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To cite this article: Vida Badu Oppong, Joseph Osafo & Angela Ofori-Atta (2021): Ethical dilemmas in psychological services in Ghana: the views of clinical psychologists, *Ethics & Behavior*, DOI: [10.1080/10508422.2021.1895795](https://doi.org/10.1080/10508422.2021.1895795)

To link to this article: <https://doi.org/10.1080/10508422.2021.1895795>



Published online: 02 Apr 2021.



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Ethical dilemmas in psychological services in Ghana: the views of clinical psychologists

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ABSTRACT

Ethics reflects the moral principles upon which most professional practices rest. It forms the basis to do good, to do no harm, to respect others, and ensure justice. The purpose of this study was to investigate ethical dilemmas experienced by 20 clinical psychologists in Ghana. Semi-structured interviews were used to investigate ethical dilemmas faced in professional practice. Using thematic analysis, the reported dilemmas included third-party involvement, (sub-themes: Therapy with Minors, Marital Disclosures, Source of referral, Duty to Warn), Dual relationships (subthemes: Collegial Relationships, Power Differential in Relationships), Cultural competence, and Policies and practices. The findings showed that although some of these dilemmas are universal, others arise (e.g., cultural competence) from the general cultural context of Ghana and the professional culture within which clinical psychologists are socialized. Recommendations to assist clinical psychologists address ethical dilemmas in Ghana and implications for the development of ethical regulations in the country are addressed.

KEYWORDS

Ethical; dilemmas; clinical; psychological; Ghana

INTRODUCTION

The changes in societal expectations, especially in relation to patient wellbeing, have 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 continuously confronted with decision-making that is ethical in nature, and requires the ability to respond appropriately to unanticipated events (Birbeck & Drummond, 2005).

The literature has shown two broad kinds of ethical dilemmas. The first kind consists of dilemmas that fit the traditional content of ethical codes for professionals such as psychologists (e.g., confidentiality). A second category concerns 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 vary as a function of time and location.

Patients' well-being is fundamental to the ethical demands that inspire 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 efficient and cost-effective, but also that their care contributes to the full appreciation of the patient as a human being (Kitson, 1996).

In comparison to justice and other universal principles, patient wellbeing is a fundamental criterion in ethical decision making (Dierckx De Casterle' et al., 1998). Moreover, there is growing concern about implementing ethical healthcare practices in the healthcare delivery system (Bishop & Scudder, 1990; Gastmans et al., 1998; Raines, 2000). Nonetheless, ethical practices often seem to be most

challenging in daily ethical dilemmas arising from situations that involve conflicting values or beliefs about what the right or best course of action is (Ham, 2004). Since these dilemmas act as a catalyst for the ethical decision-making process, it is important for health professionals to recognize and explore them. Ethical decision-making criteria cannot be employed if, the existence of an ethical dilemma is unrecognized (Jones, 1991).

Wassenaar (1998) suggested that to develop a code of ethics to guide psychologists' decisions, it is important to examine the ethical difficulties that psychologists experience and are faced with. Ethics is affected by culture which shapes the way we react and assess situations (Childress & Macquarrie, 1986).

Nel (2008) 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, may correlate with moral assumptions of good and evil. (Nel, 2009)

Within the African setting, ethics, and morality may not be very clearly delineated in practice. This might be, because in the African context, ethical decisions may be based on moral conceptions more than metaphysical ideas (Ikuenobe, 2006). There are two schools of thought about the basis of African morality and ethics. One view is that African ethics are essentially driven by religious values. The other view is that they are based on social ethics. For those who lean toward the religious perspective (e.g., Mbiti, 1989), African morality is predicated on religion. Consequently, the moral values of good and bad, or right and wrong derive from the commands of supernatural beings. Therefore, moral beliefs and principles are justified only by reference to religious beliefs and doctrines. Thus, to an African, morality, and religion are inseparable (Mbiti, 1989). A decision that dwells on morality may therefore be made based on the religious values of the decision-maker.

