated that these resources include inadequate institutions to offer social services which are necessary in guiding children. This makes ethical decisions very difficult to resolve.

The study identifies lack of laws as more likely to impede resolution of ethical dilemmas. This outcome suggests that the lack of legislation does not help psychologists in the Ghanaian context to work within their stipulated professional scope hence making the resolution of dilemmas difficult. This is because when faced with an ethical problem, the first line of defence for professionals should be their professional standards or code of conduct (Kitchener, 2000; Shapiro & Stefkovich, 2001). This implies that most Ghanaian psychologists are directed by their own individual standards. This however, according to Phillips (2000), attempts to define and explain the attributes of social and psychological constructivism. According to him, the social constructivism/constructionism theory upholds that bodies of knowledge or disciplines are built up as a result of human constructs, and that this knowledge is predetermined by such things as politics, ideologies, values, and the exertion of power and preservation of status, religious beliefs, and economic self-interest

Interdisciplinary work has also been found to hamper the Ghanaian clinical psychologists’ work. Some participants felt working with other people from other
professions at times poses a difficulty in resolving ethical dilemma. This is because each profession may have diverse ways of handling issues hence these diverse ways at a point may contradict each other and create a dilemma or make resolution of a dilemma very difficult. This in itself could be very helpful in addressing clients’ problems especially when these problems are multifaceted as some participants mentioned. Two major problems which heighten the dilemma emerged. First, each of the professions has a different focus. This problem arises especially, with regards to diagnosis and assessment. Secondly, the different professionals have different ethics which may conflict with the clinical psychologists’ work. It is worth noting in this study that the major sources of this impediment are doctors, nurses, occupational therapists and social workers.

On the facilitating factors, the study showed that clinical psychologists in Ghana rely on consultations, training and available facilities to resolve their ethical dilemmas.

Consultation as has been discussed earlier within the professional culture of the psychologist has been indispensable in the discharge of the therapists’ duty. Therapists draw on their peers, former supervisors and people with specialized knowledge and experience to help resolve their ethical dilemmas. This suggests that the therapists must know their limitations, what is expected of them, what they can do, and what they cannot, and know people who have the knowledge and experience they can consult in times of difficulty.

Training received during graduate school was also adjudged one of the best instruments or strengths that has helped in resolution of ethical issues in therapy. Continuous supervision during and after formal graduate school training, was also recounted among
the best factors that positive influences on good ethical dilemma resolution. Issues that are worth noting here include the quality of training, level of supervision during practicum and continuous revision. It will therefore be necessary for therapists to still be under the tutelage of their former supervisors (mentorship) since this is necessary for dilemma resolution (Aude, 2011).

The study identifies availability of certain referral facilities and institutions like the mental hospitals, general hospitals, and the police stations as very helpful in solving some ethical dilemmas. All these may serve as referral points as well as holding places for clients in some instances. This is what Aude (2011) identified in South Africa.

5.5 Implications for Practice and Research

Considering the major roles played by culture and religion, there is the need to develop and document ethical codes that will consider these variables that reflect the local context. This will guide clinical psychologists in addressing certain dilemmas in practice. One other implication for practice is that, therapists should consider the cultural experiences of clients when diagnosing them.

Additionally, more research will be needed on cultural and religious values in this multicultural society with its plurality of religions if psychotherapy should gain grounds in Ghana. Future researchers and clinicians should be cautious when assessing culturally diverse populations in Ghana and avoid the use of research instruments that lack psychometric properties for the client. There should be constant standardization of assessment tools / instruments to suit the Ghanaian population. This implies that
researchers should plan, design, conduct and report research that reflects cultural and religious aspects that relate to dilemmas and their resolutions.

5.6 Challenges and Limitations of the Study

In conducting this research, there were some major challenges encountered, such as the unwillingness to participate at all, or allow their voices to be audio recorded perhaps showing a lack of trust in the confidentiality of the process. However, pragmatic steps were taken by the researcher, who took her time to explain to the participants that this study was purely an academic exercise and all information provided would be treated with strict confidentiality and no one would be associated with any kind of specific information he or she provided. Another area of difficulty was that some of the participants who participated in the study wanted to influence the researcher to modify or change the direction or some aspect of the scope of the research. Perhaps this showed their curiosity and interest in this largely unfamiliar territory of research.

