Ethical decision-making in the therapeutic space: a psychoanalytic view

Melanie Silove

Submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Psychotherapy

Rhodes University
Grahamstown

December 2008

ABSTRACT

This study examined the ethical decision-making process as it transpired in the everyday context of the therapeutic space. In-depth interviews explored the subjective experiences of six South African psychologists, practicing as psychoanalytic psychotherapists, and their efforts to resolve real-life ethical dilemmas. The theoretical framework used to interpret the data subsumed professional literature in psychology on principle-based ethical decision-making as well as contemporary psychoanalytic debates on the phenomenon of countertransference enactments.

A review of ethics codes, survey research and seminal decision-making frameworks suggests that ethical dilemmas have traditionally been resolved by recourse to an objective and impartial "principle ethics" perspective. Empirical evidence shows, however, that logical thinking and the rational application of codes, principles and standards are often insufficient to secure ethical action. The establishment of reflective space and the core theoretical notion of "ethical decision-making enactments" were proposed in order to address the subjective, irrational and unconscious dimension of professional decision-making.

This study used a broadly hermeneutic research method which transformed participants' descriptions of engagement with real-life dilemmas into a psychoanalytically informed interpretive account of ethical decision-making. Twelve aspirational ethical principles were found to guide participants' daily analytic work. Beneficence was the principle most strongly identified with and nonmaleficence was the most neglected ethical principle. Unprocessed countertransference responses were shown to drive earlier prereflective phases of the ethical decision-making process. Mature ethical judgment was predicated upon the retrospective analysis of enactment phenomena.

Dissatisfaction was expressed by all participants with regard to the role of professional resources in aiding the resolution of stressful ethical dilemmas. Risk factors for compromised professional decision-making included the paucity and perceived irrelevance of postgraduate ethics training, supervisory failure to confront the ethical and countertransference dimensions of common dilemmas and professional isolation. Rather

than eliciting the hope of emotional support and greater insight, professional resources on the contrary mostly appeared to induce anxiety, mistrust and fearfulness.

Based on the data and the literature, a pragmatic psychoanalytically informed ethical decision-making model was finally generated. The model, which considers both principle ethics as well as countertransference phenomena, offers a preliminary contribution to professional dialogue on the development and evaluation of empirically based decision-making frameworks. Practical recommendations are made for both the revision of the current South African ethics code and for improving the postqualifying ethics education of psychoanalytic practitioners and supervisors. The limitations of the data are discussed and directions for future research initiatives are proposed.

ACKNOWLEDGEMENTS

I would like to acknowledge the invaluable assistance of the following people in the completion of this research:

Professor Gavin Ivey for his patience, support and thoughtful supervision over many years of work. I am very grateful for all the time he has spent reading and commenting on my thesis.

Professor Douglas Wassenaar for his kindness and for offering additional supervision that deepened my understanding of professional and research ethics.

Professor David Edwards for his guidance with the original research proposal.

My friends and colleagues, Andrea Hill, Sheila Cowburn and Esther Haumann for their insight, emotional support and encouragement which helped me weather the research process.

The six research participants for so generously and openly sharing their personal experiences of challenging ethical dilemmas.

Professor David Benatar of the Philosophy Department, University of Cape Town, for facilitating my auditing of semester courses in ethical theory and applied ethics.

Mrs Yvonne Fisher and Ms Shelley Spires for their reliable administrative assistance.

My family for their forbearance, understanding and support. I would like to thank Ian, my husband, for always believing in the value of my work and without whose love and steadfast helpfulness I could not have completed this study.

TABLE OF CONTENTS

CHAPTER 4 RESEARCH AIMS AND METHOD

CHAPTER 5 AVOWED VS LIVED VALUES IN THE CONTEXT OF REAL-LIFE ETHICAL DILEMMAS

CHAPTER 6 THE COUNTERTRANSFERENCE DIMENSION OF REAL-LIFE ETHICAL DILEMMAS

APPENDICES

CHAPTER 1

INTRODUCTION

1. PROLOGUE

Psychoanalysis has traditionally been conceived of as a morally neutral and value-free enterprise. The famous metaphor of the psychoanalyst as a surgeon adjures the latter to set aside "even…human sympathy" in the quest to perform the task of psychoanalytic treatment as objectively and dispassionately as possible (Freud, 1912, p. 115). The analyst's ethical values were accordingly not presumed to enter into the analytic process "and the great company of psychoanalysts who have followed in [Freud's] footsteps have taken great pains to disassociate themselves from anything that smacks of the ethical or the moral" (Meissner, 1994, p. 454).

These original assumptions of value neutrality were contradicted by the ethically challenging, complex and conflictual situations that I confronted in my several roles as therapist, patient, supervisee, colleague and ethics committee member. The latter subjective experiences, which contain the origins of and motivations for undertaking the present study, suggested that the practice of psychoanalytic psychotherapy includes in its endeavour an ineliminable ethical dimension. The intertwining of psychological practice with normative ethics, which seeks to determine what an individual *ought* to do (Beauchamp & Childress, 1994), is evident in Bersoff's (2003) definition of ethics as "the study of those assumptions held by individuals, institutions, organisations and professions that they believe will assist them in distinguishing between right and wrong and, ultimately, in making sound moral judgments" (Introduction, xxiii).

The observation that ethical considerations are integral to professional practice pertained not only to my subjective experiences (which are discussed in later chapters) but also to the rise in recent years of professional interest in ethical dilemmas and concerns. This has marked the field of both ethics and psychology as well as the psychoanalytic literature. Kast (1995), for example, cautions that handling unethical collegial behaviour in an ethical way necessarily involves considerations of rehabilitation and careful monitoring of countertransference reactions by "fact finders" to pre-empt retaliatory identification with the role of the aggressor. Bollas (1999) argues that the principle of absolute analytical

confidentiality has been eroded as the psychotherapeutic sanctuary comes under untenable pressure from mandatory reporting laws and demands for disclosure from courts of law. Glass (2003) distinguishes between the benign use of "boundary crossings", exploitative "boundary violations" and controversial "gray areas" of therapist-initiated interventions which can substantially disrupt the frame but which, if worked through, may result in a strengthened therapeutic alliance.

Underlying these and other diverse areas of interest is the psychoanalytic practitioner's inevitable encounter with the ethical decision-making process. Extensively surveyed and documented in the field of psychology and ethics, the phenomenon of ethical decision-making and the role of unconscious influences appear to have received less explicit and systematic professional attention in the literature on ethics and psychoanalysis. Awareness and analysis of the ethical decision-making process as it emerges in the analytic space in response to quotidian ethical dilemmas thus apparently represents a hiatus in contemporary psychoanalytic literature and comprises the core focus of the present study.

The remainder of this first chapter outlines the essential features of the psychoanalytic approach, situates this study in the context of South African psychoanalytic practice and sets out the aims and structure of the thesis.

2. THE PSYCHOANALYTIC APPROACH

Three distinguishing features differentiate the psychoanalytic approach from alternative therapeutic modalities. Firstly, the unconscious or hidden dimension of the patient's world is recognised, dispelling any illusion that "the ego … is master in its own house" (Freud, 1917, p. 143). Psychoanalysis may be construed, as Frosch (1997) remarks, " as a discipline and practice of uncovering latent meanings, of reaching below the surface of action and consciousness to reveal the disturbing elements of unconscious life" (p. 112). The self is decentred not only by the division between conscious and unconscious life but also by its "containing aspects of others in a way that … allows psychoanalysis to acknowledge that motives may not only be mysterious to the participants involved but also that they may be multiple, contradictory and generated independently of rational intervention" (Gibson, 2002, p. 39).

The psychoanalytic approach focuses, secondly, on the transference relationship wherein early traumatic interpersonal relationships are unconsciously recreated by the patient in the present psychotherapeutic setting. This suggests that powerful and irrational emotions may be experienced in relation to another person without identifying the original source or ongoing meaning of the affects concerned (Frosch, 1997). The core psychoanalytic notion of resistance refers to the patient's unconscious opposition to the uncovering and exploration of these potentially conflict-laden areas within him/herself (BMA, 1991). Thirdly, the use of verbal interpretations traditionally comprises the primary means of therapeutic intervention; this is used to foster insight into the meaning of the patient's emotional difficulties and how these unconscious conflicts may be lived out interactionally in the present transference-countertransference matrix (Ivey, 1992).

These well-known features of the therapeutic space are accompanied by a particular professional attitude, the analytic attitude, a simultaneously participatory and self-observational state of consciousness wherein the analyst allows him/herself "to be „sucked into' … temporary disruptions of the barrier between self and object, while carefully noting the determinants and meanings of such disruptions" (Gabbard & Lester, 1995, p. 45). The analytic attitude is given pragmatic expression in the treatment process through the actualisation of the analytic task, the analytic process and the analytic setting. The analytic task comprises the raison d'être of the analytic endeavour and consists of consistent efforts by the therapeutic dyad to understanding the patient's psychic state. It remains the analyst's particular responsibility to adhere to that task in a non-narcissistic manner that does not demand to be repaid or mirrored (Twyman, 2003). The analytic process refers to the gradual evolution of this task over time (Ivey, 1999). The analytic setting or "therapeutic frame" (Langs, 1982) refers to the ground rules which function to establish both a literal as well as a metaphorical space (Siegelman, 1990) wherein the often turbulent transference-countertransference relationship can be held and the meanings of strong unconscious emotional reactions can be safely explored.

One further distinction may be made between psychoanalysis „proper' and the practice of psychodynamic psychotherapy. Although fundamental assumptions and understandings about the nature of the therapeutic enterprise are substantially shared, „true' psychoanalysis involves three to five times a week contact, with the patient lying down on a couch and greater emphasis being given to interpretation of the transference and the role of insight in

fostering therapeutic change. Psychodynamic psychotherapy entails sessions on a once or twice a week basis with face-to-face contact or use of the couch and greater emphasis may be given to the supportive elements of therapy (Prochaska & Norcross, 1999, in Haumann, 2004). The practice of psychoanalytic psychotherapy in South Africa generally conforms to the latter paradigm.

Contemporary psychoanalysis emphasises that the patient and the analyst mutually, reciprocally and unconsciously engage one another in the therapeutic relationship. Thus the apprehension and analysis of the therapist's countertransference currently occupies the same theoretical and clinical significance as the understanding and interpretation of the patient's transference. Gabbard (1999) accordingly argues that the phenomenon of countertransference has shifted to the very core of psychoanalytic theory and technique, evolving from a traditionally "narrow conceptualisation of the therapist's transference to the patient to a complex and jointly created phenomenon that is pervasive in the treatment process" (p. 21).

3. THE PRACTICE OF PSYCHOANALYTIC PSYCHOTHERAPY IN SOUTH AFRICA

Professional interest in psychoanalytic ideas and practices has long been evident in this country and included the brief establishment in 1949 of the first South African Psycho-Analytic Society (Gillespie, 1992). The political climate under apartheid appeared to curtail the development of psychoanalytic activities, expediting the departure and permanent loss of luminaries such as J. Sandler, Edna O'Shaughnessy and Michael Feldman (Hamburger, 1992). This resulted in a situation where, ironically, a relatively strong South African presence prevailed in the international psychoanalytic community but "very little of this permeated, through the academic isolation under apartheid, into South Africa itself" (Gibson, 2002, p. 36). Psychoanalysis was additionally viewed with scepticism by proponents of progressive psychology in South Africa since it remains associated with wealth and social privilege in a country "where resources are few and there are pressing material and political realities asserting priority" (Gibson, 2002, p. 36). The lack of an enduring psychoanalytic tradition and professional isolation both from within South Africa and from the international psychoanalytic community at large arguably continues, with the need often being expressed by local practitioners for a "pyramid topped by the greats – the thinkers, innovators and experienced clinicians with specialist skills" (Gillespie, 1992, p. 3). Arguments for the extension of psychoanalytic theory into understanding organisational or

social processes and a detailed outline of the history of South African psychoanalysis are beyond the scope of the present study. The following comments are limited to situating this study in the broader landscape of psychoanalytic psychotherapy as it is generally practised in South Africa at present.

There currently exists no formal psychoanalytic training in South Africa nor any internationally recognised psychoanalytic society or institute. Thus the title "psychoanalytic psychotherapist"[1] is essentially self-conferred, generally indicating adherence to the foregoing outline of the psychoanalytic approach and membership of one or more local psychoanalytic societies, reading or study groups. In Cape Town, different professional groups include the Cape Town Society for Psychoanalytic Psychotherapy (CTSPP) and the Self-Psychology Group. A journal entitled *Psychoanalytic Psychotherapy in South Africa* was established in 1992 and continues to provide a national forum for psychoanalytically oriented practitioners to present, discuss and evaluate their work. The Cape Town-based South African Association of Jungian Analysts (SAAJA) offers a four year accredited training in Jungian analysis.

Local psychoanalytic societies and reading groups provide ongoing opportunities for their membership to pursue continuing professional development through the regular presentation of lectures, meetings and workshops where theoretical and clinical material is discussed. The practice of psychoanalytic psychotherapy is not confined in South Africa to psychologists alone but is the province also of psychiatrists, social workers and psychiatric nurses. Entry criteria for admission into professional groups require that prospective members have received personal therapy and regular supervision is encouraged for novice and experienced therapists alike.

The emphasis on the clinical significance of countertransference in contemporary psychoanalytic practice has been highlighted above. In the local context Ivey (1992) has raised the salience of countertransference management and argues that South African psychologists are particularly prone to compromising the therapeutic treatment process through the enactment of their own idiosyncratic "countertransference pathology". Ivey (1992) links the persistence of countertransference pathology to the predominantly

[1] The present study uses the terms "psychoanalytic psychotherapist", "psychoanalytic practitioner" and "therapist"interchangeably.

humanistic and cognitive theoretical orientations apparently prevalent in psychology departments at South African universities which tend "to minimise the transference-countertransference dimension of the therapeutic relationship" (p. 38).

By comparison with the USA and Europe, the domain of ethics has received relatively little professional attention in South Africa (Slack & Wassenaar, 1999). In particular, the ethical decision-making processes of South African psychologists practising as psychoanalytic psychotherapists have not to date been explored. The present study thus hopes to consider the role that psychoanalytic thinking may play in ethical judgment and to contribute an interpretive account of the subjective and unconscious dimension of ethical decision-making as it emerges in the therapeutic space.

4. THE STRUCTURE OF THE THESIS

This thesis consists of nine chapters including the introduction and conclusion. Chapters 2 and 3 together comprise the theoretical framework which informs an interpretive account of psychoanalytic practitioners' struggle to resolve real-life ethical dilemmas in the context of the therapeutic space.

The first part of the theoretical framework is drawn from professional literature on ethics in psychology (Chapter 2). This includes a critical overview of traditional principle-based approaches to ethical decision-making. The core characteristics of the "voices" of justice and care, two predominant modes of moral reasoning, are outlined. This is followed by a review of the uses and limitations of codes of ethics, survey research investigating professional decision-making and seminal ethical decision-making models. The sparse psychoanalytic writing on ethical decision-making is also considered.

The second part of the theoretical framework examines psychoanalytic literature on countertransference enactments and considers their potential impact on the ethical decision-making process (Chapter 3). This includes discussion of different definitions, subcategories and the classification of countertransference enactments along a "beneficence-maleficence" gradient. The establishment of reflective space and the core notion of an "ethical decision-making enactment" are proposed in order to address the irrational and unconscious dimension of professional decision-making.

Chapter 4 describes the process of how the current study was carried out. This includes discussion of the aims, assumptions, ethical considerations, the recruitment and interviewing of participants, and the detail of how the data were analysed and interpreted. The influence of the researcher's subjectivity on the research process is evaluated.

Chapters 5 to 8 present the findings of this study grouped according to main themes. The six ethical dilemmas used in the study are first presented. Chapter 5 then discusses research participants' avowed ethical principles and how these fare in the context of countertransference pressures generated by real-life ethical dilemmas. In Chapter 6 countertransference constitutes the central theoretical 'hub' from which research participants' responses to real-life ethical dilemmas are explored. Prereflective as well as mature levels of ethical decision-making are distinguished. Chapter 7 discusses participants' own experiences of accessing available professional resources to aid the resolution of ethical dilemmas. These include postgraduate ethics training, ethics codes, professional bodies, supervision, personal therapy and peer consultation. Chapter 8 presents preliminary work towards the building of a psychoanalytic ethical decision-making model which is directly based on the detailed analysis in preceding chapters.

In the concluding chapter (Chapter 9) the most important findings and conclusions are drawn together with a discussion of the limitations of the study and recommendations for further training and research. Practical strategies for changed ethical decision-making practices in the therapeutic space are made.

CHAPTER 2

CONCEPTUALISING THE ETHICAL DECISION-MAKING PROCESS: PRINCIPLE ETHICS AND PSYCHOANALYTIC APPROACHES

5. INTRODUCTION

This and the next chapter (i.e. Chapters 2 and 3) comprise the theoretical framework which is later used to interpret qualitative data pertaining to ethical decision-making as it emerges in analytic space. The theoretical framework is drawn from professional literature on ethics in psychology as well as from psychoanalysis. The framework consists of a critical overview of, firstly, rational principle-based approaches to the resolution of ethical dilemmas and, secondly, to consideration of countertransference enactments and their potential impact on the ethical decision-making process. The two chapters together thus provide a theoretical basis for the final interpretive account of six psychoanalytic psychotherapists' struggles to resolve real-life ethical dilemmas in the context of the therapeutic space.

The four sections of this chapter move sequentially from traditional rational responses to apparently less familiar and innovative approaches to the ethical decision-making process. The first section outlines the core characteristics of the "voices" of "justice" and "care" which comprise two predominant modes of moral reasoning discernible in the professional literature. Existing controversy is explored as to whether the two approaches concerned are potentially complementary or inherently antagonistic. This first section provides a broad conceptual background to the ensuing discussion of the "objective" and "subjective" poles of the ethical decision-making process which are arguably exemplified by "principle-based" systems and by psychoanalytic approaches respectively.

The second section explores the "objective" pole of ethical decision-making and sets out well established arguments regarding the uses and limitations of professional codes of ethics. It is suggested that the formulation of ethical judgments requires engagement with multiple "decision bases" (Woody, 1990, p. 134) or "norm systems" (Allen, 2001, p. 2), only one of which is comprised of formal ethics codes. Attention is given to the South

African Professional Board for Psychology's current code of ethics[2]. Review of possible lacunae includes comment on the absence of any decision-making framework and on the need to provide practitioners seeking to make sound ethical judgments with greater and more detailed assistance in relation to the ethical decision-making process.

The present study is situated, in the third section, in the context of international and local research investigating ethical decision-making in professional practice. Empirical studies suggest three primary difficulties which may beset ethical judgment and action. These include the failure to recognise the ethical dimensions of clinical practice, widespread disagreement among clinicians regarding the ethically most appropriate intervention and the discrepancy between intellectual comprehension of the ethically preferred course of action and ensuing unwillingness to actually implement the required ethical behaviour. Descriptive survey findings suggest the need for supplementary qualitative data which may contribute to the construction of a theoretically informed account of what potentially transpires in the widely observed hiatus between the declared ethical ideal and subsequent compromised ethical practice.

Discussion of seminal ethical decision-making frameworks in the fourth section brings to a closure examination of the "objective" pole of ethical decision-making. Frequently cited in the professional literature, the frameworks include those proposed by Rest (1984), Kitchener (1984), Steere (1984) and the Canadian Psychological Association (CPA, 2000). The foundational ethical principles of justice, autonomy, nonmaleficence, beneficence and fidelity are described. A brief critique is offered of the strengths and possible limitations of the frameworks concerned.

Surprisingly few direct references appear in the psychoanalytic literature to the countertransference dimension of ethical decision-making. Addressing the "subjective" pole of ethical decision-making, the fourth section therefore also considers several valuable but rare contributions to contemporary psychoanalytic thinking about ethical decision-making and intervention. Contributions include an innovative hermeneutic model (Betan, 1997), the notion of an unconscious "team of players" undergirding decision-making (Meissner, 1994), the hypothesised role of projective identification and disavowed therapist affects in clinicians' end-of-life decisions with dying patients (Varghese & Kelly, 1999) and

[2] Professional Board for Psychology (PBP). (2002, January). *Ethical code of professional conduct*.

elaboration of author-analysts' "multiply determined" decision-making in relation to ethical dilemmas surrounding publication of clinical material (Kantrowitz, 2006, p. 182).

The summary at the end of this chapter identifies commonalities and differences between the foregoing contributions addressing the countertransference dimension of ethical decision-making. Further aspects of therapist subjectivity which have apparently not to date received adequate professional attention but which may influence the formulation of ethical judgments in the context of real-life ethical dilemmas are highlighted.

6. TWO MODES OF MORAL THINKING: THE "VOICES" OF JUSTICE AND CARE

Real-life ethical dilemmas appear to challenge the psychoanalytic psychotherapist to discern different moral "voices" and to engage with the presenting moral conflict from different theoretical and relational perspectives. Two recurring moral "voices" or orientations that may be distinguished in the professional literature are those of "justice" and "care" (Brown & Gilligan, 1991; Brown, Tappan, Gilligan, Miller & Argyris, 1989; Gilligan, 1982; Kymlicka, 1990; Rachels, 2003). The two voices or modes of moral thinking each "orders human experience in terms of different priorities" (Gilligan, 1982, p. 22) and constructs a different emphasis on what is salient to the moral domain.

Central to an objective justice perspective, which traditionally prevails over public life, are impartial utilitarian directives which seek to maximise the most benefits for the most people (Rachels, 2003). Core concerns include impersonal duty, individual rights, equal treatment and principles and standards of fairness (Brown et al., 1989; Rachels, 2003). The cognitive emphasis amplified in the dispassionate voice of justice results in its formally distancing itself from the affective dimension of ethical decision-making (Jordan & Meara, 1990). This cognitivist proclivity has historically characterised traditional ethical theory which accordingly views "emotions, feelings, passions, and inclinations as distracting impediments to moral judgment" (Beauchamp & Childress, 1994, p. 89). Thus Kohlberg's (1981) final levels of mature moral judgment subordinate personal relationships to universal principles of justice (Rachels, 2003) and are "geared to arriving at an objectively fair or just resolution to moral dilemmas upon which all rational persons could agree …" (Gilligan, 1982, p. 21). The ostensibly logical and self-transparent moral agent "listens to the voice of reason, figures out the right thing to do and does it" (Rachels, 2003, p. 172).

A care perspective, in contrast, emphasises intimate interpersonal relationships, emotional commitment, empathy and compassion (Beauchamp & Childress, 1994). The voice of care speaks "about loving and being loved, listening and being listened to, and responding and being responded to …" (Brown & Gilligan, 1991, p. 47). Core concerns include people's vulnerability "to isolation and abandonment, and… the complexities of creating and sustaining human connection" (Brown et al., 1989, p. 148). The observation that moral deliberation is inevitably subjective, embodied and "always *situated*, dealing with concrete persons and problems" (Sevenhuijsen, 2003) arguably differentiates a care perspective from an objective justice or principle ethics approach. Noticeably underplayed, therefore, "are Kantian universal rules, impartial utilitarian calculations, and individual rights" (Beauchamp & Childress, 1994, p. 85). Ethical analysis is effected not by reasoned deliberation weighing objective higher order ethical principles but by reconciliation of conflicting responsibilities derived from personal attachments to particular others (Rachels, 2003). The quintessential concerns of justice and care may be summarised in the two moral injunctions "not to treat others unfairly and not to turn away from someone in need" (Brown et al., 1989, p. 142).

Controversy surfaces in the literature as to which approach might be superior (Bersoff, 2003), whether these two perspectives are essentially both elements of a complementary and unitary process (Betan, 1997; Brown et al., 1989; Cottone & Tarvydas, 1998; Kitchener, 2007; Meara, Schmidt & Day, 1996) or whether they are irreconcilable and represent singularly different ways of thinking and acting ethically (MacIntyre, 1984, in Jordan & Meara, 1990). Jordan and Meara (1990) argue, for example, that effecting ethical judgment optimally demands a morally virtuous agent in addition to ethical principles and that exclusive reliance on the latter approach is "simply not enough" (p. 109). Excluding the moral agent's "character", his/her motivation and distancing from the affective dimension of ethical decision-making raises the risk of ethical dilemmas "becoming primarily abstract thought puzzles to be analyzed according to specified rules … human pain, pathos, and historical particularity, tend to be underestimated or forgotten" (p. 108). In reply Bersoff (2003) highlights the problem of overly idiosyncratic and individualised responses to ethically problematic situations, commenting tersely that the "virtues" of "principle ethics", including rationality, are precisely what secures benevolent, prudent and respectful action. He adds that "If being virtuous means acting paternalistically, irrationally and on the basis of faith, [he would] prefer principled iniquity" (p. 154).

Offering an integrationist position, Beauchamp and Childress (1994) acknowledge that the ethics of care comprise a needed antidote to two centuries of ethical theory building characterised by the overly rational bias of principle ethics. The ethics of care, Beauchamp and Childress (1994) continue, may additionally be "especially meaningful for roles … in which contextual response, attentiveness to subtle cues, and the deepening of special relationships are likely to be more momentous morally than impartial treatment" (p. 88). However, moral responsiveness cannot be reduced to emotional responsiveness. Beauchamp and Childress (1994) argue that ethical judgments that risk overly partial emotional involvement with intimate others may stand in need of the correction offered by cognitive understanding and by reference to impartial ethical principles.

Tensions between a traditional justice orientation, with its emphasis on objective, rational analysis, and a contrasting care perspective, focusing on contextuality, subjectivity and emotional responsiveness, translate into distinctive methodologies of ethical decision-making. The voices of justice and care thus appear to constellate and to inform the "objective" and "subjective" poles of the ethical decision-making process respectively. The following discussion takes up the objective and predominantly rational pole traditionally espoused by ethical codes, empirical survey research and principle-based ethical decision-making models.

7. PROFESSIONAL CODES OF ETHICS: USES AND LIMITATIONS

Ethical issues have been described as comprising the core of every discipline[3]. In common with other helping professions, the codes of ethics developed by psychology constitute its collective "voice of conscience" (Bersoff, 2003, p. 1) which speaks of commitment to fundamental ethical values as well as of the practitioner's responsibilities to colleagues, consumers and the public. Allan (2001) and Gauthier (2004, in Pettifor & Sawchuk, 2006) observe that four universal ethical principles informed by the Judeo-Christian tradition and by Kant's deontological philosophy undergird the professional ethics codes published by the American Psychological Association (APA, 2002), the Australian Psychological Society (APS, 1999), the Canadian Psychological Association (CPA, 2000) and the European Federation of Psychologists' Association (EFPA, 1995). These four superordinate ethical principles appear to reflect international commonalities across formal ethics codes for

[3] *Universal Declaration of Ethical Principles for Psychologists*, International Union of Psychological Science (IUPsyS), Draft Proposal, 2005)

psychologists in the Western world and are also described in a draft *Universal Declaration of Ethical Principles for Psychologists* (IUPsyS, Draft Proposal, 2005). Although the nomenclature of the various codes differs, the principles essentially include respect for people's dignity and rights, responsible caring, integrity and professional and scientific responsibilities to society (Allen, 2001).

Professional ethics codes accordingly offer a consensually derived moral framework which, as Pettifor (1998) observes, provides guidance in navigating the ethical decision-making process. Cottone and Tarvydas (1998) suggest that practitioners who adhere to a "principle ethics" approach emphasising the rational and objective use of the utilitarian-deontological continuum "tend to view the application of universal, impartial ethical principles, rules, codes and [the] law as the core elements of ethics" (p. 145). Going beyond rational analysis and compliance with codified rules of conduct, Kvale (1996) in contrast highlights the role that interpretation plays in the individual decision-maker's context-dependent ethical judgments. Arguing that professional codes seldom provide definitive answers to ethically troubling situations, Kvale (1996) contends that ethical codes, principles and philosophical ethical theories "are more like texts to be interpreted than rules to be followed: they provide guidelines that must be judged according to their relevance to specific situations" (p. 110).

Professional ethical codes serve multiple purposes. Broad objectives are to promote optimal behaviour through the provision of aspirational principles and to regulate professional activities including disciplining violations of enforceable standards of conduct (Pettifor & Sawchuk, 2006). Frequently cited in the professional literature on ethics and psychology are the following five additional purposes; professional identity, socialisation, protection of the public, offering guidance and delineating minimalist as well as aspirational levels of practice. Codes of ethics thus, firstly, allow psychologists to establish their identity and status as a profession with a distinctive body of knowledge and expertise (Eberlein, 1987; Neukrug & Lovell, 1996; Sinclair, Poizner, Gilmour-Barrett, & Randall, 2001; Swartz, 1988). A formal code therefore "serves as a vehicle for professional identity and [as] a mark of the maturity of the profession" (Mabe & Rollin, 1986, p. 294).

Comprising an essential educational medium codes function, secondly, to socialise new members of the profession into the value system and accepted practices of the discipline concerned (Sinclair, 2001). Responding to the overriding need to protect the public from

harm and exploitation by professionals, codes aim, thirdly, to secure basic levels of training and professional expertise (Scherrer, Louw & Möller, 2002). This undertaking by the relevant professional psychological body to protect public interests by independently regulating its membership's activities also protects the discipline from excessive legislative interference from the state. Such extreme outside restrictiveness might arguably compromise the achievement of professional objectives (Scherrer et al., 2002; Steere, 1984; Welfel & Kitchener, 1992). Fourthly, ethics codes offer guidance on respectful and competent behaviour in relation to patients, colleagues and the community as well as assistance with the resolution of ethical dilemmas occurring across a range of research, teaching and practice settings (Bersoff, 2003; Cottone & Tarvydas, 1998; Fine & Ulrich, 1988; Seitz & O'Neill, 1996; Sinclair et al., 2001; Pettifor, 1998).

The distinction in professional ethics codes between aspirational ethical principles and prescriptive standards of behaviour (Pettifor & Sawchuk, 2006) comprises a fifth and final purpose which identifies contrasting reaches of professional practice. Hence the translation of guiding principles into enforceable ethical standards provides a means of adjudicating complaints and delineates minimal levels of acceptable behaviour or the "bottom line below which the psychologist's practice should not go" (Lindsay & Colley, 1995, p. 448). It is not sufficient, however, merely to secure minimalist standards of practice; what is required are optimal levels of service delivery that positively benefit the consumers concerned (Pettifor, 2001). Thus professional codes may actively "seek to promote the highest standards of practice and [to foreground] guidelines encouraging psychologists to practice, not merely in an acceptable manner, but in an optimal manner" (Slack, 1997, p. 10). The "social contract" articulated in the CPA's "Preamble" (cf. Pettifor, 2001) captures the spirit of aspirational practice in its emphasis that "each member will place the welfare of the society and individual members of that society above the welfare of the discipline and its own members. By virtue of this social contract, psychologists have a higher duty of care to members of society than the general duty of care that all members of society have to each other" (p. 2). In short, Bersoff (2003) declares that a code of ethics should ideally be "a grand statement of overarching principles that earn the respect of [the] public by reflecting the profession's moral integrity" (p. 1).

Ethical codes serve as a core "decision base" (Woody, 1990, p. 134) and their "necessity … cannot be denied" (Scherrer et al., 2002, p. 54). However, references to the limitations of

codes repeatedly punctuate the professional literature and include four recurring themes. Formal codes do not, firstly, pretend to be "encyclopaedic" (American Psychoanalytic Association, 2001, p. 1)[4] and hence "cannot possibly anticipate every instance of concern about ethics in an entire country" (Swartz, 1988, p. 18). Although regularly revised, a second theme to emerge is that codes are essentially "reactive in nature" (Cottone & Tarvydas, 1998, p. 145), lagging behind "the cutting edge" (Mabe & Rollin, 1986, p. 294-295) of rapidly emerging new and innovative areas of professional practice (Welfel & Kitchener, 1992). Cited instances of ethical concerns not yet satisfactorily addressed by the relevant codes include, for example, computer testing, groupwork, different aspects of marital and family therapy (Eberlein, 1987; Woody, 1990), issues pertaining to community psychology (Hadjistavropoulos, 1999; Sinclair et al., 1987), cultural diversity, recovered memories and the use of the Internet to conduct therapy (Pettifor, 1998). Whether a code fails to address a particular dilemma because it is uncommon, contentious or has only just recently emerged, the ensuing ethical vacuum highlights that "an ethical code is an evolving document and is, from the moment of its printing, out of date" (Wassenaar, 1998, p. 140).

A third theme pertains to abstract, imprecise and "disembodied" (Burke, Harper, Rudnick & Kruger, 2007, p. 114) ethical principles and rules stated in formal codes, which may bear little relevance to complex ethical dilemmas encountered in clinical practice. Practitioners may experience difficulty in extrapolating imprecise guidelines to specific situations "in such a way that they could be confident that their behavioural choices reflected the spirit of these regulations" (Slack & Wassenaar, 1999, p. 184). Finally, recourse to ethics codes may generate multiple conflicts. Commenting on the latter, Neukrug and Lovell (1996) observe that conflicts may emerge "between two codes, between the practitioner's [personal] values and code requirements, between the code…and institutional [or legal] practice, and between requirements within a single code" (p. 3). Other identified conflicts derive from the political values endorsed by repressive or totalitarian governments which violate the aspirational ethical principles espoused by the disciplines of psychology and psychoanalysis (Sebek, 2002; Steere & Dowdall, 1990). Formal codes grounded in Western liberal ideology may, moreover, promote seemingly universalist notions of individual autonomy which are at variance with the values, collective group identity and decision-making practices

[4] The American Psychoanalytic Association (APSA), *The Principles and Standards of Ethics for Psychoanalysts*, *2001*.

characteristic of diverse populations such as, for example, the Aboriginal culture (Pettifor, 1998, 2001; Swartz, 1988). Striking a pragmatic note, Bersoff (2003) writes that "a code of ethics is, inevitably, anachronistic, conservative, ethnocentric and the product of political compromise. But recognition of that reality should not inhibit the creation of a document that fully … expresses fundamental moral principles" (p. 1).

7.1. The South African Code of Ethics

The South African "Ethical Code of Professional Conduct" (2002) is currently situated in a two-tier system comprised by both the statutory Professional Board for Psychology as well as by the voluntary professional association of PsySSA[5]. The Professional Board's mandate is to protect public interests by regulating standards of training and practice whereas the primary aim of PsySSA is to support psychologists and to promote their professional interests (Wassenaar, 1998a, 1998b). Argumentation surrounding the merits and demerits of whether the foregoing functions are best addressed by a unitary or by a two-tier system lie beyond the scope of this study. For the purposes of broadly contextualising the statutorily binding South African ethics code, it is sufficient to note that a dual purpose unitary structure would arguably undermine the code's credibility in adjudicating complaints against psychologists by introducing competing professional priorities. Hence Wassenaar (1998a) writes that "the public is entitled to complain to an independent authority when dissatisfaction with services occurs. This authority should not be the same one which primarily promotes the interests of the profession itself" (p. 141).

The Professional Board's ethics code (2002) states at the outset that "Psychologists shall… maintain... high standards of professional competence to ensure that the public is protected from professional practice that falls short of international and national best practice standards" (p. 4). Central to professional competence, however, is the issue of a code's provision of ethical decision-making guidelines which should optimally enhance the individual practitioner's capacity to make well-informed and consistent ethical judgments (Hadjistavropolous, 1999). Thus Sieghart (1982, in Steere, 1984) writes that "Professional codes, if they are to be worth anything, cannot merely confine themselves to asserting that there is [an ethical dilemma] and leaving it … to individual members … to solve the dilemma as best they can … At the least … a code must say something about how to

[5] Psychological Society of South Africa

approach this kind of problem" (p. 31). Given the latter observations, the Professional Board's code of ethics arguably reveals the lacunae discussed below.

The eleven sections of the Professional Board's formal code are heavily indebted to the APA's (2002) code of ethics but appear to lack an overarching conceptual cohesiveness. The rubric "Professional Relations" (Chapter 2), for example, heads a section which includes an apparently undifferentiated mix of unidentified superordinate ethical principles (Respect for Human Rights and Others; Avoiding Harm) as well as various ethical standards (Informed Consent to Professional Procedures; Unfair Discrimination; Sexual Harassment). Alternatively, the leading rubric may unpredictably be comprised of areas of practice (Assessment and Therapeutic Activities) (Chapters 5 and 6) or an ethical standard (Confidentiality, Privacy and Records) (Chapter 3) which are seemingly elevated to the status of a guiding ethical "principle". Organisation of the ensuing document consequently appears to lack an explicit rationale. Unlike the five general principles clearly articulated by the APA's (2002) code or the four lexically ordered principles of the CPA (2000), the Professional Board's code of ethics fails to identify its "ethical foundation" (Welfel & Kitchener, 1992, p. 180) or the full range of philosophical ethical principles upon which it is presumably based. This in turn has direct consequences for the latter code's educative and pragmatic efforts to address the ethical decision-making process.

The two prerequisites for an effective code of ethics are the provision of decision-hierarchies or the ranking of ethical principles as well as direct consideration of the ethical decision-making process (Burke et al., 2007). Many familiar South African ethical dilemmas evoke competing ethical principles. In the context of suicide prevention, for example, Pillay, Wassenaar and Kramers (2004) depart from the CPA's (2002) generally recommended ranking of ethical principles, arguing that the ethical stance of beneficence (saving a patient's life) outweighs patient autonomy (gaining explicit informed consent prior to an in-patient psychological consultation). Despite such ethically defensible deviations, Hadjistavropolous (1999) nevertheless recommends that a code's ranking of ethical principles provides a much needed and practical guideline which facilitates moral decision-making. The "vague and brief" (Burke et al., 2007, p. 114) ethical decision-making guidelines set out in the South African code under "Resolving Ethical Issues" (Chapter 11) appear to fail to meet the latter authors' stated criteria for an effective ethics code. No reference is made to widely cited ethical decision-making models and, as noted, core ethical

principles are neither identified nor ranked. South African practitioners facing real-life dilemmas must do so without the benefit of an ethical decision-making framework and without guidance as to which ethical principle among competing alternatives may legitimately be accorded precedence.

The Professional Board's ethical decision-making guidelines may additionally be construed as ignoring the "complexity of lived experience" (Burke et al., 2007, p. 109). In failing to acknowledge the irrational and emotionally charged dimension of ethical decision-making, the latter guidelines seemingly demonstrate unwarranted confidence in "the lucidity of consciousness [and in the assumption] of a mind that is transparent to its own introspection ... it can [however] no longer be maintained that the first step towards being moral is to think rationally and self-consciously in a way that … is abstracted from our internal and hidden motivators" (Van Hooft, 2006, p. 44). The Professional Board's current recommendations for "Resolving Ethical Issues" arguably presuppose a consistently rational moral agent whose cognitive evaluation of ethical dilemmas is deemed sufficient to determine ethical action. The present guidelines, couched in language which is "authoritarian and instills fear rather than offering guidance" (Burke et al., 2007, p. 114), thus apparently assume that ethical decision-making is non-problematic, logical and linear. This stance is convincingly challenged by numerous empirical research studies, discussed in the following section, which repeatedly demonstrate compromised ethical decision-making processes and the violation of professional ethical standards.

In short, emotionally charged subjective responses and contextual pressures (Betan, 1997; Betan & Stanton, 1999), elements of "expediency and opportunism" (Blasi, 1980, p. 6), self-deceptive behaviour and disavowed exploitiveness (Epstein & Simon, 1990), "ethical blind spots" (Burke et al., 2007, p. 118) and "internal and hidden motivators" (Van Hooft, 2006, p. 44) may all potentially contribute to and powerfully organise the ethical decision-making process. An optimally effective code of ethics may need to offer not only a decision-making model which includes the ranking of ethical principles but one which also explicitly addresses the emotional dimension of the ethical decision-making process. The absence of such a framework in the Professional Board's present code of ethics heightens the risk that South African clinicians looking to the code for thoughtful assistance in resolving everyday ethical dilemmas may find it disappointingly prescriptive or "unduly silent, dated [and] unrealistic" (Pope & Vetter, 1992, p. 411).

8. EMPIRICAL RESEARCH HIGHLIGHTING KEY DIFFICULTIES IN ETHICAL DECISION-MAKING

Empirical research based on quantitative surveys suggests that ethical decision-making may be compromised by three primary difficulties. These include the failure to recognise the ethical dilemma, lack of consensus in decision-making and observed discrepancies between ethical ideals and ethical practice. The first area of difficulty resides in the clinician's failure to identify the ethical dimensions of clinical practice. The related concept of "ethical sensitivity" may be construed as the practitioner's ability "to recognize the ethical dimensions of a situation along with its clinical, scholarly, or pragmatic aspects" (Welfel & Kitchener, 1992, p. 179). Despite the likelihood that imperviousness to ethical problems heightens the possibility of unethical behaviour, little research has apparently been conducted in the area of ethical awareness (Welfel, 1992).

One study designed by Volker (1983, in Welfel, 1992) and later refined by Lindsey (1985, in Welfel, 1992) involved graduate psychology students and licensed psychologists in listening to taped clinical interviews containing ethical problems. Subjects were not cued in advance to the ethical dilemmas implicit in the interviews. Results across both studies were consistent; almost 50% of respondents in each sample were unable to recognise the ethical issues embedded in the clinical interviews and 25% were unable to do so even when prompted. Baldick (1980) similarly found that although psychology interns who had completed a formal ethics course were significantly more able to identify ethical problems than were interns who had received no ethics instruction, the former group still identified less than 50% of the several ethical problems included in each of 12 hypothetical clinical scenarios. Mounting a critique of professional education for its seeming preoccupation with the technical aspects of practice, Rest (1984) argues that graduate psychology students are "professionally socialized" into not looking for moral problems. As a consequence, students "are usually ill-prepared to know how to approach a moral problem when one does smack them in the face" (Rest, 1984, p. 24). It thus remains questionable as to whether ethics education is attaining its goal of training ethically astute professionals who are able to discern ethical issues as they emerge in clinical practice (Welfel, 1992).

Once an ethical dilemma is identified, moral reasoning processes help to distinguish ethical from unethical choices and to determine the ethically ideal course of action (Welfel & Kitchener, 1992). Studies based on hypothetical vignettes appear to demonstrate, however,

that psychologists generally disagree on what comprises the ideal or most appropriate ethical intervention (Chevalier & Lyon, 1993; Haas, Malouf & Mayerson, 1986, 1988; Slack, 1997; Tymchuk, Drapkin, Major-Kingsley, Ackerman, Coffman & Baum, 1982). Using a nationwide sample of clinical psychologists, Tymchuk et al. (1982) explored consensus in professional decision-making as well as the extent to which decisions were based on similar criteria. Respondents failed to agree in two thirds of the hypothetical scenarios concerned. Strong consensus existed in relation to only a minority of issues including confidentiality, sexualised dual relationships and duty to warn. The authors concluded that common "strategies for thinking about these issues" (p. 420) or consensus in professional decision-making appears to be related to topics which enjoy widespread professional and media attention and for which legal or professional guidelines exist.

One related interpretation of the lack of consensus in ethical decision-making is that it comprises a useful index of those professional situations with which psychologists are struggling in the absence of clear ethical guidelines (Chevalier & Lyon, 1993). Of interest in this regard are the observations made by Tymchuk et al. (1982) that, for all vignettes, the most frequently chosen criterion was "concern with the interests of clients" and the least commonly chosen criterion was "financial concerns of the psychologist" (p. 419). Given the forced choice format of responses to pre-selected hypothetical vignettes, the latter consciously chosen criteria arguably demonstrate a social desirability bias and fail to capture the "multiply determined" (Kantrowitz, 2006, p. 182) nature of motivation, including self-interested or frankly unethical motives, characteristically elicited by real-life ethical dilemmas. Certainly, Smith, McGuire, Abbott and Blau (1991) appear to temper calls for the further escalation of ethical guidelines with the sobering comment that "widespread agreement [exists] that the development of additional guidelines, examples and casebooks will not solve the complex problems that ethical decision-making poses" (p. 236).

Extending the work of Tymchuk et al. (1982), Haas, Malouf and Mayerson (1986,1988) explored 294 psychologists' preferred resolutions to 10 hypothetical dilemmas and their primary reasons for these choices. Findings once again demonstrated that experienced psychologists failed to reach consensus on several areas of serious professional concern. Highest consensus was around conflict of interest, mandatory reporting of threatened violence and refusal to refer to a colleague considered incompetent. Low consensus

emerged in relation to collegial misconduct and confidentiality issues in the context of family treatment. The authors suggest that lack of consensus in professional decision-making represents a troubling finding only if the task of ethics education is construed as providing instruction in the selection of "right behaviours" across a range of decision-making situations. If the task of ethics education, alternatively, is to inculcate ethical reasoning processes, results potentially indicate that divergent but ethically acceptable choices of action may stem from the same reasoning processes grounded in recognised ethical principles. Using data from the earlier survey, Haas et al. (1988) in a second study investigated the effects of psychologists' personal and professional characteristics on their choices of action as well as their professed reasons. The authors concluded that a relationship appeared to exist between taking direct action (reporting, confronting) and external codified ethical guidelines (based on the law or formal codes of ethics). In contrast, ethically defensible but less direct forms of action (discussion of feelings, encouraging a victim to report) appeared to be more strongly associated with internalised noncodified ideals (for example, personal standards, the desire to safeguard the therapy process or the protection of society's interests).

Recognition of an ethical dilemma and conceptual knowledge of the ethically most appropriate course of action do not necessarily translate into ethical behaviour. Highlighting a third difficulty which potentially compromises ethical decision-making, the following studies probe the apparent discrepancy between the ethical ideal and the actual implementation of ethical practice. Bernard and Jara (1986) presented a nationwide sample of clinical psychology students with two hypothetical ethical dilemmas depicting a peer/friend who had clearly violated professional ethical standards. Subjects received an update on the APA (1981) ethical principles pertinent to the hypothetical violations. Respondents were then asked to indicate what, according to the APA ethics code, they *should* do as well as what they thought they probably *would* do if confronted with the scenarios described. Findings indicated that approximately 50% of clinical graduate students would do less about ethical misconduct than they knew they should do. Hypothesising that the knowledge/action discrepancy is a function of personal values rather than a matter of demographic variables, Bernard and Jara (1986) argue that the problem of ethical misconduct does not apparently inhere in students' cognitive understanding of ethical principles but in "how to motivate them to implement principles that they apparently understand quite well" (p. 315).

Replicating the study with experienced clinical psychologists, Bernard, Murphy and Little (1987) found that the proportion of respondents who said they would do what they should do was substantially higher than earlier results obtained from graduate students. However, 26 per cent to 37 per cent of the sample of clinical psychologists indicated they would do less than they knew they should. Congruent with the results of the earlier study, the authors speculate that compromised ethical decision-making pertaining to failure to report collegial misconduct apparently reflects motivational phenomena and personal values rather than deficits in respondents' cognitive understanding of how the relevant ethical principles should be applied.

Smith, McGuire, Abott and Blau (1991) investigated clinicians' resolution of ethical dilemmas and the reasons for their choices of action. Responses to a questionnaire containing 10 hypothetical ethically conflictual vignettes were obtained from 102 mental health professionals. For each vignette, respondents were asked to distinguish what they believed they *should* do and then to select the action choice that best represented what they probably *would* do. For each *should* and *would* choice, subjects additionally selected a rationale that described the reasons for their elected choice of action. Findings consistently demonstrated that respondents thought they should ideally act more in accordance with existing APA ethical guidelines than they probably would do in real-life circumstances. Consistent with the results of Haas et al. (1986), the ethically ideal course of action (what *should* be done) was construed in terms of codified guidelines (based on the law and formal ethics codes). The authors suggested that conformity to the ethical ideal is most likely to occur when anticipated ethical violations involved breaches of legal statutes and professional standards (for example, duty to warn; prohibition against sexual involvement with clients). However, where an absence of clear rules of conduct exists, clinicians' behaviour was influenced by intuition, personal values, financial need and pragmatic considerations. In short, respondents tended to justify what they should do in terms of codified rationales but acknowledged that they were more likely to respond to noncodified rationales in determining what they would actually do in real-life circumstances. While the judgment/action discrepancy may be ameliorated by developing additional ethical principles pertinent to practice areas not specifically addressed by existing codes, the authors concluded that the discrepancies concerned may well reflect elements of expediency and deficits in personal integrity and honesty.

The foregoing discussion of quantitative survey research apparently reveals an untheorised gap between avowed ethical ideals and lived clinical practice (Bernard & Jara, 1986; Bernard et al., 1987; Smith et al., 1991). Empirical research as well as documentation of ethical violations by the Ethics Committees of statutory and voluntary professional bodies combine to suggest that compromised ethical decision-making may well arise when competing subjective feelings, values and contextual pressures interpose between the declared ideal and actual lived practice. This complexity of ethical decision-making, Betan (1997) remarks, is "often ignored, or at least rarely captured, in the professional literature" (p. 351). The following two studies suggest the need for significant but atheoretical quantitative findings to be supplemented with qualitative data that describe the emotional dimension of ethical decision-making. Such an account may contribute to a theoretically nuanced understanding of what potentially transpires in the often observed hiatus between the identified ethical ideal and the implementation of ethically compromised practice.

Pope and Tabachnick (1993) explored the extent to which therapists experienced anger, hate, fear and sexual feelings as well as the contexts in which these affects typically occurred. The 285 psychologists involved in the national survey additionally rated their graduate training with regard to helping them address these feelings subsequently in professional practice. Recommending caution in generalising their findings, Pope and Tabachnick (1993) reported that over 80 per cent of psychologists surveyed experienced some degree of fear, anger and sexual feeling in the context of their therapeutic work. Strongest fears pertained to client suicide, with over half of the participants indicating that debilitating subjective anxieties had negatively affected their sleep, eating and concentration. Sexual attraction to clients was reported by 87 per cent and sexual arousal by 57 per cent of participants. Compromised ethical decision-making may be inferred from the finding that over half of the respondents reported hugging patients and more than 1 in 10 flirted with both female and male clients. Moreover, more than 11 per cent of participants reported that complaints had been filed against them, with three times as many male therapists than female therapists having incurred formal complaints. Of significance was the finding that the least frequently reported feelings involved the ego dystonic affects of hate and anger which were endorsed by less than half of the participants.

Pope and Tabachnick (1993) comment that intense countertransference affects, including hatred and sexual excitement, may be exceptionally difficult for caregivers to openly acknowledge. These difficulties are compounded by the possible failure of graduate training programmes to provide adequate learning opportunities for students to develop the confidence, knowledge and skills needed to address countertransference feelings effectively in subsequent professional practice. The authors surmise that such affects may, when acknowledged and accepted, reduce tension and guilt as well as serve as a valuable therapeutic resource. Neglected or denied countertransference feelings alternatively can incur "devastating consequences" (Pope & Tabachnick, 1993, p. 142), raising the risk that the unrecognised affects underpinning ethical decision-making may eventually translate into the implementation of frankly unethical action.