Although Gyekye (1996) and Ikuenobe (1998) disagree with Mbiti (1989) arguing that African morality is a social phenomenon that lends itself to logical rigorous analysis, they do not negate the role of religion in African moral thought. They argue that religion influences moral thought and behaviors in Africa. However, they add that ethical reasoning is social and communal (Ikuenobe, 2006). A possible corollary to this is the orientation toward fulfilling responsibilities rather than asserting individual rights (Gyekye, 1996). Besides, compared to Western ethics, African ethics may be more rooted in group norms (Ikuenobe, 2006). In African morality (unlike Western morality which in light of Allen Wood's (2007) book: *Kantian Ethics*, is viewed in terms of absolutes, objectivity, rationality, and universality), actions that help sustain social equilibrium regardless of consequences may be seen as more socially acceptable, than those that cause disequilibrium in society (Osafu, 2012). Thus, the basis of Indigenous African morality diverges from that of Western morality (Nel, 2008). It would be inappropriate, therefore, to adopt fully, codes of conduct from more individualistic cultures without first assessing our cultural moral presuppositions (Behnke, 2006). Currently, however, professional ethics training for Ghanaian clinical psychologists essentially relies on ethical codes that were developed outside its context such as the American Psychological Association (APA, 2017) code which is set within the framework of Western philosophy. It is, however, imperative to actively pursue learning related to African morality and ethical thinking and how these influences psychological practice in context. This study was aimed to generate contextual ethical dilemmas/issues that could inform the development of ethical regulations in Ghana, and to examine the various ethical challenges clinical psychologists in Ghana face.

METHOD

Research approach

This study employed an exploratory and descriptive inductive approach with the aim of improving our understanding of ethical dilemmas confronting psychologists in Ghana. Semi-structured interviews were conducted. These interviews are flexible and facilitate in-depth exploration of participants' worldviews through rapport building and meaningful dialogue. As suggested by DiCicco-Bloom and Crabtree (2006), such a strategy allows co-creation of meaning between participants and the researcher, see Table 1.

Participants

Since this study focused on ethical dilemmas clinical psychologists face, clinical psychologists were purposively selected. This is because their work involves interaction with clients which may create rapport that requires mutual trust to manage. Such relationships could present ethical challenges that confront clinical psychologists in their practice. The goal was to examine such ethical challenges within the context of Ghana.

Ghana is a proscriptive culture where moral and ethical regulations are central to actions. Further, stigma toward mental health and mental help-seeking; and the fear of getting “dishonored” by a member’s misbehavior and “damaged” by an enemy is rife (Osafo et al., 2011). These contexts could be crucial to any psychological research and practice. Additionally, there is no official code of ethics for clinical psychologists in Ghana, and knowledge of dilemmas experienced will be a useful precursor to the development of a code of ethics that is sensitive to the cultural context. The criteria for inclusion were:

- (1) Trained clinical psychologist (MPhil or Ph.D.) and, practicing in Ghana;
- (2) Practiced clinical psychology for at least, a year.

Twenty-five (25) clinical psychologists were contacted, five (5) declined and the remaining twenty (20) consented and participated in the study. According to Baker and Edwards (2012), a sample size of 12–60 is usually adequate to thoroughly explore a phenomenon qualitatively.

Data collection procedure

Semi-structured face to face interviews were conducted in the English language. The first part of the interview covered demographic information (age, gender, qualification, religion, and years of practice) whilst the second part included open-ended questions about dilemmas faced professionally. Each interview lasted 25–45 minutes. With the participants' consent, the interviews were audio-recorded and assurance of confidentiality was given. The recordings only included the pre-assigned codes for the participants, with no other identifiers. The interviews were then transcribed. Ethical approval was given by the Institutional Review Board of the Institute of Statistical, Social and Economic Research (ISSER) at the University of Ghana.

Table 1. Relevant demographics of participants.