Another limitation of the study is the lack of potential to generalize the findings to other psychologists who are equally engaged in some form of consultation which require ethical reflections. At present the study focused only on practicing clinical psychologists, and left other practicing psychologists such as I/O, educational, school and counselling. Future studies could consider their experiences in ethical decision making processes.
5.7 Conclusion and Recommendations

This study was conducted to examine the dimensions of ethical dilemmas facing practicing clinical psychologists and the various means by which such dilemmas are resolved. The study has revealed that there are numerous dilemmas that clinical psychologists are liable to face in their profession. The most commonly reported dilemmas included issues of confidentiality, dual relationship, and manipulation of the therapist among others. The most unique finding in relation with the ethical dilemmas confronting psychologists in Ghana as unveiled by the study has to do with cultural competence, that is a clash between local cultural values and ethical principles in their practicing environments as they have been taught. It was discovered that there appears sometimes a clash between what the psychologist has been taught based on western knowledge and the local context (culture) when confronted with ethical dilemma.

However, the psychologists do not rely on only one means in resolving their dilemma. It was evident that psychologists in Ghana do not rely on only one value in dealing with ethical dilemmas but consider a series of values that comes into play when faced with ethical dilemmas. They consider personal values, their reputation, consultation, religion, client’s interest, and ethical principles among others. Among these, religion stood out as a major factor. They reported that, it is quite easier to resolve dilemmas using religious values especially when dealing with clients who belong to various religious groups. Thus from this study, we conclude that religion and ethics are inseparable as ethics is grounded in religion. The next part provides recommendations in helping clinical psychologist in dealing with ethical dilemma.
5.7.1 Recommendations

In line with the findings evident from this study, the following recommendations are being proposed in order to help psychologists in Ghana. The study revealed that there is currently no legally binding code of ethics that could guide the work of psychologists in Ghana. In this regard the study recommends that there is a need to develop legally binding code of ethics. Developing such ethical codes could partly serve as a mechanism through which psychologists who face diverse dilemmas could refer to in resolving such dilemma. Pettifor and Sawchuk (2006) for instance emphasize the use of codes in the ethical decision making process of psychologist when facing an ethical problem, conflict or dilemma. In this way, developing legally binding code of ethics could also serve as a device to supervise, regulate and correct professional behaviour of psychologists. In this light codes are seen as providing support to the profession as well as protection to the clients. Such codes of ethics could also support the interaction with other professionals of other disciplines and to encourage self-regulation and reflection on personal values.

Secondly, this study also calls for training psychologists and other health professionals to be culturally sensitive. As evident from the study, most of the psychologists encountered difficulties with respect to following the western–based knowledge of training that they had received or whether to respect their local culture. This calls for the need to also train psychologists to understand that while the western-based knowledge that they receive is very essential, respecting the local culture is also paramount in order not to create any difficulties in their practice. Practitioners need to be trained that local circumstances (culture) vary, and what could be applied in one context may not be necessarily applicable in another context. Following the professional training alone without factoring
in the local culture in the therapeutic process could lead to some difficulties which could affect the effectiveness of therapy.

**Recommended Key elements for Ghana Psychological Association code of ethics**

- Confidentiality and limits to confidentiality
- Dual Relationships
- Charging of Fees
- Competence / cultural competence
- Training/seminars
- Religion/morality
- Gifts

The intrinsic and extrinsic findings of the study as it relates to the ethical dilemmas faced by practicing clinical psychologists in Ghana and the discussion thereof have substantially addressed the objectives of the study and provided answers to the fundamental research questions.
REFERENCES


Arkfert, K. S. (2012). Ethical dilemmas experienced by psychological counselors working at different institutions and their attitudes and behaviour as a response to these dilemmas Educational sciences: Theory & Practice.


Buelow, J. R. Mahan, P. L & Garrity A.W. (2010). Ethical Dilemmas as perceived by healthcare students with teaching implications. *Journal of College Teaching and Learning* (TLC, 7(2)


CPA. (Canadian Psychological Association) (1986). Code of Ethics. Ottawa, Canada:


Drew, J. C., & Hardman, L. M (2007). Ethical issues in conducting research- Sage publications. Los Angeles, CA


Lindsay, G. and Clarkson, P. (2000). Ethical dilemmas of psychotherapist: explore the difficulties of psychotherapeutic work.