Quantitative and qualitative methodologies were used by Betan and Stanton (1999) to explore how emotional responses and contextual concerns influenced psychologists' willingness to implement ethical interventions. Extending Bernard and Jara's (1986) work, the authors presented 258 clinical psychology students with a hypothetical case scenario depicting a friend/colleague's impaired professional functioning due to problem drinking. Participants were asked to indicate what, according to the APA ethical principles, they should and would do, the estimated frequency of pre-selected emotional responses and the extent to which contextual concerns had influenced their decisions. Open-ended questions additionally invited subjects to elaborate on both their rationales for choosing an intervention as well as on the perceived role played by emotions in the ethical decision-making process.

Findings showed that 95 per cent of participants correctly identified that the colleague's drinking problem should be reported to the supervisor or clinic director. Similar to Bernard and Jara's (1986) results, 50 per cent of participants reported that they would do less than they believed they should. Given that half of the participants involved were unwilling to intervene in the way they believed was ethically most appropriate, Betan and Stanton (1999) argue that, consistent with previous research, the latter finding suggests "that ethical knowledge is not sufficient for producing ethical behavior" (p. 297). Examination of participants' written responses to open-ended questions elicited challenging insights into the possible influence exerted by emotions in ethical decision-making. When pulled by anxiety, guilt and confusion, qualitative data suggested that ethical judgment appeared to be

compromised and inadequate ethical behavior was likely to be effected. Open-ended responses revealed, for example, that participants' emotional discomfort might lead to minimising collegial misconduct, to slowing intervention or to doing nothing and withdrawing from the ethically conflictual situation concerned. Alternatively, participants who experienced greater ethical willingness to do what they should do reported significantly greater concern and compassion for those involved and feelings of confidence that intervention would initiate constructive change.

Betan and Stanton (1999) argue that emotions can powerfully facilitate as well as hinder ethical decision-making. These authors contend that "psychologists are making inadequate decisions about ethical dilemmas in part because they are not well attuned to the influential role of emotions, values and contextual concerns in ethical discourse" (p. 299). Whereas unaddressed anxiety, guilt or confusion may compromise the capacity for thoughtfulness and ethical intervention, Betan and Stanton (1999) concluded that awareness of emotions can alternatively be integrated with the rational analysis of ethical dilemmas to effect constructive ethical action. While the emotional dimension of ethical decision-making is emphasised, the issue of unconscious determinants potentially undergirding the ethical decision-making process was not specifically identified or theorised in this study.

8.1. South African Empirical Research Studies

Unlike the USA and Europe, relatively few publications have emerged in South Africa in the field of ethics and psychology (Slack & Wassenaar, 1999). This present lack appears to be "an indication that [the] area does not receive the research attention it deserves" (Scherrer et al., 2002, p. 63). Recent South African studies have, however, included psychologists' attitudes towards and practices regarding erotic and nonerotic physical contact with clients (Trent & Collings, 1997), the experience of sexual attraction in psychotherapy (Stevenson, 1999), unintentional breaches of confidentiality (Peel, 1998) and the principle-based resolution of an ethical dilemma involving non-fatal suicidal behaviour (Pillay et al., 2004). The following discussion considers local survey studies which helped to increasingly sharpen the particular research focus of the present work.

Ethical decision-making practices of South African clinical psychologists were explored by Slack (1997). The sample involved 122 respondents (a 20 per cent response rate) who indicated their preferred resolution to 10 hypothetical ethical dilemmas as well as the

primary reasons for their choices. Consistent with previous research, central findings revealed wide variability in professional ethical decision-making; consensus was evident in relation to dilemmas subject to high levels of professional attention and regulated by legal guidelines. Slack (1997) speculated that the wide variability identified may partially derive from idiosyncratic interpretation of broad imprecise ethical guidelines which fail to offer assistance in personally encountered dilemmas. Based on the CPA approach, Slack (1997) advocates formulating a code of ethics which ranks ethical principles and which makes the ethical reasoning underpinning valued principles explicit. This would free practitioners to apply the reasoning in a consistent manner to novel situations not specifically addressed by ethical codes. Adherence to such a "conceptual approach to regulations may provide the interpretive criteria psychologists appeared to be calling for in their efforts to extrapolate from imprecise guidelines to specific situations" (Vasquez, 1994, in Slack, 1997, p. 118). Limitations of this study include the possibility that, as Slack (1997) acknowledged, the hypothetical vignettes used may not capture the affective complexity characteristic of real-life ethical dilemmas. The questionnaire's forced choice format additionally may reveal the effects of a social desirability bias as respondents sought to sustain a positive professional self-image by consistently selecting ethically acceptable responses. Finally, the influence of emotional and interpersonal factors on ethical decision-making were not identified or theorised by this study.

South African clinical psychologists appear to experience similar ethical concerns to those encountered by their international colleagues. Slack and Wassenaar (1999) invited 487 South African clinical psychologists to describe in writing real-life ethical dilemmas which they had personally encountered in practice. The invitation formed part of Slack's (1997) foregoing larger study investigating psychologists' preferred resolution to hypothetical ethical vignettes. Apparently agreeing with Pope and Vetter (1992), Wassenaar (2002) suggests that eliciting data directly from psychologists' own experience might be more congruent with the complexities of actual practice, thus affording greater assistance with professional ethics training, ethical decision-making and guideline development.

The four largest categories of ethical dilemmas to emerge from the study included confidentiality issues (29 per cent), nonsexual dual relationships (14 per cent), payment issues (12 per cent) and collegial misconduct (10 per cent). Examples of prominent confidentiality dilemmas included concerns regarding the need to respond to court orders to

release client records as well as difficulties establishing the parameters of confidentiality in relation to third parties threatened with harm, minor clients and multiperson therapy. Nonsexual dual relationships entailed familiar tensions pertaining to social contact with current clients and conflicting ethical obligations between the psychologist's role as an employee in an institution and the need to protect client confidentiality. Payment issues included concerns regarding client requests to abuse medical aid schemes and the effects of non-payment on the therapeutic relationship. The fourth category involving perceived collegial misconduct included misrepresentation of registration category, coercion of clients and "rushed" interventions. Although based on a small sample, the authors concluded that the data suggest that strong similarities prevail between the ethical concerns of South African clinical psychologists and their international counterparts.

Of interest to the present research study is that in Slack and Wassenaar's (1999) original survey, the invitation soliciting real-life ethical dilemmas apparently emphasised descriptions of external events, cognitive analysis of the principles entailed in respondents' attempts at resolution and the reasons for, and consequences of, chosen actions. Elaboration of the impact of the individual decision-maker's subjective psychological processes and affective responses on ethical decision-making were apparently not investigated. Authorial comment on the emotional dimension of ethical decision-making is seemingly confined in the latter study to the observation that survey respondents perceived the confrontation of collegial misconduct to be "so aversive as to be consistently avoided" (p. 183).

Information regarding the violation of professional ethical standards may be sourced from the ethics committees of national psychological associations, from formal complaints submitted to state or national registration boards and from surveys of psychologists' attitudes, practices and dilemmas (Wassenaar, 2002). Such information by implication serves to document instances of compromised professional ethical decision-making. One recent study of ethical violations by South African psychologists was conducted by Scherrer, Louw and Möller (2002) who examined records of complaints, occurring between 1990 and 1999, which had been submitted to the Professional Board for Psychology. Most frequently reported public complaints pertained to accounts and fees (16 per cent), problems regarding reports (13 per cent), competence (13 per cent) and improper behavior, including sexual misconduct (12 per cent). The core finding highlighted the nominally low percentage of all complaints lodged against South African psychologists (between 1990 and 1999, only

1 per cent of all registered psychologists were charged with unethical conduct). The authors caution, however, that psychologists are often required to use their own ethical judgments in stressful circumstances which leave little time for reflection, fostering "a breeding ground for unethical behavior" (p. 54). The finding, moreover, that complaints concerning psychologists' competence took third place suggests that insufficient attention is being paid to the issue of professional ethics training. Involving considerably more than the uncritical consumption of ethical code items, Scherrer et al. (2002) concluded that compulsory ethics training at pre-professional and postqualifying levels necessarily entails "schooling in critical thinking, problem-solving and decision-making that will produce students … trained in an outcomes-based approach for the ethical dilemmas that they will be confronted with as therapists, theoreticians or researchers" (p. 63). While acknowledging that psychotherapy is often abused and that ethics training therefore comprises a vital component of quality university training, no mention is made by Scherrer et al. (2002) of the need for ethical decision-making skills to include not only "critical thinking" but also reflection on the potential influence wielded by therapist subjectivity.

Wassenaar (2002) examined the ethical dimensions of South African professional psychology. The three different data sets used included a series of public complaints against psychologists, a study of real-life ethical dilemmas reported by psychologists and a survey of South African university based ethics training programmes. Comparison of public complaints with psychologists' own self-reported ethical concerns aimed at clarifying whether the dissatisfactions of service-receiving consumers corresponded with areas of professional difficulty described by psychologists themselves. The combined analysis was intended to inform future ethics training, regulatory bodies about prevalent patterns of public complaints and the revision of ethical codes.

Major findings indicated the most frequently reported "Complaints" concerned fee issues, inappropriate practice and competence. Clinical psychologists were disproportionately more likely to attract public complaints of unethical behaviour than were other registration categories, a finding replicated by Scherrer et al. (2002). Most frequently described real-life "Dilemmas" included confidentiality, inappropriate practice and nonsexual dual relationships. General dissatisfaction was expressed by respondents regarding the quantity and quality of their university based ethics training. Comparison of the "Complaints" and "Dilemmas" data suggested that essentially the public was concerned about ethical issues

which were different from the ethical preoccupations of psychologists themselves. Wassenaar (2002) accordingly comments that the different perspectives provided by the "Complaints" and "Dilemmas" data must each be integrated into professional ethics training so that "it embraces both the views of the complaining public and the anxieties of practitioners themselves" (p. 218). Given the research cited earlier emphasising motivational rather than cognitive factors alone (Bernard & Jara, 1986; Betan & Stanton, 1999), Wassenaar (2002) comments further that ethics training should additionally explicitly recognise and integrate into the teaching of ethical decision-making skills emotional and contextual factors which influence ethical judgment and action. This observation appears congruent with the finding that adult therapy represented the second highest activity associated with public complaints (including sexual issues) and was reported by psychologists themselves as the activity in which most ethical dilemmas emerged. While acknowledging the significance of the emotional dimension of ethical decision-making, Wassenaar (2002) observes that this aspect was not a focus of his study.

In short, the preceding review of international and local research investigating professional ethical decision-making repeatedly suggests that the hiatus between the ethical ideal and compromised ethical practice will not necessarily be resolved through conceptual knowledge alone, nor through the provision of additional guidelines. Wielding an important influence on the judgment/action discontinuity is the apparently little researched emotional dimension of ethical decision-making. The professional research literature seemingly lacks in-depth accounts, grounded in empirical data, of the individual decision-maker's thoughts, feelings, anxieties, desires, fantasies and values as these emerge, often forcefully, in the context of challenging ethical dilemmas. Construction of a theorised account of the influence exerted by therapist subjectivity might comprise a rational argument for professional ethics training to supplement its teaching of traditional ethical frameworks emphasising critical thinking with consideration of the potential impact wielded by countertransference phenomena on the ethical decision-making process. No interpretive study has apparently been conducted to date of the subjective and interpersonal psychological processes experienced by South African psychologists who have grappled to resolve real-life ethical dilemmas in the context of the therapeutic space.

9. ETHICAL DECISION-MAKING MODELS BASED ON A PRINCIPLE ETHICS APPROACH

Seminal ethical decision-making models in the professional literature include Rest (1984), Kitchener (1984), Steere (1984) and the CPA (2000). These principle-dominated frameworks emphasise rational analysis and an objective problem-solving approach; they thus retain a broadly similar methodology to that deployed by numerous alternative ethical decision-making models (Beauchamp & Childress, 2001; Corey, Corey & Callanan, 1998; Eberlein, 1987; Fine & Ulrich, 1988; Forester-Miller & Davis, 1996; Knapp & van de Creek, 2007). Hierarchical levels or "contextual forces" (Tarvydas, 1998, p. 148) which affect the individual practitioner's daily ethical practices include interdependent contexts comprised by the practitioner-client relationship, the clinical multidisciplinary team, agency dynamics as well as public policy directives. The following discussion, however, focuses on ethical decision-making processes which transpire primarily at the clinical or "micro-level" (Tarvydas, 1998, p. 148) wherein the traditional practitioner-patient relationship remains the central focus.

9.1. Rest's (1984) Four Components of Moral Reasoning

Rest's (1984) model comprises the first principle-based framework that is considered in this chapter. Providing a clear outline for the ethical decision-making process (Dove, 1995), Rest's model proposes that moral behaviour consists of four component processes. These processes may be conceptualised as "major units of analysis" and include "Moral Sensitivity", "Moral Judgment", "Moral Motivation" and "Moral Character" (Rest, 1994, pp. 23-24). Moral development involves becoming proficient in all four areas. Moral failure can result from a deficiency in any one component (Rest, 1984). Betan (1997) critiques the latter model as constrained by "a linear, logical-reductionistic approach to ethics" (p. 356) but Rest (1984) evidently rebuts the notion that "the four components depict a linear sequence in real time" (p. 20). All four mutually influential components are presented, Rest (1984) argues, not in a linear but in a *logical* sequence that offers a theoretical framework for analysing psychological processes inherent to the production of moral behaviour. Thoroughly empirically grounded, the model remains influenced by cognitive theory and by Kohlberg's stages of moral development (Cottone & Claus, 2000).

9.1.1. Component I: Moral Sensitivity

This component requires that the practitioner has the capacity to discern that a moral problem exists, can imagine possible courses of action and additionally envisages the consequences of each course of action on the welfare of others (Rest, 1984). Clearly, unethical behaviour may have its genesis in the fundamental failure to perceive the moral dimension of ethically problematic situations (Neukrug & Lovell, 1996). Unexpectedly sharing with psychoanalytic psychotherapy an interest in the meanings of prereflective responses in the context of ethical conflict, Rest (1984) endorses the need to interpret "gut feelings" (p. 21) or the strong affective arousal which potentially accompanies "primitive cognitions" (p. 21) and which together may precipitate premature action. These comments suggest the unavoidable intertwining of cognitions and emotions (Tarvydas, 1998) and that, from Rest's (1984) perspective, "there are no cognitions completely devoid of affect, no affects completely devoid of cognitions, and no moral behaviour that is independent of cognitions and affects" (p. 19).

9.1.2. Component II: Moral Judgment

This component involves deciding which course of action, among competing alternatives, is morally right, fair and closest to one's ideal of justice (Rest, 1984). When an individual has to formulate a moral course of action, Rest argues, he/she generally calls upon "basic underlying conceptions of cooperation" (p. 24) that bind progressively wider social networks together and that are essentially derived from one of Kohlberg's six developmental stages of moral judgment. Each of the latter stages is characterised by distinctive moral reasoning processes and by an intuitive notion of rightness, justness and fairness. The six-stage sequence culminates in the most mature moral reasoning comprised by ideal principles of justice that govern equal, fair and co-operative interaction between people in society (Rest, 1984).

Coherent, logical and persuasive, Component II processes are nevertheless arguably experience-distant and may not capture fully the way ethics is "done" in real life (Betan, 1997, p. 350). The highly theorised and apparently objective nature of Component II processes appear to presuppose "epistemological truth unaffected by context, person or both" (Betan, 1997, p. 352). Thus from the several perspectives of virtue ethics, a care orientation and psychoanalysis, Rest's (1984) Component II processes arguably stop short of considering the influence on ethical decision-making of the individual clinician's

subjectivity and embeddedness in "contextual forces" (Tarvydas, 1998, p. 148) that may impact on the resolution of the particular dilemma concerned.

9.1.3. Component III: Moral Motivation

This component acknowledges that an individual may distinguish which among available courses of action is the morally appropriate alternative (Component II processes) but may yet be dissuaded from pursuing the latter because of the attraction exerted by competing "nonmoral values" (Rest, 1984, p. 25). Espoused moral ideals may well be compromised by "strong needs for acceptance by peers or supervisors, prestige, influence, to avoid controversy, or to be financially successful" (Tarvydas, 1998, p. 153).

Rest's distinction between the ethically ideal course of action and competing "nonmoral values" partially informs the conceptual framework used later in this study to analyse how countertransference pressures appeared to influence research participants' avowed ethical values in the context of emotionally charged real-life dilemmas. Relevant to the hiatus between participants' aspirational ethical principles and their lived ethical values are the findings of empirical studies discussed in the previous section indicating, for example, that avoidance of collegial misconduct may stem from fears of retaliation, of damage to reputation or friendships as well as from loyalty factors. Component III processes move Rest's model beyond merely cognitively identifying the optimal ethical course of action to explicitly acknowledging that the pull of competing nonmoral motives may dislodge the clinician's adherence to avowed ethical ideals.

9.1.4. Component IV: Moral Character

The final component involves the actual implementation and execution of the chosen moral course of action. In the face of alluring distractions and situational pressures, Rest (1984) avers that this is no simple matter, requiring as it does "Perseverance, resoluteness, competence, and „character' " (p. 26). As Eberlein (1987) observes, the fourth component reveals the extent to which "the ethical ideal can or will actually be implemented" (p. 355). The action in Component IV, Eberlein (1987) continues, indicates "the ability or willingness of a person to put his or her words into practice" (p. 355).

Rest's (1984) four-component model clearly privileges moral reasoning processes. However, the model also refers to the need to interpret the possible meanings of the

prereflective emotional arousal that potentially accompanies ethical conflict and that may precipitate the implementation of premature action (Component I processes). Rest's theoretical framework additionally frankly acknowledges the competing attractions of unethical and consciously self-interested motivations (Component III processes). Betan (1997) argues that while Rest recognises that subjective influences may impact on moral reasoning, this latter aspect of the ethical decision-making process requires greater elaboration in his model.

9.2. Kitchener's (1984) Model of Ethical Justification

The second ethical decision-making framework to be considered involves Kitchener's (1984) two levels of ethical justification. The primarily linear progression inherent in the different levels of ethical justification proposed by Kitchener (1984) and by Steere (1984) are illustrated below in Figures 1 and 2. Steere's (1984) formulation of an ethical decision-making model, the third framework foregrounded, is apparently the only example to emerge in South African psychological literature. As Peel (1998) observes, Steere's (1984) publication on professional psychological ethics is widely acknowledged as one of the most significant to appear to date in South Africa.

Kitchener (1984) proposed an ethical decision-making model (see Figure 1 below) which provides helpful "thinking tools" (Kitchener, 1986, p. 309) to aid analysis and the resolution of ethical dilemmas. Two basic levels of ethical justification are distinguished. For Kitchener (1984) ethical reasoning begins, firstly, at an "Intuitive" (p. 44) or prereflective level. When this level fails and more stringent analytical thinking is required, ethical reasoning progresses, secondly, to a "Critical Evaluative" (p. 45) level encompassing ethical rules, principles and theories. These differing levels of ethical analysis, Kitchener (1986) argues, facilitate "deeper understanding of the basis for ethical decision-making" (p. 44) and provide a coherent framework which can be consistently applied across ethically problematic situations.

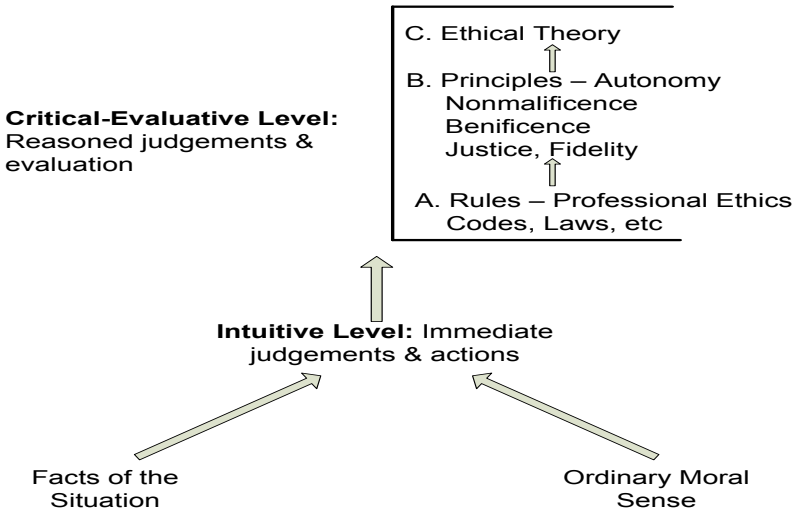


Figure 1: Two levels of ethical justification (Kitchener, 1984, p. 45)

9.2.1. The Intuitive Level

This level represents "an immediate, prereflective response to most ethical situations based on the sum of [an individual's] prior ethical knowledge and experience" (Kitchener, 1984, p. 44). Apparently similar to Rest's first component of ethical decision-making, Kitchener suggests that ethical awareness may originate in strong prereflective responses or "gut feelings" (Rest, 1984, p. 21). Kitchener's (1984) "Intuitive" level (see Figure 1 above) additionally encompasses "ordinary moral sense" (p. 45) or "a firm set of ethical beliefs" (p. 44), assumptions and professional knowledge. In the absence of relevant professional rules or when time constraints mitigate against conscious reflection, Kitchener (1984) avers that the prereflective accessing of these immediate moral feelings remains critical to informing pressing everyday ethical judgments and actions.

Intuitive ethical decision-making is associated with what "ought and ought not" (Kitchener, 1984, p. 44) to be done or with a deontological perspective which directs that morally right behaviour upholds absolute ethical principles (such as honesty, justice or respect for the dignity of all persons) independently of any consequences (Fine & Ulrich, 1988; Kvale, 1996). Intuitive judgments arise "when we automatically rely on a sense of personal morality and deeply ingrained ethical rules and principles pertaining to professional duty

and conduct" (Woody, 1990, p. 136). The central role occupied by "ordinary moral sense" in responding immediately to ethically conflictual situations apparently reinforces virtue ethics proponents' insistence that ethically responsible practice remains contingent on cultivating the moral excellence of the individual practitioner's character (Tarvydas, 1998).

Moral intuition alone, however, may fail to provide adequate ethical guidance (Kitchener, 1984). Unusual or ethically highly taxing situations may demand progression to a more intellectually rigorous "critical-evaluative level of moral reasoning [which] is necessary to guide, refine, and evaluate our ordinary moral judgment" (Kitchener, 1984, p. 44).

9.2.2. The Critical-Evaluative Level

Moral reasoning at this level progresses through "three tiers of increasingly general and abstract forms of justification" (Kitchener, 1984, p. 45). Ethical rules, principles, and theories comprise the three hierarchical tiers concerned (see Figure 1 above). When the first tier of ethical rules fails to provide the requisite ethical guidance, movement to the subsequent tiers comprised by ethical principles and theories is justified. Ethical rules or standards are generally stated in professional ethics codes; often statutorily binding, formal codes are informed by fundamental ethical principles which are themselves derived from deontological and utilitarian ethical theories (Allan, 2001; Fine & Ulrich, 1988; Kitchener, 1984; Steere, 1984).

9.2.2.1.The First Tier: Ethical Rules

The practitioner's initial intuitive response to an ethically difficult situation may be evaluated by appealing to ethical rules or "a set of standards to which all members of the profession are presumed to agree" (Kitchener, 1986, p. 309). When a single applicable rule prevails, the practitioner acts in accordance with the dictates of the ethical standard concerned. When competing ethical rules present opposing courses of action, the practitioner moves to the second tier comprised by ethical principles and assigns priority to the rule and course of action which best exemplifies the dictates of the relevant ethical principle (Steere, 1984).

Ostensibly formulated with the best interests of the public in mind, Kitchener (1984) nevertheless cautions that professional ethical codes are typically conservative, often functioning to protect the membership rather than the rights of consumers. Ethical rules may

moreover offer contradictory or ambiguous directives and, as a member of different professional associations, the practitioner may well be confounded by conflicting ethical standards espoused by different ethical codes. While formal codes, standards and principles may provide valuable ethical guidelines, their inherent limitations suggest that the conscientious practitioner cannot divest him/herself of "the burden of decision-making in ethical dilemmas" (Kitchener, 1984 p. 53).

In contrast Steere's (1984) comments reveal an apparent optimism that the provision of ethical rules or "instant guidelines" (p. 10) will ease the conflict and ambiguity integral to ethical decision-making, reducing the need for any independent interpretation of ethical priorities. The value of objective ethical rules, Steere (1984) argues, lies precisely in their capacity to relieve the individual practitioner of the "time consuming task of making independent ethical judgments … the profession and public … need [not] … rely upon every … practitioner's willingness [or] … ability … to view ethically complex conditions objectively and free of self-interest" (p. 10). Difficulties presented by Steere's (1984) linear model may arguably include the foregoing assumption that the provision of formal ethical standards releases the moral agent from the obligation to actively evaluate the appropriateness of prevailing ethical standards and to confront the impact of his/her subjectivity on the ethical decision-making process.

9.2.2.2. The Second Tier: Ethical Principles

The second tier consists of five core ethical principles which are cited by Kitchener (1984) as "the most critical for the evaluation of ethical concerns in psychology" (p. 46). The ethical principles include autonomy, nonmaleficence, beneficence, justice and fidelity. In contrast to the CPA's (2000) lexical ordering, Kitchener (1984) argues that no single ethical principle or fixed ordering of ethical principles can be established as absolutely binding without exception. Prevailing circumstances determine which ethical principle is most relevant and should take precedence. While not absolute, ethical principles are nevertheless always ethically relevant and provide "consistent advice about what moral issues need to be considered" (Kitchener, 1984, p. 52). Briefly outlined below, particular features of the principles are highlighted for their relevance to the later discussion of data pertaining to research participants' real-life ethical dilemmas.

Autonomy

This principle encompasses the right to act as a free agent and to make one's own decisions as well as the need to respect others' autonomous rights to make independent choices of their own (Fine & Ulrich, 1988; Forrester-Miller & Davis, 1996; Kitchener, 1984; 1986). Even when considered foolish, mistaken or as involving risk, the principle of autonomy dictates that, provided others' rights are not infringed upon, the patient concerned should be able to pursue autonomous choices in a context "free of compulsion or coercion by any external agent" (Steere, 1984, p. 7). The conscientious practice of "informed consent" apparently best safeguards the patient's autonomy. As far as possible the patient is provided with necessary information pertaining to the likely outcome, nature of involvement required and alternative options available before voluntarily deciding to enter into or to persist with psychological treatment (Steere, 1984).

Nonmaleficence

The concept of nonmaleficence can best be understood as "Above all do no harm" (Kitchener, 1984, p. 47). The intentional infliction of physical or emotional harm is expressly forbidden and the maxim additionally directs that the professional desist from activities which carry a high risk of harm (Kitchener, 1986). Nonmaleficence is generally held to be a stronger ethical obligation than beneficence; when choices have to be made between positively benefiting or harming an individual, other persons or society, "our stronger obligation … would be to avoid harm" (Kitchener, 1984, p. 47).

In Steere's (1984) linear ethical decision-making model (see Figure 2 below), assigning relative weighting to potential harms and benefits appears to present a principally intellectual task. Apparently screening out contextual considerations, the moral agent's subjectivity and irrational responses, the balancing of "competing moral goods" (Betan, 1997, p. 35) pertaining to psychological distress and wellbeing transpires in a seemingly impersonal process of computation termed the "detriment-benefit" analysis. This possibly overly rational approach to ethical analysis appears reminiscent of modernist thinking and of Freud's contested and now defunct metaphor of the detached surgeon/analyst who necessarily "puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skilfully as possible" (Freud, 1958, p. 115).

The noninfliction of harm has been posited as the "bedrock" (Bersoff, 2003, p. 44) or governing principle of applied psychology and analytic practice (Brown, 1982; Solomon, 2003; Stokoe, 2000). Defining the notion of "harm", Halpern (2003, in Kantrowitz, 2006) writes that "given that the goal of psychotherapy is psychological healing, harm is that which interferes with this goal" (p. 217). Pain and discomfort endured in the course of therapy, Halpern continues, is not invariably anti-therapeutic and should not be confused with harm. While supportive of these sentiments, Kitchener (1984) additionally cautions that client discomfort aroused in the context of unorthodox or high risk treatments which have not yet been empirically validated is unlikely ever to be ethically justifiable. Thus Kitchener (1984) comments that "as the risk and magnitude of potential harm increases, ethical prohibitions and limits on the treatment also increase" (p. 48).

Beneficence

This principle requires engagement in actions which positively benefit others, proactively contributing to their health and welfare (Fine & Ulrich, 1988; Forrester-Miller & Davis, 1996; Kitchener, 1984; 1986). The inherent commitment of the "helping professions" to beneficence entails promoting patients' positive growth and securing professional standards of competence that are likely to increase practitioners' beneficent practices (Kitchener, 1986). When ethical principles dictate competing courses of action, the principle of beneficence directs that the final action chosen should, in accordance with a "cost-benefit" analysis, garner the most benefits for the lowest costs where costs are calculated in terms of exposure of the patient to harm or loss (Steere, 1984).

Disembodied quantifying methods, implied by the preceding "detriment-benefit" and "cost-benefit" analyses, are arguably congruent with positivist conceptions of knowledge, privileging rationality and objectivity at the expense of acknowledging the influence exerted on ethical decision-making by the clinician's interpersonal context, biases, values and desires. The individual moral agent may alternatively be envisaged as "an experiencing individual, situated personally and historically … [whose] quest for knowledge is accordingly subject to the influence of all those historical, personal and circumstantial factors that come into play in every human action" (Atwood & Stolorow, 1984, p. 3).

Of relevance to the later discussion of a real-life ethical dilemma involving an apparently competent patient's wish to terminate therapy are the perennial tensions evoked between the

principles of beneficence and autonomy and the corresponding need to minimise infringing upon "the offended ethical principle" (Knapp & van der Creek, 2007, p. 401). The exercise of "paternalism", Kitchener (1984) remarks, presupposes "that an authority has knowledge of what is good for an individual and … [regulates] … that person's behaviour according to what the authority believes to be good" (p. 49). Failure to heed a patient's growing disillusionment and the therapist's own bias or belief in the positive benefits of continued treatment may well "entice" (Kitchener, 1984, p. 49) the paternalistically inclined clinician to override the client's autonomy and repeated requests to terminate the therapeutic relationship. Avoiding standardisation, however, and demonstrating the need for a flexible case-by-case approach, Pillay, Wassenaar and Kramers (2004) provide a contrasting dilemma, discussed later in this chapter, wherein they propose that the authority's stance of beneficence trumps informed consent and the patient's right to exercise autonomous choice.

Justice

Justice concerns were noted previously as comprising a recurring moral voice or predominant mode of moral thinking. Central to this principle, Kitchener (1986) observes, is the concept of "fairness" and the directive that others should be treated impartially and equally. Additionally, however, the formal meaning of justice suggests that "equal persons have the right to be treated equally and nonequal persons have a right to be treated differently if the inequality is relevant to the issue in question." (Kitchener, 1984, p. 49). It can therefore be argued that, for example, in addressing the issue of how scarce mental health services should be fairly distributed we should consider to what extent such services "ought to be distributed equally in regard to [fundamental] need [but] unequally to those who are less needy" (Kitchener, 1984, p. 50).

Fidelity

The principle of fidelity encompasses the notions of faithfulness, truthfulness, promise keeping and loyalty (Kitchener, 1984). The establishment of trust is perceived to be pivotal to sustaining consultative, research or therapeutic relationships. Since trust is contingent upon fidelity, Kitchener (1984) contends that adherence to this principle is vital for the practice of psychology. Conversely, deception and the neglect of fidelity potentially erodes trust in the meaningfulness and credibility of professional relationships and in the benefits that can be obtained from psychology in particular (Kitchener, 1984).

9.2.2.3. The Third Tier: Ethical Theory

The preceding core ethical principles are grounded in ethical theories which comprise Kitchener's (1984) third and final tier of ethical justification. The model does not, however, elaborate on the relevant theories. Kitchener (1984) apparently concludes that the resolution of ethical dilemmas can be effected by appeal to the foregoing five "prima facie" (p. 52) or always relevant principles. When ethics codes are silent or contradictory, reference to the five core principles facilitates a more general level of ethical reasoning than do ethical rules; the principles can accordingly be systematically applied to a wide range of ethically problematic situations.

In contrast Steere (1984) contends that when "practical" (p. 12) ethical dilemmas generate conflict between ethical rules as well as principles, consulting underlying ethical theories carries significant implications for the resolution of the dilemma concerned (See Figure 2 below). Arguing that the endless hierarchical re-ordering of principles and rules for each ethically conflictual situation dictated by the rule-deontological approach is untenable, Steere (1984) proposes that rule-utilitarianism provides the most realistic alternative for guiding ethical decision-making in clinical practice. This version of utilitarianism proposes that "the general good is most likely to be maximised by [routinely] adhering to sets of pre-agreed rules, rather than by attempting to compute a calculus of benefits for each separate action" (Hare, 1977, in Peel, 1998, p. 56). Since the basic directive of rule-utilitarianism is to „maximise the good', producing the most benefits for the largest number of people, the principle, rule and course of action finally assigned priority are those which best exemplify this approach. Notwithstanding the difficulties of application, Steere (1984) concludes that rule-utilitarianism ensures "that the practitioner's conduct is guided, not by self-interest … but by a genuine attempt to act in an ethically acceptable manner" (p. 13).

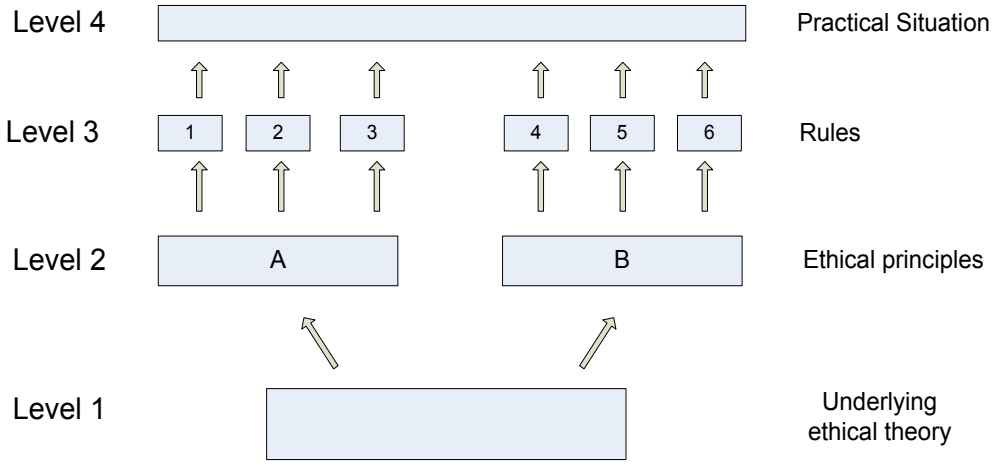


Figure 2: Representation of the underlying structure of an ethically conflictual situation (Steere, 1984, p.12)

9.3. The Canadian Code of Ethics for Psychologists (CPA, 2000)

The Canadian Code, adopted in 1986, was originally developed with the express intention of capturing "the collective wisdom" (Sinclair, 2001, p. 17) of Canadian psychologists regarding ethical issues and the ethical decision-making process. The Canadian Psychological Association's (CPA) Code of Ethics thus "reflects, in content … as well as in practice … the will of the membership" (Malloy & Hadjistavropoulos, 1998, p. 5). The following unique features of the CPA's Code include its stated objectives, use of an empirical methodology to determine its four foundational ethical principles, organisation of the Code around each of the principles concerned, differential weighting of the principles and an ethical decision-making model based on a problem-solving approach (Sinclair, 2001). The CPA's model comprises the fourth principle-based framework that is considered in this study (see Figure 3 below) and completes examination of the "objective" pole of the ethical decision-making process.

The Ethical Decision-Making Process

1. Identification of … individuals and groups potentially affected by the decision.
2. Identification of ethically relevant issues and practices, including the interests, rights, and … relevant characteristics of the individuals and groups involved and of the system … in which the ethical problem arose.
3. Consideration of how personal biases, stresses, or self-interest might influence the development of or choice between courses of action.
4. Development of alternative courses of action.
5. Analysis of … short-term, ongoing, and long-term risks and benefits of each course of action on the individual(s) / group(s) involved … .
6. Choice of course of action after conscientious application of … principles, values, and standards.
7. Action, with a commitment to assume responsibility for the consequences of the action.
8. Evaluation of the results of the … action.
9. Assumption of responsibility for consequences of action, including correction of negative consequences … or re-engaging in the decision-making process if the ethical issue is not resolved.
10. Appropriate action … to prevent future occurrences of the dilemma … .

Figure 3: CPA's Code of Ethics (2000, Preamble)

9.3.1. Stated Objectives of the CPA's Code

Stated objectives originally set for the Canadian Code of Ethics were, firstly, that all its parts should be conceptually cohesive and that the document produced should constitute an effective educational tool. Secondly, recent or innovative areas of practice should be accommodated. Thirdly, guidelines for action should be given when ethical principles conflict and, finally, the most useful decision rules (i.e. ethical principles) for ethical decision-making rules should be explicitly reflected (Eberlein, 1987; Seitz & O'Neill, 1996; Sinclair, 2001; Sinclair et al., 1987).

9.3.2. Use of Empirical Methodology to Ascertain Principles

Attempting to meet these objectives, 37 hypothetical ethical dilemmas were sent to the CPA's membership in the late 1970's. The latter vignettes represented the applied, teaching and research functions of Canadian psychologists and included competing principles, pressures and responsibilities (Sinclair, 2001). Analysis of the ethical reasoning underlying respondents' choice of action resulted in the identification and organisation of the most

consistently used principles into a coherent set of four superordinate ethical principles. As Sinclair (2001) observes, the ethical principles finally adopted "seemed to flow through the decision-making of the respondents" (pp. 17-18). In descending order of importance, the hierarchical principles are ranked as follows: Respect for the Dignity of Persons; Responsible Caring; Integrity in Relationships and Responsibility to Society (CPA, 2000). These superordinate principles appear later in this research study as an organising theoretical framework which is used to analyse the impact of countertransference pressures on research participants' avowed ethical values (see Chapter 5).

9.3.3. Organisation of CPA's Code around Four Superordinate Principles

Each of the CPA Code's four sections elaborates one of the identified superordinate ethical principles. Every principle is followed by a specific "Values Statement" which gives definition to the particular principle concerned. Following every "Value Statement" are several related ethical standards which illustrate the behavioural application of the relevant principle and values to the practitioner's daily activities (CPA, 2000, Preamble). This organisation meets the original objectives of producing a conceptually cohesive code that explicitly articulates the principles, values and standards upon which it is based and which guides decision-making by rank-ordering ethical principles and by providing a coherent decision-making model (Sinclair et al., 1987). Eberlein (1987) concludes that the Canadian Code offers a more effective educational tool than do other codes since "The Canadian Code is better organized, more coherent, and more directly related to the underlying principles that [practitioners] need to consider" (p. 354).

9.3.4. Differential Weighting of Principles

Differential weighting of ethical principles for the purpose of ethical decision-making apparently distinguishes the CPA's Code as unique among available professional codes of ethics (Sinclair, 2001). Conceptual and empirical support for the CPA's lexical ordering of principles is evident in the professional literature. Seitz and O'Neill (1996) comment, for example, that the CPA's hierarchy was empirically validated by a study demonstrating that a sample of pre-professional psychology students consistently endorsed solutions to ethical dilemmas involving competing principles that were congruent with the CPA's own recommended ranking of ethical principles.

In the context of ethically conflictual situations, the CPA's Code directs that all four principles should be equally considered and balanced in the process of ethical decision-making (CPA, 2000, Preamble). In the event of competing principles, however, the Code's differential weighting directs that the "principle highest in the hierarchy takes precedence" (Hadjistavropoulos, 1999, p. 3). While "Respect for the Dignity of Persons" is accordingly assigned the greatest weighting, the Code acknowledges that exceptions may arise when "there is a clear and imminent danger to the physical safety of any person" (CPA, 2000, Preamble). One such exception arising in a South African hospital context involved non-fatal suicidal behaviour. Hence Pillay et al (2004) contend that, in the case of elevated risk for suicidal behaviour, the benefits of offering an initial in-patient psychological consultation without securing explicit informed consent apparently outweigh potential harms. The latter authors argue that referral for consultation comprises an instance of "Responsible Caring" wherein "the ethical stance of beneficence [overrides] the valuing of the patient's right to autonomy" (Pillay et al., 2004, p. 352). Despite professional objections that the lexical ordering of principles might encourage an unduly formulaic response to the ambiguities inherent in ethical decision-making, Sinclair (2001) observes, on the contrary, that this unique feature of the CPA Code has proved useful to educative efforts aimed at helping practitioners to determine the ethically appropriate course of action.

9.3.5. CPA's Ethical Decision-Making Model

The emphasis on ethical decision-making which permeates the CPA's (2000) Code includes the formulation of a principle-based problem-solving model. Use of this model encourages rigorous thinking through of ethically complex situations and the careful deployment of a coherent set of principles in the ethical decision-making process. As Seitz and O'Neill (1996) note, ethical decision-making is viewed, in the context of the CPA Code, as involving considerably more than the simple citation and application of codified rules.

The CPA's ten clearly delineated decision-making steps reveal common as well as contrasting characteristics in relation to alternative practice-based ethical decision-making frameworks. Common patterns evident across models include, for example, review of the ethical problem, identification of the individuals or groups involved in the ethically conflictual situation, clarification of competing rights and responsibilities, consultation of available legal and ethical guidelines, consideration of the consequences of alternative courses of action and, finally, the implementation and evaluation of the chosen action

(Corey, Corey & Callanan, 1998; Eberlein, 1987; Forester-Miller & Davis, 1996; Keith-Spiegel & Koocher, 1985; Tarvydas, 1998; Tymchuk, 1986).

Contrasts with the preceding frameworks are provided, not only by the CPA Code's differential weighting of ethical principles, but also by its penultimate step. As Eberlein (1987) observes, most available problem-solving frameworks conclude with evaluation of the action taken. The Code's ethical decision-making model, however, emphasises that the practitioner continues to assume responsibility even after evaluation "for consequences of action, including correction of negative consequences … [and] re-engaging in the decision-making process if the ethical issue is not resolved" (CPA, 2000, Preamble). Added emphasis on the individual decision-maker's personal responsibility appears evident in the Code's acknowledgement that "personal conscience" (CPA, 2000, Preamble) may play a legitimate role in ethical decision-making but that it must necessarily be "based on a reasonably coherent set of ethical principles … that can bear public scrutiny" (CPA, 2000, Preamble).

9.3.6. Critique of CPA's Ethical Decision-Making Model

The CPA's empirically well grounded ten step model offers a flexible and proactive ethical decision-making framework which is applicable to resolving both current as well as anticipated ethical dilemmas (Sinclair, 2001). However, the CPA's (2000) approach to ethical decision-making appears once again to privilege rational analysis and a primarily linear progression through succeeding steps of ethical analysis. The third step alone is devoted to consideration of how therapist subjectivity may potentially skew the ethical decision-making process; this step appears limited to conscious self-reflection and dispassionate "Consideration of how personal biases, stresses, or self-interest might influence the development of or choice between courses of action" (CPA, 2000, Preamble).

Thus one possible limitation of the four ethical decision-making frameworks reviewed in this chapter (Rest, 1984; Kitchener, 1984; Steere, 1984; CPA, 2000) is that the latter models largely appear to presuppose an emotionally unobtrusive and rational moral agent who is guided in the course of ethical analysis principally by the dictates of reason alone. This view of the individual decision-maker stands in contrast to contemporary perceptions of the clinician as susceptible to unwittingly initiating actions motivated by the irrational and emotionally charged interpersonal pressures generated by the therapeutic dyad. The CPA's

(2000) Code explicitly acknowledges the Association's overriding responsibility to help establish "a moral community" (CPA, 2000, Preamble) which is externally and internally accountable for the ethical behaviour of the discipline and its membership. This responsibility extends to "developing and implementing methods to help [members] monitor the ethics of their behaviour and attitudes" (CPA 2000, Preamble). Not only is conscious consideration of the ethically relevant issues, principal stakeholders and contexts advocated by the Code's ten step model warranted but the methodology of responsible ethical decision-making arguably includes sustained reflection of the influence exerted on decision-making by competing "unconscious determinants" (Meissner, 1994). Betan and Stanton (1999) argue that what is currently needed in the burgeoning field of ethical decision-making models are contemporary approaches which integrate "rational analysis with attention to the contextual and subjective underpinnings of ethical decision-making" (p. 299). Elaboration of the CPA's third step accordingly comprises the central focus of later chapters (see chapters 5 to 8) which explore the potential influence of unconscious determinants on the ethical decision-making process.

10. THE COUNTERTRANSFERENCE DIMENSION OF ETHICAL DECISION-MAKING

The preceding principle-based models' (CPA, 2000; Kitchener, 1984; Rest, 1984; Steere, 1984) reliance upon the rational application of ethical principles foregrounds the "objective" pole of ethical decision-making. In turning to the less familiar "subjective" pole, Betan (1997) offers an innovative hermeneutic model which is envisaged as supplementary to models of ethical justification. Betan and Stanton (1999) submit that hermeneutics as a postmodern philosophy "views knowledge not as an objective „truth' but rather as interpretation that occurs in the context of human relationships" (p. 299). Accordingly Betan (1997) construes ethical decision-making as an interpretive endeavour involving a "dialectic" (p. 356) between universal ethical principles and the specifics of the therapist's subjective experience, in which each pole is interdependent and informs the other. The central thesis of the hermeneutic model, Betan (1997) continues, is that "in addition to moral reasoning, the context of the therapeutic relationship and the therapist's subjective responses are fundamental considerations in the interpretation and application of ethical interventions" (p. 348). Betan (1997) therefore argues that in addition to considering the components of moral reasoning (Rest, 1984) and core ethical principles (Kitchener, 1984), the hermeneutic approach to ethical decision-making encourages interpretation of the

meanings of the interpersonal pressures generated in the context of the therapeutic dyad and of the therapist's subjective feelings, beliefs, values, narcissistic needs and desires.

Despite its significance as a trailblazing theoretical framework, application of Betan's (1997) proposed hermeneutic model transpires in the context of a single apparently hypothetical ethical dilemma. Lack of supportive clinical data leaves the pragmatic value of Betan's theoretical model empirically unsubstantiated. Betan's reflections regarding the interactional nature of the countertransference phenomena driving the ethical decision-making process arguably lack detailed elaboration, exclude consideration of countertransference enactments and are only briefly presented. In short, neither principle-based frameworks, virtue ethics proponents nor Betan's hermeneutic model seem to interrogate in detail the impact of the individual therapist's "dumb … hard … [and] blind spots" (McLaughlin, 1991, p. 600) on the ethical decision-making process and on commonly espoused professional virtues such as trustworthiness, courage, respect or compassion (van Hooft, 2006). In shedding light on the nature of countertransference phenomena, contemporary psychoanalytic thinking promises a more precise understanding of how and why the individual decision-maker's "unresolved and disavowed issues" (Zeddies, 1999, p. 232) may seek expression in the ethical decision-making process.

Solomon (2004) observes that the analyst may feel "as if thinking about ethical issues is an unwelcome disruption or intrusion into the real analytic task" (p. 250). A recent spate of professional interest in the countertransference dimension of ethical dilemmas seemingly belies Solomon's statement (Abramovitch, 2007; Allphin, 2005; Anonymous, 2005; Gabbard, 1996; Wakefield, in Ross & Roy, 1995; Wiener, 2001). When the focus of interest narrows, however, to consideration of the countertransference dimension of the ethical decision-making process, a phenomenon which has been extensively investigated and described in the field of psychology, the psychoanalytic literature appears to offer only scattered references or to subsume the subject implicitly under general considerations of the countertransference dimension of ethical dilemmas or, even more broadly, the ethical dimension of analytic practice. Research data-bases (PsychINFO, PsychLit, EbscoHost, Google, Google Scholar, PubMed) as well as personal contact in 2006 with the Kennedy Institute of Ethics[6] and with Dr Jean Pettifor, who has published extensively in ethics and psychology, accordingly yielded little evidence of real-life clinical illustrations or of

[6] medethx@georgetown.edu

theoretical accounts which probed possible linkages between countertransference factors and the widely documented ethical decision-making process. The risks of professional exposure, Woody (1990) suggests, remain high since "to disclose an ethical problem in clinical work is to reveal much about one's own thinking process, sense of morality and ethics, theoretical biases and pragmatic concerns; this … probably accounts for the dearth of such examples in the literature" (p. 145). Collation of apparently sparse references in the psychoanalytic literature regarding the countertransference dimension of ethical decision-making revealed the four contributions discussed below.

The professional literature in psychology is replete with multiple examples of ethical decision-making frameworks (Cottone, 2001; Cottone & Claus, 2000). Researchers and practitioners are consequently well positioned to begin to "weigh the relative merits of one approach against another, providing an empirical foundation that is sorely needed in this area of study" (Cottone, 2001, p. 40). In the context of psychotherapy, Betan's (1997) hermeneutic decision-making framework in contrast currently appears to provide a first template, standing virtually alone in theorising the influence exerted on ethical decision-making by the interplay of ethical principles, unconscious interpersonal pressures and "deeply rooted [countertransference] fears, needs, desires, meanings, and values" (p. 361).

In considering the potential role of unconscious determinants on ethical judgment, Meissner (1994) offers a second contribution to the psychoanalytic oeuvre. Meissner (1994) invokes the forceful image of a continuously active "unconscious team of players" (p. 465) who, side by side with conscious calculations of consequences and risk-benefit analyses, decisively influence ethical decision-making and intervention. Potentially implicated in the "team", Meissner suggests, are aggressive and libidinal derivatives, defences such as projection or denial, superego lacunae and pathological narcissism. Reflecting on the intersection between ethics and psychoanalysis, Meissner (1994) concludes that not only is there an ethical core to psychoanalysis but there is also "an inherent psychoanalytic dimension to the deeper understanding of ethical decision-making processes" (p. 470).

A third contribution is presented by Varghese and Kelly (in Gabbard, 1999) who situate the controversy of euthanasia and end-of-life decisions in the interpersonal context of the transference-countertransference relationship which exists between dying patients and their physicians. Ostensibly rational and humane clinical decisions to participate in physician-

assisted suicide, formulated in the intersubjective context comprised by the doctor-patient dyad, may in fact be fuelled by the patient's projective identifications or by the doctor's unacknowledged aggression, hatred and unconscious wish to kill. Hence Varghese et al. (in Gabbard, 1999) emphasise "the importance of addressing countertransference issues before concluding that what one experiences with the dying patient is indeed empathy rather than countertransference enactment" (p. 92). Kelly, Varghese and Pelusi (2003) add that new tools, models and frameworks are needed to help conceptualise the meaning of unacknowledged countertransference anxieties elicited by engagement with dying patients, since such seemingly irrational affects may powerfully influence the medical professional's attempts to negotiate end-of-life decisions and interventions.

Author-analysts who confront complex decisions pertaining to the publication of clinical material comprise a fourth context for considering the unconscious dimension of the ethical decision-making process. Kantrowitz (2006) observes that author-analysts face conflicting loyalties when weighing competing demands to preserve patient privacy, to advance psychoanalytic knowledge, to satisfy professional ambition and to consider whether the material should be published at all. The decisions which govern the foregoing choices are optimally guided by ethical principles including nonmaleficence and "truth telling" (Kantrowitz, 2006, p. 265) whereby many analysts seek to eschew "deception" and gain patients' informed consent. Given the limitations of broad ethical principles in offering guidance across widely varying clinical situations, the analyst's proposed decision may additionally be usefully subjected to Clifford's "ethics of belief" (in Kantrowitz, 2006, p. 274). Before the implementation of any action, the "ethics of belief" demand an examination of alternative evidence or opposing points of view potentially contradicting one's own strongly held subjective beliefs as to the desirability of preserving confidentiality only using disguise or always asking consent or never writing about patients at all.