Demographics	Number
Number of participants and Gender	Total: 20 (Males: 8; Females: 12)
Age	Average age: 45 (Min: 32; Max: 72)
Tenure of official practice	Average: 13 (Min: 2; Max 45)
Educational background	MPhil: 14; PhD: 6
Religion	Christian: 20 (all participants)

Analysis

The coding and analysis were done by the lead researcher and two experienced qualitative researchers with doctorates. Transcripts were analyzed using thematic analysis. This was followed by the identification of subthemes based on ideas, or patterns that were. The next stage involved categorization of the data into the sub-themes. The results were analyzed, interpreted, and synthesized with reference to literature and within the context of psychological practice while noting the implications of the findings (Braun & Clark, 2008). To enhance the trustworthiness of the interpretations, transcripts, coding, and all the emergent themes were discussed and agreed upon by all the authors. The degree of concordance was above 80%. Examination of trustworthiness was conducted to help minimize bias (Creswell, 2009; Steinke, 2004).

RESULTS

The analysis produced four (4) main themes, with sub-themes for the first two themes. The themes are Third-Party Involvement, (sub-themes: *Therapy with Minors*, *Marital Disclosures*, *Source of Referral*, *Duty to Warn*), Dual Relationships (subthemes: *Collegial Relationships*, *Power Differential in Relationships*). The rest of the themes are Cultural Competence, and Policies and Practices. These are illustrated in the thematic table below.

Ethical dilemmas

Third-party involvement

This theme examines views about confidentiality and how much information can be given to a third-party concerning issues raised during therapist-client interactions. Participants (n = 17) in the study reported related dilemmas. This is discussed under the following sub-themes; *Therapy with Minors*, *Marital Disclosures*, *Source of Referral*, and *Duty to Warn*, see Table 2.

Therapy with Minors. Participants (n = 7) had to deal with confidentiality issues concerning minors where information relayed to the therapist was supposed to be kept confidential because disclosing it would betray the trust of the child. This is illustrated in the quote 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 to 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, F)

A closer look at the latter part of the voice illustrates the clear dilemma the therapist experienced: how to acknowledge the mother's anxiety for her child and give reassurance while maintaining the trust the child had in her. The quote below however expresses another aspect of the dilemma:

Table 2. Thematic table of ethical dilemmas.

THEME	SUB-THEMES
(1) Third-Parties Involvement	(a) Therapy with minors, (b) marital disclosures, (c) Source of referral (d) Duty to warn.
(1) Dual relationship	(a) Collegial relationship (b) Power differential in relationships
(1) Cultural competence	
(1) Policies and practices	

...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 their parents should know. To tell or not to tell? (Psychologist-8, F)

The therapist was torn between how much she could disclose without infringing on confidentiality issues with the client while obtaining needed social support from a guardian.

Marital Disclosures. Disclosures to either party in marital counseling was a rich source of dilemmas, 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 may be torn between the two decisions. This is illustrated by the quote below:

I am forced if possible, to tell the husband but because of ethical reasons, confidentiality, how could I? So, I had to intensify my treatment with this girl without telling the husband. (Psychologist-6, M)

Other participants perceived themselves as being gatekeepers for such information and also found it difficult if they believed that they had to reveal such information. Furthermore, other psychologists were bothered by what the other partner might think concerning secrets he or she may be holding in confidence from the other 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, M)

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, F)

The participants presented scenarios where information divulged during therapy could impact the marriage negatively. In this regard, the dilemma that occurred was rooted in a clash between 1) a commitment to keep client information and 2) a moral duty to ensure the flow of information among all parties in therapy. What is important to note here is that although the psychologist knows the basis of the misunderstanding between the couple, she is unable to disclose openly to one party. This is a source of an ethical dilemma to the practitioner.

Duty to Warn. HIV disclosures were one of the dilemmas participants recounted. Participants felt obligated to warn a partner in the event where the client refused to disclose their positive HIV status. However, they were confronted with keeping the confidentiality of clients and the dilemma was also about to whom they owed allegiance. This is illustrated by the quotes 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 [presents] significant challenge. (Psychologist-5, M)

...because I feel somebody's life is at risk on 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, F)

Dual relationships

Quite a few participants (n = 14) reported that they faced challenges with dual relationships which created discomfort and presented an ethical challenge. This theme, therefore, encompasses the various types of dual relationships that participants were confronted with. Dual relationships will be considered under the following sub-themes; *collegial relationships*, and *power differential in relationships*.