Mauthner, M (2002) Ethics in Qualitative Research, Sage Publications Ltd, UK


Phillip, B. (1995). Ethical Dilemmas and Decision Making Orientation Training for Local Government Planning and Zoning Officials and Staff
https://www.masc.sc/SiteCollectionDocuments/Land/Use/Planning/EthicalDilemmas/DecisionMaking.pdf


APPENDIX 1

INTERVIEW GUIDE ON A QUALITATIVE RESEARCH ON THE ETHICAL DILEMMAS FACED BY PSYCHOLOGISTS

Ask participants questions regarding demographics. Inform participants you are recording responses for purposes of aiding analysis.

Personal Data of Respondents

1. Sex
2. Age
3. Religion
4. Ethnicity
5. Qualification
6. Number of years as practicing psychologist

Interview begins

Introduce to participant that the interview will be recorded and transcribed verbatim. Seek participants consent and ask if they want to sign the form before interview proceeds.

8. What kind of population do you work with (probe e.g. Students, Children, Adults etc)?

Ethical Dilemmas Facing Psychologists

Ethical dilemma is a complex situation that involves an apparent mental conflict between moral imperatives in which to obey one would result in transgressing another. In other words, they are circumstances when two or more options are encountered and there is a difficulty in deciding about which one is better; as a result of the existing necessities that cannot be met by present alternatives (Lindsay & Clarkson 1999; Noureddine, 2001).

9. In your profession as a psychologist, tell me the ethical dilemmas you have encountered.
10. Now let’s focus more on some of the most difficult ethical dilemmas you have encountered in your profession? (At least 3) of them (first let him/her list the three and then ask questions)

(a)...........................................................................................................................................
(b)...........................................................................................................................................
(c)...........................................................................................................................................

For each of the most difficult ethical dilemmas probe and ask the following questions

i.  How often (frequency) do you encounter this ethical difficulty.

ii.  Why do you perceive that as a difficulty?

iii.  What did you do with this difficulty?

iv.  Did your religion play a role in the resolution of the dilemma?

Solutions to Ethical Difficulties (resources).

Introduce participants to the importance of resources in their professional practice.

12. As part of your work, tell me the consultations you have with (e.g., former supervisors, senior practicing psychologists) in handling ethical dilemmas.

13. Can you tell me the practical steps you adopt in solving the ethical dilemmas?

14. In your attempt to solve ethical dilemmas what do you consider? (e.g., personal values, beliefs, religion/moral convictions, reputation, expertise, etc)

15. Please could you tell me the relative importance of these considerations in your resolution of the dilemma?

16. What role does religion play in the ethical decisions people make?

17. How do your own religious values play a role in ethical decisions you make?

18. How satisfied were you with the solution to the dilemmas?
Factors Influencing Ethical Decision Making

19. What were the obstacles for solving these ethical dilemmas?

20. What were the opportunities available? (Probe)

21. Is there anything else about these dilemma or how it was resolved that we haven’t discussed that you think is important for me to know?

Vignettes

(Introduce participants to case vignettes and ask them to share their thoughts on these. Probe their responses)

22. Clinical psychologist Badu treated patient Agnes for depression due to a runaway husband for few weeks. The patient is now attached to the psychologist and she has openly declared her affection for the psychologist. The psychologist, who is single, responded positively and they have plans of getting married in three months’ time.

(a) What are your thoughts about the psychologist’s decision in this scenario?

(b) Is there anything different you would have done if you were the psychologist?

23. Mr. Addo is a psychopath who is assigned to you as your client. He has had previous psychologists he wouldn’t open up to. You meet him for the first time and assure him that whatever discussions you both have will be between only the two of you. In the course of therapy, Mr. Addo gives indication of going to abuse one of his siblings. All effort to change this decision he has made has proved futile.

(a) As a professional psychologist, how do you handle this information?

(c) What informed your decision?

(d) Were you right in promising this carte blanche confidentiality?
APPENDIX 2

THE RELIGIOUS COMMITMENT INVENTORY-10 (RCI-10)

Instructions: Read each of the following statements. Using the scale to the right, CIRCLE the response that best describes how true each statement is for you.