"Proper ethics" (Stoller, 1988, in Kantrowitz, 2006, p. 269) may see the analyst's formal adherence to codified ethical guidelines regarding confidentiality which require „thick' disguise or informed consent. The latter seemingly beneficent courses of action may, however, veil countertransference "blind spots", including the gratification of narcissistic and exhibitionistic needs as well as unconscious guilt about the self-interested use of patient material. Reflecting on the following instance of an apparently unproblematic ethical decision to request permission to publish, for example, Kantrowitz (2006) comments that

the analyst concerned retrospectively wondered "whether his professional ambition had unwittingly led him to exploit his patient in order … to have a publication. He also questioned whether unconsciously he had avoided showing the patient the paper in advance for fear that he might then have withdrawn his permission to have it published" (p. 272).

While cautioning that author-analysts are likely to enlist like-minded colleagues, Kantrowitz (2006) nevertheless recommends that the scrutiny of an external observer may help to identify self-serving decisions. No neat formulation exists which invariably provides guidance as to whether to use disguise or to ask consent. Eschewing standardisation, Kantrowitz (2006) concludes that ethical decision-making which foregrounds the need to protect the patient must necessarily be made on an individual case-by-case basis and must include sensitive evaluation of the possible clinical consequences for the particular patient, the analyst and the therapeutic process.

11. SUMMARY

A review of professional literature on formal codes of ethics, survey research and ethical decision-making frameworks shows that the resolution of ethical dilemmas has traditionally been effected by recourse to an impartial "principle ethics" perspective. International surveys and studies of ethical violations suggest, however, that cognitive analysis of ethical dilemmas and the rational comprehension of codes, principles and rules are necessary but often insufficient to secure ethical action. Greater understanding of the widely observed judgment/action discontinuity may perhaps be achieved by considering both the "objective" and "subjective" poles of ethical decision-making, thus integrating the distinctive ethical concerns articulated by the voices of "justice" and "care" respectively. Ethical decision-making, as it transpires in analytic space, may be served best by psychoanalytically informed training curricula, ethics codes and models which value rational analysis and rank-ordered ethical principles but which additionally address, on a case-by-case basis, the influence exerted on ethical judgment by countertransference phenomena and the interpersonal pressures generated by the therapeutic dyad.

Meissner (1994), Betan (1997), Varghese and Kelly (in Gabbard, 1999) and Kantrowitz (2006) clearly foreground the countertransference dimension of ethical decision-making and the manifold nature of ethical intervention. Comparisons between the latter contributions appear to reveal differences in their emphasis (or lack of it) on empirical research,

countertransference enactments and foreseeable as opposed to unanticipated ethical dilemmas. In the only study based on real-life interviews investigating actual ethical quandaries, Kantrowitz (2006) asserts that unconscious factors, including counter-transference enactments, may potentially determine ethical decision-making. The remaining contributions were based on hypothetical vignettes which, as a review of survey studies suggests, failed to adequately capture the ambiguities, tensions and emotionally charged complexities inherent in real-life dilemmas. Reflecting growing psychoanalytic interest in countertransference enactments, Varghese and Kelly (in Gabbard, 1999) propose an intersubjective decision-making model, arguing that apparently rational instances of ethical decision-making by medical practitioners may alternatively be construed as expressions of maleficent countertransference enactments. Reference to enactment phenomena are absent in related works by Meissner (1994) and Betan (1997) or could arguably be elaborated in greater detail.

The present study, unlike the foregoing contributions, is based on in-depth interviews with individual psychologists, practising as psychoanalytic psychotherapists, who confronted unanticipated ethical dilemmas which suddenly emerged in the therapeutic space. An analysis of professional literature pertinent to countertransference enactments and ethical decision-making forms an essential part of the theoretical framework for examining such work and this is presented in the following chapter.

CHAPTER 3

THE ETHICAL DECISION-MAKING PROCESS AND COUNTERTRANSFERENCE ENACTMENTS

12. INTRODUCTION

Real-life ethical dilemmas may transcend the pragmatic capabilities of professional ethics codes to effect resolution since their standards do not necessarily reflect the moral ambiguities, contextual tensions and subjective complexities inherent in the ethical decision-making process (Betan & Stanton, 1999; Burke, Harper, Rudnick & Kruger, 2007). Broadly based on a logical problem-solving approach, contemporary models of ethical decision-making may similarly reveal a problematic gap or "divide between abstract ethical principles… and specific ethical dilemmas faced by practitioners within heterogeneous contexts" (Burke et al., 2007, p. 110). Despite privileging reasoned deliberation, ethics codes, current models and professional publications nevertheless frequently allude to the potentially decisive impact of irrational and prereflective phenomena on the ethical decision-making process.

Widespread agreement thus implicitly prevails that ethical dilemmas routinely evoke interpersonal contextual tensions as well as subjective and unconscious countertransference responses in the therapist. Examination of professional literature in the previous chapter reveals, for example, that in the course of ethical decision-making, the practitioner is envisaged as struggling with primitive "gut feelings" (Rest, 1984, p. 21), "nonmoral values" (Rest, 1984, p. 25), intuitive judgments or "immediate, prereflective responses" (Kitchener, 1984, p. 44), subjective "biases, stresses or self-interests" (CPA, 2000, Preamble) and "potential ethical blind spots" (Burke et al., 2007, p. 118). While briefly acknowledging the influence of prereflective phenomena, the literature reviewed seemingly fails to offer theoretically grounded accounts which persuasively address the influence exerted by unconscious determinants on the ethical decision-making process. Stokoe (2000) observes that psychoanalysis is by contrast not only a form of treatment but it also provides a theory about unconscious processes which cannot be directly apprehended but which continue to affect the feelings, thoughts, perceptions and behaviour of the moral subject concerned. Professional literature, ethics codes, current models and training curricula clearly encourage increased practitioner awareness of ethical principles and standards. A psychoanalytic

perspective, however, may usefully supplement this awareness by directing that the understanding of any human behaviour, including ethical decision-making, must necessarily account for the unconscious as well as the conscious determinants of that behaviour (Meissner, 1994; Mills, 2005; Stokoe, 2000).

This chapter offers a preliminary theoretical account of how and why, in the interpersonal context of the therapeutic space, the therapist's subjectivity is harnessed in the ethical decision-making process. Comprising a valuable pathway to the patient's internal object world, the "double helix" (Epstein & Feiner, 1988, p. 282) of countertransference alternatively constitutes iatrogenic ground for the unethical "transformation of the intensity [of] the transference from its service as a means of deeper consciousness into an instrument of egoistic gratification for the analyst" (Zoja, 2007, p. 58). A burgeoning psychoanalytic literature attests to growing contemporary interest in the impact on the analytic process of countertransference enactments. Rich in theoretical understanding and clinical vignettes, this latter terrain facilitates the following exploration of the unconscious determinants which potentially animate the therapist's countertransference roles in beneficent as well as maleficent ethical decision-making enactments.

The chapter opens, firstly, with a discussion of Kleinian, classical and intersubjective definitions of countertransference enactments. These competing theoretical perspectives offer different emphases on the relative unconscious contributions of the analyst and the patient to the phenomenon of enactments. In addition to differences in conceptual outlook, points of consensus between schools of psychoanalytic thought regarding the nature of countertransference enactments are clarified. Mills' (2005) critique of the relational notion of "analytic mutuality" is outlined.

This chapter continues, secondly, with the identification of several subcategories of countertransference enactment. These include interpretive enactments (Steiner, 2006), nonsexual boundary violations (Gabbard & Lester, 1995) and the analyst's "secret delinquencies" (Slochower, 2003). Examination of the professional literature apparently reveals a further implicit subcategory comprised by "ethical decision-making enactments" which specifically addresses the influence of unconscious determinants on the ethical decision-making process.

It is argued, thirdly, that the resolution of ethical dilemmas reveals at least three implicit ethical decision-making pathways. Central to a psychoanalytic approach to ethical decision-making is the third pathway, characterised by the creation or post-enactment restoration of reflective space. The analyst's capacity for thoughtfulness and containment of emotionally charged countertransference affects is seen as the pivot which determines whether an "ethical decision-making enactment" emerges as an analytically useable or potentially exploitative process.

The chapter turns, fourthly, to the classification of countertransference enactments along a continuum. Gradients or classification systems discussed include those proposed by Louw and Pitman (2001), Gabbard and Lester (1995), Cassorla (2001) and Ivey (in press). Discernible in the preceding classifications are concerns regarding malignant countertransference enactments involving the exploitation of the patient. The fourth section draws out these concerns and, unambiguously highlighting the ethical dimension of clinical practice, proposes that countertransference enactments may alternatively be situated along "a beneficence-maleficence" gradient.

The chapter concludes with two apparently rare accounts of real-life ethical dilemmas which arguably involve "ethical decision-making enactments" (Da Silva, 2003; Kantrowitz, 2006). The vignettes address current controversies pertaining to the issues of objectivity and analyst self-disclosure. Illustrating the theoretical framework constructed in this chapter, the vignettes are situated along the "beneficence-maleficence" gradient and are used to highlight emotionally charged linkages forged between enactment phenomena and the ethical decision-making process.

13. KLEINIAN, CLASSICAL AND INTERSUBJECTIVE DEFINITIONS OF COUNTERTRANSFERENCE ENACTMENTS: CONTROVERSIES AND CONSENSUS

No common agreement exists as to any precise definition of the term "countertransference enactment" (Cassorla, 2001; Gabbard 1994; 1995; McLaughlin, 1991; Panel, 1992). Reflecting Mills' (2005) observation that the diversity and complexity of human knowledge "radically resist being reduced to a common denominator" (p. 164), contemporary psychoanalytic schools reveal sharply contested perspectives regarding the issue of

definition and the relative unconscious contributions of the analyst and the patient to countertransference enactments.

Varying definitions suggest that the phenomenon of countertransference enactment may alternatively be initiated by the patient's projective identifications, by the analyst's personal countertransference or by equal unconscious contributions from both participants. Gabbard (1994) writes that Kleinians tend towards the viewing of countertransference experience "as reflections of what the patient has deposited in the analyst via projective identification" (p. 1085). The American Psychoanalytic Association's Panel (1992, in Hirsch, 1998) accordingly reveals a Kleinian emphasis in its definition of countertransference enactment "as an actualisation of the transference, unwittingly engaged in by the analyst. It is viewed as the patient's unconscious efforts to persuade or to force the analyst into a reciprocal action: a two-party playing out of the patient's most fundamental internalised configurations" (p. 78).

Retaining a similar emphasis on the initiation of the enactment by the patient's unconscious contribution, Chused's (1991) definition underscores that "Enactments occur when an attempt to actualise a transference fantasy elicits a countertransference reaction" (p. 629). Conceptual links are established by both preceding definitions between the phenomenon of countertransference enactment and contemporary formulations of both projective identification (Bion, 1959; Feldman, 1992; Ogden, 1979; 1986; Spillius, 1992) as well as Sandler's (1976) closely aligned notion of role-responsiveness. Countertransference enactments accordingly arise when a "good-enough" fit occurs between the patient's coercive projections and the therapist's own repressed but predisposing self and object representations. Drawn out of the analytic attitude, the analyst is galvanised by verbal and nonverbal interpersonal pressures unconsciously exerted by the patient into accepting and unwittingly actualising complementary roles derived from the patient's internal object world (Gabbard, 1995; Ivey, in press; Meissner, 2002).

At the other end of the spectrum lies the traditional classical or Freudian construal of countertransference enactments as occurring only periodically and as organised chiefly by "narrow" countertransference (Gabbard, 1994; Gabbard & Lester, 1995, p. 125). While the patient's habitual mode of object relations is implicated, the analyst's unresolved and latent conflicts from the past are revived anew in the current interaction with the patient (Gabbard, 1995). Enactments stirred primarily by the therapist's "blind spots" (McLaughlin, 1991, p.

600) or florid transference to the patient raise the risk of "malignant" boundary transgressions (Cassorla, 2005, p. 709) and of avoiding confrontation with "unpleasant realities … discrepant with our self-image as caring and committed analysts" (Slochower, 2003; p. 457). Expressing similar reservations about assumptions that the clinician's motivations and feelings are invariably benign, Kelly, Varghese and Pelusi (2003) define countertransference enactment as "a term used to describe actions that arise from the emotional responses of clinicians … [these countertransference] emotions motivate clinicians' behaviour towards a patient … . Such enactments have potentially detrimental effects for the patient ... but also for the clinician, because they distract from responding appropriately to the patient's needs as they address the emotional needs of the clinician for the relief of tension and distress" (p. 369).

In contrast with preceding definitions highlighting either the patient or the analyst as the principal initiator, are definitions of countertransference enactment which derive from relational and intersubjective psychoanalysis. From the relational perspective, the evolving analytic encounter is construed as jointly created and as emerging from the mutual transferences or unconscious influence the two subjectivities of analyst and patient exert upon one another (Gabbard, 1999; Kantrowitz, 2006). Dispensing with the positivist "blank screen" analyst and one-person psychology of classical psychoanalysis, the contrasting two-person psychology embraced by the intersubjective approach holds that "whatever takes place between analyst and patient will be *co-determined* by the unconscious desires and defensive needs of *both* participants in the analytic process…the analytic relationship and process [is] *mutually* constructed out of the reverberating influence and interaction of the conscious and unconscious wishful and defensive needs and desires of the analyst and the analysand, each upon the other" (Levine & Friedman, 2000; pp. 65-66).

Productive analytic engagement from the relational perspective calls for analytic mutuality and reciprocal revelations, stresses the analyst's actual behaviours or ineliminable subjectivity in partially co-determining the patient's transference and solicits the latter's plausible or undistorted perceptions of the analyst. Such an approach places the analysis of dyadic interaction at the centre of analytic inquiry as opposed to the purportedly classical stance of maintaining an exclusive focus on the patient's mind alone (Hirsch, 1998; Levine & Friedman, 2000; Mills 2005). Transference and countertransference are, from the perspective of relational theory, jointly constructed and their inextricable "intertwining is

the starting point of interpretation and analysis" (Kantrowitz, 2006, p.78). Correspondingly jettisoned are orthodox conceptions of dual drive theory, the analyst's presumed authority or capacity for access to "objective" truth and any pretensions to maintaining analytic anonymity, neutrality and abstinence (Mills, 2005; Levine & Friedman, 2000; Renik, 1993; 1996; Treurniet, 1997).

The preceding core concepts of the relational model establish a fresh vantage point from which to consider additional definitions of countertransference enactments. Central to intersubjective and relational approaches is the notion that enactments are inevitable, continuous, bidirectional and potentially useful (Gabbard, 1994; 1999). Either member of the therapeutic dyad may initiate the enactment concerned and the analyst as much as the patient is unwittingly embroiled in the ongoing "mutual re-enactment of core transference themes" (Hirsch, 1998, p. 95). Similarly highlighting their characteristic co-creation, Levine and Friedman (2000) define countertransference enactments as "the continuous, mutual living out of important, mostly unconscious, conflicts and fantasies of both parties in the analytic relationship … the term „enactment' refers to the ways in which the analytic encounter may be viewed as a complex, overlapping, embedded series of … unconscious, interactive, mutually constructed dramas that are jointly lived out rather than only spoken of." (p. 73). Relational and intersubjective definitions, Ivey (in press) contends, appear to portray the analyst not as merely responding to the patient's transference pressures but as an equal co-participant who actively and continuously shapes the enactment at hand according to his or her own unconscious anxieties and conflicts.

Critiquing the notion of "analytic mutuality" as erroneously suggestive of equality, Mills (2005) argues that relational and intersubjectivist positions seemingly ignore the original purpose of forming an analytic relationship, the issued role asymmetry and the substantial power differentials that inexorably remain between the analyst and the patient. As Mills (2005) retorts "There is nothing equal about it: I'm not the one being analyzed" (p. 179). Relational techniques seemingly in the service of "analytic mutuality" may on the contrary generate "therapeutic excess" (Mills, 2005, p. 179). Citing several published instances, Mills (2005) cautions that relational practices involving, for example, the undisciplined disclosure of erotic countertransference heightens the risk of gross boundary violations. When the analyst, moreover, elicits the patient's perceptions and fantasies about internal conflicts occurring in the therapist, countertransference enactments may arise which blur the

boundary between who is analysing whom and open the question of whether the patient's articulation of such fantasies is in service to, not the analytic task, but the analyst's narcissism (Mills, 2005).

In the context of the analytic relationship, the respective roles of care-giver and care-receiver determine the open examination of the patient's subjective world, payment for professional services rendered, the analyst's comparative silence and the latter's formal registration with a professional organisation which enforces ethical standards. The fee entailed is presumably warranted by the analyst having mastered a particular body of knowledge and by his/her facilitation of the patient's search for self-understanding (Gabbard, 1997). While the latter features of the analytic relationship do not imply that the analyst's interpretations are invariably correct or superior to the patient's perceptions, they do arguably structure a therapeutic relationship which remains unequivocally unequal and asymmetrical (Gabbard, 1999; Louw & Pitman, 2001). The latter observations appear to csat some doubt on the relational claim that analyst and patient may be viewed as equal and mutual co-participants in the construction of enactment phenomena. Analytic mutuality, remarks Mills (2005), may in fact be confined to the sharing between analyst and patient of "collective values that define us all as human beings but they are far from being equal" (p. 179). Despite its considerable contribution to acknowledging the impact of the analyst's phenomenology on analytic work and to creating a warmer, emotionally more satisfying therapeutic climate, Mills (2005) concludes that the relational framework may simultaneously stimulate "the undisciplined use of self-disclosure … uninhibited risk taking, and flagrant boundary violations" (p. 177). It therefore remains incumbent upon the analytic community to identify questionable or excessively experimental practices in order to encourage frank discussion in professional space of "exactly what constitutes a legitimate execution of analytic method" (Mills, p. 178).

The foregoing discussion appears to confirm that Kleinian, classical and relational definitions offer markedly different perspectives on the nature of the unconscious determinants driving countertransference enactments. Despite the latter differences, the question remains as to whether commonalities can be established between the several definitions and portrayals of enactment phenomena offered in the literature. Compounding current debates as to what exactly comprises an enactment are arguments proposing that the analytic process in its entirety may be construed as a continually occurring continuum of

normal and pathological enactments (Cassorla, 2005). Enactments may span, additionally, the analyst's forgetting, altered tone of voice, subtle shifts in body posture (Frayn, 1996; Gabbard, 1995; McLaughlin, 1991) and his/her subjective experience of "inhibited responsiveness" (Ivey, in press) to the patient.

What arguably distinguishes countertransference enactments from multiple alternative therapeutic activities is the analyst's seemingly overwhelming subjective experience of being stripped of any autonomous choice as to whether to participate or to resist and "desperately … [try] to stand outside the patient's system and play no role at all" (Mitchell, 1988, p. 292). Thus apparently common to the various definitions discussed is the affective kernel or "evocative power" (Chused, 1991, p. 617) of countertransference enactments to unconsciously coerce the therapist into inadvertently crossing the boundary between thought and action. This regressive impulse may be subjectively experienced as particularly acute when "action … is motivated by [the urgent need] for tension relief on the part of the analyst" (Steiner, 2006, p. 316). Writing of erotic countertransference enactments, Gabbard (1999) similarly observes that the countertransference affects evoked "are powerful, immediate, and compelling in their tendency to override the steady reflectiveness of the analyst" (p. 1085).

Consensus moreover prevails among Kleinian, classical and relational theorists that countertransference represents "a joint creation" (Gabbard, 1995, p. 481) wherein the analyst is widely construed as vulnerable to succumbing to the irrational sway exerted by the co-created transference-countertransference matrix (Hirsch, 1998). Hence the analyst is perceived as being invariably drawn into playing a designated role derived from the patient's internal object world. The "final shape" (Gabbard, 1995, p. 480) of the analyst's countertransference response is, however, determined by his/her own subjectivity and the "fit" between the patient's projections and the "hooks" provided by the therapist's own conflicts or internal self and object representations. Capturing this sense of susceptibility, McLaughlin (1991) observes "the old truth … that the [analyst's] transference ghosts are never entirely laid to rest … . In the intensity of new work … they return in fresh shape to revive shades of significance I had long forgotten I knew. Enactments are my expectable lot." (p. 613).

14. THREE SUBCATEGORIES OF COUNTERTRANSFERENCE ENACTMENT

The professional literature reveals apparently discrete subcategories of countertransference enactments. “Interpretative enactments”, firstly, are envisaged by Steiner (2006, p. 317) to be composed of ostensibly beneficent verbal communications directed at clarifying an aspect of the patient-analyst relationship. When provoked by transference pressures, Steiner (2006) observes, the analyst’s verbal communications can constitute verbal enactments “disguised as interpretations” (p. 317) which subtly function to convey the therapist’s unacknowledged values, preferences, disavowed feelings and critical judgments. Similarly, Gutheil and Gabbard (1993) comment on the potential for the therapist’s verbal comments to comprise the forum for sadomasochistic enactments. Although ostensibly rationalised as beneficent therapeutic confrontation, Gutheil and Gabbard (1993) suggest that the therapist’s cruel verbal comments may in fact be tantamount to an aggressive enactment which derives from unresolved countertransference sadism.

“Nonsexual boundary violations” (Gabbard & Lester, 1995, p. 122) represent a second subcategory of countertransference enactments encompassing both innocuous possibly useful “boundary crossings” (p. 123) as well as egregious “boundary violations” (p. 123). Gabbard and Lester (1995) describe as an instance of the former type of countertransference enactment an analyst’s unsolicited urging of a female patient to enter into a new relationship with a male colleague. The attenuated countertransference impulse or “crossing” was retrospectively subjected to analytic scrutiny and no irreparable damage to the patient was evident. Even when eschewing overt sexual relations, “the lovesick analyst” (Gabbard & Lester, 1995, p. 142), seeking solace from the patient for an unfulfilled personal life, provides an example of a contrasting countertransference enactment. The latter enactments are characterised by role reversal, increasing exploitation of the patient’s transference vulnerability, loss of the critical “as-if” or symbolic dimension of the therapeutic relationship and the analyst’s resistance to subjecting escalating boundary violations to post-enactment scrutiny.

In contrast to unconscious countertransference enactments saturated with emotionally charged affects, Slochower (2003) identifies a third distinct subcategory of countertransference misdemeanours or enactments which she terms the analyst’s “secret delinquencies” (p. 455). These analytic lapses, Slochower argues, are intentionally

concealed from the patient who may be lying on the couch or talking to the analyst on the phone. They are committed with greater deliberation than unconsciously motivated enactments and comprise relatively minor breaches wherein the analyst deliberately disengages affectively or cognitively in order to pursue some personal desire or need. Rather than frank abuse of the patient, this enactment subcategory entails the solipsistic withdrawal of the analyst into activities that include, for example, "… adding to a grocery list … painting one's nails … checking email … buying airline tickets online …" (p. 453).

The latter shameful and guilty transgressions of professional standards may evoke perceptions of colleagues as censorious "moral police" (Slochower, 2003, p. 456) and "therapist delinquencies" accordingly seldom enter into peer discussion or supervision. The "stealing" of these "small pleasures" (Slochower, 2003, p. 462) is understood as revelatory not only of possible relational treatment configurations but also of the very human impossibility of cleaving to an analytic ideal which demands that the analyst should remain consistently fully present for the patient. Given the sensory deprivation inherent in spending long hours in a single consulting room and the intense emotional demands of "this impossible profession", Slochower (2003) argues that "unless we own and consistently struggle with our greed, sense of deprivation, or selfishness – with our very *unideal* humanity - it is almost inevitable that [such] feelings will ultimately become sequestered and thus expressed illicitly" (p. 468).

15. THE FOURTH SUBCATEGORY: ETHICAL DECISION-MAKING PATHWAYS AND RELATED COUNTERTRANSFERENCE ENACTMENTS

In addition to the preceding three subcategories of countertransference enactment, an implicit fourth subcategory pertaining to the ethical decision-making process may apparently be discerned in the professional literature. Inherent in the practice of psychoanalytic psychotherapy is a seemingly inescapable ethical dimension. Capturing this aspect, Solomon (Solomon & Twyman, 2003) observes that "ethics is with us professionally all the time in the consulting room, day by day, hour by hour … we are, as professionals, constantly living within an ethical dimension" (p. 22).

Clinical decisions which transpire in the analytic space cannot, however, invariably be relegated to the ethical decision-making process. The currently highlighted category of decisions brings into focus the analytic task, setting and attitude. Contemporary theory

defines the principal task of psychoanalytic psychotherapy as the ongoing analysis and insightful resolution of the patient's unconscious conflicts (Ivey, 1999; Stokoe, 2000). The analytic setting or frame is construed as the reliable provision of boundaried space wherein the patient's unconscious conflicts may safely be explored (Langs, 1982; Siegelman, 1990; Tylim, 2004). The analytic attitude is characterised as the therapist's dual capacity for both immersion in and understanding of the analytic process (Gabbard & Lester, 1995). The class of decisions under consideration may accordingly be narrowed to those called forth by real-life ethical dilemmas defined objectively by professional ethics codes and categorisation systems (Pope & Vetter, 1992; Slack & Wassenaar, 1999) or subjectively construed by the analyst as comprising an ethically conflictual situation wherein the analytic task, setting and attitude are rendered conspicuously vulnerable to compromise.

15.1. The First Ethical Decision-Making Pathway

Assuming that the therapist's capacity for identifying ethical dilemmas has been well established (Baldick, 1980), the professional literature on ethical decision-making apparently implicitly acknowledges three variants or pathways of ethical deliberation[7]. The linear models reviewed earlier for the most part emphasise an ethical decision-making pathway that is apparently determined by reasoned deliberation, that occurs without enactment and is in accord with nonmaleficence foregrounded as the governing principle of therapeutic engagement (Stokoe, 2000). Thus the CPA (2000, Preamble) surmises that "The ethical decision-making process might occur very rapidly, leading to an easy resolution of an ethical issue. This is particularly true of issues for which clear-cut guidelines or standards exist and for which there is no conflict between principles".

From a psychoanalytic perspective, the linear and "easy resolution" of ethical dilemmas suggests that the therapist's pre-existing "self - object - affect constellations" (Gabbard, 1995, p. 477) and intrapsychic conflicts may not have been strongly mobilised. In such

[7] The three ethical decision-making pathways may be summarised as:
1. the therapist's thoughtful emotionally appropriate resolution of the dilemma incurs no countertransference enactment and has negligible or no harmful consequences to the patient;
2. the therapist's apparently unresolved countertransference anxieties find repeated behavioural expression in ethical decision-making enactments which are not subjected to post-enactment scrutiny, raising the risk of harmful consequences to the patient;
3. the therapist's resolution of the dilemma entails ethical decision-making enactments which are retrospectively thoughtfully reviewed and openly addressed with the patient. Possible re-engagement with the decision-making process and the therapist's reparative efforts hopefully mitigate any harmful consequences for the patient.

relatively emotionally uncomplicated situations, the therapist's reflective capacity remains apparently undisturbed and capable of robustly metabolising the transference-countertransference affects, moral ambiguities and interpersonal pressures generated by the ethical dilemma concerned. Seemingly in accord with either or both the analytic attitude and the therapist's professional ethics code, this first ethical decision-making pathway is apparently ethically and technically sound, with negligible or no harmful consequences suffered by the patient.

15.2. The Second Ethical Decision-Making Pathway

The process of ethical decision-making may alternatively comprise fertile ground for the evocation of irrational and disorienting affects in the therapist. The CPA (2000, Preamble) implicitly introduces a second ethical decision-making pathway with the statement that "some ethical issues … are not easily resolved, might be emotionally distressful and might require time-consuming deliberation". This second pathway arguably encompasses the contrasting possibility of incurring emotionally charged and unresolved countertransference enactments.

Common therapeutic "sites" (Guthiel & Gabbard, 1993, p. 190) which remain susceptible to chronic countertransference enactments and harmful boundary transgressions include analyst self-disclosure, unpaid bills and repeated departures from the boundaries of the analytic frame. Implicit in the following descriptions of the different therapeutic "sites" is the notion that the analyst's idiosyncratic or "narrow countertransference" may compromise the ethical decision making process leading to the behavioural expression of an "ethical decision-making enactment". In the context of therapist self-disclosure, for example, the latter authors argue that the repeated, and presumably unexamined, self-revelation of fantasies, dreams and personal information may be experienced as burdensome to the patient. Potential revelation of "the real relationship" (Guthiel & Gabbard, 1993, p. 194) may accordingly constitute an "ethical decision-making enactment" which derives from self-interest and unfulfilled personal needs in the therapist's private life rather than from any objective appraisal of its usefulness for the patient's therapeutic journey. Mounting anger occasioned by the therapist's inability to confront the patient's unpaid bills may similarly signal a therapeutic impasse and an enactment structured principally by the former's apparently unresolved conflicts around the multiple and dynamic meanings of money. Seemingly impulsive decisions to give gifts or physical hugs to the patient and repeated

therapist transgressions of temporal or spatial boundaries comprise additional examples of "ethical decision-making enactments". As Guthiel and Gabbard (1993) comment "The obvious exploitive nature of these boundary violations destroys even the semblance of therapy for the patient's benefit." (p. 193).

In common with the three preceding subcategories of countertransference enactments, "ethical decision-making enactments" arguably reveal the therapist's continuing susceptibility to succumbing to the influence of unconscious determinants often driving the decision-making process. The ostensibly rational ethical decision-making process may often be disconcertingly congruent with Steiner's (2006) formulation of the unconscious dynamics structuring enactments in general. Rebutting Levenson's (2006) argument that countertransference enactments comprise "the behavioural component of what is being talked about" (p. 322), Steiner (2006) objects that, on the contrary, enactments more commonly represent "what is not … talked about, what is repressed or split off and projected because it is too disturbing to be talked about" (p. 327).

In short, the second ethical decision-making pathway is apparently characterised by the presence of unretrieved countertransference enactments wherein the therapist's analytic capacity is chronically impaired or "clouded" (Chused, 1991, p. 634). This suggests that "ethical decision-making enactments" may arise when the ethical decision-making process is repeatedly compromised by the analyst's personal countertransference, by the patient's unexamined projective identifications or by intersubjective admixtures derived from the sustained unconscious collusion of both members of the analytic dyad. The second pathway appears unlikely to accord with either the analytic attitude or professional ethics codes, thus raising the risk of harmful consequences to the patient.

15.3. The Third Ethical Decision-Making Pathway

The value for the analytic process lies not in the enactment itself but in retrospectively understanding its possible unconscious meanings and working through these interpretively with the patient (Chused, 1991; McLaughlin, 1990; Renik, 1993). Central to whether an ethical decision-making enactment comprises a possibly valuable "boundary crossing" as opposed to an egregious "boundary violation" (Gabbard & Lester, 1995, p. 123) appears to be the submission of the therapist's countertransference responses to post-enactment scrutiny.

The CPA's (2000) familiar ethical decision-making model clearly states the importance of the practitioner's evaluation of, and taking personal responsibility for, the consequences of the course of action finally adopted. From the perspective of psychoanalytic ethics, the third ethical decision-making pathway is similarly distinguished by thoughtfulness and the post-enactment restoration of reflective space. Given that the therapist is not a self-transparent moral agent, the third pathway invites empathic collegial assistance to help "parse" (Slochower, 2003, p. 457), or distinguish between, unconscious contributions deriving principally from the clinician's subjectivity as opposed to those arising primarily from the patient's expulsion of intolerable internal contents. Solipsistic self-analytic efforts to identify retrospectively which of the therapist's internal representations are likely to act as "hooks" (Gabbard, 1995, p. 477) for the patient's projections often appear to be markedly unsuccessful (Ivey, in press). As Stokoe (2000) succinctly observes "The container of therapy itself needs to be contained." (p. 29).

The therapist's renewed reflective functioning is directed, in the optimal context of an empathic other, to apprehending the possible unconscious meanings of the ethical decision-making enactment. The third pathway may further involve openly addressing with the patient any negative consequences that have ensued in the wake of the enactment, re-engaging with the ethical decision-making process and the thoughtful implementation of alternative courses of action. Frank and open discussion by the therapeutic dyad of the impact of possible boundary transgressions often defuses their capacity for harm and may serve to prevent a boundary crossing from becoming an entrenched boundary violation (Gabbard & Lester, 1995; Gutheil & Gabbard, 1993).

In short, the third pathway is characterised by the thoughtful retrieval of ethical decision-making enactments and, as the CPA (2000) suggests, possible re-engagement with the ethical decision-making process. Identification of negative consequences and open discussion with empathic colleagues and with the patient may generate ethically and technically sound alternative courses of action. These reparative efforts by the analyst may be construed as congruent with both the analytic attitude and professional ethics codes and hopefully mitigate any harmful consequences for the patient.

The preceding three variants of ethical deliberation represent a preliminary effort to delineate more clearly key ethical decision-making pathways that are implicit in the

professional literature. These pathways invite further refinement but inevitable exceptions render the precise identification and definition of all possible ethical decision-making pathways an elusive prospect. As Zoja (2007) comments, when ethical judgments are called for, the analyst is invariably situated in an intermediate "gray zone" or psychological territory replete with contradictions and ambiguities. Of ethics and ethical deliberation, Zoja (2007) writes that "In that [gray] zone we will never be able to claim that we have found the final truth, yet we shall always find ourselves standing in [a] landscape that is most apt for ethical elaboration." (p. 66). Despite problems of definition, retaining the notion of pathways and the subcategory of "ethical decision-making enactments" may help to highlight the need for tolerating and elaborating the meaning of the irrational affects that so frequently appear to characterise the ostensibly linear ethical decision-making process.

16. CLASSIFICATION OF COUNTERTRANSFERENCE ENACTMENTS: THE BENEFICENCE-MALEFICENCE GRADIENT

Different attempts have been made to classify countertransference enactments using a range of diverse criteria. Countertransference enactments have been conceptualised, for example, as occurring along a continuum determined at one end primarily by the patient's projective identifications and at the other by the analyst's "narrow countertransference" with considerable overlap or interaction in between (Gabbard, 1995; Varghese & Kelly, 1999). A second continuum envisaged by Louw and Pitman (2001) similarly presents countertransference enactments as determined by the relative contributions of the patient and the analyst, with the added qualification that enactments may range in time from acute to chronic. Acute, time-limited "analysand-centred actualisations" (Louw & Pitman, 2001, p. 757) are likely to be benign, allowing the analyst to utilise his/her role-responsiveness to deepen an empathic understanding of the patient's intrapsychic world. In contrast, chronic "analyst-centred actualisations" (Louw & Pitman, 2001, p. 757) at the other of the continuum derive from the latter's idiosyncratic responses or transference to the patient. These enactments are likely to be malignant "as the analyst's personal motivation is foregrounded at the expense of exploring the analysand's transference" (Louw & Pitman, 2001, p. 757). The foregoing distinctions between acute, potentially benign and chronic, probably malignant countertransference enactments, bear some resemblance to the subcategory of nonsexual boundary transgressions which appear to be marked either by discussable, relatively innocuous "boundary crossings" or by severe, repetitive and usually unacknowledged "boundary violations" (Gabbard & Lester, 1995, p. 122).

In setting out the analytic process as a succession of constantly occurring enactments, Cassorla (2005) proposes a third classification which encompasses benign actualisations at one end and prolonged or acute pathological enactments derived from massive "crossed projective identifications" at the other (Cassorla, 2001, p. 1158). In contrast to Louw and Pitman (2001) and Gabbard and Lester (1995), however, Cassorla (2001) argues that prolonged, chronic enactments are not necessarily malign and can, when understood, be productively used. Thus Cassorla hypothesises that prolonged countertransference enactments may over time permit trust in the analytic relationship to evolve, delaying the premature exposure of the patient's deeper narcissistic or destructive conflicts. A symbiotic phase or "necessary collusion" (Cassorla, 2001, p. 1166) arises wherein experiences of the analyst as a new object emerge and the patient's first developmental phases are re-lived. An acute enactment may subsequently violently disrupt this symbiosis. The disruption intuitively signals the analytic dyad's readiness to dismantle the prolonged enactment and to risk engagement with triangular relationships wherein the analyst as a third party no longer functions as a narcissistic extension of the patient.

A fourth classification proposed by Ivey (in press) conceives of countertransference enactments as occurring along "a reflective-expressive gradient". Calibrating the degree of action involved, Ivey suggests that countertransference enactments may range from a point where the analyst's emotional arousal is subjectively experienced and introspectively observed without significant behavioural expression to one where charged affects manifest in overtly disruptive verbal or non-verbal action before being „caught' and retrospectively examined. Occupying the middle ground are milder transference actualisations which find attenuated but still detectable expression. Distancing from Steiner's (2006) claim that the analyst's capacity for containment necessarily precludes action, Ivey offers the alternative perspective that "Containment is not antithetical to enactment, rather, enactment is *part* of a containing process whereby unmanageable feeling is first induced in and expressed by the analyst before becoming thoughtfully managed, understood and refined into something useable by the analytic pair".

The different criteria used in the preceding classifications include consideration of the relative contributions of the analytic dyad, the question of whether enactments are continuous, periodic, chronic or acute, the nature of "boundary crossings" and "boundary violations" as well as the "reflective-expressive" dimension of enactment phenomena.

Earlier discussion of ethical principles foregrounded nonmaleficence as arguably comprising the superordinate or governing principle of therapeutic engagement (Brown, 1982; Kitchener, 1984; Solomon, 2003b; Stokoe, 2000). This suggests that concerns implied by previous classification criteria regarding the exploitation of the patient may alternatively be reconvened under a specifically ethical rubric regarding the potential countertransference enactments carry for beneficence as well as for maleficence.

Distinctions between innocuous potentially useful analytic breaches and more serious boundary violations are inevitably "subjective, contextual, and open to interpretation. The gravity of a given breach is always colored by the particulars of the patient's experience … and the sociocultural context in which treatment takes place" (Slochower, 2003, p. 456). Given the latter difficulties in making absolute distinctions, a classification of countertransference enactments which highlights an ethical dimension may be roughly envisaged as comprised of a beneficence-maleficence gradient.

At the beneficence end lie those countertransference enactments which transpire in the context of the third ethical decision-making pathway described earlier. Characterised by the creation or recovery of reflective space, such enactments may be retrospectively construed as having probably evoked no lasting harms and as additionally carrying potential for beneficence or for positively contributing to the patient's psychological growth and well-being. The latter countertransference enactments may see the analyst's subjectivity or inner experiences as beneficently harnessed in the service of forging "a valuable pathway to understanding the unconscious of the patient" (Jacobs, 1999, p. 579). In these circumstances, Lacovics (1983) and Racker (1957) suggest, the analyst's counter-transference responses may, on examination, yield useful evidence of concordant identifications (identification with a patient's internal self-representation) or complementary identifications (identification with an object-representation). Thus, foregrounded at this end of the gradient, is the analyst's capacity for thoughtfulness, containment and for submitting the charged affects generated by ethical dilemmas to post-enactment scrutiny.

Malign countertransference enactments appearing at the contrasting end appear to be characterised by the second ethical decision-making pathway. The latter enactments may effectively destroy the core goal of the patient's psychological healing which lies at the heart of the psychotherapeutic enterprise (Halpern, 2003, in Kantrowitz, 2006). Often

emerging in the emotionally or erotically charged heat of the clinical moment, malign enactments may involve sexual and nonsexual boundary violations, are usually unretrieved, and are seemingly organised either by the patient's unexamined projections or by the clinician's unresolved countertransference needs and anxieties (Gabbard & Lester, 1995; Kelly, Varghese & Pelusi, 2003; Varghese & Kelly, 1999). In between these outer poles lie apparently milder countertransference enactments which may be initiated by either member of the analytic dyad. Attenuated in nature, apparently characterised by relatively innocuous boundary crossings and retrospective scrutiny, no significant harms would appear to accrue to the patient.

The following two vignettes (Da Silva, 2003; Kantrowitz, 2006) provide different illustrations of "ethical decision-making enactments", their respective pathways and their placement along the beneficence-maleficence gradient. The discussion below includes consideration of two core controversies evoked by enactment phenomena; these pertain to the issues of objectivity and therapist self-disclosure.

17. ILLUSTRATING THE BENEFICENCE-MALEFICENCE GRADIENT: A PATIENT-INDUCED ETHICAL DECISION-MAKING ENACTMENT

Da Silva (2003) presents a confidentiality dilemma involving prospective legal proceedings which threatened to derail the analysis of "Pandora", a patient with a propensity to invite personal disaster. Pandora was convinced that her previous analyst had "failed" her by unilaterally terminating her prior analysis with minimal explanation. It was crucial, Pandora felt, "to denounce" this failure; the alternative "was … to kill herself or to go mad" (p. 152). The patient complained to her ex-analyst's professional association and then sued him in civil court. She expressed the wish that Da Silva, now her current analyst, should testify on her behalf. With the impending threat of receiving a subpoena from Pandora's lawyer, Da Silva vacillated for weeks between conflicting moral obligations. He felt torn between trying to decide whether he would comply with the law and with his patient's expressed wishes by testifying in court or whether he would refuse, thus safeguarding confidentiality and the privacy of the analytic process.

The patient's relevant history concerned her psychotic father and melancholy mother who had failed "to denounce" her spouse's crazy behaviour towards their daughter. As a child, Pandora had been adjured by her mother to silently collude, turning "a blind eye" as if

nothing untoward ever happened. On accepting Pandora as a patient, Da Silva surmised that these early familial dramas had been recreated in the patient's transference perceptions of the "failures" of her ex-analyst and of the ethics committee "to denounce" him. The emergence in the analysis of an unanticipated confidentiality dilemma induced in Da Silva unexpectedly painful countertransference affects of anxiety, anger and guilt towards the patient, fears of going to jail and overwhelming confusion. Extensive collegial consultation afforded little relief; most colleagues concurred that no reasonable alternative existed other than that of guardedly testifying in court. Sucked into these disquieting affects, Da Silva observes that only after many weeks was he able to formulate the understanding that the patient's threats to draw him into her extra-analytic battles dramatised the intolerable circumstances she had once suffered as a child. Accordingly, Da Silva comments that "… I knew that I was in the midst of a confusion similar to the one my patient had been unable to resolve. It fell to me, and to … analysis, to contain and to tolerate her impossible demands and accusations … in the hope of doing the [analytic] work … needed to resolve this confusion" (p. 154).

This growing understanding of his subjective experiences appeared to afford Da Silva sufficient relief from countertransference pressures to decide against testifying and instead to offer Pandora an interpretation. He informed his patient that, as he would explain to any prospective judge, further analytic work would be impossible if he were to play any role in her external life. If he served as a witness, Da Silva continued, he would destroy his ethos as a psychoanalyst and he would "fail" Pandora by breaking his original pledge to her of ensuring confidentiality. Alternatively, if he went to court but refused to testify, he would again be "failing" her by his silence and refusal "to denounce" her ex-analyst. In order to maintain his original commitment of confidentiality and his professional ethical standards, he had decided not to testify but to risk being in contempt of court and going to jail. Analysis in these circumstances would, however, cease. Pandora responded to this intervention with anger and threatened to leave. "It was as if ", Da Silva writes, "I were telling her to stop the legal suit, just as in the past her mother had refused to protect her by denouncing the craziness of her father ... . So now I, too, was failing her deeply." (p. 155).

The case was finally settled out of court. A more trusting analytic relationship arose alongside the mutual recognition by both analyst and patient that the threat of third party intervention had acted as a resistance against exploring Pandora's painful internal conflicts.

Da Silva reports that the patient realised that her projected wish for perfection functioned as a cruel persecutor who tolerated no failings in herself or in others. This led to the changed perception that no analysis is "perfect" and a measure of compassion appeared to emerge in the patient for herself, her parents and her analysts.

17.1. Discussion of the First Case Vignette

International comparisons suggest that confidentiality ranks as the most troubling category of ethical dilemmas for psychologists (Pettifor & Sawchuk, 2006; Slack & Wassenaar, 1999). As discussed, the highlighted class of decisions pertains to ethical dilemmas defined objectively by categorisation systems and professional ethics codes or subjectively by the analyst's identification of an ethically conflictual situation. Both criteria prevail in Da Silva's (2003) resolution of a confidentiality dilemma which thus implicitly involves the ethical decision-making process under consideration.

The confidentiality dilemma posed two sharply conflicting courses of action. Not testifying would allow Da Silva to maintain confidentiality and his professional ethos but incurred the risk of jail. Obeying the law and testifying raised the alternative spectre of subverting the therapeutic alliance through engagement with "the real relation" (Meissner, 2002, p. 846), those extra-analytic factors that apparently serve no analytic end but increasingly endanger "the combined freedom of thought in the analyst and freedom of speech in the analysand" (Furlong, 2005, p. 380). Such external factors would include third party demands from lawyers, courts and judges for the disclosure of sensitive confidential material "as private as our own dreams at night" (Da Silva, 2003, p. 162). Da Silva's subjective feelings of anxiety and confusion, his vascillation and eventual offering of an interpretation raise queries as to whether any ethical decision-making pathways are implicit in his account and what implications these carry for the classification of countertransference enactments along the beneficence-maleficence gradient.

The clinical fragment reveals that Da Silva was inadvertently embroiled in emotionally charged countertransference affects that overwhelmed, immobilised and disoriented him for weeks. Leaving him "unsure what to do or say" (Da Silva, 2003, p. 154), Da Silva's subjective countertransference experiences effectively exclude the first ethical decision-making pathway or the resolution of ethical dilemmas through reasoned deliberation alone. Using Bion's (1962) container-contained model, Da Silva contends that the gradual

restoration of his reflective capacity enabled him to detect in his seemingly irrational countertransference reactions the presence of the patient's projected internal objects and selves. This renewed thoughtfulness likewise excludes the second ethical decision-making pathway characterised by the chronic collapse of the analyst's reflective space and by the "unforgivable analytic mistake" (Lipton, 1977, in Hirsch, 1998, p. 83) of failure to analyse the impact of the latter's participation in the enactment concerned. In short, Da Silva's account emphasises the third ethical decision-making pathway characterised by the recovery of a reflective space and by the therapist's capacity for containment of countertransference anxieties and unconscious motives. Action, in the context of the third pathway, accordingly appeared to be contingent on Da Silva's efforts to think about, to process and to make sense of the patient's projected and charged effects which consistently permeated the unfolding dilemma.

The interpersonal pressures generated by the confidentiality dilemma arguably appear to conform to a fundamentally Kleinian definition of countertransference enactment. Rather than any mysterious or mystical transportation of mental contents, Ivey (2004) argues that projective identification remains a superordinate concept which encompasses Sandler's (1976) notion of role responsiveness and which states that intrapsychic phantasy always involves identifiable intersubjective pressures or "precise interpersonal behaviors that induce the therapist to feel and act in a manner consistent with the projected [and disavowed] parts of the patient's self…" (p. 6). In her actual recruitment of lawyers, threats of subpoena and hectoring demands that Da Silva should testify, Pandora appeared to successfully provoke in her current analyst disavowed alien feeling states congruent with her internal object relational world.

Early phases of the ethical decision-making process may thus be conceptualised as the analyst's unwitting immersion in the transference-countertransference interaction generated by the analytic dyad. Impulsive implementation of either immediate course of action available, to testify or to desist, would have seen Da Silva immersed in a florid ethical decision-making enactment, ostensibly resolving the confidentiality dilemma by taking up a designated and highly compromised maternal transference role. From this perspective, testifying might additionally be construed as the patient's unconscious efforts to stampede her analyst into the further enactment of a punitive archaic superego role, "ganging up" (Steiner, 2006, p. 317) against and publicly "denouncing" her ex-analyst in court. By

contrast with these potential scenarios, Da Silva was clearly not impelled into overtly disruptive or harmful behaviour. However, enactment phenomena may by inferred from Da Silva's descriptions of his prolonged subjective feelings of confusion, emotional struggle and virtual immobilisation. Data from the vignette suggest that the latter countertransference responses arguably derive from the analyst's sustained concordant identification with his patient's projected anxious and confused self-representation as well as from a complementary identification based on a profoundly "failing" maternal part-object representation.

The clinical vignette suggests that the third ethical decision-making pathway encompassed not only the foregoing immersion in the patient's internal object world but also later phases, relatively free of countertransference pressures, wherein the confidentiality dilemma was contained, "digested" and retrospectively thought about. Accordingly, Da Silva writes that "The essential thing is to hold the projections long enough to allow … the "unthinkable" in the patient's mind…. to be thought about and contained in the mind of the analyst. This is an important part of the process [whereby] meaning emerges in the analytic space." (p. 159). Growing understanding that his overwhelming countertransference reactions reflected in part his patient's habitual object relational patterns apparently led to Da Silva feeling less gripped by the dyad's emotional field, helping to secure thoughtful decision-making and the eventual resolution of the confidentiality dilemma. Thus Da Silva lucidly describes the implementation of his final decisions to safeguard his original pledge of confidentiality and his professional ethos by not testifying, to accept the "repugnant" possibility of jail and to attempt to collaboratively work through with his patient the possible meanings of the preceding countertransference enactments.

Da Silva's protracted experience of confused states, of feeling alternatively pulled towards testifying and of immobilisation suggests a primarily patient-induced "ethical decision-making enactment" which might arguably be situated at the beneficent and "reflective" (Ivey, in press) ends of the classification gradients concerned. The attenuated expression of Pandora's internal object world through a series of concordant and complementary countertransferences (Lakovics, 1983; Racker, 1957) incurred no significant harms to the patient. Da Silva moreover contends that his subjective countertransference responses were beneficently deployed in providing "a valuable pathway to understanding the inner experiences of the patient …" (Jacobs, 1993, p. 7). Hence empathic understanding of the

patient's unconscious childhood dynamics appeared critical to engagement with the later phases of the ethical decision-making process which sought to secure the analytic process and the patient's continued emotional growth.