Collegial Relationships. Four participants expressed that, they found themselves in a situation where they had to see a colleague as their client. Although they all found it ethically challenging, there were two different kinds of responses. Some considered that they could not treat colleagues while others felt that, regardless of what the ethical principles said, they had to attend to their colleagues. For the latter, their reason for treating their colleagues was predicated on the social arrangement of interdependency that pervades Ghanaian society, and the manpower crisis in providing mental health services. 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, M)

The above quote indicates that the participant felt he may be biased when dealing with a colleague in the 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, M)

Here both the therapist and client, who is also a colleague, overlooked the rules governing their profession, and entered into a therapeutic relationship because the therapist had a certain specialty perceived to be needed by a colleague therapist. The dilemma, therefore, arises when the boundaries in these two relationships are not clearly defined.

Power Differential in Relationships. This sub-theme describes an obligation to enter into multiple roles such as a student being a client or a client being a customer etc. Participants reported that these kinds of relationships compromised the therapeutic relationship and affected their primary role as therapists. Others also thought that because of the interdependent social arrangements, certain dual relationships were quite difficult to avoid. This dilemma is expressed below:

Because some of the decisions you might have to take from the problem may affect the student down the line. Or some of the decisions 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 can be a problem. (Psychologist-16, F)

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, F)

From the above narratives, it is evident that most of these relationships may compromise the fiduciary duties of the therapist hence pose an ethical challenge. The cultural non-specificity of the ethical codes being adhered to also make the dilemma worse.

There were other situations where amorous advances from clients and their families created dilemmas for the therapist. This is illustrated below;

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

Cultural competence

This has to do with the different philosophical bases of Western psychotherapies and different situational contexts of test construction and test use. The dilemma experienced here by some participants (n = 12) is due to a lack of culturally specific training, instruments/tools, and case examples which are foreign to the culture within which they operate:

Our training is Western-based which to a large extent I learned that some of the things don't fit our culture. (Psychologist-14, F)

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 it's counter-intuitive. (Psychologist-11, M)

. . .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, F)

Policies and practices

This theme addresses dilemmas that arise from institutional policies, cultural expectations, resources, and so forth which clashed with ethical principles psychologists were expected to adhere to. This is illustrated by what some of some participants (n = 2) said:

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 did not want her at home. (Psychologist-3, F)

From the above quote, 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 creates an ethical dilemma for the psychologist. For example, gift-giving to show appreciation would be against institutional policies bribery and exploitation of patients:

. . . in Ghana . . . people, eh . . . usually like to show their appreciation for whatever you have 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 foodstuff . . . 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. (Psychologist-15, F)

DISCUSSION

The study led to unearthing ethical dilemmas experienced by participating psychologists in Ghana. Using thematic analysis, the reported dilemmas included those arising from third party and privacy involvement, dual relationships, policies, and practices that conflict with ethical guidelines and cultural competence. It was observed that these dilemmas arose from the general cultural context of Ghana and the professional culture within which the psychologists were socialized and trained.

The results show that clinical psychologists in Ghana experience dilemmas in their line of practice. The most commonly cited type of dilemma in this study related to confidentiality and privacy. Lindsay and Clarkson (2000) reported that the issue of confidentiality remained the largest category of dilemmas experienced by psychologists in Europe. This conclusion is also supported by Hurst (2007), Capuzzi (2002), Davis and Mickelson (2003), and Slack and Wassenaar (1999) as well as Knapp and Ve-vandecreek (2010). When working with minors, it is more common to breach confidentiality across cultures (e.g., Arkfert, 2012; Barnett, 1998). Corning (2005) cautioned that even if the third party is a parent or guardian or any close relation, practitioners by their ethical standards must be cautious in how much information can be relayed or the extent to which third parties may be involved in the therapeutic process. Further to the issue of disclosure, information that emerged in therapy may involve the risk of prosecution or harm to third parties: (e.g., disclosure of information related to child abuse and neglect, threatened violence, HIV and threatened suicide) medical agencies, other colleagues, close friends and relatives. (Lindsay & Clarkson, 2000). It is important to note that in generally, psychologists are encouraged to discuss limits to confidentiality with all parties in advance of the therapy in order to inform all parties of the risks involved.