NOT AT ALL      SOMEWHAT      MODERATELY      MOSTLY
TOTALLY
True of me  true of me  true of me  true of me  true of me

1  2  3  4  5

1. I often read books and magazines about my faith.
   1  2  3  4  5

2. I make financial contribution to my religious organization.
   1  2  3  4  5

3. I spend time trying to grow in understanding of my faith.
   1  2  3  4  5

4. Religion is especially important to me because it answers many questions about the meaning of life.
   1  2  3  4  5

5. My religious beliefs lie behind my whole approach to life.
   1  2  3  4  5

6. I enjoy spending time with others of my religious affiliation.
   1  2  3  4  5

7. Religious beliefs influence all my dealings in life.
   1  2  3  4  5

8. It is important to me to spend periods of time in private religious thought and reflection.

9. I enjoy working in the activities of my religious affiliation.
   1  2  3  4  5

10. I keep well informed about my local religious group and have some influence in its decisions.
    1  2  3  4  5
APPENDIX 3

ETHICAL CLEARANCE

UNIVERSITY OF GHANA

OFFICE OF RESEARCH, INNOVATION AND DEVELOPMENT

Ethics Committee for Humanities (ECH)

PROTOCOL CONSENTFORM

<table>
<thead>
<tr>
<th>Section A- BACKGROUND INFORMATION</th>
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<table>
<thead>
<tr>
<th>Title of Study:</th>
<th>A qualitative study on the ethical dilemmas faced by clinical psychologists in Ghana</th>
</tr>
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<tbody>
<tr>
<td>Principal Investigator:</td>
<td>Vida Badu Oppong</td>
</tr>
<tr>
<td>Certified Protocol Number</td>
<td></td>
</tr>
</tbody>
</table>
General Information about Research

Dear Esteemed psychologist,

The title of the study in which you are being invited to participate is a “qualitative study on the ethical dilemmas faced by clinical psychologists in Ghana”. This study is being carried out to document the ethical dilemmas faced by clinical psychologists and how they resolve them. You will be interviewed on the kinds of ethical dilemmas you have faced during the course of your professional duties and how you resolved these. You will also be asked to answer questions on your age, length of training in ethics, length of professional practice, etc and also to fill a ten item questionnaire on your religious commitment. Kindly look over the interview schedule which is attached to this consent form. We hope this interview takes not more than 30 min to 45min of your time. Your permission is needed to audio record the interview.

Benefits/Risk of the study

Possible risks: This study will not expose you to any higher risks than you would normally face in the course of carrying out your duties. You may experience fatigue as a result of long period of interview. You will be given ample time in the form of a break to prevent fatigue during the interview. Some of the questions may be easy, while others may be difficult. You are not required to answer all the questions correctly or to perform all the tasks perfectly.

Possible Benefits: Upon completion, you may not derive direct benefits from the study. However, this study will increase our understanding of the dilemmas faced by the Ghanaian psychologist and how they have been resolved. The results will provide a platform for psychologists to discuss difficult ethical decisions they had to make in the course of professional practice. The study will also provide useful information for the
training of graduate psychology students on ethical dilemmas they are likely to face and the sources of help available to assist them in its resolutions.

Confidentiality

Any information you give will be stored to ensure anonymity and treated as confidential and will be used for research purposes only. Where quotations are used, every attempt will be made to ensure anonymity of the subject, otherwise they will not be used at all. The information and responses you provide will be treated with utmost confidentiality. Only the researcher and approved research assistants will have access to the individual data you will provide. Under no circumstances will any individual participant be identified in a publication or presentation describing this study.

Compensation

This study will not include any compensation apart from a verbal appreciation of your valued time and efforts.

Withdrawal from Study

Your participation in this study is voluntary (not compulsory), and you may choose not to participate, in which case there will be absolutely no negative consequences to you. You may also choose to stop participation at any time during the study without any negative consequences to you. We also respect your right to ask us further questions to clear any doubt you may have about any aspect of the study before agreeing to participate.

We are grateful for your valuable effort and time and appreciate this very much. Results of the study may be presented at various conferences and reported in various academic journals so as to reach decision and policy makers Thank-you for your time. Please sign below if you choose to participate
Contact for Additional Information

The following numbers can be contacted in case of any discomfort, explanation or further information.

Student researcher: Vida Badu Oppong (# 024 341 1195)
Supervisor: Dr Joseph Osafo (# 020 737 3222)
Supervisor: Prof. Angela Ofori-Atta (# 020 201 5050)

Section C-VOLUNTEER AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

Name of Volunteer

__________________________________________________          _____ ___

Signature or mark of volunteer          Date

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

____________________________________________________

Name of witness

__________________________________________________          ________

Signature of witness          Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

________________________________________________________

Name of Person who Obtained Consent

__________________________________________________          _____ ___

Signature of Person Who Obtained Consent          Date