17.2. The Controversy of Objectivity

Da Silva's (2003) apparently successful negotiation of the third ethical decision-making pathway opens a window onto acrimonious debates pertaining to the notion of objectivity. Since the analyst's capacity for retrospective thoughtfulness presupposes a measure of objectivity and comprises the distinguishing feature of the third pathway, current controversies concerning the possibility and nature of objectivity carry relevance for the ethical decision-making process. The following quotations demonstrate that different psychoanalytic schools of thought embrace strongly opposing theoretical positions:

> *... objective reality is unknowable by the psychoanalytic method, which investigates only subjective reality ... there are no neutral or objective analysts, no immaculate perceptions, no G-d's-eye views of anything (Stolorow, 1998, p. 425).*

> *... I think that it is possible for the analyst to be subjectively involved in the analytic interaction but to take at least a partly outside view of it ... there is usually a fluctuation in the session between being 'in' and being somewhat 'outside' the interaction...sometimes [in very heated moments] it is not until the session is over that the analyst may have another additional view to set alongside the feelings and thoughts he experienced in the session (Bott Spillius, 2004, p. 1059).*

> *... it is **impossible** for an analyst to [objectively focus on a patient's inner reality] **even for an instant** ... our technique, listening included, is **inescapably** subjective (Renik, 1993, p. 560).*

> *... I disagree with Renik's dictum that „even an implicit pretence of objectivity on the analyst's part is to be avoided' (1993, p. 566). The presence of the analyst's subjectivity does not automatically eliminate the validity of that analyst's outside or object-based perception (Gabbard, 1997, p. 23).*

Relational and intersubjective arguments appear to mount an unrelenting assault on the analyst's authoritative access to objective knowledge (Mills, 2005). The latter approaches seemingly insist that the influence of the analyst's subjectivity on the analytic interaction is irreducible, ever present and cannot be transcended. This vantage point eschews the traditional classical or modernist view that the analyst potentially retains the capacity to observe reality in an objective or nondistorting manner and to exercise privileged access to pre-existing hidden "truth" (Levine & Friedman, 2000). Post-modernist thinking

accordingly refutes the notion that any objective reality exists "out there" (Gabbard, 1997, p. 16) and scepticism is duly expressed about the possibility of ever obtaining objective knowledge about the patient's psyche. Summarising the relational and intersubjective approaches, Meissner (2002) observes that the latter seemingly cast the analyst and the analysis "adrift on a sea of uncertainty" (p. 834). When any objectivity regarding the analyst's understanding of his patient is rendered suspect or nonexistent, when his capacity to form reasonably objective judgments is considered dubious, then, Meissner (2002) comments, the very grounds for undertaking meaningful analytic work must correspondingly be undermined.

Apparently underpinning relational and intersubjective argumentation lies the philosophical claim that the individual human being is limited by and cannot entirely transcend his/her own point of view (Louw & Pitman, 2001). Accepting that the analyst's subjectivity is ineliminable, a more subtle notion of objectivity singularly appropriate to the analytic space might be construed as, not the absolute transcendence of subjectivity, but rather as the gathering and entertaining of additional or "multiple points of view" (Louw & Pitman, 2001, p. 749). These progressive changes in perspective, Louw and Pitman (2001) write, "in so far as they involve the *addition* of different points of view, seem best understood as *gains in objectivity"* (p. 751). Thus the analyst's subsequent reflection and self-analysis of the influence of his/her individual psychology on the analytic interaction may succeed in creating an additional and changed perspective on the nature of both his/her participation as well as of the patient's internal world.

An integrative position proposed by Gabbard (1997) suggests that relative objectivity may be forged through creating a dialectic between modern and post-modern thinking or between a one-person and a two-person perspective. Similar to Bott Spillius' (2004) view, Gabbard (1997) suggests that the analyst vacillates between a two-person intersubjective focus and a one-person relatively objective intrapsychic focus. From the latter vantage point, the analyst, as an „object' separate from and external to the patient's subjectivity, offers a different perspective from that of the patient's internal experience. This new perspective, Gabbard (1997) argues, is potentially helpful in that it may enlarge the patient's understanding of his/her habitual mode of object relatedness and contribute to the creation and negotiation of new meanings generated in the discussion between the analytic pair.

In struggling to resolve a confidentiality dilemma, Da Silva's account presents evidence of an ethical decision-making process which similarly partakes of a "state of double consciousness" (Gabbard, 1999, p. 18). In the earlier phases of ethical decision-making, Da Silva recounts being unwittingly thrust into the patient's internal world or into a painful two-person intersubjective interaction. Later phases of ethical decision-making were, however, characterised by the recovery of the analyst's reflective stance and contrasting status as a separate individual. This pole of the dialectic was comprised by establishing a one-person or relatively objective intrapsychic focus which helped Da Silva to clarify the possible meanings of the sustained ethical decision-making enactments which had earlier gripped the analytic dyad. Refuting the relational and intersubjective approaches, Meissner (2002) concludes that "It has taken us considerable … debate to find our way back to more reasonable middle ground in which we can come to terms with the pervasive fact of our subjectivity and find room within it for forms and degrees of objectivity" (p. 835).

18. AN ANALYST-INDUCED ETHICAL DECISION-MAKING ENACTMENT

Kantrowitz (2006) discusses the attitudes and practices of relational and classically oriented analysts who were confronted with complex ethical decisions pertaining to using disguise and/or obtaining patient consent when publishing clinical material. Commenting on the following brief research interview with a relational analyst, Kantrowitz (2006) observes that the latter's decision to show his written paper to his patient was apparently consciously motivated by the wish to secure the latter's informed consent for publication. Deliberate introduction of his paper into the therapeutic context was additionally viewed by the analyst concerned as a benign relational innovation or "tool for … treatment" (Kantrowitz, 2006, p. 167), stimulating open discussion of the co-constructed meaning of the dyad's analytic work. The research fragment described below invites consideration of the controversial issue of analyst self-disclosure; more particularly, it focuses on the revelation of erotic countertransference.

In the context of the brief interview, the relational analyst recounted that his patient's father had kissed his daughter good-night, an action which was experienced by her as eroticised. In his written paper, the analyst had included his countertransference reaction to the patient, material which had not previously emerged in the treatment situation. Although no details are provided, Kantrowitz (2006) surmises that the analyst's written material served as an inadvertent self-disclosure of his "attraction" (p. 169) or erotic countertransference to the

patient. While the analyst was apparently aware of his original countertransference reactions, Kantrowitz (2006) concludes that he did not apparently perceive that "by giving the patient the paper to read, he bypassed a prohibition, communicating his [erotic] feelings without consciously deciding that he was going to do so" (p. 169).

18.1. Discussion of Second Case Vignette: The Controversy of Self-Disclosure

Prior to discussing the research vignette, and in anticipation of qualitative data generated by this study, the controversy in the professional literature pertaining to the issue of analyst self-disclosure is addressed. Analytic self-disclosure may be considered from the several vantage points of inadvertent self-revelations, deliberate self-disclosure and disclosure as arguably comprising an ethical dilemma. Inadvertent self-revelations comprise "an ineradicable constant" (Meissner, 2002, p. 833) encompassing, for example, the clinician's dress, manner of speech, office décor and nonverbal communications (Gabbard, 1999; Gutheil, 2005; Gutheil & Gabbard, 1998). These self-revelations may be distinguished from the specific technical interventions comprised by intentional self-disclosures which refer to "what an analyst actively chooses to make explicit to a patient in a deliberate and conscious way" (Miletic, 1998, p. 594, in Meissner, 2002, p. 833). Deliberate self-disclosures span, for example, the clinician's decision to discuss other patients with their analysands, to answer patients' questions regarding the analyst's subjective thoughts or feelings, to disclose erotic affects or sexualised dreams and to reveal personal data pertaining to the analyst's private life (Davies, 1994; Mills, 2005; Norris, Gutheil & Strasburger, 2003).

The current relational emphasis on analytic mutuality has apparently facilitated wider acceptance of deliberate analyst self-disclosure as a specific psychotherapeutic technique (Allphin, 2005; Davies, 1994; Gabbard, 1999; Jacobs, 1999). Although Levine and Friedman (2000) concur that intersubjectivity does not necessarily translate into the technical use of intentional self-disclosure, Meissner (2002) contends that relational and intersubjective approaches are generally distinguished by their advocacy of open communication which seemingly "not only allows, but calls for, deliberate self-disclosure by the analyst" (p. 828). Proponents of self-revelatory approaches argue that free communication of the analyst's thoughts and feelings facilitates the demystification and de-idealisation of the therapist, thereby contributing to authentic affective engagement and greater egalitarianism in the therapeutic relationship (Gutheil, 2005). Any heightened transference-countertransference interaction which results from deliberate

countertransference disclosure is apparently welcomed by relational analysts since "it approximates the way real relationships are naturally formed in patient's external lives, including the rawness, tension and negotiability of the lived encounter, with the exception that the process falls under analytic sensibility" (Mills, 2005, p. 180). Several relational analyst-authors in Kantrowitz's (2006) research tended to construe the effect on patients of reading about themselves and of increased exposure to the analyst's intentional disclosure of countertransference responses as having positively benefited the analytic work. Not only was analysts' sharing and reviewing of their written material perceived by them as having promoted a new consciousness of previously unrecognised aspects of themselves at work, but their writing was also understood to have effected the relevant patient's psychological change by validating the latter's perceptions about his/her analyst and by boosting awareness of central conflicts and defences.

Opposing mainstream self-revelatory trends are contrasting arguments cautioning that the long-term effects of deliberate self-disclosure are as yet unknown. The technique, moreover, risks burdening patients with unsolicited information regarding personal struggles (Gabbard, 1999; Norris, Gutheil and Strasburger, 2003), precipitating unhelpful role reversal (Gutheil & Gabbard, 1998) or a "two-patient paradigm" (Meissner, 2002, p. 843) and curtailing patients' freedom to explore "the analytic space of „as if" and play" (Kantrowitz, 2006, p. 180). In deploying the seemingly plausible rationale of promoting openness and "honesty", the technique of deliberate self-disclosure may on the contrary hasten descent down "the slippery slope" (Gabbard & Lester, 1995, p. 88), fostering countertransference-based interventions such as "When you say that, I became sexually aroused; how can we understand that?" (Norris, Gutheil & Strasburger, 2003, p. 517).

The fundamental issue, argues Meissner (2002), is whether self-disclosure, under the guiding principle of neutrality, serves the best interests of the patient and the analytic process. Deliberate self-disclosure, Meissner (2002) cautions, may tilt the therapeutic process towards personal affective investment by the analyst in "the real relation" (p. 846) and away from exploration of the transference in the context of the therapeutic alliance. Any proposed self-disclosure accordingly needs careful sifting for countertransference implications and for ascertaining the degree to which it is consistent with "neutrality". The latter guiding principle, Meissner (2002) suggests, is defined, not in behavioural terms, but as an aspect of the analyst's mental stance which strives to hold itself equidistant from the

demands exerted by ego, id and superego. Whether any particular self-disclosure is "neutral" thus depends "on the degree to which it is consistent with the norms for understanding and facilitating the analytic process" (Meissner, 2002, p. 831). Apparently shared by Meissner (2002), Miletic (1998) and Mills (2005) are concerns that relational and intersubjective proclivities towards deliberate self-disclosure may on occasion service situationally inappropriate unfulfilled personal needs, impeding the analyst's capacity to move freely between states of affective engagement and reflective observation. Expressing in a series of disquieting questions, Miletic (1998) asks "What of the analyst's thoughts, feelings, reactions and personal details are to be consciously and deliberately disclosed in order to be helpful to the patient and to the unfolding of the analytic process? How much do we say about ourselves, and how far do we go? ... How do we know which motives are being served when we talk about ourselves? Our own, or those of the patients?" (p. 515).

In addition to inadvertent self-revelations and deliberate self-disclosure, the professional literature refers to a third usually implicit vantage point. While the decision to disclose or not has been envisaged as one which primarily involves "analytic technique" (Levine & Friedman, 2000; Meissner, 2002; Renik, 1993a; 1993b), Allphin (2005) suggests that analyst self-disclosure additionally presents an unambiguous ethical dilemma. The analyst's narcissism, Allphin (2005) comments, may unconsciously motivate unethical "self-disclosures that come from our own need to talk and [to] be seen" (p. 464). Similarly, Bott Spillius (2004) highlights the inherent ethical dimension intertwined in clinical practice when she observes that the problem incurred by self-disclosure revolves around the analyst's capacity to discriminate "between analytically useful disclosures and self-serving disclosures" (p. 1060).

Given that deliberate self-disclosure may be construed as an ethical dilemma, rather than as compromising a principally technical intervention, its resolution may not be immediately apparent and gives rise to the recurring recommendation to effect decision-making on an individualised, case-by-case basis (Allphin, 2005; Gutheil, 2005; Jacobs, 1999). One caveat, however, is the enactment of erotic countertransference where the following arguments uniformly appear to recommend constraint on the analyst's part.

Countertransference awareness has been viewed as contingent on countertransference enactment (Renik, 1993a; 1998). Since consciousness of countertransference is always

retrospective, only emerging subsequent to enactment, Renik (1993b) contends that "elimination of countertransference enactment is not only unattainable as a practical technical goal, but it is misconceived even as a technical ideal toward which the analyst should strive" (p. 139). The accrual of benefits from any given countertransference enactment is apparently twofold. Commenting on Renik's (1993a) view of enactments, Ivey (2008) observes that, from this perspective, countertransference enactments are, firstly, perceived as a necessary prerequisite for the analyst's retrospective self-insight into the personal and interpersonal unconsciously organising the relevant transference–countertransference configurations. Secondly, the patient's positive psychological change is wrought through corrective emotional experiences or through the provision, via countertransference enactments, of spontaneous, emotionally alive, authentic therapeutic encounters. Since enactments or "*unconscious* personal motivations expressed in action by the analyst" (Renik, 1993a, p. 564) are perceived to be indispensable to successful analysis, Louw and Pitman (2001) conclude that the core technical consequence of Renik's stance appears to be that it "implores the analyst to abandon the ideal of minimising countertransference enactment" (p. 756).

Tempering the latter portrayal of countertransference enactments as invariably benign phenomena are contrasting arguments suggesting that deliberate disclosure of erotic countertransference may signal failed containment and comprise a likely forerunner to sexual boundary violations (Gabbard, 1999; 1996; Gabbard & Lester, 1995; Norris, Gutheil & Strasburger, 2003). In the wake of eroticised countertransference, the "as-if" nature of the analytic space potentially collapses as "symbolisation is dismissed" (Tylim, 2004, p. 612) and the analytic dyad lurches towards "the real relation" (Meissner, 2002, p. 846) or "perilously close to feeling like an incest taboo has been broken" (Gabbard, 1999, p. 15). Acknowledging the innovative method relational analyst-authors have developed, Kantrowitz (2006) nevertheless observes that decision-making is always "multiply determined" (p. 182) and that the relational technique of sharing written material risks ignoring the analyst's unconscious motivations. Self-disclosure of erotic countertransference may hypothetically enhance a patient's self-esteem, freeing the latter to love and be loved, but it may equally generate iatrogenic difficulties in developing loving relationships with significant others. Capturing Bott Spillius' (2004) earlier distinction between useful and self-serving disclosures, Kantrowitz (2006) similarly cautions that "It is not always clear when the analyst is revealing these feelings for the sake of the patient and when it is for

himself or herself. Unconscious factors push these decisions. How can we be sure?" (p. 181).

Review of professional opinion regarding self-disclosure suggests that it ranges from the reticent approach characteristic of early analytic writings to proponents of deliberate self-revelations (Gutheil, 2005). The middle ground appears to be occupied by advocates of selective self-disclosure recommending restraint because unconscious self-interested agendas often underpin decisions to pursue self-disclosure. Given the likely exception of erotic countertransference, resolution of the ethical dilemma posed by deliberate self-disclosure cannot be effected by reference to a "neat code of do's and don'ts" (Maguire & Fargnoli, 1991, p. 47) but apparently rests upon individual assessment of each case and an interpretive act. As Jacobs (1999) succinctly words it "each instance of self-disclosure must be evaluated on its own terms in the light of the clinical situation in which it occurs and its effect on the analytic process" (p. 159).

Discussion of the merits and demerits of analyst self-disclosure informs the following analysis of the second ethical decision-making enactment presented in this chapter. Professional codes, including psychoanalytic ethics codes (American Psychoanalytic Association, 2001; British Psychoanalytic Society, 1991; Canadian Psychoanalytic Society, 1993), do not specifically address the ethical dilemma posed by deliberate self-disclosure. Concerns expressed in the professional literature regarding the rationalisation of self-interested and unconscious motivations suggest, however, that intentional analyst self-disclosure may be included in the highlighted class of ethical decisions under consideration. As in Da Silva's (2003) account, the research vignette raises queries as to whether any implicit ethical decision-making pathways are discernible and what implications these carry for the placement of the enactment entailed along the beneficence–maleficence gradient.

The analyst correctly identified the ethical dilemma pertaining to confidentiality and the need to secure informed patient consent for publication (American Psychoanalytic Association, 2001; APA, 2003; CPA, 2000). Resolution of the presenting dilemma was ostensibly effected by implementing the decision to show the patient the relevant paper. The research vignette at first sight apparently offers a straightforward instance of the first ethical decision-making pathway wherein the ethical dilemma is recognised and resolved without enactment and through reasoned deliberation. However, the presenting dilemma appears to

mask a second and seemingly significantly more emotionally conflicted ethical dilemma pertaining to the disclosure of erotic countertransference. As Kantrowitz (2006) observes, the analyst's conscious decision to show the written material may have functioned as an unacknowledged "meta-communication" (p. 168) through which sexual attraction to the patient was "successfully" conveyed. Although apparently conflicted about direct disclosure, it remains unclear from the brief excerpt whether the relational analyst, even retrospectively, clearly identified the disclosure of erotic countertransference as comprising not principally a matter of compromised technique but rather an instance of an unambiguous ethical dilemma. As Steiner (2006) observes, words do more than merely communicate information. Potentially experienced by patients as seductions or attacks, verbal communications may comprise verbal boundary violations which have their counterpart in more easily recognisable gross behavioural boundary violations (Steiner, 2006).

In the context of the ethical decision-making process (and despite the relational analyst's apparently positive evaluation of the ensuing therapeutic benefits) the sharing of the relevant written material may alternatively be construed as expediting a rapid transition from the initial identification of the presenting dilemma to the premature implementation of action. This precipitous development suggests the possible evocation of the second ethical decision-making pathway. The latter pathway is typically characterised by premature or thoughtless action and by the collapse of a reflective space wherein the origin and interpersonal meaning of the charged countertransference affects undergirding ethical decisions are retrospectively apprehended and thought about. It is not clear from the research vignette whether the relational analyst did indeed explicitly identify the nature of his unconscious contribution to the erotic countertransference enactment concerned (in which case the excerpt would illustrate an instance of the third ethical decision-making pathway) but, as Kantrowitz (2006) remarks, the analyst was presumably "in a state of denial not to anticipate the impact of the paper on the patient" (p. 169).

The brief research report contains little evidence to suggest that the countertransference enactment derived principally from the patient's projective identifications or that it was equally and mutually co-constructed by unconscious contributions from both members of the analytic dyad. The analyst was apparently aware of his original erotic feelings but remained seemingly unconscious of "using his request for permission to publish to reveal these feelings to the patient" (Kantrowitz, 2006, p. 169). The excerpt thus apparently

provides a possible instance of an unretrieved analyst-induced "ethical decision-making enactment". In the tradition of the classical construal of countertransference, the enactment concerned may be defined as one that was driven primarily by "narrow" countertransference or the analyst's idiosyncratic and unresolved anxieties, wishes and conflicts that were revived in interaction with the patient.

Perhaps lacking in this exchange of professional debate and evaluation regarding the benefits and harms of erotic self-disclosure are first person accounts which foreground the patient's own voice. One seemingly rare anecdotal exception is provided anonymously by an analysand who, in the midst of her analyst's escalating professions of love, wonders if she "was laying [her] psyche bare to an ill man … It would be like suddenly realising in the middle of undergoing brain surgery that the person operating was a charlatan who had falsely represented himself as a qualified surgeon" (Gabbard & Lester, 1995, p. 137).

Since the immediate and long-term consequences of the analyst's countertransference enactment are not available, possible harms or positive benefits to the patient and to the analytic process remain difficult to evaluate. No supportive evidence suggests that the enactment was repeated and, in agreeing to participate in the research process, the analyst may have sought a reflective space wherein to understand his own countertransference reactions. Balancing the latter's claims of therapeutic benefits against the current state of professional knowledge widely emphasising the heightened risks of erotic self-disclosure for the analytic process, the analyst-induced ethical decision-making enactment may tentatively be situated towards the maleficent and "expressive" (Ivey, in press) ends of the classification gradients concerned.

Far from comprising a rational and sequential series of clearly defined steps, the research vignette clearly illustrates that on the contrary the ethical decision-making process is likely to be ambiguous and suffused with disquieting countertransference affects which disrupt and challenge the analyst's judgment and professional self-image as a benevolent care-giver. As Kantrowitz (2006) cautions "The motives for writing and showing patients what is written are always multiply determined. Revelation … that a patient is special or loved may have to do with the analyst's need to bind the patient to the analyst … [The danger may be not] so much … that the patient knows what the analyst feels as that analyst may begin to lose his or her own sense of being the analyst ..." (p. 182).

19. SUMMARY

Emotionally charged ethical dilemmas routinely appear to arise in the daily context of analytic practice. Ethical codes and contemporary models of ethical decision-making provide essential normative guidelines for identifying and resolving ethical dilemmas through the rational use of hierarchical ethical principles and standards. Review of the relevant professional literature suggests, however, that supplementary frameworks are needed which address not only the conscious but also the irrational and unconscious determinants of the ethical decision-making process. Current interest in countertransference enactments has stimulated theoretically informed accounts describing how transference-countertransference configurations arising in analytic space are co-created by the unconscious dynamics of both the analyst and the patient.

This chapter has sought to establish a preliminary psychoanalytic understanding of the nature of unconscious linkages potentially forged between the ethical decision-making process and the analyst's subjectivity as it is harnessed in unfolding countertransference enactments.

Definitions, subcategories, the delineation of ethical decision-making pathways and the classification of countertransference enactments accordingly provided four initial and experimental units of analysis in formulating a psychoanalytically oriented understanding of the ethical decision-making process. An overview of Kleinian, classical and intersubjective definitions reveals, firstly, contested views of the relative unconscious contributions of the analyst and the patient to the phenomenon of countertransference enactments. Consensus prevails, however, that the analyst is not a consistently rational agent but one who remains unwittingly susceptible to the regressive sway exerted by enactment phenomena, including the patient's often forceful efforts to transform him/her into a desired transference object. Further agreement is reached by theorists from competing persuasions that the affective kernel or compelling emotional power of enactments may well dispel the analyst's customary reflective attitude, stripping the latter of autonomous choice as to whether to refrain from, or to participate in, the countertransference enactment concerned.

Identified subcategories of countertransference enactments included, secondly, interpretive enactments (Steiner), nonsexual boundary violations (Gabbard & Lester, 1995), the

analyst's "secret delinquencies" (Slochower, 2003) and the implicit notion of "ethical decision-making enactments". Examination of professional literature suggests, thirdly, that inherent to the resolution of ethical dilemmas are several discrete ethical decision-making pathways distinguished from one another by the fate of the analyst's reflective space. The first pathway includes the therapist's rational and appropriate resolution of the ethical dilemma at hand; ethical decision-making occurs without enactment and with few if any harmful consequences to the patient. The second pathway is characterised by the therapist's failure to create or to restore a reflective space. Unexamined countertransference anxieties may find disruptive and repeated behavioural expression in ethical decision-making enactments driven variously by the patient's projective identifications, by the therapist's unresolved personal countertransference or by unconscious collusion co-created by the analytic pair. The ethical decision-making enactment concerned is not subjected to post-enactment scrutiny, raising the risk of harmful consequences to the patient. The third pathway is distinguished by the recovery of the therapist's reflective space and by his/her willingness to retrospectively submit disorientating countertransference affects and interventions to post-enactment scrutiny. Re-engaging with the ethical decision-making process and the therapist's reparative efforts hopefully allow for the transformation of the raw ethical decision-making enactment into a potentially beneficent and useable analytic process, thereby mitigating the possibility of harmful consequences for the patient.

The classification of countertransference enactments included consideration of the different gradients offered by Louw and Pitman (2001), Gabbard and Lester (1995), Cassorla (2001) and Ivey (in press). The fourth and final unit of analysis highlighted the ethical dimension of clinical practice and proposed that countertransference enactments may accordingly be situated along a beneficence-maleficence gradient.

The two vignettes presented in this chapter provided contrasting instances of a primarily patient-induced as well as a therapist-induced ethical decision-making enactment. The vignettes concerned functioned as a preliminary forum wherein to rehearse the utility of the foregoing theoretical units of analysis in examining the resolution of ethical dilemmas. The subcategory and key notion of "ethical decision-making enactments" provided a potentially useful conceptual vantage point from which to grasp how even well qualified and experienced analysts, confronted with disorienting and often distressing ethical dilemmas, may be dislodged from his/her familiar reflective stance, adherence to ethical values and

carefully nurtured professional image as a benevolent caregiver. Rather than the equal and mutual co-creation of countertransference enactments advocated by intersubjective and relational models, of interest was that the real-life dilemmas presented in the two vignettes appeared to offer supportive data for investigating, in the future context of ethical dilemmas described by the research participants of this study, the viability of Kleinian and classical formulations of countertransference enactments. It is hoped that the various units of analysis described in this chapter will be of value in the understanding and later interpretation of qualitative data generated by the present study.

The next chapter sets out the specific aims of the research study, followed by a detailed account of the methodology used in gathering and analysing the data. Guiding ethical principles and challenges which arose in the course of conducting the research process are discussed.

CHAPTER 4

RESEARCH AIMS AND METHOD

1. INTRODUCTION

The review in previous chapters of professional ethics codes, ethical decision-making models and survey studies of decision-making suggests that traditional approaches appear to present the resolution of ethical dilemmas as a fundamentally conscious and rational process. The latter frameworks may minimise the role played by emotions in resolving ethical conflict and arguably fail to accommodate the intrapsychic and interpersonal dimension of the ethical decision-making process. As Packer (1989) maintains, emotions "provide the grist which any moral deliberation must have to grind upon if it is to lead to action of any consequence. Correlative to this are the limitations inherent in reason as a tool with which to resolve conflict" (p. 115). One possible consequence of the emphasis by quantitative research procedures on hypothetical dilemmas and moral reasoning processes is the relative dearth of first-hand, in-depth accounts of the subjective feelings, struggles, and preoccupations that potentially beset the clinician's lived encounter with real-life ethical dilemmas.

Quantitative research is concerned mainly with formulating general laws of human behaviour while qualitative research by contrast "seeks to understand and articulate the meanings of people's experiences" (Hadjistavropoulos & Smythe, 2001, p. 163). Since I was principally interested in understanding and making sense of participants' lived experiences, I situated this research study within a qualitative research paradigm and a related set of research practices. Out of my original engagement with existing literature as well as personal experiences as a psychotherapist, as a patient and as an Ethics Committee member of a local society, four preliminary research questions arose:

- What subjective feelings, thoughts, fantasies, concerns or actions initially announce the psychoanalytic psychotherapist's identification of an ethical dilemma? How might these psychological processes potentially evolve in the course of struggling with the dilemma concerned?
- How does the psychoanalytic psychotherapist's subjectivity potentially affect the well-documented phenomenon of ethical decision-making and intervention?

- What professional resources does the psychoanalytic psychotherapist call upon to help him/her resolve the ethical dilemma at hand?

These questions would help to elicit "simple descriptions" (Packer, 1989, p. 112) of what happened when participants encountered an ethical dilemma and what they did to resolve it. Interpretive research, however, requires "thinking on one's feet" (Kelly, 1999b, p. 417) and "no pre-packaged designs exist" (Crabtree & Miller, 1999, xvi) which offer straightforward instructions or immediate access to understanding the phenomenon of interest. The fledgling researcher is confronted with the demanding task of choosing from "multiple … sampling, data collection … and data analysis options … Almost any mix and match is possible and depends on the aims, objectives, and research question" (Crabtree & Miller, 1999, xvi). Hence careful selection of different research strategies is required in order to create a question-specific design that is uniquely suited to the qualitative researcher's particular project (Miller & Crabtree, 1999a; O'Leary, 2004).

Informed by the initial research questions, the original aim of this study was to provide an inductively grounded understanding and interpretation of psychoanalytic psychotherapists' subjective psychological experiences in the presence of unanticipated ethical dilemmas. As my engagement with the data and related theory intensified, this broad research objective gave way and was replaced by a new and narrower aim, that of providing a psychoanalytically orientated interpretive account of the phenomenon of ethical decision-making as it transpires in the everyday context of analytic space. Kelly (1999b) proposes a generic approach to the interpretation of qualitative data which he terms "interpretive research" or "hermeneutics in action" (p. 398). This "fundamental interpretive continuum" (Kelly, 1999b, p. 399) incorporates, on the one hand, empathic understanding of contextually derived self-accounts and, on the other, a more distanciated, sceptical, theoretically led perspective. Setting off rather naively on an exploratory quest for answers, I used the latter paradigm to negotiate research territory which often elicited anxiety but which also held the lure of clinically relevant findings, as well as a more complete theoretical understanding of the ethical decision-making process.

2. LEAPING INTO THE CIRCLE: A HERMENEUTIC APPROACH TO RESEARCH

Hermeneutics traditionally comprises the study of the interpretation of written texts[8] (Kvale, 1996). Central to the hermeneutic task or to "the business of interpretation" (Addison, 1992, p. 110) is "the process of bringing a thing or situation from unintelligibility to understanding" (Palmer, 1969, p. 13). This striving after understanding and the attribution of meaning is not confined to hermeneutic research efforts but may be construed more fundamentally as ontological, structuring "our way of being in the world, our living, our actions and interactions before it characterizes our knowledge and our sciences" (Packer & Addison, 1989, p. 34). Accordingly Palmer (1969) maintains that "Hermeneutics as a methodology of interpretation for the humanities is a derivative form … growing out of the primary ontological function of interpreting" (p. 130).

Interpretive research strategies distilled from the philosophy of interpretation may be applied to the reading and analysing of transcribed interview texts. Dilthey (in Terre Blanche & Kelly, 1999) argues that "Verstehen" or "empathy" is the only model of understanding appropriate to the human sciences and entails imaginatively grasping the context of a text's creation as well as the author's intended meaning.

Rebutting Dilthey's argument, Ricoeur's "model of the text" (Brown, Tappan, Gilligan, Miller & Argyris, 1989, p. 145; Kelly, 1999b, p. 399) asserts that the acquisition of knowledge about complex human phenomena subsumes a dialectic between "Verstehen" (empathy) and "Erklaren" (explanation) or the more distantiated understanding deployed by the natural sciences. Thus Ricoeur proposes that "understanding of a situation needs to be developed both from the perspective of being in the context (empathy) and from the perspective of distantiation, using interpretation" (Kelly, 1999b, p. 400-401). Reading and analysing a text in an attitude of open inquiry optimally incorporates both the "experience-near" and "experience-distant" perspectives of "Verstehen" and "Erklaring" respectively and ideally maintains a balance between them (Kelly, 1999b).

The ongoing cyclical movement evident in this research study between "experience-near" and "experience-distant" perspectives hopefully provides a pragmatic illustration of Kelly's

[8] Encompassing discourse, action and human creations, the greatly expanded contemporary notion of "text" includes "any record of life held over after the moment of its production for later comprehension and interpretation" (Kelly, 1999a, p. 379).

(1999b) “fundamental interpretive continuum” (p. 399) as well as of the concept of the hermeneutic circle. Interpretive inquiry holds that “establishing a point of view, a perspective, is the forward arc [of the hermeneutic circle], and evaluation forms the reverse arc” (Packer & Addison, 1989a, p. 33). “Thrown forward” into an ambiguous new phenomenon, the researcher’s preliminary and projected everyday understanding inevitably shapes the phenomenon concerned to fit his/her preconceptions, expectations, subjective opinions or “fore-structure of interpretation” (Addison, 1989, p. 52). Thus “leaping into the hermeneutic circle” (Heidegger, in Packer, 1989, p. 103) or endeavouring to secure legitimate access to the phenomenon of interest entails recognising and critically examining the potential influence exerted on the research process by the researcher’s personal prejudices, biases and misconceptions. The developing account otherwise stands “in danger of becoming [the researcher’s] own preunderstandings projected onto the process [he/she is] investigating” (Addison, 1989, p. 53). The latter activity may not secure irreproachable access to the circle of understanding and interpretation but it does enhance the chances that the researcher’s “starting point in the hermeneutic circle [will] be an informed and aware one” (Packer, 1989, p. 103). The process of reflecting on my own taken-for-granted assumptions will be considered later in this chapter.

Once entry into the hermeneutic circle has been effected, a continuous back and forth movement between the whole text and its constituent parts is initiated (Addison, 1992; Kelly, 1999; Kvale, 1996; Packer, 1989). Brown, Tappan, Gilligan, Miller and Argyris (1989) write that “the interpretive procedure is a fundamentally circular one, because while the whole can only be understood in terms of its parts, by the same token the parts only acquire their proper meaning within the context of the whole” (p. 144). Reading and analysing field notes, memos, diagrams and transcribed interview texts regarding participants’ subjective engagement with real-life ethical dilemmas mobilised both the “experience-near” and “experience-distant” poles of “the interpretive continuum”, inducing the repeated experience of “spiralling around the hermeneutic circle” (Addison, 1992, p. 118). Each time I completed a research interview, I immersed myself for prolonged periods in listening to the audiotape, in studying the transcribed text and in reading my detailed field notes. The latter immersion generated an empathic understanding of the many subjective meanings the lived encounter with an ethical dilemma had held for the particular participant as well as a heightened appreciation of what it had been like for the clinician concerned to struggle, often alone, with its resolution. Over time this “experience-near” empathic

understanding shifted as discussions with supervisors, close examination of the transcribed texts and continued theoretical reading created a "change in the mode of engagement" (Packer, 1989, p. 56) from understanding into more distanciated and theoretically led interpretation. A reflective space opened out wherein I could stand back and think more freely about the possible and previously unrecognised meanings of the intense, disorientating affects coursing through both the original dilemma as well as through the interview process. I began to formulate tentative interpretations about how and why the struggle to resolve common ethical dilemmas appeared to have mobilised charged countertransference responses.

Fed by the iterative, back and forth movement between empathic understanding and interpretation for each of the eleven research interviews, a rich interpretive account began to take shape, "thick" (Geertz, 1973) with contextual detail regarding the emotional, somatic, cognitive and unconscious processes evoked in the course of individual participants' struggle with real-life dilemmas. At the same time, inconsistencies and discontinuities appearing in the developing account, including vivid descriptions of compromised ethical reasoning, suggested that reanalysis in each interview of data pertaining to the possible impact of countertransference responses on ethical decision-making appeared warranted. This return from global account back to individual interviews sparked fresh bouts of reading contemporary psychoanalytic literature and new questions arose concerning the possible unconscious and interpersonal determinants of ethical decision-making. Thus in the course of slowly "spiralling around the hermeneutic circle" (Addison, 1992, p. 118), each discrete interview played its part in contributing to the meaning of the overarching interpretive account which in turn conferred fresh significance on contextually-bound individual descriptions of grappling to resolve disturbing real-life ethical dilemmas.

The hermeneutic circle is not inevitably "a vicious one" (Packer, 1989, p. 103) where interpretations simply function to confirm the opinions, speculations and personal prejudices of the interpreter. Not only does the forward arc of projection entail scrutiny of the researcher's "fore-structure of interpretation" (Addison, 1989, p. 52) but the backward arc involves ongoing evaluation of answers being "uncovered" (Packer & Addison, 1989b, p. 278) to the research questions which prompted the inquiry in the first place. Rather than neatly marking the beginning and ending of the research process, the two arcs are conceived of as existing on the circumference of the circle and in constant dialogue (Packer &

Addison, 1989a). This suggests that this research inquiry included from the start regular efforts to evaluate the validity of the emerging interpretive account.

3. THE RESEARCH PROCESS BEGINS: REFLEXIVITY, POWER AND COUNTERTRANSFERENCE

3.1. Clarifying the research topic

I came to this research process aware that my interest, concern and choice of topic had been stimulated by four principal sources. As a psychotherapist, firstly, involved in a psychoanalytically oriented doctoral programme, I had over the years confronted ethical dilemmas in the context of the therapeutic space. In common with other colleagues, for example, I had struggled with the legal threat of an impending subpoena and the prospect of releasing confidential case notes as well as with the ethicality of charging for scheduled appointments when patients had clarified in advance that they would not on these occasions be present[9].

As a patient, secondly, I had had the seemingly not unusual experience in South Africa of a long-term personal therapy being terminated at very short notice as the clinician concerned sought employment overseas. As an Ethics Committee member of a local psychoanalytic society, I had, thirdly, participated in organising post-qualifying ethics training and in the challenging task of constructing a psychoanalytically based ethics code. Conversely, I had experienced the Ethics Committee concerned being riven by decisions as to whether it was ethical to initiate dual role relationships by including into its structure highly competent individuals who worked, however, with existing Committee members in an alternative professional capacity. And, fourthly, disquieting stories continued to circulate of colleagues who had purportedly become sexually involved with their patients or whose own analysis or training had allegedly been marred by eroticised transference involvement with personal therapists and supervisors.

These and other experiences created a lively impression that, on the one hand, there appeared to be a local need and a willingness to explore the ethical dimension of clinical practice. On the other hand, anxiety and resistance apparently prevailed around, for

[9] The apparently widely accepted practice in Cape Town among psychologists practising as psychodynamic psychotherapists of charging for missed but scheduled appointments appears to contravene the South African statutory "Ethical Code of Professional Conduct" (2002) which states that "Psychologists shall not…bill for services partially or not delivered" (p. 11).

instance, how to recognise an ethical dilemma, about "whistle blowing" (Pope & Vetter, 1992, p. 12) in relation to unethical colleagues and about whether it was "safe" to risk revealing to the public gaze of peers ethically controversial, ambiguous or compromised clinical practices which had arisen in the privacy of the therapeutic space.

As I pursued the possibility of researching real-life ethical dilemmas, I reviewed the proposed study with recognised academics and peers and submitted a research proposal to both the University and Departmental Research Ethics Committees. In the course of this initial process, I became aware not only of others' interest and curiosity but also once again of a diffuse sense of anxiety and threat that seemingly hovered over the potential research project. It was difficult to discern in these early phases whether the anxiety derived principally from myself as I prepared to undertake a challenging research endeavour or whether it was inherent to a topic that might be subsumed under the notion of "sensitive research" (Kelly, 1999a, p. 385). Such research arguably includes exploration of deeply personal and/or professional experiences which may evoke narcissistic wounding (Hadjistavropoulos & Smythe, 2001) as well as fantasies and fears regarding punitive action by statutory organisations.

Questions and comments, sometimes generous but occasionally hostile in tenor, began to accumulate. Did I think anyone would volunteer to talk truthfully about real-life ethical dilemmas which might entail possible evidence of poor professional practices? Would feelings of guilt, shame and professional embarrassment not deter prospective research participants? Wouldn't it be wiser (and easier) to investigate participants' subjective responses to pre-selected hypothetical ethical vignettes? How would I cope with my limited knowledge regarding the extensive field of philosophical ethical theories? Wasn't it likely that the onerous burden of protecting the confidentiality of participants' material and the need for documentation to counter the vagaries of interviewees' fallible memories be likely to scupper the project at a later stage? Wasn't countertransference a technical rather than an ethical issue? In short, wouldn't it be better to focus on research participants' experiences of and attitudes towards using the South African statutory "Ethical Code of Professional Conduct" (2002) when faced with ethical dilemmas in clinical practice?

Out of this confusing turmoil greater clarity emerged about what this research study was and was not about. It was not, for example, principally about clinicians' knowledge or use of

either statutory ethics codes or philosophical ethical theories. Neither did the proposed research aim at identifying the type or frequency of ethical dilemmas encountered in professional practice as had previously been done in South Africa (Slack & Wassenaar, 1999), Sweden (Colnerud, 1997), the United Kingdom (Lindsay & Clarkson, 1999; Lindsay & Colley, 1995) and America (Pope & Vetter, 1992). As discussed earlier, my initial engagement with anonymous quantitative survey studies in professional decision-making suggested that the latter were descriptive and had also largely neglected the subjective embodied experiences and voices of individual practitioners who had confronted real-life ethical dilemmas. The few psychoanalytic accounts or studies of ethical decision-making that I discovered later either lacked clinical data, were not adequately theorised or did not take up directly the issue of resolving unanticipated ethical dilemmas arising in the context of the therapeutic space.

The foregoing impressions and reflections helped to refine my preliminary choice of topic. I thought that it might be theoretically and clinically useful to investigate in an open-ended, exploratory manner the in-depth countertransference experiences of psychologists, practising as psychoanalytic psychotherapists, who had encountered real-life ethical dilemmas in the ordinary course of their daily work. My primary interest thus lay in exploring the potentially multiple ways in which prospective participants had engaged with the subjective and emotional dimension of resolving everyday ethical dilemmas. Signposting the general direction forward, Pope and Bajt (1988) ask "How can psychologists … ensure that their actions are based on sound professional judgment rather than on self-interest, prejudice, rationalisation and the sense that one is „above the law?'" (p. 829). Clarifying the research topic gave rise to the tentative hope that, in some as yet unforeseen way, the proposed interpretive study might prove to be of pragmatic value, helping to uncover clinically relevant answers to practical difficulties that aided the implementation of sound professional judgment in the context of the analytic space.

3.2. The fore-structure of interpretation: examining three taken-for-granted assumptions

Engagement with a hermeneutic framework is never as an objective observer nor as a "true *tabula rasa*" (Henwood & Pidgeon, 2003, p. 137). As previously discussed, unless the researcher's subjectivity and taken-for-granted assumptions are reflexively examined, the danger exists that these will be unthinkingly projected onto the research process, compromising the devising of the research question, the interview encounter, thematic

construction and the developing account (Addison, 1999; Burman, 1994; Kvale, 1996, O'Leary, 2004). Before embarking on the data gathering process, I attempted to clarify the following three taken-for-granted assumptions. These included, firstly, my beliefs around power dynamics and the negotiation of meaning and, secondly, the critical need to establish a reflective space to examine my ongoing countertransference responses. A third taken-for-granted assumption, which I was not initially aware of, was my conviction that participants' engagement with real-life ethical dilemmas would eventually reveal, despite the inevitable vicissitudes involved, their thoughtful resolution through the use of, for example, professional ethics codes, consultation or supervision and collegial guidance.

3.2.1. First taken-for-granted assumption: Power dynamics in the research relationship

Throughout this research study, the term "participant" or "interviewee" reflects, as Berman (1994) suggests, attempts to do research "with" rather than "on" people. Instead of perceiving interviewees "as a data source … [or] as a locus of variables to be observed and manipulated" (Hadjistavropoulos & Smythe, 2001, p. 164), I assumed a fundamentally egalitarian research relationship. Since structural disparities in terms of age, class and education were likely to be minimal, I anticipated the emergence of only relatively small power differentials. The research process would accordingly be essentially characterised by a process Shrijvers (1991, in Kelly, 1999a) terms "studying sideways" as opposed to "studying down" or "studying up" (p. 386). I took for granted that researcher and researched alike would be actively involved in negotiating and constructing the possible meanings of events and processes occurring in both the research encounter as well as in the context of the original ethical dilemma. While efforts to establish open dialogue and to grasp the elusive meanings of interviewees' subjective experiences often appeared to be a successful, mutually negotiated process, my subsequent interpretations of participants' professional practices were independent of the latter's self-accounts. Raising the question of who exercises power and control over the interpretation of research participants' stories, the experiencing subject or the interpreter of the subject's subjective understanding, the latter issue is addressed later in considering the ethics of qualitative research.

Further power differentials which unexpectedly emerged included gender relations and the researcher's status as a purported "expert" on ethical issues. Burman (1994) comments, for example, "that where traditional power relations are departed from, where men are positioned as subordinate within the researcher-researched relation….this structural power

relationship [may become] evident through their attempts to subvert it" (p. 68). Thus power dynamics apparently played out in my resistance on occasion to challenging the authoritative but seemingly intellectualised stance of highly articulate male interviewees and in participants' apparent transference perceptions of myself as a powerful yet threatening "expert interpreter" of ethical material. These latter perceptions provided a stark contrast with interviewees' often painful "confessions" pertaining to, for example, a lack of information or lapses of professional judgment.

3.2.2. Second taken-for-granted assumption: Countertransference and creating a reflective research space

The concept of countertransference is congruent with the contemporary emphasis on "reflexivity" or the need for reflection on the researcher's "own experience and role within the conduct of the research" (Berman, 1994, p. 52). Additionally, however, the notion of countertransference underscores the unconscious dynamics that shape the researcher's interests and activities and that are "at once the source of our insight and our folly" (Berg & Smith, 1988, in Hollway & Jefferson, 2000, p. 33). Central to my approach to research was the taken-for-granted assumption that both the researcher and the researched are defended subjects who deploy unconscious defences against anxiety (Hollway & Jefferson, 2000). From the start of the research project, I therefore contrived to establish a reflective space which would assist with interrogating both participants' countertransference responses as well as with questioning my own countertransference "blind spots" mobilised by the interactive process of gathering and analysing the data.

The promotion of critical, analytical thinking in this research inquiry was fostered by the creation of a "research team". This consisted of auditing semester courses at a local university on moral philosophy and applied ethics, continued theoretical reading, dialogue with interested peers and the regular presentation of the developing account to two supervisors who held very different theoretical orientations and professional interests. On the one hand, the supervisor concerned described his theoretical orientation as strongly psychoanalytic in approach, expressed a preference for qualitative research and had been deeply involved in the development of psychoanalytic thinking and training in South African clinical practice. The second supervisor, by contrast, observed an "eclectic" theoretical orientation, had been pivotal in developing the field of ethics in South African psychological practice and, holding a clear preference for quantitative research, expressed

the disconcerting reservation that qualitative research studies invariably result in "finding what you are looking for".

Packer and Addison (1989b) argue that testing the validity of an interpretation necessarily involves trying to persuasively convince others who hold a different perspective from one's own that the interpretive account concerned improves on understanding the phenomenon of interest by offering a *better* account of it than do those given by rival interpretations. The sharp divergence of supervisory interests created a challenging reflective context which supported scepticism, open theoretical disagreement and rival interpretations regarding alternative meanings of the data. Discussions with both supervisors were directly based, not on the researcher's private inferences, but on the "public data" (Spence, 1989, p. 24) comprised by the actual transcribed texts. As Spence (1989) argues, reading the original raw data allowed the sceptical reader direct access to research participants' abundant detailed descriptions of the ethical dilemmas in question and the option of reaching independent conclusions from the evidence supplied. The credibility and veracity, for example, of my evolving interpretations regarding the unconscious determinants of ethical decision-making were consistently challenged by supervisory demands to return to the data, to search for disconfirming evidence and to ensure that qualitative research "findings" were scrupulously supported by textual evidence rather than swayed by personal bias or by attempts at persuasion through appeal to standard psychoanalytic rhetoric (Spence, 1989).

Reflecting on my own countertransference responses in the context of supervision helped to restore and to deepen a more distanciated, theoretical or "etic" perspective (Kelly, 1999b; Spence, 1989) which was often lost under the impact of the emotionally charged interactions between myself and defensive research participants or, later, between myself and the transcribed interview texts. Dual supervision thus helped to safeguard the developing account from being skewed by "going native" (Kvale, 1996, p. 118), that is, by my unconscious identification with research participants' emotionally laden subjective experiences and "emic" everyday understandings (Kelly, 1999b; Spence, 1989) of the ethical dilemmas at hand. Over-identification with patients, by contrast, in the form of unduly critical interpretations levelled at participants' professional practices were likewise checked and subjected to thoughtful review. This sustained experience of supervisory empathy and thoughtfulness was to play a key but wholly unanticipated role in the later construction of a pragmatic, psychoanalytically orientated ethical decision-making model.

3.2.3. Third taken-for-granted or unconscious assumption

In contrast to conscious, taken-for-granted understandings, a third assumption apparently operating out of my initial awareness included the conviction that participants' descriptions would reveal evidence of ethical quandaries that had been thought about and largely resolved in the several contexts of professional codes of ethics, supervision, personal therapy, collegial networks and legal frameworks. Addison (1999) remarks that what the researcher initially "discovers" is coloured by his/her preliminary "conscious, acknowledged, or foreground assumptions" (p. 147). As the research evolves, the interpreter learns more about "unconscious, unacknowledged, or background assumptions" (p. 147).

Despite earlier experiences of apparent collegial anxiety, what was not immediately evident to me was the emotionally saturated and seemingly unprocessed character of research participants' engagement with real-life ethical dilemmas. Prospective interviewees were not "naive subjects" but were on the contrary highly qualified, psychologically sophisticated clinicians well versed in regularly presenting and discussing their work in the context of local psychoanalytic societies. Lulled by my taken-for-granted expectation that the forthcoming research interviews would somehow conform to the structured nature and reasonable affect characteristic of monthly psychoanalytic meetings, I anticipated only that the research encounter would provide an opportunity for discussing in a coherent, preferably theoretically informed way, troubling ethical dilemmas that had been safely relegated to the past. This suggests, retrospectively, possible countertransference anxieties fuelled by the researcher's unacknowledged desire for the overly swift translation of participants' inconsistent "emic" or everyday understandings into the familiar esoteric rhetoric or "etic" formulations characteristic of standard psychoanalytic theory (Spence, 1989, p. 219). What I expected, however, was not what I got! Taken-for-granted assumptions of "narrative smoothing" (Spence, 1989, p. 214) were rudely and decisively dispelled in the course of successive research interviews and are discussed in the following sections.

4. THE ETHICAL DIMENSION OF THE RESEARCH STUDY

Ethical considerations arose throughout the entire research process and were integral to the planning, implementation and writing up of the research study. Durrheim and Wassenaar (1999) observe that "the essential purpose of ethical research planning is to protect the welfare and the rights of research participants" (p. 65). While critical objections to this research project had originally included the ethical problem of confidentiality, the approach

I adopted was that "The difficulty of doing something ethically is not a sound reason for not persisting in finding a way of doing it. Researchers should address ethical issues … with the same intellectual and creative vigour that they use to develop methodologies and analytical methods" (Wassenaar & Mamotte, 2008, p. 6). Based on the ethical principles of autonomy, nonmaleficence and beneficence, the following discussion addresses the major ethical issues of informed consent, confidentiality, expected benefits to participants and the notion of harm in qualitative research.

Autonomous informed consent procedures were implemented by giving each potential participant a detailed letter of information (see Appendix 1) well before the proposed research interview. The letter functioned as a written contract and marked the start of the research project's "audit trail"[10] (Kelly, 1999c; Ramcharan & Cutcliffe, 2001). The contract stated the overall purpose of the research study, clarifying that the central aim was to explore how psychoanalytic psychotherapists engage with and attempt to resolve real-life ethical dilemmas. Drawing attention to anticipated risks, I noted the sensitive nature of the research and that participants would "be involved in talking about their personal experiences of ethical dilemmas, and any related conflicts, in the context of their work as psychotherapists". While the probability of serious harms accruing to prospective participants appeared relatively low, the letter noted that expected benefits included a valuable opportunity to share and to reflect on individual experiences of working with real-life ethical dilemmas and to make a contribution to professional debate in South Africa regarding the ethical dimension of psychoanalytic practice.

A clear description of the research procedure and participants' expected time commitment were included in the letter, as was a simple statement that raw data would be kept under secure conditions and that participants were free to withdraw from the study at any time. Couched in an open, deliberately non-technical manner, the letter attempted to avoid prejudicing the study by "signalling" (Hollway & Jefferson, 2000, p. 86) to prospective participants my theoretical interests or any professional responses interviewees might erroneously assume were desirable to display in resolving ethical dilemmas. The only "inducement" provided was my offer in the initial telephone contact to secure a plentiful

[10] The raw materials contained in the appendices hopefully provide a clear "trail" or record of the research process, allowing prospective readers to trace the original research path and to replicate, support or refute the research findings and conclusions.

supply of tea and chocolate biscuits to sustain both researcher and researched through the interview process!