As mentioned above, the collective nature of Ghanaian society means that extended members of the family are often called for support when things go wrong. It is also 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 paramount to the entire family

regardless of age or status. For instance, grown-up children continue to be under strong parental influence even when they have constitutionally attained adulthood status in Ghana. When a family head pays for therapy or brings a relative in for therapy, the lines may often get blurred. There are, however, clear provisions in the Domestic Violence Act (2004), the Children's Act (1998) (ACT 560), and Juvenile Justice Act (ACT 653) which require the protection of the child and in the case of any abuse, disclosure of any act of abuse of a minor to the security and legal apparatuses. Nevertheless, cultural factors such as patriarchy and myths about child abuse, influence nondisclosure or under-reporting of child sexual abuse in Ghana (Boakye, 2009). Perhaps the dilemmas of disclosing issues concerning minors to third-party in this study reflect the impact of these factors on ethical practice in Ghana.

Concerning marital therapy and confidentiality, findings from several studies (e.g., Capuzzi, 2002; Davis & Mickelson, 2003; Knapp & Ve-vandecreek, 2010; Lindsay & Clarkson, 2000) corroborate our findings that psychologists experience difficulty concerning the extent to which information from one spouse can be shared with the other. This represents a major dilemma in a fundamental domain of practice for psychotherapists and psychologists working with couples. The need to reconcile the benefits of not disclosing marital issues to partners (to maintain and ensure trust, keeping the marriage and hence effective psychotherapy and intervention) is compared to the need to protect the client and others from harm (Lindsay & Clarkson, 2000). Indeed, a common ethical dilemma experienced by psychologists involves the decision to either break confidentiality with clients in the arena of marital disclosures or to uphold it. It is noted that, in general, psychologists working with couples are expected to explain the ground rules about disclosure and to ensure that all parties are in agreement about the ground rules before therapy begins.

It is important however to mention limits to confidentiality. Lindén and Rådeström (2012) state that, cooperation and contact with authorities such as the police, social welfare, and school staff challenged the confidentiality of Swedish psychologists in their study. Furthermore, in situations where there is a potential danger to spouse or children, confidentiality should be broken. However, the client must be informed about it. Moreover, limits to confidentiality should be discussed with patients at the beginning of therapy.

In a typical Ghanaian society, individual privacy in marriage is hardly recognized especially with regard to women. This is partly because the man is always viewed as the head of the family [or the marriage] and thus all decisions that concern each member of the family must be channeled to and through the head [husband]. As corroborated by Nukunya (2003, p. 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, and this could threaten their union. 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).

The decision to break confidentiality seems to be one of the most frequently encountered and serious ethical issue that psychologists face all over the world (Sullivan et al., 2002). It is important to ask what varies from one cultural context to the other when it comes to confidentiality.

This study identified cultural expectations that may clash with ethical principles and work standards (e.g., when it comes to gift-giving). It is not surprising that Atuobi (2007) asserts that corruption is culturally constructed and depends on the setting within which the psychologist operates. He asserts, however, that corrupt individuals hide behind culture to selfishly gain at the expense of society. Accepting gifts while being paid for services is one such example. Developing clear guidelines about gift-taking would be a pro-active way to prevent this dilemma.

To an African, morality is closely linked to human welfare. Although the decision taken may be consistent with the ethical standards of the profession, a Ghanaian psychologist may consider the general

good a particular decision may bring to 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 relationships, and solidarity. Consistent with Nel (2008) and Behnke (2008), we would agree that it is important to craft our own code of ethics, or carefully adapt a well thought out widely accepted code to our cultural context. On the flip side, the tension between respecting local customs and foreign values can lead to dilemmas when the local cultural values endorse unjust discrimination and practices such as early childhood marriage, polygamy, female genital mutilation, and the limitation of information for gender or political control (Hunt, 2009).