Central to establishing and maintaining trust with prospective participants were the issues of confidentiality and anonymity. The letter of information outlined the following measures that would be taken to safeguard confidentiality. Firstly, all identifying data including names, places and demographic details, would be deliberately disguised or removed from the transcribed interview texts and from the final research report. In the event, each transcribed text was thoroughly and repeatedly "swept" for any material that could inadvertently reveal the identities of not only research participants but also of any third parties involved. The major ethical problem in the latter case derives from the fact that third party individuals have not given consent to being presented or discussed in publicly available documents (Hadjistavropoulos & Smythe, 2001). When subsequently I became aware, in the context of the research interviews, of the actual identities of personal analysts, supervisors and training universities, I responded with increased vigilance and the use of generic descriptions to ensure that no identifying information appeared in either the transcribed texts nor in any of the many anonymous quotations later used for discussion purposes in the body of the research report itself. Careful use of generic descriptions rendered it highly unlikely that any third party would be recognised by others, although supervisors and personal analysts familiar with the details of particular real-life ethical dilemmas might presumably recognise themselves. The latter strategies of altering or removing identifying details did not apparently detract from either the scholarly or pragmatic value of challenging questions raised by the data analysis regarding ethical decision-making practices, supervisory competence and the content and quality of South African pre-professional and post-qualifying ethics training.

A second measure that ensured confidentiality involved the shredding of transcribed interview texts on completion of the research project and the assurance that audio cassettes would be similarly erased or returned to participants at their request. An unanticipated analytical device used in the data analysis process requiring confidentiality and informed consent, but not covered in the original letter, concerned the writing up of clear and detailed descriptions of each real-life ethical dilemma (see beginning of Chapter 5). I decided on reflection that, before the final interpretive account was officially lodged in the public domain, each participant would be approached and asked for his/her permission for the

relevant description to remain as an integral part of the research report. Should former interviewees be unavailable or decline to give consent, prospective readers would be informed that the pages concerned had, for confidentiality reasons, intentionally been left blank. On further reflection, and using consultation, I finally decided that the most beneficent course of action was to offer participants a synopsis of the main findings on completion of the study. The third measure protecting confidentiality ensured that the final research study appearing in public would not contain the transcribed interviews. Access to the fully transcribed interviews would be restricted to supervisors and examiners alone. Acknowledging the researcher's responsibility to make the research findings known to participants (Wassenaar & Mamotte, 2008), the letter concluded by offering interested interviewees a copy of the research report on completion of the project. Formalisation of the informed consent procedure was completed when research participants signed the letter, indicating that they had read the information concerned and had agreed to participate on a voluntary basis. The written contract attempted to address in a clear, unambiguous manner key ethical issues. The problem with "the ethics of consent" (Hollway & Jefferson, 2000, p. 86) is that the interviewer and the interviewed cannot predict in advance of the research interview exactly what is being consented to or what personal topics and emotional affects may be provoked by an open-ended interview process which allows for free association and the following up of participants' unanticipated leads. In place of a once-off signed consent procedure, future research investigating ethical dilemmas might by contrast anticipate an on-going process of consent that runs throughout the research study (Hadjistavropoulos & Smythe, 2001; Hollway & Jefferson, 2000). Implementation of the newly emerging "ethics as process" model in qualitative research (Ramcharan & Cutcliffe, 2001, p. 363) would allow for ongoing monitoring of harms and benefits, actively encouraging participants to periodically re-evaluate their original decision to participate in the research study.

Nonmaleficence or the obligation to avoid harm to research participants and other persons is cited as a central ethical principle guiding the research process (Durrheim & Wassenaar, 1999). However, the question is raised by Ramcharan and Cutcliffe (2001) as to "what exactly constitutes „harm' "? (p. 359). Of central concern to this research study were the potential risks of inflicting emotional harm on interviewees as a result, firstly, of inducing subjective distress in the context of open-ended research interviews and, secondly, as a consequence of participants subsequently reading my interpretations of their accounts of ethical dilemmas.

The relatively unstructured nature of the qualitative research interview may unexpectedly re-stimulate unresolved conflicts, feelings and „traumatic' memories. This highlights the first area of concern in this study regarding possible harmful consequences to participants both during and after the research interview. Thus Hadjistavropoulos and Smythe (2001) observe that risk factors in qualitative research include the evocation of "negative mood states" (p. 167), potentially undermining of research participants' needed defensive strategies. The likely intimacy of the interview can, additionally, be seductive (Kvale, 1996), swiftly transforming the research encounter into a quasi "psychotherapy session where the respondent discloses thoughts and feelings that she or he may not have previously admitted having, even to her- or himself" (Kelly, 1999a, p. 387).

From a psychoanalytic research perspective, Hollway and Jefferson (2000) by contrast argue that harm needs to be evaluated independently of subjective distress. The latter authors contend that from the perspective of psychoanalysis "it is not necessarily harmful if research raises painful and distressing experience, though it may be discomforting" (p. 98). Central to obviating harm in qualitative research, Hollway and Jefferson (2000) continue, is the research participant's subjective experience of a relational research context characterised by honesty, sympathy and respect. As the beneficiary of a competent qualitative researcher's capacity to tolerate emotional distress and to offer "true recognition" (Hollway & Jefferson, 2000, p. 102), including an honest and realistic appraisal of anxiety provoking events, the participant may be assisted in coming to terms with painful experience. While the foregoing characteristics are integral to a good therapeutic relationship, "they are also very effective in eliciting … [research] information which goes beyond rationalisation ... and which conveys emotional significance and [which] does not avoid potentially distressing issues" (Hollway & Jefferson, 2000, p. 87).

Participants in this research study represented a group of highly qualified individuals who did not overtly comprise a "vulnerable population". None of the quantitative research literature I had read suggested that researching real-life ethical dilemmas was likely to evoke subjective distress and intense affect. Wassenaar and Mamotte (2008) comment that, by foreseeing likely harms and by remaining abreast of current developments in research ethics, competent Ethics Review Committees can add considerably to the value of proposed

research studies, effectively reducing or preventing harm to both the researcher and the researched. While university and departmental research ethics committees, before approving this research project, addressed relevant aspects of the proposed research methodology, the ethical issue of responding to participants' potential stress and distress in the context of challenging research interviews was not raised nor apparently foreseen.

The eleven research interviews consistently elicited anxiety and, on occasion, marked distress. Where participants' vulnerability and emotional pain were evident, I attempted to respond with compassion and respect. As outlined earlier, recourse to supervision helped to maintain my focus as a researcher and to avoid collapsing into a quasi therapeutic or supervisory role. When participants' self disclosures seemed to indicate that unresolved and private childhood experiences of abuse or loss might be re-stimulated, I acknowledged the material, but consciously refrained from further questioning, allowed the conversation to shift and to assume a changed focus. The pursuit of knowledge regarding the identification and resolution of ethical dilemmas was consequently temporarily set aside in favour of a spontaneous decision to safeguard the individual participant's dignity and right to privacy. On completion of the research interviews, I followed up expressions of distress, suggesting to individual research participants that it might be helpful to address their emotional responses in the context of personal therapy or supervision. By contrast I confronted in a hopefully respectful, but unambiguous manner, different instances of participants' current participation in ethically compromised professional practices, foregrounding the latter practitioners' apparent need to seek expert consultation.

While confusion and emotional pain were often evident in the research interviews, participants' subsequent comments challenged the notion that unsettling affects are invariably experienced as "wrongs" or "harms" (Wassenaar & Mamotte, 2008, p. 8). Breaking the silence of professional isolation, participants' remarks suggested that on the contrary the interview process had apparently offered the unanticipated benefit of relief incurred by sharing with an empathic listener details of emotionally troubling ethical dilemmas. The issue remains, however, that qualitative research interviews apparently retain far more potential than do quantitative methods for eliciting subjective distress (Wassenaar & Mamotte, 2008) Congruent with the approach advocated by the "ethics as process" model (Ramcharan & Cutcliffe, 2001, p. 363), future research into real-life ethical dilemmas might anticipate the possible evocation of profound emotional affects and unresolved traumatic

material in even experienced and well qualified research participants. Informed consent procedures might allow for this eventuality by routinely including the offer of appropriate debriefing facilities conducted by a competent counsellor.

The second area of concern regarding harmful consequences pertained to participants' possible reading of the research study and, more particularly, to what I had written about them. Smythe and Murray (2000, in Hadjistavropoulos & Smythe, 2001), for example, express concern that "the emotional impact of having one's story reinterpreted and filtered through the [authoritative] lenses of social scientific categories" (p. 321) can significantly impair the research participant's capacity to interpret his/her own subjective experience in his/her own way. Hollway and Jefferson (2000) argue by contrast that if the notion of harm and participant distress are consistently conflated, this effectively precludes the publication of "any interpretive work which assigns motives other than those admitted to by the parties themselves, since the impact of such revelations can never be wholly predicted….The idea of a critical social science could hardly survive such an ethical strait-jacket" (p. 99).

The many anonymous quotations presented in this research study attempt to ensure that research participants' individual voices, perspectives and self-understandings were not overridden but were on the contrary articulated and clearly represented. However, my subsequent interpretations of participants' self-accounts may have raised disquieting questions and highlighted apparently unreflective aspects of professional practice. Active interpretation of interviewees' self-understandings found me struggling to manage the ethical strains generated between what Kelly (1999b) terms "insider and outsider perspectives" or between "trying to be true to the voices of the researched, but yet trying to answer [my] research questions" (p. 403). Thus in the course of writing up the research study, I wondered often and hard about the possible negative emotional consequences of my interpretations on individual colleagues who had courageously and generously entrusted their subjective experiences to me. Unexpectedly confronted with an unforeseen real-life dilemma in research ethics, I reluctantly conceded that no guarantee could be given that my interpretations would not occasion further participant distress or anger.

The position I finally adopted after reflection was devoid of neither ongoing ethical conflict nor of self-serving motivation. Although my interpretations held the potential for further narcissistic wounding, I considered that participants had given their written informed

consent and were fully aware that I would be using and discussing their stories of professional ethical dilemmas in the context of this research. Moreover, I considered that I "owned" (Goldberg, in Kantrowitz, 2006, p. 277) my intuitive "hunches", perceptions, thoughts and tentative formulations regarding the potential role of countertransference phenomena in the resolution of ethical dilemmas. I thus argued that I retained the right to present these in public and in detail independently of obtaining participants' further consent. On the other hand, I have attempted to craft my interpretations with deep respect and to avoid writing that is patronising, shaming or pathologising in tone (Kantrowitz, 2006). I have also tried, throughout the discussion of research results, to acknowledge multiple examples of participants' thoughtful concern for their patients as well as their courage in openly discussing and sharing their subjective experiences of real-life dilemmas with me.

The final interpretive account hopefully extends the current professional knowledge base. As Kelly (1999b) avers, any research account which is comprehensive, rigorous and generic in character thereby succeeds in surpassing the subjective understanding of the individual participant's single voice or lone self-account. This suggests that this study, focusing as it does on the countertransference dimension of ethical dilemmas, may potentially extend interviewees' self-understandings. The final interpretive account might arguably be construed as helpful rather than as harmful to individual practitioners prone to translating temporarily compromised and reparable ethical judgments into "evidence" of personal failings. The sheer volume of data and expense incurred by approximately 16 hours of interviewing precluded initiating a fresh round of research interviews. Future research, possibly burdened by less data, may be better positioned to provide additional opportunities for research participants to check and, if necessary, to change not the researcher's independent interpretations but the latter's detailed descriptions of interviewees' subjective experiences and self-understandings (Kelly, 1999b; Ramcharan & Cutcliffe, 2001). This in turn may contribute to building a respectful qualitative research process wherein the quest for professional knowledge and personal advancement remains subordinate to the researcher's paramount ethical concern for the care and well-being of the researched.

5. GAINING MOMENTUM: RECRUITING RESEARCH PARTICIPANTS

5.1. Clarifying selection criteria

Efforts to recruit research participants were guided by two considerations. Potential interviewees were assessed, firstly, according to particular selection criteria. Evaluation of

the suitability for the purposes of this research study of ethically problematic situations required, secondly, establishing a pragmatic definition of what arguably constitutes an "ethical dilemma". Participant characteristics and different definitions of "ethical dilemmas" are discussed below.

In order for participants to convey vivid, detailed, "thick" descriptions (Geertz, 1973), it appeared essential to identify interviewees who were articulate, well experienced and willing to participate in a research study they perceived to be professionally relevant. The main selection criterion was based on the individual participant having personally encountered and engaged with a real-life ethical dilemma in the context of the therapeutic space. Sampling was purposive as I sought currently practising psychologists who had encountered troubling or challenging ethical dilemmas within the past twenty-four months and who had at least five, but not more than twenty, years of professional clinical experience. Recency of experience and written documentation, including possible case records and supervision notes, enhanced the likelihood that recall of the ethical dilemma would be emotionally alive, rich in detail and credible in tenor.

The planned sample size was limited to 6-8 research participants. In determining the number of subjects needed for an interpretive study, Kelly (1999a) observes that "it is necessary to have enough material to begin to develop generalisations on the basis of the specific instances we look at" (p. 381). The proposed number of subjects appeared to be small enough to be practically manageable but arguably remained large enough to develop generic understanding of the phenomenon at hand. Since object relations comprised my primary theoretical orientation, I decided to recruit participants who worked within a broadly similar approach. This homogeneity would hopefully provide the researcher and the researched with a common language and shared understanding of the nature of the patient-therapist dyad as well as of the significance of the therapeutic boundaries framing the ethical dilemma concerned. Within the selected sample, some degree of diversity or sampling for heterogeneity seemed achievable. Research subjects could include both male and female participants of different ages and population groups; primary work contexts might encompass private practice, academic institutions and medical/hospital or psychiatric settings. Diversity could further be promoted by accepting a range of real-life ethical dilemmas reflecting prospective participants' different experiences, feelings, thoughts, attitudes, choices and efforts at resolution.

5.2. Definition of an "ethical dilemma"

Selection criteria included consideration not only of prospective participants' characteristics but also of clarifying which professionally problematic situations would be accorded the status of comprising an "ethical dilemma". The following descriptions of "ethical decision-making" and "ethical dilemmas" appeared pertinent; Colnerud's (1995, in Lindén & Rådeström, 2008) observations were discovered later in the research process but appeared congruent with the ideas set out below.

Slack (1997) argues that the notion of ethical decision-making is invariably "an abstract summary for an innumerable set of cognitive, affective and interpersonal attitudes and behaviours" (p. 115). More particularly, Steere (1984) suggests that ethical decision-making is characterised by constant choices between alternative courses of action. These include self-interested actions or those behaviours "one desires, or would *like* to choose" (Steere, 1984, xi) and contrasting conduct which is guided by moral conscience or by considerations of which actions "one *should* choose, or….would be the *right* thing to do" (Steere, 1984, xi) in a given situation. Commenting that ethical dilemmas are inherently imbued with ambiguity, Packer (1989) writes that "from a researcher's perspective there is never an unequivocal indication of who acted properly, or an obvious choice of who gave a correct account of events. We talk of moral *dilemmas* with good reason: they have two facets, each of which has a claim to validity" (p. 115). Pope and Vetter (1992) apparently construe ethical dilemmas as "actual situations which required ethical decisions" (p. 2). In distinguishing between ethical problems, ethical conflicts and ethical dilemmas, Colnerud (1995, in Lindén & Rådeström, 2008) contends that "The common denominator….is that the situation always includes a decision-making process for the psychologist contemplating how to solve the situation" (p. 2). Integral to an ethical dilemma, Colnerud (1995) continues, is a complex process of ethical decision-making ""where the appropriate course of action is not given or obvious and does not include one solution only" (p. 2). *The Concise Oxford Dictionary* (1982) defines the word "dilemma" as "a position that leaves only a choice between equally unwelcome possibilities" (p. 268); this gives rise to the common expression "on the horns of the dilemma" (p. 268).

The foregoing observations suggest that at the core of any lived "ethical dilemma" lies a "multiply determined" (Kantrowitz, 2006) ethical decision-making process where both self-interested as well as more beneficent motivations vie for behavioural expression. Central to

the preceding arguments is the notion that real-life "ethical dilemmas" subsume the subjective experience of conflict or of emotional tension aroused by having to make a decision from among apparently competing alternatives. For the purposes of this research study, I decided to accept real-life ethical dilemmas as defined objectively by professional ethics codes (APA, 2002; CPA, 2000; South African "*Ethical Code of Conduct*", 2002), accepted categorisation systems (Pope & Vetter, 1992; Slack & Wassenaar, 1999; Wassenaar, 2002) or as subjectively construed by the therapist concerned as comprising an ethically problematic situation wherein the analytic task, attitude and setting (previously discussed in Chapter 3) were rendered vulnerable to compromise. This research study posited, however, that an additional criterion to be satisfied was that prospective research participants' subjective experience should reflect a sense of having been "on the horns of the dilemma" or of having felt torn between conflicting courses of action. Excluded from this research study, therefore, would be professionally problematic situations requiring an ethical decision where the therapist concerned had apparently experienced minimal psychological conflict and was evidently able to effect resolution in a reflective and emotionally appropriate manner.

5.3. Searching for participants

The search for suitable participants was arduous and time consuming. At the start of the research, the four local professional groups which focused on adult psychotherapy included the Self-Psychology Group, the South African Association of Jungian Analysts (SAAJA), the Cape Town Society for Psychoanalytic Psychotherapy (CTSPP) and the South African Institute for Psychotherapy (SAIP). Since I was a member of the latter two groups, I decided to begin my search by approaching the CTSPP and the SAIP; the membership consisted largely of clinical psychologists and object relations was firmly established as a primary theoretical orientation.

To stimulate awareness and interest, I addressed several meetings of the different branches of the CTSPP and SAIP. I outlined the aims of the study, the research procedure, expected benefits and risks, time commitments and how confidentiality would be safeguarded. Polite interest was expressed but the general response seemed muted and yielded no volunteers. These early efforts were then followed up by posting letters to each of the combined membership (112 psychologists) of the two groups concerned. This was done to remind interested practitioners that the possibility of participating in the research study still existed

and to cover any psychologists who may have been absent at the initial meetings. Twelve psychologists working in local psychiatric facilities were additionally emailed with details of the proposed project. Several weeks passed in silence. This was broken at last by a single volunteer who, after outlining a troubling ethical dilemma in a preliminary phone call, agreed to become the first research participant.

By this stage I was considering broadening my inquiry to psychoanalytic groups based in cities other than Cape Town. Exploring my predicament informally with a supportive colleague resulted in her suggesting that I should directly approach local clinicians reputed to be helpful and ask whether they were prepared to become involved in the study. To my relief, the strategy of "snowballing" (Strydom & Delport, 2002) or "the friend of a friend approach" (Kelly, 1989a, p. 384) finally broke the impasse and a network of potential interviewees began to emerge.

Each time I spoke to a possible participant, I also asked whether they were aware of anyone else who might be willing to be interviewed. A demanding process of evaluating the suitability of potential participants and ethical dilemmas now arose. Twenty-five local psychologists were personally contacted by phone or by email. Some did not return my calls or emails. Others declined, saying that they were too busy, were eclectic in theoretical orientation or had had no experience of encountering ethical dilemmas in their clinical practice in recent years. Several dilemmas had occurred more than five years ago, thus contravening an inclusion criterion. Three participants volunteered suitable ethical dilemmas including collegial misconduct or eroticised countertransference involvement only to withdraw later, citing ambivalence or concerns about the possible negative impact of the research interviews on ongoing therapeutic relationships. Still other dilemmas proffered, but deemed unsuitable, included two practitioners' subjective experiences as former patients who had become sexually embroiled with local analysts; a third practitioner perceived himself as having broken the boundaries of the analytic frame by visiting an ill patient in hospital but considered that the decision was motivated by ethical and thoughtful regard for the best interests of the patient. Striking reactions that retrospectively again signalled that I was treading on sensitive research terrain included one clinician's refusal to participate on the grounds that I might "report" him. He then refused to refer me to other colleagues on the grounds that I might be equally inclined to "report" them! The stories of the six participants who were eventually selected encompassed a range of real-life ethical dilemmas. I felt

excited and hopeful that, after months of preparatory work and setbacks, the "real" research was about to begin! I started setting up the research interviews and concurrently worked on creating a semi-structured interviewing guide.

5.4. Characteristics of selected research participants

The six research participants consisted of three men and three women. Five agreed to participate after I had personally approached them and one was self-selected. All were white, middle-class and English speaking except for one whose first language was Afrikaans. Ages ranged from the late twenties to early fifties. Five participants were registered as clinical psychologists and one was an educational psychologist[11]. Object relations was described as practitioners' primary theoretical orientation; four participants additionally cited Self-Psychology and/or Jungian thinking as exerting a strong influence on their clinical practices.

Work settings included private practice and hospital or clinic contexts. Two participants were in full-time and three worked part-time in private practice. One was employed in an educational institution. Post-qualifying clinical experience ranged from four to twelve years; four participants had six or more years experience in working within a broadly psychoanalytic psychotherapy framework. While most participants focused primarily on adult long-term psychotherapy, some work with couples and adolescents was also evident. Prior to the research interviews, I was slightly acquainted with all six research participants on a collegial basis.

The use of professional resources is discussed later (See Chapter 7). The following summary outlines salient features of participants' ethics education, supervision and personal analysis as well as the type of ethical dilemma that was encountered in the context of the therapeutic space. All participants held a Masters degree and had trained between 1991 and 1999 at local universities. Four participants' postgraduate training had included a formal coursework component on professional ethics while, in the remaining two Masters degrees, ethics education was described as either entirely absent or as having been taught on an informal basis only and as an adjunct to another taught course. The research participants had thus all trained before 2002. This is the date when the mandatory Continuing Professional Development (CPD) system administered by the South African Professional Board for

[11] All psychologists in South Africa are required to register in one of five registration categories; these include clinical, counselling, educational, industrial or research psychology.

Psychology stipulated that every practitioner is annually required to collect a specific number of points in professional ethics in order to maintain his or her registration (*HPCSA, CPD Guidelines for Psychologists and Registered Counsellors*, 2001). In general, participants expressed dissatisfaction with their postgraduate ethics training. Given that participants' evaluation of their graduate ethics coursework was largely negative and that continuing mandatory education had only recently been instituted, interviewees' formal ethics training prior to the research interviews in 2003 appeared to be relatively sparse and potentially lacking in relevance.

When the ethical dilemmas arose, all six participants were in regular supervision and/or personal therapy. Four participants consulted five different supervisors whose theoretical orientation (barring one who adopted a principally problem-solving case management style) included Jungian, Self-Psychology and object relations approaches. The sample included two participants who received no supervision, of whom one remained apparently entirely professionally isolated throughout the duration of the dilemma concerned. Three interviewees were in Jungian analysis and three were not in personal therapy at the time of the dilemmas. A combined total of eight supervisors and personal analysts were consulted by five participants with regard to resolving the relevant dilemmas.

Ethical dilemmas in this research study were assigned to categories based on the South African categorisation system developed by Wassenaar (2002) as well as Pope and Vetter's (1992) earlier design. Primary dilemmas described included confidentiality issues, non-sexual dual role relationships, collegial misconduct and child abuse interventions. Participants' struggle to resolve the various dilemmas ranged in duration from approximately two weeks to three years. At the time of the research, four dilemmas (two of which were still current) remained unresolved after one year. While day-to-day case records regarding patients' therapeutic process were available, no corresponding documentation apparently existed which detailed research participants' subjective and countertransference responses to the core ethical dilemma.

All participants expressed an interest in participating in the research interviews. Preliminary reservations included anxiety about the perceived "messiness" of professional interventions. Prospective interviews were generally, however, viewed as a valuable opportunity for further reflection on participants' individual engagement with real-life ethical dilemmas as

well as providing a chance to contribute more generally to professional knowledge regarding ethics in psychoanalytic practice.

6. GATHERING DATA: THE INTERVIEWING PROCESS

Open-ended interviews comprise an interpretive research approach which is used to access participants' lived experiences and feelings about their everyday world. The interviewer accordingly "creates an environment of openness and trust within which the interviewee is able to authentically express her or himself" (Terre Blanche & Durrheim, 1999, p. 153). Since researcher and researched are regarded as co-inquirers, the meanings that are "created in the interview are treated as co-constructed between the interviewer and interviewee" (Terre Blanche & Durrheim, 1999, p. 153). This implies that the emergent interview text is not simply a reflection of the lone participant's "reality" but remains "always a product of the relationship between interviewer and interviewee" (Hollway & Jefferson, 2000, p. 45). Reciprocal ways in which the research pair simultaneously influence one another may in addition be "initially … out of the awareness of the parties involved, [hence] scrutiny is an absolutely necessary part of social science research" (Berg & Smith, 1988, in Hollway & Jefferson, 2000, p. 33).

I have previously discussed the need to set up a reflective research space wherein to scrutinise subjective or countertransference responses. I was aware that my taken-for-granted assumptions would be implicated not only in the interpretation of the research material but also in the very questions I elected to ask in the interviews and in the answers and participant responses I chose to pursue. Planning for the interviewing process foregrounded a new aspect of the iterative cycle of "reflective reflexivity" (Addison, 1999, p. 152). This involved preparing a research journal in which to enter free-form "jottings" or "memos" (Charmaz, in Denzin & Lincoln, 2000, p. 44) after every research interview. These eventual scribblings were to prove descriptive rather than analytical in character, drawing my attention back to fleeting feelings, embodied responses, awkward moments, off-the-record opening and closing remarks and seeming inconsistencies arising in the research encounter as well as in participants' stories of real-life dilemmas.

Preparations for interviewing also included developing several drafts of a semi-structured "Interview Guide". The final version (see Appendix B) was broadly based on professional literature pertaining to ethical decision-making, the three preliminary research questions and

a helpful series of interview questions designed by Brown, Tappan, Gilligan, Miller and Argyris (1989) to elicit stories of real-life moral conflict and choice. The Interview Guide allowed freedom to follow up unexpected events (for example, when speaking of feeling overwhelmed by trauma cases at work, one participant held his throat) but it also provided the structure needed to ensure in-depth steady coverage of key topics. This combination of flexibility and structure was aided by my thoroughly memorising the Guide prior to the research interviews. Whatever digressions occurred, I felt reasonably confident that I would remember the interview format and would retain the overall focus and direction of the interview concerned.

Participants were offered the choice as to where the interviews should be conducted. Peaceful every-day settings chosen included clinicians' consulting rooms and my own consulting room. The testing of the Interview Guide in two pilot interviews introduced structural changes to the interviewing process. The first pilot interview was completed in a single session. Originally discussed in a preliminary phone call, the presenting dilemma reflected the therapist's concerns about social contact with an ex-patient's significant other. In the pilot interview, however, the therapist's attention switched unpredictably to focus instead on an entirely new and painful dual role relationship. This unanticipated development in a first-time situation left me, as the following "jotting" indicates, unsure of how to respond. Thus in my research journal I wrote that "there seemed to be a lot of involvement between us at times … at others, I felt „flat', as though I were missing important clues associated with this dual relationship….its broken boundaries and sense of threat … am left with feeling that [the participant] did not find the *thoughts* she was perhaps looking for … we didn't get to the heart of things ...".

The researcher and the researched may be construed "as anxious, defended subjects ... both will be subject to projections and introjections of ideas and feelings coming from the other person" (Hollway & Jefferson, 2000, p. 45). The seemingly unaccountable confusion and anxiety evident in the first pilot interview left me dissatisfied. A different interviewing strategy appeared to be needed, one that would allow for the notion of a defended research pair and that would afford an opportunity for interim reflection, discussion, replaying the tape and the formulation of specific questions directed at following up and clarifying new, ambiguous or contradictory material. Renegotiating the research contract with the next participant, I experimented in the second pilot interview with two sessions, each of one-and-

a-half hours, which were separated by an interval of approximately one week. This structure was adopted for the remainder of the research interviews. The extended period of interviewing seemed to foster a greater sense of familiarity and trust, often providing a basis in the second session for deepened interaction and the emergence of new and significant research material.

Every interview commenced with informal chatting, setting up the tape recorder and organising tea. These apparently simple tasks helped both the researcher and the researched to relax and to establish some preliminary sense of rapport. The Interview Guide similarly opened with relatively non-threatening, introductory questions eliciting information about participants' registration category, work setting, supervision, personal therapy and prior ethics education. The foregoing prelude provided an essential relational context for the later elaboration of troubling dilemmas and helped to build up mutual interest in one another and in the topic at hand. This was then succeeded by the first open-ended "grand tour question" (Miller & Crabtree, 1999b, p. 97) which was derived from Pope and Vetter's (1992) original study (See Figure 1 below).

1. Can you describe as fully as possible an ethically challenging or troubling dilemma that you've encountered in practice over the past 24 months where you weren't sure what you should do?
2. Can you describe in as much detail as possible how you processed this dilemma and what professional resources you used to help you?
3. Can you describe what your final decision was and how you implemented it?

Figure 1. "Grand Tour" questions from an interpretive study on psychoanalytic psychotherapists' ethical decision-making practices (adapted from Crabtree & Miller, 1999b).

The Interview Guide thus essentially consisted of three main "grand tour" and associated, follow-up questions inviting participants to tell extended stories about their feelings, thoughts and efforts to resolve real-life ethical dilemmas. A relatively consistent interviewing pattern gradually evolved wherein the use of prompts and probes (Miller & Crabtree, 1999b, p. 98) seemed to encourage the flow and articulation of as yet largely unspoken narratives. The first interview focused primarily on eliciting in-depth, first-hand accounts of ethical dilemmas encountered in the therapeutic space and of participants' subjective responses to these. The second interview, often more challenging and emotionally demanding in tenor, included following up "tailor-made" questions (Hollway &

Jefferson, 2000, p. 43) and tentative interpretations of emerging research material. Interviewees' everyday ethical decision-making practices and their use of professional resources were also explored.

Research participants are not expected to be fully aware of the meanings of their motivations, feelings and actions (Hollway & Jefferson, 2000). Of interest, therefore, were not only interviewees' conscious, rational thoughts and explanations but also unfamiliar descriptions of their embodied responses to real-life dilemmas. This feature of the interviewing process aimed at accessing "that [unsanitized] aspect of the person's experience and understanding that was lived before it was reflected upon" (Kelly, 1999a, p. 392). However, earlier taken-for-granted assumptions that interviews would additionally yield data demonstrating the thoughtful transformation of initially confused and disjointed subjective experiences began to unravel. Kelly (1994) observes that narrative smoothing refers to that "process whereby the inchoate and fragmented moments of life….are transformed into sequential, coherent, unambiguous accounts of experience" (p. 56). Welling up by contrast in the context of the research interviews were thickly textured stories still dense with participants' descriptions of apparently unthought feelings, fantasies, memories, discordant inner moral "voices" and experiences of disappointment, disillusion and professional isolation. This spontaneous countertransference saturation of myself generated by participants' recounting of their lived struggles and often primitive affects was eventually to act as a principal source of information concerning my theoretical understanding of the unconscious irrational dimension of ethical decision-making as it transpires in analytic space.

Post-interview contact consisted of five to ten minutes which were mostly spent in sharing mutual impressions of the foregoing interview. In contrast to the intensity of the research interviews, closure to some extent ushered in a "cooling off" period and permitted me to express gratitude for participants' very considerable expenditure of time and effort.

7. TRANSCRIBING THE RESEARCH INTERVIEWS

The eleven recorded research interviews were transcribed over six months with the help of a trustworthy and reliable assistant with whom I had worked for several years. I was confronted at the outset as to whether to transcribe the entire interview verbatim or only selected aspects of the conversation. Using the concept of the hermeneutic circle, I considered that the multiple meanings of the different parts of the conversation were only

explicable in the context of the global meaning of the entire interview and, reciprocally, that interpretation of the whole transcript was contingent on a deepening understanding of its parts. As Kvale (1996) argues, when psychological interpretations are to be made, even seemingly insignificant "hm's", pauses or digressions may well be relevant for later analysis. Despite costs and the length of time entailed, I decided to transcribe the interviews in their entirety rather than prematurely to attempt to discern which parts of the recorded interviews were significant and which superfluous.

The translation of oral discussion into written text remains, however, fraught with difficulties; not least of these is the tendency to regard the transcript as a rock-solid, reliable representation of the "reality" of the original research encounter. Kvale (1996) contends that on the contrary taped interview transcripts are frozen "decontextualised conversations" (p. 167), stripped of the temporal, spatial, visual and social dimensions which confer immediate meaning to face-to-face conversations. Although not exhaustive, I have attempted to restore a sense of the flow, the contextual detail and emotional nuances of the lived research encounter by indicating in the text repetitions, broken sentences, emphases in intonations, non-linguistic expressions including pauses, silences, pointing and the use of fillers such as "ja's" and "hm's".

Repeated playing of the taped conversations facilitated checking the reliability of the transcribed texts. Re-reading my rough "jottings", listening to the recorded conversations and scrutinising the transcripts also helped to re-immerse me back into the intimate atmosphere of the original research interviews. The "emotional topography" of the numerous transcripts became ever more familiar. I began to understand more about what interviewees' engagement with real-world ethical quandaries had individually meant to them. At the same time, I increasingly used psychoanalytic theory to help construct a generic account of participants' engagement with real-life dilemmas. In interpretive research, there exists "no clear point when data collection stops and analysis begins" (Terre Blanche & Kelly, 1999, p. 139). In effect, data analysis in this research study was instilled at the very start of the ongoing iterative process of conducting, transcribing and interpreting the research interviews.

8. DEVELOPING AN INTERPRETIVE ACCOUNT: DATA ANALYSIS

Interpretive analytic styles may be located on a continuum ranging from quasi-statistical styles to immersion/crystallisation styles (Miller & Crabtree, 1999a). Situated at the latter end of the continuum, the "editing organising" style (Miller & Crabtree, 1999a, p. 21) and aspects of an "immersion/crystallization" style (Borkan, 1999, p. 179) were used in this research inquiry for entering and analysing the data. The latter "organizing styles" of data analysis are congruent with hermeneutics as well as with the assumptions and practices of grounded theory (Addison, 1999; Glaser & Strauss, 1967; Strauss & Corbin, 1990), a qualitative research tradition which is summarised by Kelly (1999b) "as a system for developing theoretical accounts whilst keeping close to the phenomenological ‚ground'" (p. 405). Beginning with the particulars of participants' lived experiences and building slowly up towards theoretically informed generalisations, the adoption of an "idiographic" (Smith, 1995) stance towards the data helped to maintain a circular relationship between "ground" and theory in which each perspective informed the other. Kelly (1999b) maintains that "theory which is not grounded, and description which is not theorised stand in danger of being alienated from the advantages of the opposite perspective" (p. 406). This suggests, as argued earlier, that a satisfactory interpretive account embraces both experience-near, contextually-derived as well as experience-distant, theoretically led perspectives.

Integral to the data analysis process were two broad movements comprised of "vertical" and "horizontal" passes (Borkan, 1999, p. 186) of the data. The six interview texts were initially individually analysed "vertically" and in detail from beginning to end. "Horizontal" passes of the data increasingly shifted the focus away from local descriptions towards comparing similarities and differences within, between and across emerging codes, themes and categories of experience. Contextually derived individual transcripts were thus gradually transformed into a trans-situational, theoretically informed account of psychoanalytic psychotherapists' efforts to resolve real-life ethical dilemmas in the therapeutic space. While the latter account remains arguably well grounded in the data and draws extensively from grounded theory methodology, it offers a limited conceptual analysis of research participants' lived experiences rather than the provision of formal grounded theory (Charmaz, 1995). For the purposes of discussion, analysis of the data is presented in the form of the following five steps. Rather than a formulaic procedure, the recursive process involved may be likened more to "a multileveled roller-coaster than [to] a [linear] staircase" (Borkan, 1999, p. 183).

8.1. Step 1: Reflexivity and Countertransference

The most critical tool in interpretive research is arguably the researcher's self which comprises "the primary instrument for both collecting and analysing the data" (Terre Blanche & Kelly, 1999, p. 126). The need for a reflective research space has previously been discussed. Henwood and Pidgeon (2003) likewise observe that it is logically impossible for the researcher to approach the work of data analysis as a "true tabula rasa" (p. 137) without reference to prior conceptual frameworks and existing literature. From a constructivist grounded theory perspective, the latter authors accordingly assert that the generating of theoretical accounts presupposes "a constant two-way dialectical process or "flip-flop" between data and the researcher's [own] conceptualizations" (p. 135).

The data in this study were consistently filtered through the lens of psychoanalytic theories and models. The latter thus acted as pre-existing "sensitizing concepts" (Charmaz, 2000, p. 515) or "points of departure to look at….and to think analytically about the data" (Charmaz, 1995, p. 32). Theoretical sensitivities may, however, be "vision-blinkering" as well as "vision-creating", telling "us where to look at the same time as, potentially, keeping us from seeing" (Henwood & Pidgeon, 2003, p. 135). Construction of an ongoing reflective research space appeared to help safeguard the emerging account from being skewed by researcher bias or from "taking off on theoretical flights of fancy" (Charmaz, 1995, p. 37). Theoretical sensitivities in the form of psychoanalytic concepts and models were by contrast carefully evaluated in the context of the reflective space for their "fit" (Henwood & Pidgeon, 2003, p. 139) with the data and, if appropriate, were integrated into the evolving account. Brenner's (1985) notion of "countertransference as compromise formation", for example, was examined and set aside as its apparently exclusive focus on the individual analyst's intrapsychic dynamics failed "to fit" the data. Hence Brenner's theoretical formulations appeared unable to accommodate the interpersonal dimension critical to understanding the unconscious interaction between the original therapeutic dyads and research participants' ensuing charged and seemingly irrational responses to lived ethical dilemmas.

8.2. Step 2: Immersion and Open Coding

This entailed gathering preliminary fieldwork observations, theoretical and supervision notes as well as the transcribed interview texts. Implementing a line-by-line reading and coding process, I immersed myself in the raw data and in studying participants' stories or lived worlds once again. Charmaz (1995) writes that "unlike quantitative coding that

[involves] applying preconceived codes….qualitative grounded theory coding means *creating* the codes as you study….interact with….and ask questions of [the data]" (p. 37).

Using an "editing organizing style" (Miller & Crabtree, 1999a, p. 23), I entered the data of the first transcript, subsequently completing serial readings of the entire body of text. I underlined everything that appeared pertinent to the research objective of exploring and understanding participants' subjective and countertransference responses to real-life ethical dilemmas. This "open coding" (Charmaz, 1995, 2000) resulted in fourteen flexible preliminary codes. "Pre-reflective feelings", for example, consisted of multiple underscored text segments which collectively began to suggest that ethical dilemmas may often be apprehended not by ethical reasoning processes but by the practitioner's predominantly physical sensations of shock, excitement, anxiety, "sickness", "sinking", "blankness" or sleeplessness. Behavioural interactions evident in the transcripts were likewise treated "as a type of text" (Addison, 1999a, p. 153) to be analysed and interpreted. Hence I marked and coded unexpected nonverbal events such as prolonged silences, tearfulness or an interviewee's holding of his throat as instances of a provisional open code termed "The slippery slide of countertransference". Of particular interest were "Contradictions, gaps and anomalies", an open code pertaining to "fractures" in the data (Hollway & Jefferson, 2000, p. 70) where participants' manifest ethical stance appeared to be unexpectedly dislodged by the appearance of discordant verbal expressions or behaviour. Stated aspirational ethical principles, for example, were often seemingly unconsciously contradicted by research participants' sustained engagement with apparently self-serving therapeutic interventions.

Charmaz (2000) observes that "memo-writing" serves as an "intermediate step between coding and the first draft of the completed analysis" (p.517). Unconstrained by the demand of having "to fit" the data, "memoing" may be likened to "free writing" (Charmaz, 1995, p.44). This mode of expression, without thought for the public, frees the researcher to explore processes, patterns, assumptions or concepts subsumed under codes and "to start digging into implicit, unstated and condensed meanings" (Charmaz, 1995, p. 43). The open code "Professional consultations and contacts", for example, sparked scribbled memos noting my own reluctance to expose my not understanding the many implicit meanings inherent to participants' descriptions of wrestling with everyday ethical dilemmas. This spurred reflection on whether participants' similar avoidance on occasion of available professional resources was an unconscious strategy designed to shield the professional self

from narcissistic wounding incurred by exposing "messy dilemmas" to the fantasied judgmental or punitive gaze of colleagues and professional organisations.

These early phases of open coding and initial memoing have been likened by Henwood and Pidgeon (2000) "to stepping deeper into a maze, a confusing place that may generate considerable uncertainty and anxiety. During the later phases of analysis, suitable routes out of this maze have to be found" (p. 140).

8.3. Step 3: Description of Dilemmas and Construction of Reading Guide

This step involved generating a clear description of each of the six real-life dilemmas as well as establishing a "Reading Guide" (Brown, Tappan, Gilligan, Miller & Agyris, 1989) through which the data was read. Detailed raw data provided by personal interviews may be further enriched by contextualising the phenomenon of interest, "adding a description of the situation, the interaction, the [interviewee's] affect and [the researcher's] perception of how the interview went" (Charmaz, 1995, p. 33). The six vignettes (See beginning of Chapter 5) were intended to make the participants and the interview process "come alive" (Hollway & Jefferson, 2000, p. 70), orienting the reader to the drama of the individual stories and providing an overview of the main relationships, conflicts, chronological developments and professional as well as legal and organisational structures within which the dilemmas were embedded. No attempt was made in crafting the vignettes "to iron out inconsistencies, contradictions and puzzles" (Hollway & Jefferson, 2000, p. 70). Rather participants' constructions of the evolution and resolution of ethical dilemmas raised challenging questions about the potential role played by unrecognised emotional pressures on the processes of ethical judgment and intervention. Using the typologies proposed by Wassenaar (2002) and Pope and Vetter (1992), formal coding of the presenting ethical dilemmas was also completed at this stage.

The generating of fourteen flexible open codes and six vignettes represented initial ways of thinking about, reorganising and "fracturing the data" (Charmaz, 2000, p. 521). An analytical device was now required that would help shift the research endeavour further along the interpretive continuum, away from individual anecdotes and towards the identification of common features, key patterns, themes and conceptual categories. Implementation in this study of the Reading Guide method appeared to comprise a useful analytical strategy that aided thematic and theoretical development both within as well as

trans-situationally across contexts. Kelly (1994) writes that "It is an important principle of phenomenological as well as hermeneutic research that the data does not speak without being asked questions" (p. 78). Reading and listening guides hence offer to guide the reader-listener through the text, extracting specific text segments that appear salient to the provision of "answers" that are central to the research endeavour (Brown & Gilligan, 1991; Brown, Debold, Tappan & Gilligan, 1991; Brown et al., 1989; Gilligan, Spencer, Weinberg & Bertsch, 2003). In a series of multiple readings, the reading or listening guide questions are put to the text one by one. Each question acts as a "different interpretive lens" designed "to amplify"(Brown & Gilligan, 1991, p. 32) salient moral "voices", beliefs, processes, events and relationships that sound in the story told by the participant.

The Reading Guide questions constructed for this study (See Figure 2 below) "crystallized" (Borkan, 1999, p. 182) after repeatedly delving into the interview transcripts, struggling to make sense of participants' subjective experiences and sifting though the original research questions, new questions that had arisen in the course of data collection and unanticipated questions suggested by the newly created open codes. Over twelve preliminary Reading Guide questions were initially generated; these were revised to ascertain which were redundant and which could be subsumed under others. The emergent list of seven Reading Guide questions reflected an interplay between deductive and inductive approaches to the analysis of the data. Some questions accordingly reflected the influence of theoretical sensitivities whereas others were principally derived from the data themselves and were closer to the phenomenological ground of participants' lived experience. The Reading Guide thus continued to deploy both arcs of the hermeneutic circle "[from] particular to general and general to particular … [fostering] … an interpretation that accounts both *for* contexts and *across* contexts" (Kelly, 1999b, p. 413).

8.4. Step 4: Application of Reading Guide and Construction of Master Themes

The Reading Guide questions were written up on sheets of paper as seven provisional headings. Photocopies were then made of all transcripts. Applying the Reading Guide to the first transcript, the text was read and searched for meaningful "answers" in the form of processes, conflicts, contradictions, relationships, stated values, events and moral "voices". The first Reading Guide question (see Figure 2 below), for example, asking what ethical principles the participant considered central to his/her everyday practices, was addressed to the initial interview transcript. Textual segments deemed to hold a common thread and to

constitute possible “answers” were marked in colour, cut out from the photocopied pages, grouped together and pasted in a “cluster” under the provisional heading concerned.

Each cut out segment of text was carefully marked, indicating from which interview the excerpt had been extracted and including the relevant page and line number. A segment might be labelled, for instance, as Interv. 1, p. 20, 43-45. This labelling ensured that any particular segment of raw text could easily be accessed, compared with other segments and replaced back into the context of the original transcript. The latter labelling system was retained for all interview quotes and verbatim material appearing in chapters 5-8.

Regarding the first interview transcript, the grouping and labelling process generated “clusters” of colour coded text fragments. Each “cluster”, comprised of many text segments and containing a range of responses or possible “answers”, pertained to one of the seven Reading Guide questions. Where the same text segment appeared to be pertinent to more than one Reading Guide question, it was marked accordingly and allocated to the additional “clusters” concerned. The cut-and-pasted text fragments under each overarching question were then read, compared with one another and explored for connections, patterns, processes, similarities and differences. Out of this predominantly “vertical” pass of the data, a rough and tentative list of themes and sub-themes emerged for the first interview.

The seven Reading Guide questions were subsequently systematically applied to the remaining interview transcripts. For each Reading Guide question, therefore, six clusters of answers were derived from each of the six interview transcripts. The emphasis shifted from analysing single interview transcripts, one by one, to exploring more broadly between and across clusters of text fragments for superordinate or master themes that subsumed both preliminary open codes as well as tentative lists of themes that had emerged in the earlier course of “vertical passes” (Borkan, 1999, p.186) of the data.

READING GUIDE QUESTIONS		MASTER THEMES	CATEGORIES	FINAL INDEX OF FOUR CORE CATEGORIES
1	What does the participant consider his/her core ethical principles and values to be and how does s/he describe living these out in the context of the real-life ethical dilemma?	Guiding principles … I *walk* with…(Interv.5, p.166, 40-43)	Avowed vs lived values	**Avowed vs lived values**
2	What does the participant perceive the core ethical dilemma to be and how was its presence first identified?	Shock….definitely "shock" is the word (Interv.2, p.44, 28-39)	Pre-reflective identification of core ethical dilemma	**The countertransference dimension of real-life ethical dilemmas**
3	In the context of the participant's lived dilemma, what salient:	Who are we in relationship together? (Interv.4, p.124, 5)	Transference- countertransference processes generated in the presence of real-life ethical dilemmas	
a)	feelings, somatic responses, observations and subjective concerns are described?	Feelings, somatic responses, observations and subjective concerns		
b)	images, metaphors, fantasies and childhood memories are generated?	Images, metaphors, fantasies and childhood memories		
c)	inner ethical "voices" does the participant "hear" and what are they "saying"?	A multiplicity of "voices"		
d)	images, metaphors and processes pertaining to thinking or reflective experiences are described?	Like a pressure cooker with no outlet….things just accumulate (Interv.6, p.229, 23-24)		
4	What descriptions were offered by the participant of the relationships that existed between him/herself and the professional resources that were available to him/her?	It's….difficult to reach out…(Interv.1, p.14, 46)	Absolution, penance or excommunication: therapist perceptions of professional resources	**Absolution, penance or excommunication: therapist perceptions of professional resources**
5	What subjective experiences does the participant describe in relation to the ethical decision-making process?	Putting [conflict] out of….mind (Interv.1, p.10, 23)	Ethical decision-making in the context of the therapeutic space	**Ethical decision-making in the therapeutic space: Towards a Psychoanalytic model**
6	With reference to the paranoid-schizoid (PS) and depressive (D) positions[1], how does the participant's countertransference responses and descriptions of ethical thinking and decision-making reflect the dialectical interplay between them?	Oscillating between the PS and D positions		
7	How did the participant appear to perceive me and how did I in turn experience him/her?	Transference-countertransference experiences in the research encounter	Transference- countertransference processes generated in the context of the research encounter	

Figure 2: Development of Reading Guide questions into master themes and core categories.

[1]Steiner (1992) observes that a dynamic relationship and continuous fluctuation exists between the paranoid-schizoid and depressive positions which Bion (1963) captures by the notation PS ←→ D

Inducing codes, clusters, themes and sub-themes had the effect of allowing familiar text fragments which were originally viewed in a linear, chronological sequence to suddenly be brought together in unexpected ways. This "winnowing process" (Seidman, 1991, p. 89) potentially opens up "a fresh view on the data", fostering the identification of "finer nuances of meaning not captured by [the] original…possibly crude, coding system" (Terre Blanche & Kelly, 1999, p. 144). Thematic development now entailed repeatedly implementing "horizontal passes" (Borkan, 1999, p. 186) of the data. Using grounded theory's "constant comparative method" (Addison, 1999; Charmaz, 1995, 2000; Henwood & Pidgeon, 2003), all six clusters of answers pertaining to each Reading Guide question were systematically read, scrutinised and compared in detail with one another. This process entailed comparing one participant's experiences, thoughts, values and actions with another; comparing the same participant's experiences but at different points in time and comparing themes and sub-themes that had already been identified in the initial analysis of the interview transcripts.

At this stage, I sought to establish a clear list of "master themes" (Smith, 1995, p.19) or "focused codes" which captured and synthesised earlier codes but were "less open-ended and more directed" (Charmaz, 1995, p.40). I discovered that "in vivo coding" (Addison, 1999; Charmaz, 1995; Terre Blanche & Kelly, 1999) or using a participant's actual words was often successful in succinctly naming the essential quality of themes emerging between and across the different clusters. Repeated "horizontal passes" of the data pertaining to the use of professional resources, for example, suggested that one participant's sentence, "It's difficult to reach out", apparently reflected not only an experience particular to a single interviewee but identified a superordinate theme cutting across the various clusters and discrete interview texts. Actively highlighting what was happening in the data, further *in vivo* codes or master themes followed including, for instance, "Guiding principles…I walk with", "Shock…shock is the word" and "Who are we in relationship together?" (See "Master Themes", Figure 2 above).

I was particularly interested in "amplifying" (Brown & Gilligan, 1991, p. 45) participants' several voices regarding reflective experiences and the relational contexts (or absence of these) in which that thinking had occurred. Listening Guides systematically "guide the listener in tuning into the story being told on multiple levels … [hence this method] is distinctly different from traditional methods….in that one listens to, rather than categorizes or quantifies, the text of the interview" (Gilligan, Spencer, Weinberg & Bertsch, 2003, p. 159). In addition to breaking the text down into

colour coded clusters, I therefore experimented with creating "I-poems"[12] (Gilligan et al., 2003) which "press the researcher to listen to the participant's first-person voice … to hear how this person speaks about him-or herself" (p. 162). Rather than constructing formal "poetry", creation of the "I-Poems" was used as a supplementary analytical device and represented an instance of what Terre Blanche and Kelly (1999) describe as "playing around with ways of structuring [the research material] until you feel that you can give a good account of what is going on in [the] data" (p. 144).

Central to the six "I-poems" constructed (see Appendix C for examples) were striking images and metaphors which vividly conveyed research participants' struggle to think about disturbing and emotionally saturated ethical dilemmas. Examination of each "I-poem" and comparing one "poem" with another helped to distil the "in vivo" codes "Like a pressure cooker with no outlet" and "Putting [conflict] out of…mind". The latter phrases apparently reflected a common dimension of participants' individual experiences pertaining to thinking and to ethical decision-making respectively, emerging as recurring themes within, between and across the pertinent "clusters" of text.

Construction of the "I-poems" raised sharply contested debates regarding the role of theoretical literature in grounded theory studies. Henwood and Pidgeon (2003) comment, for example, that classical grounded theorists perceive the use of professional literature at the start of a project as potentially inhibiting "open-ended, exploratory research activities" (p. 138) and as compromising the researcher's capacity "to maintain sensitivity to relevance in the data" (p. 138). The latter authors argue, however, that this absolutist stance could be helpfully modified by adopting "a more discriminating strategy" (p. 138). The early use of literature may arguably be employed "to promote clarity in thinking about concepts" (Henwood & Pidgeon, 2003, p. 138) and, as Cutliffe (2000) remarks, to help the researcher "reach conceptual density, enhance the richness of concept development, and subsequently the process of theory development" (p. 138).

The literature review conducted in the early phases of this research project covered key studies and seminal articles on ethical codes, ethical dilemmas and decision-making models. Construction of the "I-poems" in the course of an intensive data analysis phase initiated a fresh round of reading and thinking about the phenomenon of countertransference enactments and about the role of

[12] Construction of an "I-Poem" involves underlining the "I" pronoun within the selected text, the associated verb and significant accompanying words. These phrases are then sequentially arranged on separate lines in the same order as they appear in the original text, hopefully providing "the listener with the opportunity to attend….to the sounds, rhythms and shifts [of meaning] in [the participant's] usages of "I" in his or her narrative" (Gilligan et al., 2003, p. 163).

containment in the creation and recovery of a reflective space. New links to relevant theoretical literature were generated, including, for example, Bion's (1962a, 1962b) theory of thinking and his container/contained model as well as Britton's (1998) notion of "triangular psychic space" (p. 45). Similarly, only in the process of writing up the final interpretive account did the scattered descriptions participants offered of experiencing themselves as "wounded healers" impress themselves upon my attention, leading to renewed engagement with, and reconfiguring of, the traditional Jungian "wounded-healer" paradigm from an object relations perspective. Congruent with the iterative, cyclical nature of data collection and data analysis, I likewise adopted a similar stance with regard to the use of the professional literature. Hence I implemented throughout the overlapping phases of the research endeavour "repeated cycles wherein the researcher goes to theory, looks at the data, [then again] goes to theory" (Borkan, 1999, p. 191).

Breaking the whole body of text down into multiple "clusters" of colour coded textual fragments and repeatedly implementing "vertical" and "horizontal" passes of the data laid the basis for the establishment of a clear and coherent list of "in vivo" codes or master themes. The transition from "Reading Guide" questions to selected master themes is illustrated in Figure 2 above.

8.5. Step 5: Construction of an Index of Core Conceptual Categories

Immersion in the interview transcripts, open coding, the systematic application of "Reading" and "Listening" guides and the identification of "clusters" of text segments comprised the groundwork necessary for the further transformation of master themes into a single index of core categories. Considered by Henwood and Pidgeon (2003) to fully tax the imagination and interpretive skills of the researcher, the latter process is "nevertheless disciplined by the requirement that … [the] categories generated should *fit* (provide a recognizable description of) the data" (p. 139). Subsuming subordinate categories, the final index of four categories (See Figure 2 above) included "Avowed vs lived values"; "The countertransference dimension of real-life ethical dilemmas"; "Absolution, penance or excommunication: therapist perceptions of professional resources" and "On the horns of a dilemma: ethical decision-making in the therapeutic space".

Intuitive "crystallization" (Borkan, 1999) of the latter four core categories marked the decisive point of exit from the earlier "maze" of memos, codes, questions, "clusters" and constant comparisons. Hence it was at this stage that "in vivo" codes or master themes were raised from descriptive higher-order labels to the level of comprising "theoretically meaningful resources" (Henwood & Pidgoen, 2003, p. 148) or conceptual categories that appeared to have particular significance for explicating the data concerned. This study did not reach the grounded theory stage

of "theoretical sampling" (Glaser & Strauss, 1967; Charmaz, 2000; Henwood & Pidgeon, 2003) which entails returning to the field to collect additional but increasingly selective data "for the purpose of developing [and refining] the researcher's emerging theory" (Charmaz, 1995, p. 45). However, the final index of core categories, from which are derived the titles for the following four chapters, hopefully constitutes a substantive framework for organising and developing a conceptually rich account of participants' discovery of and efforts to resolve lived ethical dilemmas.

9. RETROSPECTIVE THOUGHTS ON THE DATA ANALYSIS PROCESS

The foregoing five steps of data analysis appeared to reveal a "darker" aspect of the research process. In this respect, Miller and Crabtree's (1999c) portrayal of qualitative analysis as a creative, exciting, "exhilarating big dance of interpretation" (p. 138) between interpreters and texts may be too sanguine a metaphor. By contrast, Seidman (1991) refers to a "dark side" of interpreting and assigning meaning to interview texts wherein the researcher may "lose confidence in….[sorting] out what is important….and [may] feel considerable doubt about what [s/he] is doing" (p. 90).

Rather than participating in "a big dance", I experienced myself as unexpectedly and unwillingly pulled into a turbulent relationship with texts that were suffused with participants' repeated expressions of anger, anxiety, disillusion, distress and confusion. Kvale (1996) observes that, from a hermeneutic perspective, the particular text under consideration asserts its own autonomous meaning. In this study the data, pertaining to individuals who were both professional peers and trusting interviewees, unambiguously appeared to insist on the "darker" or less edifying aspects of countertransference phenomena which were apparently revived in the charged atmosphere of emotionally saturated ethical dilemmas. Since successive readings of the interview transcripts and multiple clusters of text fragments failed to persuade the latter to assume a more conciliatory or genial aspect, I felt submerged for considerable lengths of time beneath a mass of seemingly unprocessed and hostile data.

When the researcher allows the text to affect her, Brown, Debold, Tappan and Gilligan (1991) suggest that "a process of connection begins between [the participant's] feelings and thoughts and the feelings and thoughts of the reader ... so that … [the latter] ... begins to learn … about [the participant], about herself, and about the world they share … thus relationship or connection, rather than blurring perspective or diminishing judgment, signifies an opening of self to other, creating a channel for information, an avenue to knowledge" (p. 41). The initially conflicted

relationship between myself and the interview texts was gradually modified through the mediation and assistance offered by collegial discussion, supervision and the professional literature. A calmer, more reflective stance ensued wherein I found myself freer to think about participants' intense reactions to ethical dilemmas and my corresponding reactions to the related interview texts. Using the medium of my own responses, "like a clinician who identifies her countertransference….to her client" (Gilligan, Spencer, Weinberg & Bertsch, p. 161), I slowly began to formulate the possible origins and interpersonal dimension of participants' powerful affects and to apprehend the roles these potentially played in ethical decision-making practices. The latter formulations represent an elaboration of the final four core categories identified and are central to the following discussion (See Chapter 5-8) on the psychoanalytic understanding of ethical decision-making as it transpires in analytic space.

10. EVALUATING THE INTERPRETIVE ACCOUNT

This chapter opened by posing four preliminary research questions. Efforts to discover and to create satisfying answers continued throughout the writing up of this study. Traditional standards of validity ("the degree to which the research conclusions are sound") and reliability ("the degree to which the results are repeatable") (Durrheim & Wassenaar, 1999, p. 61-63) were eschewed. Hence efforts to assess the "correctness" of the answers generated to the research questions posed raised the issue of what comprises credible evaluative criteria in qualitative research. Kelly (1999c), for example, suggests that interpretive research has entailed "a rejection of positivist notions of reliability and validity, without much agreement about what standards of proof should replace these" (p. 423). The following section outlines various ways in which I have nevertheless endeavoured to ensure that the emergent interpretive account was comprehensive and credible and that its evaluation was rigorous and integral to the research process.

In building an interpretation of the transcribed interview texts, I have attempted to write an account that is grounded in the data and that leaves behind a clear "trail of evidence" (Brown, Debold, Tappan & Gilligan, 1991, p. 33). Raw materials presented in this chapter and in the appendices accordingly include, for example, field notes or "jottings", the Interview Guide, Grand Tour questions, vignettes of real-life dilemmas, I-poems and the translation of the Reading Guide into master themes and core categories of experience. I have also accounted for the personal motivations and different experiences that originally prompted the research undertaking as well as for the different decisions I took in collecting and analysing the data. Included in this recounting of the research process are several descriptions which convey some sense of my personal struggle to remain open to, and to make sense of, the often conflicted interchanges between myself and the

data concerned. In these and other ways, "the audit trail" (Kelly, 1999c, p. 427) generated illuminates the route I followed as I entered "the uninterpreted field" (Kelly, 1999c, p. 427) of the original research interviews and slowly made my way through to the transcribed texts, the Reading Guide, the core categories and on to the writing up of findings in the final interpretive account. Rather than presenting a "smooth and seamless" (Kelly, 1999c, p. 426) record, the "audit trail" is by contrast an account of a halting and flawed journey which portrays transparently and in detail how I arrived at a deeper but still partial and provisional understanding of the subjective and unconscious dimension of professional ethical decision-making.

Earlier discussion of the "vicious circularity of understanding" suggested that the unreflective "discovery" of "findings" may alternatively be construed as tantamount to dropping "into a swamp of mere opinion and speculation" (Packer & Addison, 1989b, p. 275). As Kelly (1999c) maintains "it is all too easy to embark on a self-fulfilling quest….to find what you set out to find and find convincing reasons to convince others of the veracity….of these findings" (p. 424). Potentially vicious cycles of understanding in this research inquiry were disrupted by invoking "the return or evaluative arc" (Packer & Addison, 1989b, p. 275) of the hermeneutic circle. Central to "the return arc" was the concept of "uncovering" or examining whether the evolving interpretive account "uncovered….a *solution* to the problem, the confusion, the question, the concern and the breakdown in understanding that motivated [the] inquiry in the first place" (Packer & Addison, 1989b, p. 279).

Evaluation of whether the emergent account was indeed "uncovering" plausible "answers" to the relevant research questions involved efforts to keep alive my own reflective attitude and to engage in debate with critical and interested others. Thus I interrogated the possible impact of idiosyncratic defences, taken-for-granted assumptions and my own affective responses on the research process. I also questioned inconsistencies and limitations appearing in the account, the appropriateness of the chosen research methodology and the sense of "fit" between the data and the psychoanalytic theories and models chosen to explicate them. "Interpretive validity" (Brown et al., 1989, p. 160) or evaluating the veracity of a particular interpretation of the data was furthered in the context of repeated discussions with both "sympathetic and sceptical" (Packer & Addison, 1989b, p. 288) supervisors and colleagues. As previously discussed, competing arguments for and against different interpretations of the same texts were openly debated, critiqued, adopted or discounted. This was not done, as Packer and Addison (1989b) observe, to secure inter-observer or inter-rater reliability but in order to generate diverse and multiple points of view. The latter "gains in objectivity" (Louw & Pitman, 1989, p. 751) apparently helped to uncover a seemingly better

and more comprehensive understanding of the disturbing affects evoked by charged ethical dilemmas than did rival explanations. It is thus argued that the following interpretive account, which addresses the therapeutic context and unconscious determinants of ethical decision-making, stands a better chance of uncovering a more credible response or answer to the problem of unethical or compromised decision-making than do rival explanations that draw upon philosophical ethical theories (Benatar, 2002; Rachels, 1999) or the notion of universal stages of moral development (Kohlberg, 1981).

Approaches to evaluation included not only establishing an "audit trail", self-reflection and engaged debate but also an appraisal of the interpretive account's capacity for opening up new possibilities for changed practices (Addison, 1999). No single methodology or "model of ethical decision-making holds all the answers" (Barnett, 2007, p. 9). The interpretive account elaborated in the remainder of this study similarly does not contain "all the answers" and inevitably "falls [far] short of the "perfection" I had hoped for" (Wharton, 1998, p. 222). As noted, however, what provided the original impetus for this research inquiry was a practical concern with how psychoanalytic psychotherapists grappled with everyday ethical dilemmas and "what is uncovered when things go well is an answer to this concern. This answer should have direct implications for practice… " (Packer & Addison, 1989b, p. 287). This suggests that any evaluation of an interpretive account necessarily includes consideration of its power to produce pragmatic, problem-solving strategies and to change practices. Although unintentional, the findings uncovered and discussed in the following chapters may have clinical relevance. Providing an additional and comprehensive theoretical perspective on countertransference phenomena, the interpretive account hopefully offers a potentially new and credible point of view that supports changed ethical decision-making practices in the everyday context of the analytic space.

Based on the final core categories, the next four chapters identify the aspirational ethical principles espoused by research participants and follow the initial discovery of the presenting dilemmas through to their attempted resolution. These results chapters are first introduced by the following descriptions of the six real-life ethical dilemmas.

DESCRIPTIONS AND CODING OF SIX REAL-LIFE ETHICAL DILEMMAS

INTRODUCTION TO THE FIRST PILOT INTERVIEW

CONTEXT

This research interview was completed in a single two-hour session. The participant, Cathy, an experienced psychotherapist, offered her consulting room which provided a peaceful setting. At the outset, Cathy commented that she should have thought more about the ethical dilemma concerned but had instead found herself preoccupied with a case where the parent was threatening legal action against her. She described how, in this latter instance, her supervision and case notes had been particularly thorough and detailed.

In my field notes, written immediately afterwards, I recorded my different impressions, feelings and thoughts. This description would later provide a meaningful and emotionally nuanced context for the transcribed conversation. I was also aware that I would attempt to use my countertransference responses as a point of entry into understanding the participant and the multiple meanings of her story (Gilligan et al., 2003). I had found Cathy open and willing to share despite her pre-interview acknowledgement that the dilemma concerned had been "messy" and unresolved. As a novice researcher, I had experienced a sense of uncertainty as to the ethical legitimacy of pursuing for research purposes an unexpected angle which had emerged pertaining to the private possibly conflictual history of the triangular relationship between Cathy, her current partner and the latter's ex-wife (Ramcharan & Cutcliffe, 2001). This was the only interview to be completed in a single session. The alternative structure followed in subsequent interviews, of two sessions separated by an interval, might have afforded me the opportunity of reflecting on my own confusion and whether I was unconsciously colluding by not opening Oedipal dynamics suggested by the triangular relationships concerned.

Bearing in mind Cathy's apparent preoccupation with a threatening parental figure, I reflected on future participants' unconscious perceptions of me. I wondered whether Cathy had experienced me as a therapist/confessor or as somehow a threatening legal figure who might take her to task for having breached therapeutic boundaries relating to confidentiality and dual role relationships. Finally, I noted that in this first pilot interview, I had felt anxious as to whether I would remember the „flow' of the "Interview Guide" and about managing the tape recorder.

PRESENTING ETHICAL DILEMMA

In the pre-interview telephone contact, Cathy outlined the following ethical dilemma. Earlier in the year, Heather, the ex-wife of Cathy's partner, had phoned eager to initiate social contact. When Cathy responded by inviting her to dinner, Heather had asked whether she might also bring a male friend. During this conversation Cathy realised that the male friend mentioned, Pete, was both an old contact of her own partner as well as the father of an ex-patient who had indicated that she would resume therapy in the near future. Despite this complication, Cathy initially yielded to Heather's request. Over the following days, however, Cathy grappled with whether she should disguise her professional identity and host Heather and Pete (potentially compromising the safety of any future therapeutic relationship) or whether she should avoid all social contact with her ex-patient's father. Struggling with these alternative courses of action eventually resulted in Cathy deciding to inform Heather that boundary difficulties precluded her altogether from having dinner with Pete.

During the research interview a second ethical dilemma unexpectedly emerged. Cathy disclosed that she had confided in her own partner regarding the boundary difficulties raised

by seeing Pete socially. In a later telephone call, she again breached confidentiality by informing Heather that she did not feel able to host Pete because she had seen his adult child in therapy. Heather had immediately recognised the ex-patient and had shared that the latter had also confided in her as a long-standing family friend. What eventually transpired was that Heather came alone. Neither she nor Cathy referred to the various telephone conversations nor to the ensuing breaches of therapeutic boundaries. Disclosing confidential information pertaining to her ex-patient had had the effect, Cathy said, of "loading" a difficult and awkward situation onto Heather, entrusting someone who "was not even a psychologist" to safeguard the boundaries of the therapeutic relationship, including the fact of the ex-patient's treatment.

Cathy's feelings of confusion and blankness were accompanied by painful remorse that by remaining "too unconscious" and by not allowing herself to think about the ethical dilemma, she had inadvertently breached confidentiality, "betraying" both the ex-patient and her father. As the research interview progressed, the therapist's anxiety shifted from the presenting dilemma and appeared to devolve increasingly on Heather, an ambiguous figure who evoked in Cathy apparently contradictory feelings of liking but also of mistrust. While recognizing the ethical problems attendant on dual relationships and breaches of confidentiality, Cathy's professional capacity to protect the boundaries of the therapeutic frame appeared in this situation to have been temporarily overwhelmed by the need to respond graciously to the social demands exerted by the relationship between herself, her partner and his ex-wife. Neither supervision nor peer consultation was sought and Cathy remained professionally isolated throughout.

The primary significance of this case arguably inheres in the therapist's strong feeling reactions and subjective construal of relatively innocuous "boundary crossings" (Gabbard & Lester, 1995, p. 123) as an emotionally loaded ethical dilemma. Unprocessed countertransference responses appeared to have resulted in decision-making organised by an apparently unconscious need to both express and to conceal feelings of hostility towards the ex-wife through breaching confidentiality and subsequent engagement with a social dual role relationship.

CODING

I have coded this situation as a breach of confidentiality (primary ethical issue), non-sexual dual relationship (secondary ethical issue), adult psychotherapy context (Wassenaar, 2002).

INTRODUCTION TO THE SECOND PILOT INTERVIEW

CONTEXT

This interview consisted of two sessions, each lasting one-and-a-half hours and separated by a fortnight's interval. David, an experienced psychoanalytic psychotherapist, was under pressure from work and family demands but agreed to meet in the evening at his home. Several cups of tea and interruptions by children and dogs created an informal atmosphere between us. I used field notes to record and to reflect on significant processes which are not necessarily obvious in the interview text but which manifested rather in the interactions between us.

I wrote, for example, that David's unexpected cancellations of interviews might indicate some ambivalence around disclosure of the ethical dilemma concerned. This theme of therapist ambivalence was echoed in David's own pre-interview remark that he thought local psychologists were feeling anxious about the potential professional exposure involved in this research. Rather than talking truthfully about what they were actually experiencing and doing in their daily practice, David said, therapists showed instead "tremendous investment in presenting the perfect case".

Gender and power relations between researcher-researched emerged. As a female researcher, I felt intimidated by David's intellectual status; at times I desisted from probing the relevant patient's homoerotic transference relationship, feeling apprehensive of engaging with theoretical debates or of provoking rationalisation in relation to sensitive material. During the course of conversation, I was struck by David's unusual request to switch off the tape recorder just prior to his showing me photographs of the patient's previous therapist. Although I did not pursue this episode, I recorded the event and reflected on the possible meanings of my countertransference unease at having participated in behaviour which felt, somehow, illicit and off the record. Retrospectively, I realised that I could have explored in greater depth David's contradictory countertransference responses towards the patient's former gay therapist and how these may have influenced his decision to desist from collegial confrontation. Finally I noted my increased ease with the "Interview Guide" and tape recorder, compared with the first interview.

PRESENTING ETHICAL DILEMMA

David described a young male patient who had presented with difficulties concerning his sexual identity. This therapy, which saw the emergence of a homoerotic transference, was conducted over a period of several years. Although it had been formally terminated, the patient continued to maintain sporadic telephonic contact. A number of months passed before the patient disclosed that his previous therapist, a gay male mental health practitioner, had initiated ongoing sexual relations and had persuaded him to sign a document to the effect that the therapeutic relationship had been terminated and that no legal action should be instituted for breach of professional conduct.

David had felt angry and uncertain as to what he was legally or ethically obliged to do in relation to these disclosures of collegial misconduct. He recognised the practitioner as an older colleague he had once worked with and whom he continued to regard as a respected mentor figure who had professionally "fathered" him well. In the interview, fantasy material emerged regarding confronting the practitioner which was not, however, translated into action. While perceiving that this patient (and possibly others) had been sexually abused and needed protection, David expressed deep uncertainty as to what course of action should be adopted. Different options identified included informing the patient's parents, exploring the possibility of either the patient or David himself laying a formal complaint or initiating an

informal confrontation with the practitioner concerned. Despite securing patient permission to implement this last option, David desisted on the grounds that the patient's distress and confusion precluded his thinking rationally and giving informed consent. This perception was seemingly contradicted when David later presented his own apparent avoidance of informal confrontation as an instance of promoting patient autonomy, thereby facilitating the latter's capacity to decide for himself whether or not to press charges. In the course of the evolving therapy the question of how to respond to the re-emergence of homoerotic material again demanded further engagement with an ethical decision-making process. Contradictory responses appeared as David described both his apparent emotional ease with this development while also acknowledging that feared sexual "entrapment" had impelled him "to kill" the erotic transference early in the therapeutic relationship.

Supervision, discussion with professional peers and contact with the Ethics Committee of the statutory body concerned proved to be disappointing and unhelpful. Eventual closure of the dilemma was reached for David when the patient's former therapist advised colleagues that he would be out of the country for an indeterminate period. In his closing comments, David reflected that this ethical dilemma had left him feeling very much alone. No-one, he said, had really helped him to construct a thinking or reflective space; he had had "to continually try and inflate this space himself ".

CODING

The system of coding used by Wassenaar (2002) does not allow for a category pertaining to collegial behaviour. I therefore decided to retain an earlier, well-known classification system and have categorised this situation as pertaining to the „Conduct of colleagues' (Pope & Vetter; 1992), adult psychotherapy context.

INTRODUCTION TO THE THIRD RESEARCH INTERVIEW

CONTEXT

The third interview was conducted over two sessions separated by a week's interval. Gillian, an experienced psychologist and psychoanalytic psychotherapist, explained in the preliminary phone call that she had been working with a female patient and that "a double connection" existed between them. She was not only the patient's therapist but was also her cousin. Gillian expressed doubt as to whether this was a "real" ethical dilemma but acknowledged that it sometimes provoked disturbing feelings and a concern that the "double connection" had adversely affected the nature and progress of the therapeutic relationship. In order to clarify the complex family background, I requested a genogram prior to the initial interview. We agreed to meet in my living room which was quiet and free of interruptions.

When she arrived, Gillian immediately remarked that my home looked old and as if it "had been lived in for generations". This sensitivity to the past was again apparently reflected in her comments regarding the "beautiful old cups" used during tea-breaks. At the end of the first research interview, Gillian was tearful and said she felt saddened by past separations, old memories and the dispersal and loss of her family. In field notes written afterwards, I wondered whether the participant's fragmented personal history had led to her projecting onto me, an unfamiliar colleague, an idealised sense of linkages and connectedness that was missing between generational figures of her own. I recorded my impression that regular contact with her patient/cousin could thus provide Gillian with potentially gratifying opportunities to reconnect with early childhood experiences and significant family figures who had been lost through death and family dispersal. I noted points of mutual uncertainty that occurred during the interviews as a result of Gillian confusing how a significant female figure, now dead, had been related to her and to her patient respectively. This apparent diffusion of boundaries and over-identification between the therapeutic dyad had perhaps, I thought, affected Gillian's decision to continue seeing the patient.

Gillian's professional environment included receiving individual supervision from an experienced clinician. Initial feelings of shock gradually gave way to deference to the authority and status of the supervisor who did not appear to view the dual role relationship as an obstacle to the initiation and maintenance of a therapeutic relationship. Exploration of the supervisee's strong countertransference responses were thus seemingly neglected in supervision as was consideration of the ethicality of conducting an in-depth dual relationship with the patient concerned. I commented in my field notes that the follow-up interview seemed more stressful as we attempted to explore the possible subjective meanings that the ethical dilemma might hold for Gillian as well as how she had tried to process and resolve it.

This was the first interview that directly confronted me, as a researcher, with an unanticipated dual role relationship pertaining to a therapist working with an individual who was simultaneously both a patient and a relative. Aware that this research probed unreflective and potentially humiliating aspects of professional practice, I was tempted not to make any direct intervention that might evoke further conflict. Supervision helped clarify that, in the course of the research endeavour, I continued to carry an obligation to address actively ethical issues that might affect the well-being of either patients or therapists. At the conclusion of our interviews, therefore, I commented that I had been struck by Gillian's distress and tearfulness. I suggested that additional consultation with her new supervisor and reading the South African Professional Board of Psychology's code of ethics (2002) might be helpful in furthering reflection on the countertransference difficulties that appeared to have arisen in the context of conducting this dual role relationship.

PRESENTING ETHICAL DILEMMA

Gillian described a female patient who was referred two years prior to the research interviews for help with relationship difficulties. While taking a history, Gillian suddenly realised from family details disclosed by the patient that they were in fact cousins and she experienced at the same time vivid childhood memories of several of the patient's deceased significant others. The unexpected discovery of a cousin elicited excitement but also unease as to whether and how the familial link to the patient might impact on the therapeutic relationship. Thus Gillian was troubled by the possibility that the "double connection" might cause her to depart from empathic and reflective service delivery to include in her response a qualitatively different "extra dimension of caring". She raised, too, in a straightforward manner the fact that financial need had played a role in overriding her doubts and uncertainties in this case.

Consultation with her supervisor appeared to encourage rather than to challenge Gillian in the belief that the latter's countertransference could be contained. Early resolution of the ethical dilemma seemed to have been reached when Gillian made a final decision to inform her cousin openly of their shared family background while, at the same time, also offering to see her as a patient in regular psychoanalytic psychotherapy. In the context of the research interviews, two years later, Gillian acknowledged that there had been no substantial change in the patient's presenting difficulties. A few days after my intervention, made at the close of the second interview, Gillian initiated contact to say that her decision to continue seeing this patient remained unaltered and that therapeutic contact had in fact increased from fortnightly to weekly sessions.

CODING

I have coded this situation as a non-sexual dual relationship, adult psychotherapy context (Wassenaar, 2002).

INTRODUCTION TO THE FOURTH RESEARCH INTERVIEW

CONTEXT

The fourth interview was conducted over two sessions separated by a fortnight's interval. Patrick, a psychoanalytic psychotherapist, offered his consulting room as a pleasant meeting place. In the preliminary phone call, he outlined an ethical dilemma which involved the establishment of non-sexual dual role relationships with several male patients in the recent past. These "double relationships" had, Patrick said, entailed a rethinking of the traditional structures of the psychoanalytic frame. In contrast with other research participants, Patrick commented that anticipated disclosure of the ethical dilemma evoked no anxiety. However, I reflected in my field notes that ambivalence may have been expressed by the cancellations and delays in setting up the interviews.

The two research interviews differed in affect. In the first interview, Patrick initiated a vigorous critique of psychotherapy and of the local psychoanalytic establishment, including legitimate observations about the restricted global impact psychotherapy has had on community mental health. He additionally described several dual relationships which he had initiated in the course of professional practice. In particular, he spoke of a dual role relationship which had arisen in the context of both he and a patient belonging to Organisation B which was dedicated to the personal growth of men. Pivotal issues addressed included the search for advanced spiritual consciousness and the provision of "living mentorship" for men seeking to redefine their sense of masculinity and male identity. Membership entailed progression to closed groups where the disclosure of intimate material occurred on a regular basis. After the first interview, I recorded Patrick's closing comments that he had felt vulnerable and conflicted in the earlier stages of this dilemma but currently remained convinced of the therapeutic efficacy of working simultaneously with his patients in Organisation B as well as in individual psychoanalytic psychotherapy.

The second interview by contrast appeared to be marked by anxiety as we attempted to explore what professional resources Patrick had used to help process the transference-countertransference implications of conducting an ongoing dual role relationship. Contentious issues arose regarding patient autonomy, informed consent and the power differential inherent to the therapeutic relationship. Patrick reiterated his conviction that the dual relationships had not been self-serving but had been conducted solely in the best interests of his patients' healing. At the same time he appeared concerned that his actions may have endangered his registration and might be construed as a violation of the South African Professional Board of Psychology's code of ethics (2002) which he had not to date consulted.

Once again these interviews confronted me as a researcher with an unanticipated active ethical dilemma. What was unexpected was to encounter apparently unexamined countertransference reactions and to attempt to understand how personal countertransference may potentially have informed the participant's ethical decision-making. At the conclusion of the research interviews, I commented that formal supervision and perusal of the relevant ethics code might be helpful in assisting Patrick to reconsider the appropriateness of engaging in dual role relationships where circumstances did not deem this strictly necessary.

PRESENTING ETHICAL DILEMMA

Patrick described a recent male patient, Rod, who had been in psychoanalytic psychotherapy for over a year. At the start of the therapy, Rod informed his therapist of his intention to attend a relaxation group, unaware that Patrick was the facilitator for the group concerned. Anticipated contact with a new patient outside the therapeutic space initially evoked strong

anxiety for Patrick; however, he considered that the relaxation therapy offered unique healing opportunities and that no other realistic option presented itself. Extra-therapeutic contact deepened into a situation where Patrick continued to see his patient in intensive psychoanalytic psychotherapy but they also pursued their relationship in the context of Organisation B. Thus therapist and patient "muddled their way through [the] years". After terminating individual therapy, Rod joined Patrick's closed group in Organisation B where, in a role reversal, he saw his former therapist "being processed as a patient and in the most vulnerable of spaces". The relationship evolved into a personal friendship where Patrick considered his ex-patient to be "his buddy and mate".

Patrick originally experienced carrying these two contrasting roles as "incestuous". Intercourse between the different contexts, he said, resulted in blurring the different psychologies of the therapeutic space and Organisation B. He worried that the extra-therapeutic contact might impair the patient's sense of safety and his capacity to establish a viable transference relationship. Exposure of the therapist's "real me" while the patient was in the midst of a "thick" transference compromised the symbolic experience of who the therapist potentially represented for the patient. Simultaneously, Patrick perceived himself to be an innovative pioneer "in the Wild West", reformulating the ground rules and boundaries inherent to Lang's (1982) notion of the therapeutic frame. Since Patrick anticipated that his unorthodox practices were unlikely to gain professional support, no formal supervision was sought. Similarly, the Professional Board for Psychology and PsySSA were regarded with mistrust rather than as helpful organisational resources that might offer useful consultation. In the course of the research interviews, Patrick described a fantasy that, if the dual relationships were discovered, he would be sent to Coventry by punitive "psychoanalytic police". The latter image referred to professional colleagues who despite their adjudicating powers were portrayed as apparently lacking in theoretical understanding of the psychoanalytic paradigm.

In my field notes, I reflected that Patrick appeared to have progressed down a "slippery slope" (Gabbard & Lester, 1995, p. 88). While initially experiencing doubt, anxiety and conflict, he had nevertheless continued to engage in dual role relationships. Avoidance of formal supervision appeared to have sealed off examination of the possibility that repeated decisions to engage with dual relationships had resulted in seemingly inappropriate therapist gratifications rather than servicing the best interests of the patients concerned. I was cognisant, however, that Patrick had taken a courageous risk in exposing and entrusting his practice to a colleague known to him to be working within the paradigm of psychoanalytic psychotherapy.

CODING

I have coded this situation as a non-sexual dual relationship, adult psychotherapy context (Wassenaar, 2002).

INTRODUCTION TO THE FIFTH RESEARCH INTERVIEW

CONTEXT

Riaan is an experienced psychotherapist who works in a community health centre situated in a black township. In his quiet suburban garden, he described the community centre as servicing an area where daily shootings, gang attacks and domestic abuse "are more the norm than the exception". Riaan's role is the provision of psychotherapy for patients suffering from the effects of violence. Literally hundreds of women, Riaan said, had over the years disclosed personal histories of extreme abuse to him.

Daily exposure to trauma had left Riaan wondering whether he should continue working in the township. In field jottings, I noted that a sense of feeling endangered seemed to pervade Riaan's experience of himself professionally and personally and to have been present even in childhood. Describing an ethical dilemma which had involved a young rape survivor, Riaan appeared to have experienced an unexplored identification with the latter patient; as a child, Riaan had similarly experienced the law as an ineffectual force and his own story of chronic abuse had likewise gone unheard and unheeded.

These disclosures raised a tension between my roles as a researcher as opposed to that of a therapist or trauma debriefer. When speaking about the emotional pain suffered by trauma survivors, for example, Riaan appeared to struggle with intense but unprocessed affect. While his experience of childhood abuse may have been pertinent to researching how countertransference could potentially affect ethical decision-making, I made a clinical decision not to conflate these roles and hence not to pursue Riaan's memories in any detail. Had I done so, I was concerned that we might cross the boundary between a research interview and a therapeutic session; the former project might then have been difficult to retrieve. I acknowledged his distress but retrospectively thought I could have made the additional observation at the close of our work that the research interviews appeared to have reactivated childhood trauma, a subject which might be helpful to pursue in supervision as an issue of personal countertransference that possibly continued to influence his work.

PRESENTING ETHICAL DILEMMA

Two years prior to the research interviews, a 12 year old in-patient, Laeticia, was assessed as suffering from depression and referred for supportive psychotherapy. On first seeing Laeticia, Riaan was struck by her appearance of vulnerability and neediness. During the initial contact, Laeticia disclosed for the first time that she had been raped by a 15 year old male who was affiliated to a gang and that she had been too scared to tell her parents. Fearing gang reprisal and acutely aware that he had not secured his young patient's permission to breach confidentiality, Riaan desisted from parental contact as well as from his statutory obligation to report the rape. Following discharge, Laeticia did not return to therapy. Riaan acknowledged that he remained confused and uncertain as to whether he had tried to initiate further patient contact. The referring doctor, apparently perturbed by this lack of follow-up, had subsequently on his own initiative seen the patient and had informed both the parents and the police.

Riaan experienced this ethical dilemma as an ambiguous and contradictory triangle where statutory obligations, self-interest and the welfare and well-being of his patient conflicted, leaving him deeply insecure as to which course of action he should pursue. Thus Riaan felt torn between his knowledge that, as a minor, Laeticia had suffered statutory rape and that he was legally obliged to report the case. Reluctance to breach confidentiality and fears for his

own safety as well as that of his patient translated into inaction and apparent avoidance of the patient's parents and the police. Bereft of parental and statutory protection left Laeticia exposed, Riaan said, to the future risk of repeated violation and rape. Thus the trust Laeticia had originally placed in her "parent-like" therapist was seemingly betrayed by his failure "to hold her hand right through" the therapeutic and court process. These "decisions" had in turn left him feeling inadequate, guilty and derelict in his performance as a psychologist and psychotherapist.

Vicarious traumatisation (McCann & Pearlman, 1990) and Riaan's strong countertransference anxieties appeared to have "wiped out" (Hill, 2007, p. 2) the therapist's reflective capacity. Rather than being regarded as potentially helpful professional resources, Riaan's transference to the law and to the statutory Code of Ethics was characterised by mistrust as was his attitude to key professional organisations. Supervision offered emotional support and role clarification but apparently failed to engage with the specific Acts governing child abuse reporting (the Child Care Amendment Act 74 of 1983 and relevant sections of the Prevention of Domestic Violence Act, of 1993). The impact of personal countertransference on ethical decision-making was likewise deflected by the constantly changing focus on new trauma cases. Supervision appeared to leave unexamined the central contradiction informing Riaan's therapeutic engagement with his patient; the therapist's apparent need to dissociate from abusive childhood memories was directly at variance with his young patient's need to disclose and to work through her traumatic experience of rape. At the conclusion of the research interviews, Riaan wondered whether his desire "to walk away from stuff that's extremely emotionally complicated" had unconsciously been communicated to new patients, discouraging any further disclosures of violence.

In the face of feeling overwhelmed, Riaan acknowledged avoiding his work briefcase, frequently leaving "all its stuff safely buckled up". With regard to the presenting ethical dilemma, strong countertransference reactions appeared to have similarly generated an emotionally saturated or "buckled up" psychological space. Rather than thoughtful evaluation of the costs and benefits of the different options available, the ethical decision-making process appeared by contrast to be compromised by anxiety and inaction. At a more hopeful level, Riaan's participation in this research may arguably be construed not only as a substantial contribution to exploring therapists' subjective experiences of real-life ethical dilemmas but also as a significant attempt to voice his own struggle to survive a personal history of abuse and marginalisation.

CODING

I have coded this situation as a confidentiality dilemma, child abuse intervention (Wassenaar, 2002).

INTRODUCTION TO THE SIXTH INTERVIEW

CONTEXT

Theresa is a member of a counselling team which provides therapeutic support for students in an educational organisation. She was the only participant to volunteer to be interviewed. In the preliminary phone call she commented that the difficulties she had encountered continued to be of concern and that further reflection might help her to integrate more fully the process and outcome of this particular ethical dilemma. We met over two consecutive weeks in my consulting room.

Theresa described the organisation as exerting pressure on staff and students to achieve high academic standards. By contrast the counselling team provided a nurturing environment with regular access to case conferences and individual supervision. While staff members from the educational institution were also seen by the team, the primary focus remained the provision of supportive counselling for students. Working in a system where multiple relationships were considered normative resulted in Theresa juggling different "hats" or the role conflicts inherent to dual relationships. Ethically problematic aspects of engaging with dual role relationships and alternative therapy arrangements, such as outsourcing, did not appear to have been identified as options either by the supervisor or by members of the counselling team concerned.

The ethical dilemma pertained to the therapy of a gay staff member, Karen, whose repeated decision to terminate had finally been implemented several months prior to the research interviews. In discussion, Theresa identified herself to me as a member of the gay community. Recurring boundary difficulties encountered in the course of therapy had appeared to Theresa to derive principally from the patient's apparent borderline personality structure but had been compounded by dual role relationships. Ambivalence had emerged in Theresa as to whether discontinuation of the therapy would have been the "right" thing to do. She wavered between agreeing with inner "analytic voices" who counselled that the wearing of multiple "hats" had compromised the therapeutic relationship and alternative ethical "voices" who suggested that Theresa had been "brave" to persevere and that the patient had greatly benefited from the therapy. What did not appear to have been addressed in Theresa's supervision or personal analysis was the ethical dilemma inherent in conducting a dual role relationship and the therapist's countertransference feelings underpinning her insistence that the therapy should continue.

In field notes I recorded Theresa's comments that she felt she was "in dangerous waters" and that she wondered how she would be perceived as a professional if she "participated in making a mess like this". I was struck, however, with Theresa's courage in being the sole participant to volunteer to explore her subjective experience of struggling with a real-life ethical dilemma. I was struck also by her commitment to protect the identity of her patient as well as by the effort she made to grapple with challenging issues raised in the research interviews. Reviewing the transcript, I reflected that I had seemed able to explore several pertinent aspects of the conflict pertaining to the continuation or termination of the dual role relationship concerned. What I had desisted from exploring were possible homoerotic countertransference responses and their influence on the ethical decision-making process. This may have stemmed from anxiety about confronting in a research interview potentially uncomfortable sexual and power dynamics between "straights" and "gays".

PRESENTING ETHICAL DILEMMA

Theresa described the patient, who was referred by a colleague, as presenting with strong conflicts around her sexual identity. The therapeutic endeavour entailed two major ethical decisions; firstly, whether to provide psychoanalytic psychotherapy for a fellow staff member in an educational setting and, secondly, whether to continue with the relationship concerned. Despite "alarm bells ringing" around potential boundary conflicts generated by seeing an individual who was also a colleague working for the same establishment, Theresa followed what seemed to be the institutional norm and offered the patient weekly psychotherapy sessions.

As the therapy unfolded, so too did the inherent frame violations manifest themselves. Running a workshop, Theresa had found herself wearing three "hats" belonging to her roles as therapist to the patient, group facilitator to the patient's adolescents and staff member/group facilitator to Karen and her partner in giving parental feedback. Given the financial constraints involved, the core dilemma, Theresa said, was between termination (which would probably leave the patient without adequate access to therapeutic support) or continuing with an imperfect therapeutic situation involving multiple relationships. Conviction that considerable therapeutic progress had been made, professional pride, the determination not to abandon the patient, as well as possibly unprocessed homoerotic countertransference responses, appeared to combine into a second major ethical decision to persevere with the therapeutic relationship.

Contradictory descriptions emerged. Theresa remarked that she perceived herself to be a therapist who felt great clarity with regard to her role and that she had offered the patient a consistent relational context "where things could be processed and thought about together". On the other hand, a compromised therapeutic space was depicted, one which had been assailed by "imploding" boundaries, doubts as to whether she had acted in her patient's best interests and organisational demands that militated against individual psychotherapy. Theresa also expressed guilt about whether the emotional costs to the patient had outweighed the benefits, whether something that had originally been intended as supportive had become so contaminated as to act as a formidable deterrent to the patient ever seeking future therapy. Following a final incident in which Karen saw her therapist in what she construed to be an "intimate moment" with a significant other, the patient implemented an abrupt termination.

Despite the professional resources available, Theresa had experienced herself as isolated and alone with the ethical dilemma concerned. Theoretical formulations cast in terms of the patient's projective identifications contrasted with more homely descriptions of the therapeutic space as "a pressure cooker" that had itself been devoid of an empathic and reflective supervisory container where ethical considerations and countertransference responses could have been explored and rendered meaningful. At the close of the interviews, Theresa commented that she did not intend to pursue psychoanalytic psychotherapy in the organisational setting concerned. She remained uncertain as to whether the frame deviations had derived from the dual role relationships generated or whether these had primarily been a consequence of the patient's apparent borderline personality structure.

CODING

I have coded this situation as a non-sexual dual relationship, adult psychotherapy, organisational context (Wassenaar, 2002).

CHAPTER 5

AVOWED VS LIVED VALUES IN THE CONTEXT OF REAL-LIFE ETHICAL DILEMMAS

1. INTRODUCTION

This chapter discusses research participants' avowed ethical principles and how these fare in the context of the therapeutic relationship and countertransference pressures generated by real-life ethical dilemmas. The six participants identified an array of 12 aspirational ethical principles and standards that guided and informed their daily professional practices. As discussed in earlier chapters, the CPA's (2000) code of ethics is widely regarded as comprising a well organised and conceptually rich document which provides comprehensive guidelines for resolving ethical dilemmas encountered in psychological practice. The distinguishing features of the first three principles and related standards presented in the CPA's code were therefore summarised and used to structure participants' descriptive accounts of their primary ethical concerns and values. The CPA's relevant ethical principles include Principle I: Respect for the Dignity of Persons; Principle II: Responsible Caring; and Principle III: Integrity in Relationships. Data were also related to Gilligan's (1982) ethic of care concept and to the familiar ethical principles of autonomy, beneficence, nonmaleficence, justice and fidelity (Beauchamp & Childress, 1993; Kitchener, 1984).

Participants' avowed values pertaining to therapeutic boundaries and the analytic frame were considered under Principle II, Responsible Caring, where the emphasis lies on actively promoting the welfare of vulnerable others in the context of an intimate but asymmetrical relationship. From the perspective of psychoanalytic ethics, research participants' avowed principles and standards appeared to represent "a continuum of ethical functioning" (Solomon, 2003, p. 10), ranging from concerns about adherence to the "ground-rules" (Langs, 1982) or structural features of the analytic frame to attempts to restore the optimal participative yet reflective stance characteristic of the analytic attitude (Gabbard & Lester, 1995).

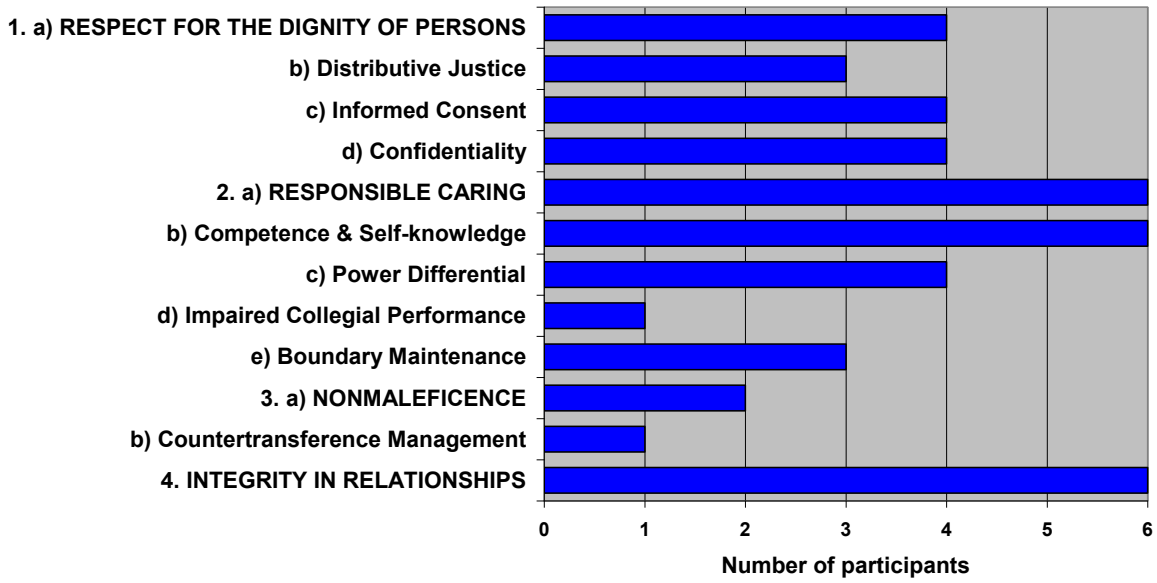
Clarkson (2000) distinguishes between avowed and lived values, commenting on the potential gap between publicly espoused ethical principles and contrasting incongruent private behaviour. Initial discussion in this chapter of participants' avowed ethical principles

is followed next by detailed examination of how the latter fare in the context of real-life ethical dilemmas. While some congruence was found to exist between participants' avowed and lived values, the results of this section appear to lend weight to previous research studies which revealed significant discontinuities between aspirational ethical ideals and compromised professional practices (Bernard & Jara, 1986; Bernard et al., 1987; Smith et al., 1991). The latter studies utilise hypothetical ethical dilemmas. By contrast this section considers the potential impact of unconscious determinants on participants' avowed values in the context of real-life ethical dilemmas.

Analysis of the interview texts facilitated both the identification of participants' avowed principles as well as how frequently these were spontaneously endorsed by interviewees. This procedure arguably clarified the perceived significance of the different principles for participants' daily professional practices. Frequency of reference to avowed ethical principles and standards is illustrated in Figure 1 below.

2. THE CPA'S (2000) CODE AND PARTICIPANT DESCRIPTIONS OF AVOWED PRINCIPLES

Figure 1: Frequency of reference to the four avowed ethical principles & related standards



2.1. Principle I: Respect for the Dignity of Persons

The CPA's first ethical principle asserts the primacy of the need to respect the dignity of all persons and to appreciate their innate worth as human beings. The code thus states "that each person should be treated primarily as a person or an end in him/herself, not as an object or a means to an end" (CPA, 2000, p. 8). Promotion and protection of moral rights is pivotal to respect for the dignity of persons and subsumes both the concept of **distributive justice** as well as the ethical standards of **general respect**, **informed consent** and **confidentiality**.

2.1.1. Distributive Justice

The CPA's first principle is firmly embedded in the Kantian-based universal principle of individual justice (Malloy & Hadjistavropoulos, 1998). With its emphasis on an impartial ethic of individual rights, it retains a "masculine" cast and may be aligned with Gilligan's (1982) "justice voice" which upholds as a relational ideal a vision of respect and "equality, reciprocity, and fairness between persons" (Brown et al., 1991, p. 28). In the multiplicity of different moral voices that surrounded participants at work, the "justice voice", while not the predominant avowed principle, was clearly evident and was lucidly expressed by David in the following fragment:

> *... when things do become locked up in rules and regulations, ... there's a blip on my screen ... and I want to know **why** and if the rule is **justified** and I need to understand the **justice** or the **fairness** in the rule ... (Interv. **2**, p. 58, 44-47)* [1].

The CPA (2000) states that all individuals have the right to benefit equally from contributions made by the profession and to access equal quality in the procedures and services offered by psychologists. Discriminatory practices that are directed only to particular groups such as the white middle class, Kitchener (1984) remarks, are incommensurate with the broader concerns of the profession which pertain to justice and to fair and equal treatment for all individuals.

Three participants described how their awareness of historical injustice and inequities of access to, and quality of, mental health resources under Apartheid had shaped their current professional practices in reaching out to previously disadvantaged groups. Despite the emergence in 1994 of a democratic South Africa, Riaan's decision to work with a

[1] For each excerpt from the interview transcripts, the reference abbreviations are as follows: Interv. (Interview), p. (page number), followed by the line numbers.

marginalised sector of the black population demonstrated his altruistic commitment to redressing continuing disparities in the distribution of psychological services:

> *... not everybody wants to work there. If you look at the population figures for that area, the ... black population is about ... twice as big as the white population and if you look at the percentage of psychologists working there ... it's disproportionate ... stuff needs to happen there ... research needs to be done there ... there are more and more and more African patients coming to us and there are two psychologists ... and a million people (Interv.* ***5****, p. 65, 39-47; p. 166, 2-14).*

2.1.2. General Respect

Four participants described respect for persons as comprising a core ethical principle (See Figure 1 above). The following excerpts highlight that Theresa and Gillian, for example, saw the principle of respect as integral to their professional identity and daily practices as a therapist:

> *...one of the first things that comes to mind is the way that I work, I come with ... a spirit of respect, I don't know if that's the right word ... but despite the dynamic, maybe the age difference or the ... power difference, I feel very sensitive to respecting people and their experience and where they're at ... and the fact that they've sought help and that they're placing themselves in a vulnerable position (Interv.* ***6****, p. 204, 4-10).*

> *I suppose the core belief is the respect towards the client in terms of where they coming from ... the sense that ... they're coming for some kind of help from me and I really need to respect who they are (Interv.****3****, p.77, 39-42).*

In a similar vein, helping patients to rediscover their dignity comprises an aspirational and constant guiding principle that informed Riaan's everyday professional practice:

> *I think ... that some of my work isn't just about working with the presenting problem, it's about helping people rediscover their own dignity ... that's one of my ... constant guiding principles ... that I ...* ***walk*** *with when I walk down the passage to my office every morning (Interv.****5****, p.166, 34-43).*

2.1.3. Informed Consent

The CPA's (2000) ethical standard of informed consent directs the psychologist to secure the active collaboration of those affected by the anticipated decision under conditions that are free from undue pressure or coercion. Prospective clients should be provided with full information regarding the proposed activity, including any likely harms and benefits, the availability of alternatives and the right to refuse or withdraw from treatment at any time.