Issues related to cultural competence arose from the use of tests and therapies designed for other countries, and from attempts to generalize research results (based on different populations) to the Ghanaian context. The literature indicates that this type of dilemma may be very common in the African context (Schwartz et al., 2010). Psychological tools, therapies, and principles that have been developed in the West continue to influence psychology education in Ghana (Oppong, 2016; Oppong et al., 2014). Several researchers have, therefore, called for psychological research and practice in the context of Ghana, to make the findings and practice culturally relevant and facilitate cultural competence of practitioners (Oppong, 2017; Osafo, 2018). Training programs will need to focus more on training psychologists to improve their cultural competence in Ghana.

It is becoming increasingly clear that 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 a likelihood that they may also lack the skills to resolve ethical issues presented by clients of diverse cultural backgrounds.

A large set of dilemmas that evolved around the therapeutic relationships had to do with boundary crossings and dual relationships. Our participants reported discomfort with having to see colleague therapists. They also questioned whether it was ever right to date a client, and wondered how to best draw boundaries with relatives. Colnerud (1997) reported that the second most frequently reported dilemma facing psychologists in Sweden concerned the issue of “blurred, dual, or conflictual relationships”, reported by 18% of psychologists (e.g., involving the treatment of minors or acting on behalf of different authorities while at the same time caring for the client). Thankfully, damaging dual roles are rarely engaged in according to Borys and Pope (1989). Nevertheless, dual relationships remain a major source of concern for psychologists (Erdur-Barker & Ve-Cetinkaya, 2007; Hurst et al., 2007; Moleski & Kiselica, 2005).

Although the current study was conducted in urban settings (Accra, Takoradi, Cape Coast, and Tema), findings from other national surveys (Campbell & Gordon, 2003; Helbok et al., 2006, 2006) show that psychologists in rural areas experience significantly greater difficulty with dual relationships than psychologists in urban areas because of the overlapping social and business relationships in small communities. 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 & Skovholt, 1997).

Implications for practice and research

Considering the major influence of cultural factors on ethical decision-making, there is a need to develop and document ethical codes that will consider variables that reflect the local context. This will guide clinical psychologists in addressing certain dilemmas in practice. Additionally, more research is needed on cultural values in this multicultural society if psychotherapy should gain ground in Ghana. 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 the cultural aspects that relate to dilemmas and their resolutions.

Challenges and limitations of the study

In conducting this research, there were challenges encountered, such as the unwillingness of some individuals to participate in the research or refusing to allow their voices to be audio recorded, perhaps given the sensitivity of their dilemmas. Another limitation of the study is the exclusion of participants from the fields of industrial/organizational, educational, school, and counseling psychology. Future studies should consider their experiences in ethical decision making to widen the discourse.

CONCLUSIONS

This study was conducted to examine ethical dilemmas facing practicing clinical psychologists. The most commonly reported dilemmas related to confidentiality, dual relationships, policies and practices, and cultural competence. A unique finding related to cultural competence in relation to the different philosophical bases of western psychotherapies and different situational contexts of test construction and test use. There appears to be a clash between what the psychologists have been taught based on western knowledge and the local context (culture) when confronted with ethical decision-making.

In light of the findings from this study, it is proposed: that a code of ethics be developed by the Ghana Psychological Association and be incorporated into the training of all psychologists. Pettifor and Sawchuk (2006) emphasize the importance of codes in the ethical decision-making process of psychologists. The code of ethics would be a device to supervise, regulate, and correct professional behavior of psychologists. In this light, the codes are seen as providing support to the profession, protection to the clients, encouraging self-regulation, and reflection on personal values.

Secondly, the findings in the study could guide the training of psychologists and other health professionals in African philosophy and morality to better contextualize the Western-based principles, therapies, and assessment tools of psychology. In Gauthier et al.'s (2010) proposed model of the Universal Declaration of Ethical Principles for Psychologists, they did not only aim to provide a universal code for psychologists but also provided guidance on how to establish codes of ethics which are culture-sensitive and compliant to the cultural particularities of various peoples. In this study, we have attempted to show and highlight some of the cultural peculiarities in ethical dilemmas-cultural competence, policies, and practices – which could shape the development of context-based ethical codes for psychological practice in Ghana.

Acknowledgments

We want to acknowledge all the support and help of the participants who gave consent to participate in this study.

DISCLOSURE STATEMENT

No potential conflict of interest was reported by the authors.

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