The patient's self-determination and autonomous right to make informed decisions free from paternalism (Kitchener, 1984; Steere, 1984) or the imposition of therapist beliefs and values constitute one of nine central ethical values guiding the clinical practice of master therapists (Jennings, Sovereign, Bottorff, Mussell & Vye, 2005). While the importance of informed consent and patient autonomy was briefly acknowledged by three participants, these standards do not by contrast appear to emerge in the present study as core avowed values. During the initial consultation process, however, Gillian described her efforts to impart to patients considering entry into therapy needed information pertaining to the structural features of the analytic frame as well as to the nature of the therapeutic endeavour as a collaborative but uncertain enterprise:

> *I really need to … try and … convey to them, let's say, both the limitations and the possibilities of the help they can get, so not kind of saying, well, … I can sort out your problem and in six months you'll be fine, but really trying to communicate to them that what we're doing is a shared enterprise and that it doesn't … always have a fixed outcome (Interv.* ***3****, p. 77, 42-47).*

Confidentiality

The CPA's (2000) ethics code states that the psychologist has an obligation to safeguard and to hold confidential all information gained in the course of professional activities. Confidential information is accordingly released only in the event of informed consent, or in a manner that ensures that those involved cannot be identified, as required by the law or when the possibility arises of serious harm or death.

The CPA's (2000) code and APsaA[2] (2001) appear to situate the issue of confidentiality in medico-legal discourses pertaining to patient rights and the protection of privacy. An alternative perspective is proposed whereby strict confidentiality in psychoanalytic treatment is regarded not as an inalienable patient right but rather "as a technical means" (Furlong, 2005, p. 377) that is used to shield the intensely private analytic process from reality claims exerted by nonanalytic third parties. Confidentiality is thus envisaged as promoting a "free space of mind" (Da Silva, symbolic, 2003, p. 161) wherein "creative illusion" (Siegelman, 1990, p. 186) or the symbolic properties of the therapeutic relationship can flourish.

[2] The American Psychoanalytic Association (2001): Principles and Standards of Ethics for Psychoanalysts

Four participants referred to the avowed ethical standard of confidentiality. No references were made explicitly linking confidentiality with either the issue of patient rights or the furtherance of analytic treatment but research participants' descriptions seemed to contain elements of both discourses concerned. The following research fragment suggests, for example, that breaching confidentiality evoked a sense of betrayal and guilt in the therapist since the patient's autonomous right to choose to whom information should be revealed was forfeited:

> *... I thought I've got to keep this boundary at all costs ... I shouldn't be seeing the [patient's significant other] socially ... I didn't actually think of the **other** boundaries that I was violating ... [breaching confidentiality involved] exposing ... my patient to being discussed by people who I don't even know (Interv. **1**, p.15, 39-43).*

In one of the comparatively few instances of congruence between avowed and lived values in the context of a real-life ethical dilemma, Theresa described her successful attempts to maintain confidentiality, protecting her patient's rights as well as the integrity of the therapeutic space from nonanalytic third party contamination:

> *I've been very **careful** about ... this particular case and I haven't taken it to ... team meetings, I mean, I've discussed a whole lot of spaces that are available for, for this kind of thing to be discussed ... but in this particular case, I felt quite careful not to „spi**l**' ... ja, I felt ... protective over this person because this person works within the system and ... has working relationships with my colleagues (Interv. **6**, p. 203, 36-41).*

2.2. Principle II: Responsible Caring

The CPA's (2000) second ethical principle directs the psychologist to maximise benefits whilst minimising the exposure of vulnerable others to the risks of harm. Benefits and harms include both psychological and physical dimensions and entail careful consideration of current, medium and long term effects. The code states that care must be taken "to proceed only if the potential benefits outweigh the potential harms, to develop and use methods that will minimise harms and maximise benefits, and to take responsibility for correcting … harmful effects that have occurred as a direct result of [the psychologist's] … activities" (CPA, 2000, p. 14).

Responsible Caring subsumes the ethical standards of **general caring**, **competence** and **self-knowledge**, **minimising harm** and **offsetting or correcting harm**. The two latter standards include consideration of the power differential inherent to the therapeutic relationship and

confronting impaired collegial performance respectively. Given the emphasis in this second ethical principle on the promotion of the psychological and emotional well-being of the other, research participants' avowed values pertaining to therapeutic boundaries and to the psychoanalytic frame are included in the following discussion.

Adopting a utilitarian-consequence position, the second principle enjoins the psychologist to consider the pragmatic effects of any proposed activity and to ensure that the activity is likely to benefit and not harm either the individual or society (Malloy & Hadjistavropoulos, 1998). With the foregrounding of active caring and concern for the other, this principle retains a "feminine" cast and may be related to Gilligan's (1982) "care voice" or moral orientation which upholds as a relational ideal a vision of "loving and being loved, listening and being listened to, and responding and being responded to …" (Brown et al., 1991, p. 28). Central to accounts of the ethic of care, Beauchamp and Childress (1994) write, lies an emphasis on intimacy, interpersonal relationships, emotional commitment and the core notion of "taking care of others … modelled on relationships such as those between parent and child" (p. 86).

The different moral voices and relational perspectives of justice and care were discussed in earlier chapters. At this point, it may be noted additionally that the two moral voices are conceived of as gender-related – the justice voice is articulated more frequently by males and the care voice by females – but that they are neither gender-specific nor mutually exclusive (Gilligan & Wiggins, 1987). All human relationships, including those involved in real-life ethical conflicts and choices, may be spoken and conceived of both in terms of equality and inequality as well as in terms of attachment and detachment (Brown et al., 1989; Brown et al., 1991). In summary, the first two ethical principles of the CPA's (2000) code appear to correspond with Gilligan's (1982) moral voices of justice and care. With regard to the process of ethical decision-making, Malloy and Hadjistavropoulos (1998) caution that the CPA's (2000) hierarchical ranking of the Kantian-based impartial principle of universal justice, a supposedly masculine orientation, above care, sensitivity and concern for personal relationships, a supposedly feminine orientation, remains controversial.

While some research participants' descriptions of avowed values showed evidence of a justice voice or orientation, the data in the following sections revealed that beneficence and the relational mode as elaborated by the ethic of care emerged as a dominant avowed ethical

principle. Beneficence or Responsible Caring accordingly appeared to represent the ethical principle that interviewees considered most closely directed their everyday practices and that most clearly defined their identities as professional caregivers.

2.2.1. General Caring

All six participants described their daily striving to care for others and to act in what they perceived to be the best interests of the patient and the process of therapy (See Figure 1 above). Beneficence or the promotion and protection of the patient's psychological and emotional well-being arguably comprised the first "rule" or principle of therapeutic engagement:

> *What's best for the patient? Above all … that's … the first rule … I need to always ask myself what is best for this patient? What [are] this patient's needs? And what's going to help this patient? (Interv. **5**, p. 166, 18-22).*
>
> *… there's a … commitment to take care of the person I'm working with … [my work's about] **honouring** my agreement to look after them and their psychology (Interv. **4**, p. 139, 16-18).*
>
> *… in a way you're always … thinking and reflecting on what you're doing … whether what you're doing is in their best interests and in the best interests of the process of the therapy … which is … the central enterprise (Interv. **3**, p. 103, 21-24).*

The following description foregrounds Riaan's disillusion with the impersonal justice system and the perceived corruption of the law. The excerpt provides an example of the valuing of the contrasting ethic of care and of concern for the intimate relational connection with the patient:

> *The law was unjust ... the law doesn't protect (pauses) the person who has been raped, the law doesn't protect **me** as a professional person … the law will protect the rapist, the law will protect the person who gets put in jail … It felt better for me to look after the **person** because the law's not going to look after this child. So I can look after [the patient] emotionally as a therapist … the law thing, I don't even try and go there because it's just so big and **messy** … (Interv. **5**, p. 186, 1-18).*

While professional dedication to benefiting and to caring for vulnerable others was accorded prominence, the counterpoint of the noninfliction of harm, or **the ethical principle of nonmaleficence**, was granted only brief recognition. This may suggest participants' resistance and distancing from the issues of therapist self-interest (Steere, 1984), capacity for exploitiveness (Gabbard, 1989; Gabbard & Lester, 1995; Epstein et al., 1990; Pope & Bouhoutsos, 1986) and the need to confront unethical impulses or "the tremendous potential

to do damage in the therapeutic relationship" (Jennings et al., 2005, p. 39). Nonmaleficence was accordingly referred to as an explicit avowed principle only twice (See Figure 1 above) in the entire body of data:

> *... one of the things that I do before I see ... a person is I kind of ... say a prayer, if you like, very briefly ... which is just a few seconds, ... and I just ask for ... enough consciousness* ***not to harm*** *the person, enough courage not to flinch in the face of what I see and enough wisdom to embrace human phenomena (Interv.* ***2****, p. 33, 11-17).*

> *I suppose I was very concerned with doing the right thing, I wasn't quite sure what the right thing was but the thing that would be in the patient's best interests ... you know ... the Hippocratic Oath, firstly,* ***do no harm*** *... and beyond that ... if possible, help improve the life of or help to facilitate a positive experience for. So, I know ... that's where the feeling was coming from but ... I felt quite thrown because ... I wasn't quite sure which ... route was ultimately ... of benefit to her ... (Interv.* ***6****, p. 227, 23-34).*

2.2.2. Competence and Self-Knowledge

The CPA's (2000) code directs that competence and self-knowledge necessitate acquiring and maintaining theoretical and clinical proficiency through keeping abreast with professional literature, peer consultation and continuing education. Competence additionally demands self-reflection and evaluation regarding how life experiences, stresses, values, individual beliefs, needs and social context influence psychologists' current choices and interactions with others.

All research participants appeared highly motivated to sustain and to enhance professional competence, actively seeking out new opportunities to increase theoretical knowledge, clinical skills and psychological growth. The six psychoanalytic psychotherapists were thus involved with professional reading groups and regularly received either personal therapy and/or formal supervision. Two participants were involved with both activities while a further two indicated that financial considerations alone constrained their re-entry into personal analysis. Exposure of one's work to professional peers was deemed to be highly anxiety-provoking but was acknowledged as a potentially valuable learning experience. The following quotations suggest, for example, that participants' continued desire to learn at least partially motivated their decision to participate in this research:

> *I'm interested in the topic (pauses) and maybe in some way I thought ... I'd um learn ... I would learn maybe as much as I would share, if that makes sense? But ... I feel maybe with this particular case ... that I'm gonna talk*

*about, that it, it felt like it needed further processing (Interv. **6**, p. 203, 27-31).*

*I found [the society's workshops on professional ethics] fascinating, the readings that we were given … made me think about things that I hadn't actually thought about before … in fact, I then … took the same readings to [a self psychology reading] group and we read them through together (Interv. **1**, p. 6, 6-9).*

*So, that would really be my … main push … is to offer something … just let's work together … that's how we look after each other best, by exposing our work, letting other people see what we're doing, that's the best learning curve (Interv. **2**, p. 30, 31-34).*

The CPA's ethical standard is recast from a psychoanalytic perspective by Jennings et al. (2005) who suggest that key to professional competence is self-awareness of personal conflicts, defenses and vulnerabilities. Management and resolution of countertransference issues are thus considered by "the master therapists" examined in their research to be fundamental to the provision of optimal care and to reducing the risks of harm to their patients.

Self-awareness, self-reflectiveness, thoughtfulness, consciousness or deepened psychological understanding similarly appeared as a pervasive avowed value throughout the research interviews. While the value of a thoughtful, reflective attitude was intellectually acknowledged and theoretically privileged by all six participants, the data paradoxically revealed that, in contrast to the foregoing "master therapists", the processing of personal countertransference and the need for "the disciplined avoidance of those behaviours that may inappropriately skew or compromise the transference" (Ivey, 1999, p. 2) did not appear in the present study as specific avowed values.

One exception to the latter finding emerged in relation to a research participant's clear awareness that unprocessed countertransference issues might negatively impact upon the therapeutic work at hand. As the "master therapists" reviewed in Jenning's et al. (2005) study observe, when the therapist's self-care is insufficient, the risk of the latter's personal needs intruding upon the therapeutic session are heightened. The following extract suggests that self-knowledge or awareness of his own psychological "scar" alerted Riaan to the potential for personal countertransference to compromise therapeutic efficacy, often inducing the therapist to turn to the patient for solace or for gratification of unmet emotional needs:

> *I bumped into a [patient] ... who said "Ah, you're the person who helped me, you'll **never** know what you did for me!" And I kind of, I know it kind of feeds the sort of narcissistic self but sometimes I just **need** that kind of feeding when there is just so much **sucking** that happens, sort of **draining** of one's emotional resources ... (Interv. **5**, p. 179, 45-46; p. 180, 1-2).*

Contemporary psychoanalytic theory situates the transference–countertransference relationship within "a bipersonal field" (Baranger & Baranger, 1966) of therapeutic interaction. Whilst appearing erroneously to imply that the therapist's personal countertransference responses can somehow be removed from the therapeutic context, the following comments are, nevertheless, anomalous and unique in the body of data, suggesting as they do that striving to manage personal countertransference constituted a core avowed value that underpinned Riaan's daily professional practices:

> *... I think that's, that's my own stuff and (pauses) and I think that's what I have to keep out of there, all the time (Interv. **5**, p. 181, 9-10).*

> *I grew up in a home where there was ... violence and ... the scar, in the end hasn't gone away. (Long pause, then speaks very softly) And, as always, I have to be ready for the next person, kind of have to clear this [feeling] completely if I'm going to be clinically fair for the next person I'm seeing (Interv. **5**, p. 177, 34-39).*

2.2.3. Minimize Harm: the power relationship in therapy

The CPA's ethical standard "Minimize harm", directs that sexual relations with clients are unethical both during therapy and after termination for that period of time during which the power relationship could reasonably be expected to continue to influence the client's decision-making. The CPA's code further cautions that the client's trust or dependency should not be exploited for the psychologist's personal, professional, political or business gain. The following discussion identifies different examples of research participants' efforts to respect the power differential inherent to the therapeutic relationship. Contrasting instances also emerged in the context of posttermination contact wherein the declared ideal of respect for the asymmetrical power differential was arguably compromised.

The potential for erotic transference-countertransference treatment configurations to escalate into sexual misconduct and frank abuse has not only been well documented (Feldman-Summers & Jones, 1984; Norris et al., 2003; Pope & Bouhoutsos, 1986) but also constitutes the ethical issue responsible for generating the most publications in professional ethics (Wassenaar, 2002). In the following fragment, David eloquently highlighted the

asymmetrical power relations and lack of reciprocity involved in therapist-patient sexual contact; he holds up as avowed values the virtues of constraint and abstinence:

> *I believe that a therapist who is treating a patient **cannot** engage in an intimate sexual relationship with that patient for no other reason other than there is … a fundamental disequilibrium of psychological position, which can never be taken care of … if there is [an]in-depth therapy process going on, there is no way that that is an equal relationship … it's **really** up to the therapist to understand that, no matter how powerful the erotic transference dynamics, if you enter into that relationship, it's **unfair** to the other person. They're at a **major** psychological disadvantage … in fact, I don't believe that they're entering into that relationship with informed consent (Interv. **2**, p. 57, 38-49).*

Power dynamics inherent to class, race, gender and age were acknowledged by research participants to be inescapable features of the broader South African landscape and were integral also to the therapeutic space situated within it. Congruent with the CPA's ethical principles of Respect for the Dignity of Person and Responsible Caring, respecting the power differential was described as an aspirational ethical value that broadly informed the professional practices of four participants. The following fragments, for example, illustrated interviewees' respectful efforts in the context of the therapeutic space to redress the skewed power differential originally effected by the Apartheid system:

> *A lot of the time people have been broken down by social (pauses) circumstances … race, class, gender all … push people along a continuum of marginalisation and I can't … begin to work without thinking about those things and, for me, … I need to bring the person back to here where we are, where we're two people encountering each other in this room … (Interv. **5**, p. 167, 4-10).*

> *What I like about the short-term work is that it's often people … who're not … psychologised … so-called coloured or darker skinned people ... and I feel that it's really important to reach those people as well … because I don't want to have just kind of a middle class practice where people come and they've got money and they pay (Interv. **3**, p. 73, 45-50).*

Betan (1997) comments that the therapeutic relationship by its very nature involves "ethical dimensions of dependency, power, influence and will" (p. 347). Since treatment may be compromised, constraint is urged with respect to therapist behaviour that is likely to misuse the power differential inherent to the transference – countertransference relationship (ApsaA, 2005). While respecting the power differential was consciously acknowledged by four participants as an avowed ethical value, the data apparently reveal the precariousness of the differential concerned. In the following description, for example, the research participant extended an invitation to several current patients to join an extra-therapeutic organisation in

which he maintained a personal interest. The ensuing dual role relationships foreground the sway of the transference relationship and the fundamental disequilibrium of power relations that pervades the notion of "informed consent" in psychoanalytic psychotherapy:

> *... I wouldn't call it informed consent in the normal sense of the term, I think the power relation is* ***huge*** *there ... if you want to ... say that the patient was influenced by me because I was in a powerful position, I agree that's true ... (Interv.* ***4****, p. 150, 46-49).*

> *... but it wasn't like, you know, equal dialogue in which like, let's make an agreement that we've both fifty – fifty power base here, absolutely not (Interv.* ***4****, p. 151, 40-47).*

One striking anomaly appeared to emerge from the data with regard to the asymmetrical power relations integral to the therapeutic dyad. Norris, Gutheil and Strasburger (2003) comment on the contemporary backlash against boundary theory wherein its proponents are chided for stifling creative innovation and for advocating "procrustean prescriptions of proper performance" (p. 517). Congruent with this latter critique, in the following excerpt the research participant in the following excerpt advanced a persuasive theoretical argument (seemingly in the patient's best interests) that advocated the equalisation of therapist-patient power relations and the assumption of a "normal" posttermination relationship:

> *And if that termination process has been worked through ... well toward the aim of having a ... relationship outside of the therapeutic space, then there's a third space that comes into play ... first space is the therapeutic space, second space is the death where there's no contact but there's a third place which is there's the death ... of the therapeutic relationship and the birth of a new, in inverted commas, "normal" relationship out, out in the world (Interv.* ***4****, p. 120, 10-16).*

Implementation of self-revelatory and egalitarian relations with ex-patients in the context of posttermination social contact was construed by the participant concerned as facilitating de-idealisation of the therapist as well as the healthy resolution of the transference relationship through the reintegration of previously split off and projected aspects of the self. In the following extract, the therapist accordingly presented the asymmetrical power relations involved in posttermination "business dealings" as a seemingly beneficent forum wherein the ex-patient brought to a constructive closure his former transference relationship:

> *[the patient has to] come to terms with the fact that you're a normal other person in the world. And* ***that learning*** *... can be* ***huge*** *... .I was just yesterday speaking to this chap who ... is still in a kind of transference with me but he's working it through because we have contact ... we had some, oh, I suppose one can call it business dealings um just on a sort of once off thing but ... a lot of stuff came up for him and we were able to talk about it*

> *just in the normal passing … about his … desire to please me and so forth and so on. And really … it's been incredibly powerful for him to um (pauses) experience* ***me*** *as not … his therapist but as a real person and have a retrospective sense of the kind of projections he … had on me during the therapy and how … some of them weren't really true at all … Ah, obviously* ***each*** *case has to be very carefully considered in terms of its own unique merits … certain patients you would definitely* ***not*** *get any value from having contact post therapy but I guess … there are cases in which (sighs) one, one would get tremendous value out of seeing the person afterwards (Interv.* ***4****, p. 120, 16-31; p. 121, 9-12).*

Gabbard and Lester (1995) contend that "Studies demonstrating the obliteration of the transference following termination of analysis do not exist" (p. 152). No professional consensus prevails as to what boundaries are optimal in the posttermination period but research over the past three decades reported by Gabbard and Lester suggests that not only does transference persist for years following closure but that it may well intensify. Collusive denial coupled with the promise of posttermination contact may be mobilised by the therapeutic pair in order to usher in for patient and therapist alike not a definitive ending but merely a new beginning. Defensive avoidance of grief associated with the decisive closure of a significant relationship potentially applies, Gabbard and Lester observe, to both the therapist as well as to the patient.

Beauchamp and Childress (1994) comment that the ethical principles of nonmaleficence and beneficence are conceptually distinct and do not necessarily retain hierarchical significance. Knapp and VandeCreek (2007) point out that different codes, including the ethics code of the APA (2002), combine beneficence and nonmaleficence into one overarching ethical principle. Other authors (Colnerud, 1977; Kitchener, 1984) contend that nonmaleficence is the overriding obligation and the most critical in applied psychology and psychotherapy (Brown, 1982; Stokoe, 2000). From the perspective of psychoanalytic ethics, the therapist's subjective construal of posttermination contact as singularly beneficent does not apparently address the ethical obligation to interrogate the intervention concerned from the counterpoles of nonmaleficence and personal countertransference. The establishment of posttermination nonsexual dual role relationships may on the contrary suggest the evocation of boundary violations and unresolved countertransference enactments. Patient efforts to effect the resolution of loss, mourning and the permanent giving up of the therapist as an idealised part-object appeared in the process to have been compromised.

2.2.4. Offset/Correct Harm: impaired collegial performance

The CPA's ethical standard "Offset/correct harm" prescribes formal and/or informal intervention when collegial performance, whether that of a psychologist or member of another discipline, results in harmful activities. Openness to the concerns of others and a nonretaliatory attitude are recommended with respect to perceptions of harms that have been incurred as the direct result of one's own professional practice.

Key to clinicians' ethical conduct is not only the provision of ethical standards but also the acknowledgement of "situational pulls" (Betan, 1977, p. 356) exerted by the context of the therapeutic relationship as well as by the therapist's own subjective needs and dynamics. Intellectual comprehension of the regulating ethical standard may well be overridden by loyalty to the colleague concerned, guilt, fear of collegial reprisal as well as anxiety pertaining to personal reputation or financial security (Betan, 1977). Research participants' "indirect countertransference" or acute feelings of being endangered, menaced and professionally castrated by third parties (Racker, 1957) were often in evidence when talking about how their work might be perceived by peers, supervisors, other therapists or professional organisations. Perhaps not surprisingly the avowed ethical ideal of active intervention in the case of collegial impairment emerged only once in the body of data. In contrast with pervasive collective anxiety, an alternative image of aspirational practice was portrayed by David who argued that dubious or "borderline" collegial behaviour needed to be directly addressed in an empathic and nonjudgmental manner:

> *... there are things that people might do that are kind of borderline ... and we should talk to each other ... you're discussing a matter with a colleague who gets very hot under the collar and very charged emotionally ... does one say, at a different time to that colleague, ... when we were talking about the case of X, my perception was that you were drawn in, in a very powerful way and you need to think about ... about what the charge is for you ... and that can be done in a very ... generous and giving way (Interv.* ***2****, p. 63, 37-45).*

> *I think ... I do a disservice ... to not inform the colleague who's not functioning or practising at least adequately ... they don't get the feed-back ... [and] we don't gather together as a group supporting each other in an open and honest manner (Interv.* ***2****, p. 63, 13-18).*

2.2.5. Boundaries & the Maintenance of the Analytic Frame as Avowed Values

Transferences may be established not only with other people but also with ideas, psychoanalytic institutions, belief systems and ideologies (Frosh, 1997; Ivey, 1999). Whether experienced as benign and protective or as prohibitive and oppressive, boundaries and the analytic frame consistently emerged from the data as a pervasive influence that informed research participants' everyday professional practices:

> *Boundaries for me are **extremely** important ... [the] frame and adherence to the frame, in my experience, has definitely helped people to feel safe in the work and I think it also serves a protective function for the therapist, that there's a beginning and an end to each session and that experience is contained in that time (Interv. **6**, p. 204, 11; 32-36).*

> *... I pick up a very strong **oppressive** ... superego voice that's alive in the culture of the [Psychoanalytic Society] which is about ... saying something like you're wrong, you're breaking the rules, you shouldn't have extra-therapeutic contact with your patients ... . My feeling now is ... I don't really care about that voice and actually would be ... open to **publicly** challenging that kind of rhetoric (Interv. **4**, p. 132, 16-25).*

> *I suppose the core thing that I have is ... respecting [patients'] boundaries ... to communicate that I will ... **not** overstep their boundaries ... I'm also thinking of those people who overstep **your** boundaries ... and that I need to let them know that I'm not going to just be uncontained and, you know, anything goes (Interv. **3**, p. 78, 5-15).*

> *It's about keeping boundaries and, for me, the whole concept of boundaries has been um (sighs) the guiding principle (Interv. **1**, p. 6, 28-30)*

> *Just yesterday I worked with a couple ... the [one partner] had been a victim of torture ... and they told their story and when it was over the [other partner] asked if she could hug me, (pauses) that's **not** analytical, to **hug** your therapist but she needed to ... immediately when she posed the question to me, I thought, is this right? Do I push her away? Do I reject her? What do I do here? (Interv. **5**, p. 166, 24-32).*

Boundaries and the maintenance of the psychoanalytic frame emerged as the core or central "guiding principle" for three research participants. All interviewees, however, described their struggles with common boundary difficulties which have previously been identified in the professional literature. These included, for example, timekeeping, money, place, physical contact, self-disclosure or making exceptions for special patients (Epstein & Simon, 1990; Gutheil, 1999; Gutheil & Gabbard, 1993; Norris et al., 2003). Integral to the aspirational standard of boundary maintenance and to the securing of a benign therapeutic space lay an

apparent emphasis on the disciplined maintenance of the structural features of the analytic frame:

> *... the frame ... creates a sense of safety, in terms of knowing, understanding ... the kind of patient/therapist relationship and ... the parameters of that relationship ... The fact that the time is consistent, predictable ... There are certain* ***boundaries****, there's the word again, to the amount of time spent in a session ... (Interv.* ***6****, p. 204, 24-32).*

> *... I will be there for them when I say I'm going to be there and if ... I can't be there, I'll let them know timeously ... that I'm very committed to the frame of being there ... of fulfilling all my obligations in terms of, say, their accounts, that they get their accounts on time ... (Interv.* ***3****, p. 78, 1-5).*

Writing of the analytic attitude as quintessentially an ethical attitude, Solomon (2003a) comments that the analyst's reflective capacity or analytic function "represents the third element which both structures and limits the pre-oedipal tendency towards fusional states" (p. 9). Gabbard and Lester (1995) similarly suggest that the analytic attitude entails both therapist participation in, as well as efforts to reflect upon, the unconscious meanings of countertransference enactments arsing in the context of the therapeutic space. In general, research participants' foregoing descriptions appear to reflect their deep concern and conviction that protecting the boundaries of the analytic frame enhanced their capacity for effective therapeutic work. In the context of real-life dilemmas, however, failure to implement retrospective analysis of countertransference phenomena apparently often led to repeated boundary transgressions, arguably compromising the avowed commitment to beneficence and to the ethical ideal of boundary maintenance. Later discussion in this chapter returns to the issue of the impact of countertransference enactments on avowed ethical principles and standards.

2.3. Principle III: Integrity in Relationships

The third ethical principle of the CPA's (2000) code emphasises that public confidence and trust are contingent upon the latter's expectations that the psychologist's professional relationships will be honest, open, objective and will avoid conflicts of interest. Self-knowledge is once again considered fundamental and includes the capacity to evaluate the potential influence on current professional activities of personal backgrounds, experiences, stresses, attitudes, needs and values. Dual relationships constellate potential conflict-of-interest situations and are to be avoided as they "can motivate psychologists to act in ways that meet their own personal, political, financial, or business interests at the expense of the best interests of members of the public" (CPA, 2000, p. 21). When dual role relationships

are unavoidable, ongoing supervision or consultation are recommended in order to safeguard public interests.

Malloy and Hadjistavropoulos (1998) comment that the consequentialist emphasis evident in the CPA's code widens from consideration of the well-being of the individual to consideration, in the third ethical principle, of the well-being and greatest good of the profession specifically and science more generally. The allied ethical principle of fidelity was discussed in earlier chapters and similarly involves truthfulness, promise keeping and open communication, all of which are basic to the issue of trust in professional practice. Failure to be trustworthy potentially destroys faith in the viability not only of the therapeutic relationship but also in the benefits to be obtained from the profession of psychology in general (Kitchener, 1984). The CPA's third ethical principle subsumes the ethical standards of **accuracy and honesty**, **straightforwardness and openness** as well as avoidance of **conflict of interest**.

2.3.1. Professional Integrity, Truthfulness and Openness

The values of honesty and openness emerged in all six interviews in the form of vivid descriptions of aspirational as well as lived practices (See Figure 1 above). Integrity in relationships was not articulated by participants as an avowed value in relation to maintaining public trust; it appeared, however, to emerge in contrasting ways with respect to collegial relationships and the individual therapeutic dyad. Research participants referred extensively to the visible and invisible "networks" (Brookes & Hodson, 2000) of professional relationships which surrounded them at work. The latter "networks" of collegial relationships optimally generate hope that creative work can be collectively achieved and that the professional matrix concerned "can contain depressive pain rather than emanating persecutory anxiety" (Harris & Meltzer, 1986, in Brookes & Hodson, 2000, p. 19). Congruent with the previous finding that direct confrontation of impaired collegial performance found only limited expression as an avowed value the following excerpts suggest that truthful self-disclosure to professional peers elicited equally strong anxiety. Apparent fear of collegial censure may impede the authentic exposure of work to peers, thus heightening professional isolation and the potential for unethical behaviour:

> *... there is an **incredible** sense in this city of how ... **private** people are inclined to be about how they work, **truthfully**, how they actually work. And there seems to be a fear for people to say this is what being a therapist **actually** means for me ... people don't often feel safe enough, or have the courage enough, to ... stand up and speak their truth in groups because*

> *there is no ethos in the group encouraging … and supporting that (Interv.* ***2****, p. 30, 20-22; 44-46).*
>
> *… if I think about … a psychoanalytic society … very few real conversations … happen in our meetings. Most of the conversations are theoretical … and when people do talk about the patient, they talk* ***only*** *about the patient. They don't talk about themselves … when there's case presentations, … if I step back … and say what is my sense of that presentation, my sense is that I can only see the patient, I can't see the therapist … there's nothing about the therapist that's in there (Interv.* ***4****, p. 124, 8-19).*

In relation to the individual therapeutic dyad, all six research participants provided by contrast moving examples of openness, integrity and truthfulness as an avowed as well as a lived value (See Figure 1 above). Ivey (1999) writes that the analytic task "is to think the unthinkable and speak the unspeakable in the hope that this will assist our patients in thinking and conversing more freely" (p. 4). Avowed commitment to confronting the emotional truth of the analytic situation accordingly emerges in the following extracts:

> *… there was something about learning not to flinch … people sometimes come … with very deep, difficult wounds, or their own sense of shame and unhappiness and, if I can't go there, I'm useless to them (Interv.* ***2****, p. 34, 2-5).*
>
> *Ethics for me is about lying or covering up or hiding because of fear or desire for something that isn't agreed upon … the* ***agreement*** *really between us is that I will spend my time … getting to the heart and truth of things … (Interv.* ***4****, p. 123, 1-4; 36-37; p. 124, 3-5).*

This declared commitment to the truthful discovery of who the therapeutic dyad might symbolically represent and to examination of "the countertransference piece … that gets skipped" (Interv. **4**, p. 123, 26-27) foreshadows discussion in the following chapter of countertransference enactments.

In the context of lived practice, adherence to the ethical values of honesty, integrity and truthfulness appeared to waver, sometimes lost under the emotional impact of real-life ethical dilemmas but regained with the support of the research interviews. Hence subjective experiences of exploitiveness, defensiveness and troubling feelings of therapeutic doubt and failure were courageously and frankly shared in the interview situation. Reflecting on his reluctance to confront impaired collegial conduct, the participant in the following excerpt, for example, openly acknowledged his defensive avoidance. Similarly, in the second extract, the interviewee recalled her need to inform her patient truthfully at the earliest possible

opportunity that they were in fact relatives. A note of guilt entered her frank admission in the third extract that financial self-interest may at least partially have informed her decision to continue to work with a dual role relationship:

> *I think there might've been a part of me that ... decided, in a defensive way, that the [the patient's] parents knew, that it was their responsibility ... but [perhaps] there was a part of me that **avoided** the confrontation, by ... saying, well, it doesn't matter now because I've done everything I need to do and I don't need to pursue this ... it might be that I just thought fuck this ... I don't need this business in my life actually. So I'm just playing with the thoughts in my head, you know, this is a new thought to me as I am speaking (Interv. **2**, p. 51, 46-49; p. 52, 7-10).*

> *I mean I needed to talk about it ... I didn't want to sit there having her kind of engaging with me ... [And so] I went back to therapy and I said to her ... this is the situation, I've realised that we are in fact ... cousins (Interv. **3**, p. 94, 45; p. 95, 33-35).*

> *I also want to add that if I had a very, very full practice I'm not sure what I would've done, because I didn't have a very full practice so I **needed** patients, I mean I just wanted to say that as part of the ethical dilemma ... I can't say I've ever seen anybody for longer than I ought to have but sometimes, you know, there is that sense of, oh, you know, I need the referral so ... (Interv. **3**, p. 87, 3-10).*

In the following excerpts, Riaan and Theresa likewise steadily confronted feelings of guilt and inadequacy, expressing concern that therapeutic failure may carry future iatrogenic consequences:

> *... she shared something very private, very scary, very traumatic and maybe I **should have** held her hand right through it but I didn't and...for that, I feel guilty, I feel ... inadequate ... I think [the patient] needed a strong parent to be there for her and I think she might have felt the potential for that with me but didn't get it (Interv. **5**, p. 173, 33-41).*

> *I'm hoping that ... this experience has given [my patient] a taste, **enough** to pursue ... another experience which would be hopefully...much safer without this kind of dual [relationship], but ... at the ... same time I **fear** ... **this** very experience has done the opposite, it's ... decreased the chances of her ever pursuing ... good [therapy] experiences ... which I'm afraid, ja, will mean that she ... won't get the support and ... the therapy that she might need ... (Interv. **6**, p. 218, 40-49).*

2.3.2. Avoidance of Conflict Of Interest: Nonsexual dual role relationships

Steere (1984) comments that ethical code injunctions against dual role relationships appear to derive from the principle of nonmaleficence. The relative absence in the present study of recognition accorded to nonmaleficence as an avowed ethical principle has already been

noted. The following examples suggest that the derived ethical standard of avoiding dual role relationships, with their latent potential for exploitiveness, arguably followed suit and failed to emerge clearly as an avowed standard of practice:

> *I felt at the time that my patient would've been very uncomfortable to have had her [parent] visit me socially ... **now** I think that she might have been ... pleased that I could have witnessed ... he was so out of his tree (Interv. **1**, p. 15, 39-40; p. 19, 29-30).*
>
> *I don't know, I don't remember, learning about that, I can't say that there's a specific "voice" when it comes to that ... I can't say that I have any "voice" around multiple roles (Interv. **6**, p. 225, 39-46).*
>
> *If they've made a code, the Professional Board, that says that you can't do [dual relationships], then my judgment is that they are ... **highly** limited in their ... awareness because ... I absolutely guarantee that ... all the patients I work with found this incredibly valuable and that the risks involved are very limited (Interv. **4**, p. 153, 37-42).*

3. RESEARCH HIGHLIGHTING DISCREPANCIES BETWEEN ETHICAL IDEALS AND LIVED BEHAVIOUR

Previous research discussed in earlier chapters (See Chapter 2) has identified the discrepancy which frequently mars the relationship between ethical ideal and action choice. The discrepancy concerned has been traced to multiple factors. These include, for example, the consideration that clinicians may struggle to identify the ethical dimension of clinical situations (Baldick, 1980), that widespread professional disagreement prevails regarding the most appropriate intervention for hypothetical ethical dilemmas (Haas et al., 1986; Slack 1997; Tymchuk et al., 1982) and that clear conceptual knowledge of ethical codes and principles does not necessarily secure the ethically preferred course of action (Bernard et al., 1987; Bernard & Jara, 1986). Empirical research further suggests that ethical ideals or what 'should' be done are formulated according to relevant principles or legal guidelines; in situations where anticipated ethical infractions do not violate ethical codes or legal precedents, practitioners are less likely to act as they should, giving greater weight to personal or pragmatic considerations (Smith et al., 1991). This suggests that deficits in integrity and honesty may at least partially account for the observed discrepancy between what should be done and the implementation of contrasting compromised ethical behaviour (Smith et al., 1991). Failure by ethical codes to elaborate the reasoning process underpinning broad imprecise ethical principles may additionally confound the therapist's ability to apply the latter guidelines to specific ethical dilemmas encountered in professional practice (Slack & Wassenaar, 1999; Wassenaar, 2002).

Given the substantial research evidence available that moral reasoning and cognitive knowledge of ethical code items are necessary but are not apparently sufficient to secure ethical practice, Betan (1997) points out that competing contextual and subjective considerations may interfere with therapists' commitment to implementing ethical behaviour. This complexity of ethical decision-making, Betan (1997) observes, is "often ignored, or at least rarely captured, in the professional literature" (p. 351). While the quantitative studies reported provide valuable insights into the nature of potential "judgement-action" (Day, in Tappan & Packer, 1991) discontinuities, they appear to presuppose a subject who is transparent to him/herself and whose motivation for action is derived principally from rational or conscious intent. Meissner (2004) by contrast holds that cognitive and volitional processing contributing to the ethical agent's decision-making may transpire on a largely unconscious level. From a psychoanalytic perspective, for ethical judgment and action to occur "without any unconscious input would be unacceptable" (Meissner, 2004, p. 556). What appears to emerge from the data is that the observed discrepancies between the ethical ideal and lived behaviour were organised by an array of manifest factors which converged with competing countertransference pressures to drive "the moral performance" (Day, in Tappan & Packer, 1991, p. 40) of participants in their efforts to resolve real-life dilemmas.

The emotional turbulence generated by the therapeutic encounter may be psychologically hazardous not only for the patient but for the therapist as well (Siegelman, 1990). Unresolved countertransference feelings of hate, envy or aggression towards the patient or, alternatively, feelings of sexual attraction (Stevenson, 1999) or "lovesickness" (Gabbard & Lester, 1995, p. 96) may unexpectedly emerge in the therapeutic space (Winnicott, 1949; Searles, 1959; Lambert, 1972). Inadequate training may augment therapist unpreparedness to respond appropriately to disorienting subjective experiences involving powerful affects (Ivey, 1992; Pope & Tabachnick, 1993; Stevenson, 1999). When deep levels of transference-countertransference are mobilised and a state of "participation mystique" or mutual projective identification prevails (Solomon, 2003b, p. 26), it may even be unclear whose psychological wound is being tended to or to whom the various affects belong (Perera, 1981; Siegelman, 1990). When the clinician routinely identifies himself as a benign, beneficent caregiver, such ego-dystonic affects may be difficult to acknowledge and to address (Searles, 1959).

What may be insufficiently recognised by the professional literature is that the context of the therapeutic relationship as well as the therapist's subjectivity appear to remain fully implicated in any encounter with lived ethical dilemmas. This suggests ethical quandaries "inevitably touch deeply rooted fears, needs, desires, meanings and values" (Betan, 1997, p. 361). The discussion below considers the "judgement-action" relationship in the light of how participants' avowed ethical values fared when the psychological terrain generated by real-life dilemmas was suffused with anxiety and disorientating countertransference pressures.

4. AVOWED PRINCIPLES IN THE CONTEXT OF REAL-LIFE ETHICAL DILEMMAS

4.1. Informed Consent and the Collapse of Responsible Caring and Respect for the Dignity of Persons

The avowed principle of beneficence or contributing to patients' health and well-being emerged as the dominant ethical value across the research interviews. Weighing beneficence or Responsible Caring (the CPA's second ethical principle) against patient autonomy or Respect for the Dignity of Persons (the CPA's first principle) raises concerns about paternalism or presuming "that an authority has knowledge of what is good for an individual and undertakes to regulate that person's behaviour according to what the authority believes to be good" (Kitchener, 1984, p. 49). From the perspective of psychoanalytic ethics, the issues of patient autonomy and informed consent raise additional questions with respect to who is giving consent to whom, for what is consent being given and how might the analytic process subsequently be affected (Lear, 2003).

Given the unequal power differential in therapy and the patient's apparent "desire to please" (Interv. **4**, p. 120, 27), the excerpts below from different interviews open debate as to who or for whom or what aspect of the patient "consented", firstly, to the therapist's invitation to enter into an extra-therapeutic organisation; secondly, to the therapist's insistence that a dual relationship should continue, overriding the patient's own efforts to terminate and, thirdly, to continued involvement with therapy despite the therapist's acknowledgement that acute countertransference fears had led to his "decision" to abruptly foreclose exploration of the patient's homoerotic transference:

> *But there's no question about it … I've no sense that there was informed consent … in the normal use of the term … [but] it wasn't like a sort of* ***sell****, I always raised it … like, look, this is not* ***really*** *part of the therapy but …*

> *this is out there and I think you should know about it … and check it out (Interv. **4**, p. 151, 40-41; p. 152, 10-13).*
>
> *And I did … I did **push** for continuation rather than termination, I **did** promote that, I **did** feel like, it was something that I thought would be possible (Interv. **6**, p. 207, 50-51).*
>
> *In terms of [the patient's] erotic transference to me, I killed that very early, I interpreted it very early and I stopped it very early (Interv. **2**, p. 48, 19-20).*

The danger of an axiomatic belief in the benefits or goodness of therapy, Kitchener (1984) avers, is that the therapist may well be "enticed" into implementing decisions that disregard or disrespect the patient's autonomy, often unconsciously coercing the latter into adopting the therapist's preferred course of action (Steere, 1984). Denial of "blind spots" (Freud, 1912, p. 116) with regard to homoerotic countertransference, gratification of narcissistic needs for professional affirmation as well as seeming unawareness of the relevant code items were apparently partially responsible for participants' failure in the foregoing excerpts to actively seek out treatment alternatives and to inform patients explicitly that multiple relationships are ordinarily not professionally recommended as the practitioner's objectivity, competence and effectiveness may be significantly impaired (APsaA, 2005; CPA, 2000; South African Ethical Code of Professional Conduct, 2002). In the context of the preceding ethical dilemmas, the principle of beneficence appears to have trumped autonomy or the patient's right to make fully informed decisions. As Kitchener (1984) argues, however, beneficence provided in the foregoing excerpts an ostensible rationale for unconscious therapeutic interventions which were arguably not in the interests of enhancing the patient's well-being but in serving the practitioner's inappropriate needs for professional affirmation and the alleviation of countertransference anxiety. As a result, the avowed principles of Responsible Caring or beneficence and Respect for the Dignity of Persons (which includes informed consent) appear temporarily to have been suspended.

4.2. Collegial Sexual Misconduct and the Collapse of Nonmaleficence and Beneficence

Research participants were clearly committed to promoting and to protecting the psychological and emotional well-being of vulnerable others. Caring for patients involved wrestling on a daily basis with considering whether proposed therapeutic interventions were in the best interests of the patient and the process of therapy. One participant was confronted with the ethical dilemma of confronting collegial sexual misconduct. As illustrated earlier in this chapter, the interviewee concerned appeared conceptually clear that mismanagement of

the sexual power differential remains harmful to the patient (Interv. **2**, p. 57, 38-49) and that confrontation of "borderline" collegial behaviour needed to be actively addressed in an open and honest manner (Interv. **2**, p. 63, 37-45).

For the duration of the dilemma which extended over at least a year (Interv. **2**, p. 34, 23-25), and despite having secured patient consent, the participant desisted from informal confrontation of the latter's previous gay male therapist. The therapist concerned was described as a rare and respected mentor (Interv. **2**, p. 36, 22-27), who had once professionally "fathered" the participant well (Interv. **2**, p. 42, 28-30) but who had also repeatedly violated sexual boundaries in the context of the former therapeutic relationship. Violent fantasies emerged in which the participant imagined "hitting", "smacking" and attacking the ex-therapist concerned (Interv. **2**, p. 41, 17-18; p. 66, 8-9). In psychoanalytic terms, the valued mentor/father-figure appeared to have been introjected as an idealised part-object representation standing in relation to a loving self and safely split off from a hating self standing in relation to a hated, dissatisfying object (Ogden, 1986). Writing of compromise formations, Peterson (2002) notes that neurotic compromise formations occur largely out of conscious awareness and that the behaviours entailed simultaneously satisfy multiple competing intrapsychic and interpersonal demands. In this instance, the compromise formation appeared to entail fantasies of violent confrontation as well as actual behaviours involving prolonged and contrasting non-confrontation. The latter dynamic apparently allowed the participant to avoid risking his mentor's actual rejection or retaliation, protecting from contamination an idealised paternal part-object representation while simultaneously expressing, in fantasy only, split off hating and aggressive feelings towards the abuser.

The participant's "decision" to forgo informal confrontation arguably colluded with the erring therapist's apparent avoidance of the issue of causing serious harm to the patient and the potential risk that future patients would similarly be exposed to sexual violation. In the context of the lived ethical dilemma, the participant's avowed ethical principles of nonmaleficence and beneficence hence appeared to be temporarily lost under the impact of unprocessed countertransference reactions. Although "consciousness" and courage to confront the emotional truth of the therapeutic situation constituted further ethical ideals (Interv. **2**, p. 33, 11-15), these too were apparently abandoned in the context of the emotionally charged dilemma. The participant acknowledged that, fuelled by

countertransference feelings of anxiety, he had been unable to work with "the psychology" of the patient's homoerotic transference but had instead "killed that … interpreted it very early, … stopped it very early" (Interv. **2**, p. 48, 19-20). Premature foreclosure or "killing" of the homoerotic transference suggests counter-resistance to the patient's unconscious (Ivey, 1999) or the collapse of the capacity to reflect upon the possible meanings of heightened countertransference feelings of anxiety. As the interviewee himself remarked, both he and his supervisor had lacked the courage to language what needed to be thought about and dealt with (Interv. **2**, p. 53, 1-2; 8-10), that is, to confront the participant's hostility to the paedophiliac aspects of the mentor/abuser's sexual misconduct as well as the homoerotic dimensions of the present transference relationship. Finally, and contrary to the avowed ethical value of open and honest self-disclosure to peers (Interv. **2**, p. 30, 31-34), the participant commented poignantly on his perceived lack of freedom to speak unreservedly about the phenomenon of erotic transference, saying that he had felt unsupported by ostensibly shocked colleagues. In future, the interviewee thought that he would have to rely on himself or that he would alternatively seek consultation with colleagues from disciplines other than those of psychology or psychotherapy (Interv. **2**, p. 65, 8-16; p. 65, 33-41).

4.3. Conflict-of-interest situations and the Collapse of Integrity in Relationships

While nonmaleficence and the derived ethical standard of avoidance of multiple relationships (Steere, 1984) did not emerge as prominent ethical ideals, unconscious interpersonal pressures exerted by dual relationships appeared to compromise participants' avowed commitment to professional integrity. In the context of multiple relationships, confronting the emotional truth of the analytic situation seemingly gave way to therapist self-interest and/or self-deception. The following fragments, for example, suggest that dual relationships secured several inappropriate therapist gratifications. The first example portrays the therapist's use of a dual relationship to service her immediate social obligations. These involved a patient's significant other and temporarily took precedence over the need to maintain the boundaries of the therapeutic frame. The succeeding excerpts highlight that dual relationships were used for the accrual of money for the gratification of therapist needs for "friendship", for increasing feelings of professional self-esteem and for business dealings:

> *Who is [the patient's significant other] going to tell (laughs) about these … awkward [social] arrangements? … Anyway she came and … we didn't discuss my patient at all … but I still was left feeling that I'd made the wrong decision (Interv. **1**, p. 8, 42-45).*

... there was a lot of tensions around ... I mean the ... one was the, the money and ... the fact that I had someone coming to see me who was wanting to see me for therapy in an ongoing fashion which I was really needing at the time. So ... I'm still not sure whether or not if I had a very full practice I would have [seen] ... my cousin (Interv. ***3****, p. 101, 28-33).*

So we've become very good friends, in fact [the ex-patient and] I went on holiday ... we had coffee, we're mates, we're friends (Interv. ***4****, p. 128, 19-21).*

I suppose, at the time, I was a relatively inexperienced ... clinician, and it felt like [the dual relationship] ... could be ... a good learning experience. I didn't want to give up ... it felt like it would be giving up ... to terminate and maybe there was a kind of ***pride*** *driving me (Interv.* ***6****, p. 217, 47-49; p. 218, 1-2).*

Ah, in fact [the ex-patient] did some [input] for a programme that I was part of and so we had some, oh, I suppose one can call it business dealings just on a sort of once off thing ... we had some meetings (Interv. ***4****, p. 120, 21-34).*

Dual relationships are widely acknowledged as inducing conflict-of-interest situations, rendering the therapist vulnerable to impaired integrity and to implementing actions that seek to meet the latter's own personal, financial or business interests at the expense of the best interests of the patient. One therapist described the practice of maintaining dual relationships during in-depth therapy and after termination as "pioneering" (Interv. **4**, p. 133, 15-20) and considered them to be "incredibly valuable" to patients. The CPA (2000) and different authors, however, express concern as to whether such high-risk interventions are ever ethically justifiable in the absence of any or little research validation. Caution is sounded with respect to the possibility that narcissistic difficulties render the clinician vulnerable to avoiding formal consultation as well as to believing that his/her "special" professional practices are absolved of the usual rules that ordinarily apply to the therapeutic situation concerned (Epstein & Simon, 1990; Kitchener, 1984; Norris et al., 2003).

4.4. Therapeutic Boundaries and the Collapse of Self-reflectiveness

All research participants addressed the issue of therapeutic boundaries. As discussed, three interviewees in particular regarded the maintenance of the psychoanalytic frame as the guiding ethical principle that underpinned their daily efforts to secure a well sealed therapeutic space. Reflectiveness, self-awareness, thoughtfulness and consciousness were likewise consistently foregrounded as an avowed ethical standard. In the context of real-life ethical dilemmas, however, the disciplined maintenance of the analytic frame gave way as unprocessed affects and potentially harmful boundary "violations' as opposed to "crossings" emerged (Gabbard & Lester, 1995; Gutheil, 2005; Gutheil & Gabbard, 1993).

Self-reflectiveness and the formulation of therapists' own idiosyncratic contributions to the following countertransference enactments appeared to remain largely absent. The first extract below portrays an ongoing nonsexual dual relationship. The countertransference enactment found the therapist concerned sitting next to her patient's partner. The fragment vividly illustrates how the safety of the therapeutic space was predictably endangered by the collapse of the structural and relational boundaries of the analytic frame:

> *... it's the multiple relationships ... the ... discomfort I felt ... in relation to this [partner who'd] probably no idea that [my patient] had spoken about very intimate things, ... I was sitting there with knowledge [the partner] was oblivious to ... things were concealed and the frame, I mean, the frame just was temporarily ... non-existent or completely suspended, I mean,* ***what frame****? No, it just felt wrong (Interv.* ***6****, p. 221, 32-38).*

In the second example, the boundary of confidentiality, a constituent component of the psychoanalytic process (Lear, 2003), was impulsively breached. The identity of the patient and the fact of the latter's treatment were revealed to nonanalytic third parties, not for treatment purposes and in the service of the analytic task but rather to meet the therapist's personal and social needs:

> *Ja, first of all ... I spoke to my [spouse] about [the boundary problem], then I spoke to [the patient's significant other] about it, not knowing who* ***she*** *would speak to ... I've got the feeling that she didn't speak ... about it at all, to anybody, but I don't know (Interv.* ***1****, p. 10, 1-3).*

Discontinuities between lived professional practice and the ethical ideals of thoughtfulness and boundary maintenance emerged in the third example as the research participant precipitously implemented her decision to see her relative as a patient. When over a period of two years (Interv. **3**, p. 83, 8) object relations appeared primarily to take the form of projective identification without the benefit of being mediated by an interpreting „I' (Ogden, 1986), psychological boundaries between the therapist and her patient/relative apparently blurred. This rendered the patient vulnerable to being unconsciously used as an idealised part-object by the therapist to re-establish a sense of familial intimacy and to assuage seemingly unresolved childhood feelings pertaining to death, loss and family dispersal:

> *... was there a kind of interest that I would like to see her* ***because*** *she is my [relative] ... there's still a connect, a connectiveness which happens when I hear about these [family] things and so* ***perhaps*** *unconsciously there was another dimension that I would've wanted to see her* ***because*** *she was my family, you know, and that saying to her I've got to refer you to someone else would've meant I'd lost that connection (Interv.* ***3****, p. 101, 33-43).*

The fourth example involves the seeming failure to translate into practice the declared commitment to self-awareness and to the ideal of confronting the emotional truth of "who we are in relationship together" (Interv. **4**, p. 124, 3-5). In the context of sharing a closed therapeutic group in the posttermination phase of a nearly two year dual role relationship, the role reversal between the therapist and his ex-patient appeared to result in a diminution of psychological boundaries and self-other differentiation. The final extract suggests that the ex-patient, once the client and now the idealised healer, became the unwitting container for his therapist's projections and assumed the burden of caring for his former caregiver:

> *So now [the patient] was ... a member of a support ... group that I was also a member of ... the rules of psychoanalysis say that you shouldn't do that because ... it complicates things and da da da he's going to witness me going into process and witness me self-disclosing and it's going to damage the transference. Um now this guy was my patient for nearly two years in a psychoanalytic therapy ... and he's seen me in the most vulnerable of spaces, he's seen me in inverted commas „as a patient' being processed by others (Interv. **4**, p. 127, 43-44; p. 128, 11-25).*

5. SUMMARY

Research participants readily identified an array of twelve aspirational ethical principles and standards which guided their daily professional practices. These consisted of four overarching ethical principles and eight related ethical standards. In apparently descending order of significance, the principles included Responsible Caring or Beneficence, Integrity, Respect for the Dignity of Persons and Nonmaleficence.

Adherence to clearly articulated avowed ethical principles often seemed to give way in the context of real-life ethical dilemmas to countertransference enactments. This suggests that efforts to resolve ethical quandaries were motivated not only by rational considerations but also by apparently unconscious determinants. Unretrieved enactments, of which the majority lasted for over a year, raise disquieting questions with regard to the unconscious role played in ethical decision-making by countertransference anxieties and self-serving therapist gratifications. The research interviews appeared on occasion to help participants to regain a reflective stance wherein renewed commitment to ethical values was demonstrated.

A striking finding was the consistent emphasis research participants placed upon the avowed ethical principle of beneficence or Responsible Caring. The latter principle was strongly endorsed by all six interviewees. This finding is congruent with the observation made by

Knapp and VandeCreek (2007) that beneficence is the principle that is most identified with health care professionals. Participants were accordingly deeply concerned with considering the best interests of the patient and with promoting the latter's emotional and psychological well-being. While the moral voice of justice and corresponding concerns with equality and fairness were evident, beneficence and Gilligan's (1982) ethic of care, which emphasises relational commitment and connectedness, appeared to characterise most accurately the perceived nature of participants' engagement with their patients and their professional work.

The principle of Responsible Caring or beneficence subsumes the ethical standards of competence and self-knowledge. Maintaining professional competence emerged as a prominent aspirational as well as a lived ethical standard. Participants' several descriptions revealed their determination to actively seek out new learning opportunities in order to increase their professional knowledge and to enhance their clinical skills. Membership of professional societies, peer consultation, additional reading as well as receiving regular supervision and/or personal therapy provided valuable post-qualifying opportunities for continued personal and professional growth. Closely allied to maintaining professional competence was the avowed ethical standard of self-knowledge. Thoughtfulness, self-awareness and consciousness were thus deemed by research participants to be integral to the therapeutic endeavour and appeared as a pervasive avowed value throughout the interview data.

The overarching ethical principle of Integrity was similarly acknowledged by all participants as an aspirational ethical guideline. While clearly reticent to openly and honestly expose their professional practices to colleagues, participants provided poignant descriptions of their avowed commitment to confronting the emotional truth of the analytic situation. In addition, participants courageously and frankly shared in the context of the research interviews several instances of exploitiveness, defensiveness and therapeutic failure. In short, Responsible Caring or beneficence and Integrity in Relationships emerged from the interview data as research participants' two dominant avowed ethical principles.

Respect for the Dignity of Persons constituted the third avowed ethical principle. Striving for therapeutic relationships which were characterised by "a spirit of respect" (Interv. **6**, p. 204, 4-10) hence comprised a core aspirational principle for four interviewees. Participants provided sensitive descriptions of the need to be mindful of, and respectful towards, patients'

emotional vulnerabilities as well as differences pertaining to the latters' age, colour, class and culture. While the importance of informed consent and respecting the autonomous decision-making ability of patients were briefly mentioned, these did not by contrast emerge in the present study as prominent avowed ethical standards.

Perhaps the most unexpected finding was the seeming lack of status accorded to the fourth ethical principle. Nonmaleficence apparently constituted the most neglected or "offended" (Knapp & VandeCreek, 2007) ethical principle, explicitly receiving only brief and passing acknowledgement from two interviewees. Earlier discussion of nonmaleficence in this chapter considered both the concept of countertransference management as well as the need to avoid multiple relationships where possible. Congruent with the minimising of nonmaleficence, the ethical obligation to avoid or to limit potential harm by managing personal countertransference was likewise explicitly acknowledged as an avowed ethical value by one participant alone. Steere (1984) claims that ethical code injunctions against dual role relationships appear to derive from the principle of nonmaleficence. Given the striking absence of countertransference management as an avowed ethical value, the avoidance of unconsciously gratifying but nonetheless unnecessary dual role relationships arguably followed suit, failing to emerge in this study as an aspirational ethical standard. This finding is of some concern since multiple relationships rank as the second most frequently reported ethical dilemma experienced by South African clinical psychologists (Pettifor & Sawchuk, 2006; Slack & Wassenaar, 1999) and since four of the seven dilemmas described in the present study involved past or current nonsexual dual role relationships.

The directive "primum non nocere" ("above all do no harm") suggests that nonmaleficence assumes a superordinate status among competing ethical principles. Knapp and VandeCreek (2007) argue that on the contrary no single ethical principle permanently retains the highest priority and that "theoretically any one may be trumped by another depending on the circumstances" (p. 399). Earlier discussion of nonmaleficence (see Chapter 2) clarified that the non-infliction of harm has by contrast been posited as the "bedrock" (Bersoff, 2003, p. 44) or governing principle of applied psychology and analytic practice (Brown, 1982; Solomon, 2003; Stokoe, 2000). What appears to emerge from the data is the relative absence of a collective recognition that the therapeutic encounter potentially mobilises the therapist's capacity for beneficence but also the latter's enduring capacity for unethical behaviour or for maleficence. As Epstein and Simon (1990) observe, therapist exploitiveness may manifest

along a continuum ranging from gross narcissism and sexual acting out to less severe countertransference gratifications including power seeking and enabling behaviours unconsciously designed to bolster therapist self-esteem.

In the context of real-life ethical dilemmas, research participants' rational consciously held avowed ethical principles repeatedly appeared to unravel under the impact of unresolved countertransference pressures. Aspirational principles and standards were thus often translated, not into congruent professional practices, but into sustained countertransference enactments involving ethically compromised behaviours. Bad practice is not about being swept up in unconscious processes, however, it is about remaining so (Stokoe, 2000). The challenge presented by the data may in part devolve on how to redress the apparent neglect of the offended moral principle of nonmaleficence. This suggests, for example, that where beneficence is presented as the primary ethical principle informing the therapist's conscious ethical choices, this does not nullify the obligation to generate "a third area of reflection" (Solomon, 2003c, p. 174) wherein to retrospectively examine repeated frame deviations from the counterpoles of nonmaleficence and personal countertransference.

Norris et al. (2003) comment that "the bad apple" paradigm hardly provides a satisfying explanatory framework whereby the phenomenon of countertransference difficulties and boundary violations is resolved through the eviction of a few anomalous "bad" individual practitioners. Such an "us-them" divide, Gabbard and Lester (1995) contend, merely functions defensively to diminish temporarily therapists' own anxieties about their potential vulnerability for countertransference enactments and boundary transgressions. Noting the shame and professional isolation that frequently surround the clinician grappling with an ethical dilemma, Levin, Furlong and O'Neil (2003) suggest that "there is clearly a lack of more general opportunities to exchange firsthand experiences in a context where colleagues can speak freely without fear of judgement" (p. 167).

What the data seemingly call for are innovative ways to reinstate nonmaleficence as arguably comprising the governing principle of analytic engagement. Foregrounding nonmaleficence may involve local forums and societies in thoughtful consideration of both principle-based ethical decision-making as well as the countertransference dimension of clinical practice. In a hopefully open and nonjudgmental manner, collegial discussion might then embrace the likelihood that common ethical dilemmas arising in the therapeutic space routinely appear to

provoke enactment phenomena and to mobilise anti-analytic countertransference impulses or desires. Discussion of the unconscious and sometimes self-serving dimension attendant upon the resolution of dilemmas may see the dismantling of the idealised notion of the professional caregiver as uniformly beneficent as well as provide a useful reminder that "the therapist's countertransference … [is] indeed … the single most important conceptual link to ethical practice" (Hewitt, 2003, p. 35).

In the light of the foregoing observations, the next chapter explores the impact of unconscious determinants and countertransference phenomena on the ethical decision-making process.

CHAPTER 6

THE COUNTERTRANSFERENCE DIMENSION OF REAL-LIFE ETHICAL DILEMMAS

1. INTRODUCTION

Research participants' subjective experiences of real-life ethical dilemmas appeared to reveal an unanticipated disjunction between espoused ethical principles and lived clinical practice. Intense countertransference affects seemingly dislodged interviewee's conscious adherence to avowed ethical principles over periods of time ranging from eight weeks to three years. Reading Guide questions elicited data pertaining not only to the fate of avowed principles but also to the impact of unresolved countertransference responses on ethical decision-making enactments. Noting the proliferation of professional literature on countertransference, Louw and Pitman (2001) observe that the final decades of the twentieth century may come to be designated as "the countertransference years" (p. 748). In this chapter, countertransference constitutes the central theoretical 'hub' from which participants' idiosyncratic responses to real-life ethical dilemmas is explored.

In the context of the emotionally charged therapeutic relationship, countertransference may be mobilised "as a virtue" but also "as a vice" (Louw and Pitman, 2001, p. 754). As discussed in earlier chapters (see Chapter 3), countertransference as a virtue encompasses the notion that the therapist's subjectivity or inner experiences may be harnessed in the service of deepening an empathic understanding of the patient's hidden internal object world (Casement, 1985; Ivey, 1992; Jacobs, 1993; Renik, 1993; Sandler, 1976). "Nudged" (Sandler, 1976) and "bullied" (Symington, 1990) by the interpersonal pressures exerted by the patient, the therapist may unwittingly find him/herself playing out a prescribed role in a potentially benign enactment scripted by the patient's internal object world. Countertransference may be considered as "a joint creation" (Gabbard, 1995) wherein the patient unconsciously seeks to actualise particular responses in the therapist but it is the latter's own pre-existing internal conflicts and self and object representations that "shape" the final countertransference outcome (Gabbard & Lester, 1995). Such benign countertransference enactments include the effort to secure, retrospectively and in collaboration with the patient, a deeper understanding of the latter's psyche rather than inappropriately gratifying the therapist's archaic needs.

Countertransference as a vice by contrast encompasses the notion that therapeutic progress ceases or is at least impeded as the therapist's unresolved emotional difficulties and "unwashed psyche" (Stein, 1984) are restimulated in the interaction with the patient. It is a distortion, Racker (1957) argues, to conceive of analysis as an "interaction between a sick person and a healthy one … it is an interaction between two personalities, in both of which the ego is under pressure … each personality has its … dependencies, anxieties, and pathological defences … and each … responds to every event of the analytic situation" (p. 162). Racker's statement suggests that the therapeutic interaction may on occasion be skewed by the therapist's unconscious exploitation of the patient; the therapeutic couple accordingly can potentially collapse into a therapeutic misalliance (Langs, 1975) or malign countertransference enactment.

A continuum may be envisaged that charts the relative contributions of the patient and of the therapist to the countertransference enactment concerned. At one end lie those enactments where the patient attempts to induce the therapist into complying with an "internal cast of characters" (Gabbard, 1994) or into actualising an internal object relation. In collaboration with the patient, the therapist optimally uses countertransference as a virtue to discover and to construct retrospectively the meaning of the enactment concerned (Gabbard, 1995; 1997). At the other end, when countertransference as a vice is mobilised, contrasting malign therapist-driven countertransference enactments may occur. Louw and Pitman (2001) add that enactments may be viewed as "acute" or "chronic", resulting from patient-centred or analyst-centred actualisations respectively. "Acute" patient-centred enactments appear less egregious and may even be helpful since the "boundary crossings" entailed are likely to constitute single incidents that are "caught" by the therapist, thought about and then interpreted or openly discussed with the patient in an attempt to advance understanding of the transference relationship (Gabbard & Lester, 1995). Chronic analyst-centred enactments, however, gratify "the analyst's personal motivation … at the expense of exploring the analysand's transference" (Louw and Pitman, 2001, p. 757). Such malign enactments characteristically include repetitive boundary violations that are neither "caught" nor brought to consciousness. The latter enactments are usually not rationally discussed with the patient or in formal supervision and they typically result in unequivocal harm being wrought to the therapeutic relationship (Anonymous, 2005; Glass, 2003; Gutheil, 2005; Gutheil & Gabbard, 1993).

The six core ethical dilemmas presented by research participants may be construed as principally involving therapist-centred ethical decision-making enactments. Examination of the data in this chapter reveals three related areas of interest. The chapter considers, firstly, the emergence of four levels of differentiation discernable in participants' capacity for thinking and ethical decision-making. Rather than privileging rational cognitions alone, the possible meanings of the bodily and visceral countertransference experiences reported by interviewees are also explored and integrated into an interpretive account of the phenomenon of ethical decision-making enactments. Potential linkages are revealed between unprocessed countertransference arousal and its impact on premature ethical decision-making as well as on enduring decision-making enactments.

The chapter examines, secondly, inner moral "voices" and research participants' subjective concerns as well as countertransference fantasies, images and metaphors. Analysis of the data suggests that participants' reported phenomenological experience provides empirical support for Day's (1991) notion of an "inner moral audience" to whom the moral agent or actor feels accountable. Thus interviewees describe a multiplicity of "voices" that comprised their "inner moral audience", including those of familiar colleagues, analysts and supervisors. Surprising conflicts, deficits and absences in the "inner audience", however, gradually become evident.

In a similar vein, Tappan (1991) writes that "authoring" an authentic moral account entails drawing on "internally persuasive discourses" or the internalised "voices" of helpful inner others which are integrated into one's own increasingly independent moral "voice" or perspective. But participants provided evidence not only of contrasting "authoritative discourses" (Tappan, 1991), which demanded unthinking obedience to statutory and legal injunctions, but also of struggling to access "internally persuasive discourses" that might have aided their "authoring" of ethically sound resolutions of the dilemmas concerned. Vivid imagery arose which depicted participants' subjective experiences of impoverished reflective spaces and the need for nonjudgemental, ethically attuned consultation or supervision was repeatedly voiced.

The chapter considers, thirdly, the relevance to ethical decision-making of the traditional wounded-healer paradigm which is reconfigured from an object relations perspective. For

the most part, the data suggest that participants were identified with a professional image of themselves as healthy, expert caregivers whose primary interest lay in healing patients' emotional wounds. Research participants' psychodynamic formulations appeared to reveal, however, the "countertransference piece that gets skipped" (Interv. **4**, p. 123, 28); hence a noticeable absence emerged regarding the therapist's acknowledgement of his/her own potential contribution to the chronic decision-making enactments. Bruising encounters with real-life ethical dilemmas and with the research interviews challenged the vulnerable image of the "healer-redeemer" (Groesbeck, 1975). Reluctant exposure of countertransference "wounds" accordingly revealed participants' feelings of anxiety, vulnerability, anger and shame. A therapist-driven countertransference enactment unexpectedly emerged in the research interview and is discussed below. This fragment seemingly supports the notion that, when real-life ethical dilemmas mobilise countertransference as a vice, the healer's idiosyncratic internal object world may become deeply implicated in the process of ethical decision-making.

The summary which concludes this chapter draws together the main findings pertaining to the three foregoing areas of interest. In particular, it is suggested that self-analysis or self-monitoring of ethical blind spots and biases comprises a contradiction and an arguably problematic practice in South Africa since no formal training in psychoanalytic psychotherapy is currently available. An alternative approach is broached which suggests that the requisite third area of reflection may be secured through regular peer supervision and consultation. Use of the wounded-healer model in postqualifying ethics training may also contribute to securing a much needed professional space wherein to implement the normative practice of examining anti-analytic impulses and interventions.

2. THE FOUR LEVELS OF ETHICAL DECISION-MAKING

The ethical demands inherent in psychotherapy cannot be resolved solely by appeal to universal ethical principles (Betan, 1997). From a hermeneutic perspective, ethical understanding and interpretation of a dilemma emerges from the dialectical movement between moral reasoning about universal ethical principles and sensitivity to the subjectivity and particular context of the individual therapist, in which each pole informs the other. Ethical judgment is accordingly not objective and value free but continues to be "subject to projections, distortions, identifications, sways and pulls" (Betan, 1977, p. 355). This theoretical acknowledgement of the centrality of the therapeutic context and of the

therapist's subjectivity paves the way for the following exploration of the impact on the individual decision-maker of powerful countertransference affects generated by real-life ethical dilemmas (Abramson, 1996).

Of particular interest are four apparent levels of differentiation discernible in participants' capacity for thinking and ethical decision-making. Distilled from examination of the ethical decision-making pathways described in the professional literature (see Chapter 3) as well as from analysis of the interview transcripts, the four levels provide an organising framework for the discussion of participants' accounts of the different elements which comprised their countertransference arousal. Bion's (1962) concept of the "container-contained", as well as Ogden's (1989) delineation of the dialectical interplay between synchronic modes of generating psychological experience, inform the following exploration of the different decision-making levels concerned.

2.1. Level I: Prereflective Identification of an Ethical Dilemma

Da Silva (in Levin et al., 2003), following Bion (1963), comments that the process of thinking commences with an emotional experience. Such experience is first registered as a bodily event before being transformed through dreams and symbol formation into thinking and meaning. The real-life dilemmas encountered by research participants appeared to be invaded by a conglomeration of apparently unprocessed feelings, fantasies, images, inner moral "voices" and unintegrated childhood memories. Britton (1992) and Wilson (2007) observe that the infant's unprocessed feelings or "Beta elements" constitute the precursors of thought and that, prior to their "sojourn" (Bion, 1962) and transformation into something more mental in the "container" of the good breast, these elements are originally near-sensory and somatic in character. Writing from a constructivist perspective, Stern (1983) argues that "unformulated material", some of which will never enter consciousness, pertains to "murky" experience which has not yet attained sufficient clarification or differentiation to allow for the application of the traditional defence mechanisms.

Data analysis revealed several striking reports by participants of visceral or somatic states which signalled the advent of the prereflective identification of the ethical dilemma concerned. Strong bodily reactions also manifested subsequently as the dilemma unfolded as well as occasionally during recall in the context of the research interviews. The latter "Beta elements" were not apparently processed and contained; they accordingly remained

untransformed "on the boundary of somatic and psychic experience, of mental and physical" (Britton, 1992, p. 105). Thus the prereflective or first level of ethical decision-making often appeared from the start to be rooted in strong countertransference arousal and physiological reactions, the psychological implications of which had not yet been cognitively grasped. In the following extract, for example, David gave the following account of his immediate ‚gut' reaction to his gay patient's disclosure of sexual involvement with a former therapist:

> ***Shock*** *....* ***Shock****. „Cause .... I'd been working with this boy for some months and I was aware that he'd had a lover and ... that he was in therapy with a [mental health practitioner]. He'd not revealed that the lover was the [practitioner] ... When he told me, I just felt* ***shock*** *... I mean, I actually felt* ***my body grow cold*** *when the two came together .... (Interv.* ***2****, p. 44, 28-39).*

When Gillian initially realised that her patient's parent was her cousin, she similarly described a powerful affective response:

> *Well, I think just when I realized that her [parent] was my cousin I felt* ***shocked****, I felt really* ***shocked*** *and I felt, gosh, you know, I must actually talk to my supervisor about this (Interv.* ***3****, p. 86, 39-41).*

In the next excerpt, Cathy recalled her first responses to anticipated social contact with the ex-patient's significant other. Behind the social veneer and the participant's overtly conciliatory attitude lay an apparent sense of threat and anxiety:

> *... it was a* ***sinking*** *feeling „cause I knew it was going to be complicated um I responded socially, saying, yes, of course, „cause I knew I needed some time to think about it ... (Interv.* ***1****, p. 12, 37-39).*

Anxiety and feelings of uncertainty signalled the start of a nonsexual dual role relationship and the "slippery slope" phenomenon (Gabbard & Lester, 1995; Glass, 2003; Gutheil & Gabbard, 1993; Simon, 1989):

> *... when [the patient] told me in the session [that he'd] registered for [my] workshop, ...* ***an alarm bell*** *went off in my head, I remember it very clearly, thinking „Oh, shit!' ... going to have this guy in my workshop now* ***and*** *he's a patient of mine ... I remember thinking that I wasn't sure what to do, like I felt unprepared for that (Interv.* ***4****, p. 134, 14-21).*

Vague feelings of uneasiness and the metaphor of an alarm bell appeared again when Theresa first confronted the prospect of a nonsexual dual role relationship in an organisational context:

> *... a little alarm bell ... went off ... around both of us ... being employed by the same organisation ... I felt **niggled** by it ... I don't think I **realized** what I was actually getting myself into, I didn't **realize** how **toxic** the situation would become, how **dangerous** it would become ... I had no idea, really, that it would become that **bad** (Interv. **6**, p. 214, 35-46).*

Grosz (1994) claims that consciousness is always corporeally constituted and that "mind … is always embodied, always based on corporeal and sensory relations" (p. 86). Day (1991) points out that, contrary to Kohlberg's assertion that cognition alone is responsible for moral action, research suggests that affect as well as cognition influences the "judgement-action" relationship and that both together combine to drive moral performance. Kitchener (1984; 1986) suggests that the strong emotional arousal that precedes reflectiveness is critical for ordinary everyday ethical decision-making and that it may indicate an intuitive level of moral reasoning or "an immediate, prereflective response to most ethical situations based on the sum of [an individual's] prior ethical knowledge and experience" (p. 44). Thus across the interviews, research participants' prereflective or ‚gut' reactions appeared to usher in the first level of ethical decision-making and to signal the original presence of the real-life dilemma concerned.

2.2. Level II: Registering Continuing Somatic or Emotional Countertransference Arousal

Da Silva (2003) suggests that we have a great reluctance to learn about ourselves and need to be reminded of Oedipus' prototypical attempt to blind himself to the unbearable truth. Similarly, Ogden (1989) comments that "Not knowing deprives us of our sense of who we are, and yet to know is to see that which we cannot bear to see" (p. 3). The second level of ethical decision-making in the therapeutic space often appears to be characterised by the need to keep unacceptable or "undigestible" thoughts and feelings out of awareness. The following five fragments provide evidence across the interviews of fears and anxieties which were not worded but which were apparently largely expelled into somatic or bodily states.

Examination of the interview data reveals that Cathy commented seventeen times on her difficulties in thinking about the triangular dynamics involved in the dilemma concerned. Over a period of eight weeks (Interv. **1**, p.8, 11-12; 30), the participant found herself grappling with feelings of confusion, acute discomfort and disappointment. The extract below however suggests a more primitive, somatically based dimension of subjective experience:

> *... but I also got **a sick feeling**, I got **a sick feeling in my stomach**, ja, about it. Um I didn't really want to think about it very much ... it felt too complicated, it felt, as I say, **this sick feeling** and the way I dealt with it (very softly) was to push it away (Interv. **1**, p.16, 17-38).*

When Riaan spoke of his repeated decisions not to follow up or to report statutory rape, "unspeakable" feelings of fear and anxiety appeared suddenly to well up and to find bodily expression in the research interview. The pain blocking Riaan's throat could be understood as somatisation of difficulties in thinking about and voicing his own as yet unheard and unprocessed story of childhood abuse:

> ***P**: I'm finding it ... anxiety provoking, this ... going back ... some of the detail has been lost [but] **the feelings** aren't lost ... This is coming up, I'm feeling, ja, just when you asked that question, I'm kind of, kind of feeling it here.*
>
> ***(Participant holds his throat)***
>
> ***R: What are you feeling in your throat?***
>
> ***P**: Ja.*
>
> ***R: What is that, that you're pointing to your throat?***
>
> ***P**: Pain ... I mean I, I should be in therapy and two weeks ago in supervision, I kind of broke down ... I grew up in a home where there was violence ... and ... the scar, in the end, hasn't gone away (Interv. **5**, p. 177, 6-36).*

"Beta elements" which are expelled into the body, perceptual sphere or action (Britton, 1992) suggest not only the absence or breakdown of a "container" (Bion, 1962) but also the related need to keep "unthinkable" emotional experience at bay or out of awareness. "Unformulated experience" or "familiar chaos", Stern (1993) comments, may constitute a state of mind that is familiar and comforting but it is potentially defensively perpetuated in the service of the wish not to think and hence not to learn. Thus Stern (1983) argues that it is phenomenologically plausible to suggest that "disturbing glimmers of meaning" (p. 92), of which we may be momentarily aware, can lead to the discarding or decaying of a disturbing thought or feeling before it is fully formed. The next fragment suggests, for example, that Cathy's earlier description of "**a sick feeling in [her] stomach**" pertains to the possible defensive somatisation of disturbing feelings and nascent thoughts. Apparently unconscious hostility directed at a former spouse of her current partner appeared to drive Cathy's premature decision to breach confidentiality regarding a patient's treatment. This unsolicited information had the effect of rendering the former spouse acutely uncomfortable:

> *But I felt that ... I'd been too unconscious and I'm not too sure what level of unconsciousness I'm talking about (laughs) ... that I'd allowed myself* ***not*** *to think about it (Interv.* ***1****, p. 10, 31-33).*

> *I wonder what the word is (pauses) because ‚dangerous' feels too, too harsh? Risky, I suppose. Risky in terms of relying on somebody out there* ***who's not even a psychologist*** *to keep the boundary safe (laughs). (Interv.* ***1****, p. 14, 22-24)*

Resistance is similarly evident in the next extracts as disquieting "glimmers of meaning" threaten to emerge into consciousness. Two participants described working with intense homoerotic transference relationships. Heimann (1960) and Sandler (1976) comment on the therapist's need for "free-floating attention" but also for a "free-floating" emotional responsiveness which facilitates attunement to the patient's unconscious communications about his/her internal object world. Common to both descriptions of homoerotic transference, however, appears to be a sense of anxiety and countertransference feelings of cautiousness or guardedness. The potential meanings of these affects were not apparently brought to conscious awareness but they found instead bodily or somatic expression. Such emotional inaccessibility may be indicative of defensive "counter-resistance" to the patient's unconscious communications (Ivey, 1999). Thus when a research participant confronted the dilemma of a gay colleague's sexual misconduct, he reported, but could not elaborate on, the potential meanings of his "decision" to carefully monitor his own physical responsiveness to young male patients:

> *... for a while I had disturbed sleep, ... felt very confused, very angry ... with that came little bits of paranoia ... looking at other therapists and wondering ... [There] was a period of a lot of caution around working with my own male child patients, ... being* ***extra careful*** *and* ***extra cautious*** *... „cause ... when you work with little children, often they'll climb on you ... there's a lot of tactile stuff going on ... a part of me ... felt an extra need to keep a boundary between myself and ... particularly boy patients, in particular ... (Interv.* ***2****, p. 39, 5-18).*

Despite her gay patient's expressed desire to terminate and repeated attempts "to sabotage" the therapeutic space, Theresa acknowledged that she had nevertheless made the apparently paradoxical decision "to promote" and "to push" for continuation of the therapy (Interv. **6**, p. 207, 50-51). This unretrieved enactment was characterised by inhibited countertransference responses of guardedness and of marked bodily reactions to the patient's sexually charged overtures:

> *... I had ... strong bodily reactions ... I would feel ... almost like the hair on my back lift .... I'd become increasingly* ***on guard*** *around ... attempts to*

> *expose me ... She'd actually say "What's **your** girlfriend's name?" ... moments like that where ... I would ... get ... a strong physical reaction as if my body was saying **don't invade, don't, don't do that!** (Interv. **6**, p. 213, 41-48; p. 214, 1-14).*

Meissner (1994) comments that the conscious and unconscious dimensions of psychic life are mutually implicative and take place simultaneously. In relation to ethical decision-making, Meissner (1994) asks whether "ethical reflection [can] run its course without any regard for the unconscious determinants … that dog its footsteps stride for stride?" (p. 470). In short, the preceding five fragments suggest that ethical decision-making at the second level may often be defensively organized around the need to keep Meissner's (1994) "unconscious determinants" or Stern's (1983) disturbing "glimmers of meaning" from emerging into conscious awareness.

2.3. Level III: Naming Countertransference Arousal

At the next and third level, whilst unconscious determinants apparently remained outside awareness, some elements of countertransference arousal were retrospectively identified and brought to language. In the following extracts, for example, Patrick spoke of the anxieties and fears that had surrounded his „decision' to continue to engage with a nonsexual dual role relationship:

> *... we continued to work in the therapy and have this contact outside and it was tremen... very anxiety provoking for me and I felt like if, if I was **found out**, so to speak, that I was having this dual relationship ... that I'd be, in inverted commas, "in trouble" ... (Interv. **4**, p. 126, 22-25).*

> *I was aware that there weren't any (pauses) legal or (pauses) Board boundaries that I was breaking ... although initially I wondered if I was and I had a lot of fear around that initially ... (Interv. **4**, p. 132, 2-6).*

When Gillian accepted her family member as a new patient, she noted that "questions of countertransference" were not thought about much either by herself or by the supervisor concerned (Interv. **3**, p. 103, 41-44). Yet talking about the ethical dilemma in the research interview evoked tearful behaviour and, as the following fragment shows, stimulated feelings of sadness and loss:

> *... it brings up feelings of feeling sad about our family in a way being separated and my sibs being far away and just a loss of an incredibly intense experience with that side of the family when I was young ... (Interv. **3**, p. 90, 46-48).*

While different affective responses were identified at this third level, the unconscious determinants driving the premature „decisions' to accept, and then to continue, with a non-sexual dual role relationship appeared to remain outside conscious awareness. In a context where the therapist had suffered personal deprivation and family breakdown, consistent contact with the patient/family member appeared to secure a gratifying "link" (Interv. **3**, p.81, 1-7) to memories of emotionally supportive childhood figures and places. The following extract, one of many interview texts, emerged from Gillian's exploration of a family matrix shared by therapist and patient alike. It is situated in the context of a long vanished family farm; feelings of sadness are again articulated and a sense of yearning is voiced for a childhood space symbolic of freedom, emotional nurturance and aliveness:

> *... it was a very beautiful, amazing place [with] a sense of incredible freedom ... they were very happy moments for me ... in a context of my own childhood, which wasn't very happy ... I think .... what comes up is sadness ... for loss of ... a kind of innocent ... space ... and the memories of these ... young sons who ... looked after me, ... so in the dark ... when I was afraid ... one would come with a candle ... but there is a sense of loss „œos that part of my life has gone (Interv. **3**, p. 82, 1-21).*

One striking aspect of premature ethical decision-making was the unexpected appearance in three of the dilemmas involving nonsexual dual role relationships of the "slippery slope" phenomenon with its characteristic repetition of boundary violations. Gabbard and Lester (1995) caution that the dynamics of nonsexual boundary violations frequently resemble those of sexual boundary transgressions since a gradual escalation from minor irregularities to more seriously exploitative behaviour is likely to occur in both contexts. Later interpersonal boundary transgressions, Gabbard and Lester (1995) suggest, are the expression of an earlier erosion of inner boundaries between self and object representations. The therapist may thus gradually come to consider the idealised patient as "a soul mate" and the therapeutic relationship as capable of generating a perfect understanding between its two members. These observations appear to be borne out by the following examples:

> *I don't think that I realised how ... **radical** ... this sort of dilemma was that I negotiated ... how successful it was ... it didn't all happen at once, it was a slow process ... it **slowly** occurred over time. It wasn't like this **sudden** dual relationship ... it was a process over two years, fortunately it was like that because it, it allowed for a lot of time for **adjusting** and working through, imagine if one had to **suddenly** do that, it would be overwhelming ... (Interv. **4**, p. 129, 22-31).*

Descent down the "slippery slope" apparently to culminated in a relationship which saw the final erosion of inner, interpersonal and therapeutic boundaries:

> *... our relationship is definitely one in which (pauses) we should honour the contact we've had together, we shouldn't separate ... It's much deeper than that ... So we've become very good friends ... he ... came to my [celebration] and he ... was with us on holiday, ... we had coffee, we're mates, we're friends (Interv.* ***4****, p. 128, 15-21).*

Previous discussion of ethical decision-making pathways (see Chapter 3) suggested that ethical dilemmas arising in the therapeutic space often evoke the analyst's own unresolved "narrow countertransference" responses. Unexamined countertransference anxieties may find disruptive and repeated behavioural expression in ethical decision-making enactments. Since the latter enactments are not subjected to post-enactment scrutiny, the risk of harmful consequences to the patient is arguably heightened. Relating these theoretical ideas to real-life dilemmas, the data in this chapter suggests that prereflective somatically based countertransference arousal may often accompany the earlier phases of the ethical decision-making process. Given that the paranoid-schizoid mode seemingly predominates, defensive strategies are apparently organised around the need to keep disturbing thoughts and feelings out of conscious awareness. At these earlier levels of decision-making, the data accordingly suggest that interviewees' thinking often appears to reveal the relative absence of an interpreting subject who experiences guilt and concern and who can reflectively mediate between themselves and their experience (Ogden, 1989).

2.4. Level IV: Recovery of Reflective Space and Thoughtful Ethical Decision-Making

While numerous examples of depressive position functioning were evident across the interviews, only two appeared to connote the fourth and advanced level of ethical decision-making. Partial insight into Meissner's (1994) "unconscious determinants" was accordingly achieved. In contrast with the three preceding levels of decision-making, the context of the research interview appeared to have inadvertently provided "a third area of reflection" (Solomon, 2003c, p. 174). Thus in-depth exploration of the dynamics of a nonsexual dual role relationship apparently facilitated fleeting recognition and formulation of the possibility that Gillian's original decision to enter into a therapeutic relationship with her relative was organised by the hitherto unconscious need to circumvent the threatened loss of yet another family fragment:

> *... and so perhaps unconsciously there was another dimension that I would've wanted to see her* ***because*** *she was my family ... and that saying to her I've got to refer you to someone else would have meant I'd have* ***lost*** *that connection (Interv.* ***3****, p. 101, 40-43).*

Analysis of the text suggests that what apparently could not be fully apprehended was the ongoing impact on the transference-countertransference relationship of the therapist's unconscious attempts to ward off depressive pain pertaining to loss, family dispersal, death and the process of mourning. The sustained "decision" to continue to treat a family member can therefore be understood as an unretrieved principally therapist-driven ethical decision-making enactment. The latter enactment appeared to comprise a repeated unconscious attempt to re-unite not only the fragmented family unit externally but also to cohere split or fragmented aspects of an internal object world.

Similarly, while exploring his decisions not to follow up or to report the statutory rape of a minor, Riaan expressed guilt in relation to his young patient and commented on a previously unconscious identification with an overwhelmed, passive parental part-object representation that had failed to care for him:

> *... while we were talking now, this previous hour, I thought about ... two things ... it doesn't help to report and ... the other one was ... a kind of guilt, ja, well, you're doing the same ... I mean I* ***didn't think*** *it at the time but ... ja, you're an adult now, it's safe for you ... I'm just wondering whether the fact that I didn't [report] was about ... doing the same as people might have done when I was in that position myself or similar position myself (Interv.* ***5****, p. 188, 44-48; p. 189, 1-8).*

In relation to the final ethical decision-making pathway discussed earlier (see Chapter 3), the foregoing two extracts are similarly distinguished by the therapist's renewed thoughtfulness and by his/her willingness to submit disturbing countertransference affects to post-enactment scrutiny. This arguably mature level of decision-making is characterised by Britton's (1998) critical third position where it becomes possible to tolerate object relationships not only as a participant but as an observer and as a witness. What distinguishes these extracts is participants' passing experience of themselves not as objects "buffeted" by thoughts, feelings and perceptions but as interpreting subjects who can, if only briefly, mediate between themselves and their experience and who clearly assume responsibility for their psychological actions (Ogden, 1989). The emergence of Stern's (1983) "glimmers of meaning" and insight into possible linkages between participants' ethical decision-making and their personal countertransference appears however to have been rapidly disestablished. The following fragment provides an example of how an advanced phase of ethical reflection may be succeeded by the re-emergence of paranoid-schizoid functioning:

> *[There's] ... **anxiety** around information getting out .... how many mental healthcare professionals are working in these sort of settings? ... the other thing is that [the research interviews have] evoked a lot of emotion around that case ... it's ... highlighted a sense of being **alone** out there ... it's too big for me, it just feels, now, so what? ... I can't take it to supervision „œause I don't have time there for **this** ... old case or emotions ... and I'm not in therapy ... (Interv. **5**, p. 194, 1-19).*

Bion (1963) and Ogden (1989) emphasise the continuous oscillation or dialectical movement between different modes of generating psychological experience where "Each mode creates, preserves and negates the other" (Ogden, 1989, p. 4). By contrast, ethical decision-making models often seem to be portrayed in the professional literature as characterised primarily by depressive position functioning and by linear thinking which proceeds through a series of well-defined steps of ethical analysis (Betan, 1997; Day, 1991). Yet examination of the data suggests that the four levels of ethical decision-making did not unfold in an orderly sequential pattern. Each dilemma appeared rather to encompass not a single but a series of overlapping acts of ethical decision-making. Participants' descriptions of their struggles with real-life dilemmas provided strong evidence across the interviews of multiple shifts between the paranoid-schizoid and depressive positions. While the original process of decision-making appeared to transpire in the absence of a "third area of reflection" (Solomon, 2003c, p. 174) and in a predominantly paranoid-schizoid mode, Ogden (1989) observes that no one position can exist independently or is permanently foregrounded in the dialectical and synchronic interplay between the different modes of generating experience. Thus, for example, depressive position functioning and the phase of mature ethical decision-making temporarily emerged through the medium of the research interview which seemingly provided "the creative potential of the third, whether a third person, a third position or a third dimension" (Solomon, 2003c, p. 169). Unprocessed new anxieties, however, soon followed and saw the disestablishment of this third area of reflection and the emergence once again of the paranoid-schizoid functioning that was characteristic of earlier phases of decision-making.

3. COUNTERTRANSFERENCE FANTASIES, IMAGES, MORAL VOICES AND SUBJECTIVE CONCERNS

Although one or other psychological mode may temporarily predominate, the autistic-contiguous, paranoid-schizoid and depressive positions are all present in every facet of human experience (Ogden 1989). Rich descriptive accounts of inner moral "voices", countertransference fantasies, images and participants' subjective concerns helped to clarify

which mode appeared to be foregrounded at different points in the interview texts, stimulating consideration of possible factors which facilitated shifts from one mode to another.

Characteristic of the paranoid-schizoid position are splitting, projective identification and the related effort to secure safety "by separating the endangered from the endangering" (Ogden, 1989, p. 22). Thus positive self and object representations are rendered discontinuous and kept safely separate from contamination by their negative and endangering counterparts (Gabbard, 1989; Ogden, 1986). As a consequence of the evacuation of bad or aggressive parts of the self or internal objects into an external object, which is subsequently experienced as persecutory, the leading anxiety is paranoid and preoccupation is with the survival of the self (Rosenfeld, 1988).

The following descriptions highlight the apparently threatening psychological terrain in which countertransference fantasies, images and inner "voices" were frequently situated. These descriptions suggest that the paranoid-schizoid mode predominated and that projective identification conceived of as an interpersonal elaboration of an intrapsychic splitting process (Bion, 1962; Ivey, 2004; Ogden, 1986) was instrumental in generating the often persecutory context in which the dilemmas unfolded:

> *[there] is a sense of ... **mistrusting my patient** ... part of my fear ... was that somehow he could entrap me in a similar [sexual] dynamic ... that was the intensity of the paranoia, I suppose, that was floating around, in the whole dilemma ... (Interv. **2**, p. 49, 50; p. 50, 9-11).*
>
> *... if you have a child patient who's wanting to stick a knife in, you're not saying something around how you think he feels or ... what his object relations are, you have to say, **no**, you are **not** sticking a knife into **me**! (Interv. **2**, p. 50, 26-29).*
>
> *... there were a lot of paranoid elements ... it was very persecutory ... psychically speaking, there was a lot of **danger**, predatory danger, should my patient launch a full-on attack ... and make a complaint ... essentially like fuck [the practitioner] up and have him struck off the roll ... (Interv. **2**, p. 62, 12-15).*

3.1. The Inner Moral Audience and its Many Voices

Day (1991) writes that narratives or stories about ethical dilemmas typically unfold before the subject's "inner moral audience" whose „members' are crucial to decision-making or to the mediation of the "judgment-action" relationship. The moral actor thus always holds

him/herself accountable to exemplary inner presences which comprise the "inner audience" and which could include, for example, deceased others, family members, work associates or even literary characters. The moral actor "rehearses" and explains anticipated courses of action before the watchful but supportive gaze of the "inner audience" in order to effect judgment and to discern more accurately the sense or meanings anticipated ethical actions might hold. Rehearsing his/her understanding of the dilemma before these influential inner figures also allows the moral actor "to recruit" from them additional meanings and interpretations pertaining to potential actions and to resolution of the dilemma concerned. The course of action finally adopted is consistent with and guided by the moral perspective and standards of the "inner audience" which the subject seeks to uphold. Judgment and action, argues Day (1991), are brought together through the act of narration and "produce a psychological house in which [the moral actor] can dwell" (p. 33).

What is not considered in Day's account of what may be construed as an elaboration of the ego ideal, are the possible unconscious presences or "superego lacunae" (Meissner, 1994) that inhabit the "inner audience" and that may in part be responsible for the self-interested "judgment-action" discontinuities discussed in previous chapters. Thus not all inner presences are necessarily benign or supportive. The following fragment, for example, provides an intriguing window onto Cathy's "rehearsal" of alternative courses of action before an "inner moral audience" comprised of "Lynn" and "Nadine" - two internal "colleagues". The insinuating "non-therapist" (Interv. **1**, p. 14, 13) voice of "Nadine" urges the easy (and ethical) way out of a looming dual role relationship:

> *… if I consulted **Lynn** she would tell me one thing but if I consulted **Nadine** she would tell me the other and Lynn, I thought, would say **most definitely not**, you must not see this [patient's] father [at dinner] and … Nadine would say, you've a different name from your practice, I practice under my maiden name … so the father wouldn't make the link anyway and um I could have dinner and nobody would be any the wiser (Interv. **1**, p. 8, 15-21).*

Discussion in the previous chapter of "Avowed vs Lived Values" saw the emergence from the interview texts of the two moral voices of justice and care. Brown, Debold, Tappan and Gilligan (1991) write that use of the Reading Guide facilitates "a polyphonic view" of interview texts; hence the researcher's multiple readings of the data each "amplifies" different voices and perspectives implicit in the moral conflict concerned. Application of the Reading Guide to the interview transcripts accordingly appeared to reveal the presence

of a multiplicity of unprocessed "voices" and "hundreds" of stories (Interv. **5**, p. 181, 2) that suffused the body of text. Some "voices" were harsh and condemnatory, others muted, silenced or even noticeably absent. Commenting on Freud's notion that the rightness or wrongness of behaviour is governed by two regulatory systems, Solomon (2003a) writes that the superego pertains to prohibited behaviour and to "the internalisation of (usually) the parental figures representing power and authority and capable of evoking in talionic ways such affects as shame, humiliation, the fear of revenge, and the desire for triumph" (p. 22). By contrast, the ego ideal is "based on agapaic emotions such as empathic guilt and the wish to preserve and identify with the internalised good parents" (Solomon, 2003a, p. 22). This suggests that the paranoid-schizoid position may be envisaged as operating according to talionic principles whereas the depressive position sees the emergence of agapaic responses as evidenced by the subject's capacity for guilt, concern and reparation.

Foregrounded in the inner cacophony reported by research participants were aggressive superego voices, "flogging" and "kicking" (Interv. **1**, p. 10, 16-19; p. 14, 13-16) the violating and "sinning self" (Meissner, 1994). Such persecutory superego voices may be considered as derived partly from participants' own projected aggression and partly from identification with hostile part-object representations based on the internalisation of external parental figures or surrogates present in the latter's interpersonal world. Participants' emotionally charged relationships to these inner judging and judgmental voices revealed an array of remorseful, fearful, rebellious or distancing attitudes:

> *It's … the **voice** of the … pure analysts who would be **appalled** … those voices … [said] **this is outrageous, what are you doing? You should know that this is not appropriate!** But those voices didn't have any advice … it was more a judgment of what they observed rather than actually being helpful in terms of how to proceed … So it was about **how could you … how could you have allowed this to start in the first place?** … when I speak of … those critical analysts, I'm amused because … I don't really identify personally with those voices (Interv. **6**, p. 229, 39-46; p. 230, 1-4).*
>
> *… at the end … I kind of felt … an internal kick, it was you **haven't** thought about it enough, you **haven't** put enough energy into it … **you idiot therapist**! … **you're not good enough**! (Interv. **1**, p. 10, 17-18; p. 12, 9-10).*
>
> *… the group keeps everybody in order … there are voices … which will say **don't** step out of line … **if** you step out of line, you'll be punished … excommunicated in some way (Interv. **2**, p. 31, 4-7).*
>
> *… there's a … very … **oppressive** … superego voice that's alive … which is about … saying … you're wrong, you're breaking the rules, you shouldn't*

> *have extra-therapeutic contact with your patients, what you're doing is bad, is dangerous … My feeling now is … I don't really care about that voice and would be … open to **publicly** challenging [it] … The thing is … it's not really a public thing, it's more, it's more fantasy based (Interv. **4**, p. 132, 16-26).*

The real-life ethical dilemmas encountered by participants appeared to evoke an "inner moral audience" included not only frankly unethical interjections and punitive superego tones but also unintegrated or silenced child-like voices. Potential linkages between current ethical decision-making and unprocessed anxieties pertaining to participants' internal object worlds thus appear in the following three fragments. Reflecting retrospectively that she had not perhaps sufficiently thought for herself in deciding whether to see her relative as a patient but had prematurely accepted the supervisor's reassurance that countertransference issues seemed of little concern, Gillian revealed her anxiety with respect to the disjunction between the child-like, overwhelmed voice of her subjective self and the contrasting adult demands of her professional role:

> *… maybe it's **my** sense of myself as someone who's taken a long time to own myself as a professional … maybe always feeling … I'm the youngest in the family, I'm the baby of the family, my feelings don't count, my thoughts don't count … So I'm not important enough … to be in a profession … not ever believing that I'm big enough to be really grown up and do those big things … So it's like taking on serious responsibilities … and I think that connects … with am I **really** a psychologist, am I **really**, is this **real**, can I charge full rates … and are people going to pay me … ? (Interv. **3**, p. 99, 35-40; p.100, 8-32).*

Riaan similarly referred to his silenced childhood voice in the context of family violence. Anxiety was expressed that revived childhood feelings of trauma stirred by professional engagement with statutory rape had led to "decisions" not to report the rape concerned and to Riaan's own unconscious silencing of any further patient disclosures of sexual abuse:

> *… my own experiences were, (pauses) were also unheard and … that's why it was maybe easier for the child [patient] to relate to that part of me that really understood about having a story, having something to talk about, having not been heard (Interv. **5**, p. 188, 9-12).*

> *That case **did** have a negative impact on me. (Sighs) I haven't thought about it before … but I think … I had **far** more disclosure of sexual trauma **before** that than I have had since then. Again, it could be part of unconscious communication … I don't know and I hope it isn't … **I don't want to go there**, ja, and I don't know whether that's been communicated … (Interv. **5**, p. 193, 26-36).*

Although not a focus of the present research study, of interest are research participants' reports of patients' implicit or explicit voices. The first excerpt below suggests that the patient's previously unheard stories appeared to find an empathic listener in the participant concerned. Embroiled in dual role relationships, patients alternatively expressed their apparent excitement or their unease through faint protest and silence:

> *… her story hadn't been told and it … oozed down to … a whole range of* ***severe*** *somatic complaints … and I felt … that's what I'd done for her, there'd been … somebody who'd listened and somebody who believed her story and if that's the only thing that I was able to do for her then I think it was worth our encounter (Interv.* ***5****, p. 178, 37-45).*
>
> *I saw you at the meeting last night … you're very different [there] … to the way you're in the therapy room … it was quite uncomfortable seeing you because I didn't know how to be around you (Interv.* ***4****, p. 137, 41-44).*
>
> *And then I went back to the therapy and I said to [the patient] … I've realised that we are in fact … cousins … I don't remember her evidencing … surprise or that much interest (Interv.* ***3****, p. 95, 33-35).*
>
> *And [the patient] said I wanna go into that group, I like … in that group, which was my group.* ***You*** *have been* ***absolutely instrumental*** *in the … changes … going on for me, you're my therapist …* ***why*** *would you not want to be in a group with me and … I couldn't answer that question other than … the rules of psychoanalysis say … da, da, da … it's going to damage the transference (Interv.* ***4****, p 128, 1-13).*

3.2. Authoritative and Internally Persuasive Discourses

Bakhtin (1981, in Tappan, 1991) argues that the process of "authoring" or claiming authority and responsibility for one's moral thoughts, feelings and actions derives originally from the internalisation of words, voices and forms of discourse to which an individual is exposed in the course of development. Preserved in the psyche, these inner voices engage in constant dialogue with one another. Two primary types of discourse may be distinguished and their relative prominence in narratives of moral dilemmas calibrates the degree to which an individual claims moral authority for what he/she says and does. "**Authoritative discourse**", says Bakhtin (1981, in Tappan, 1991) is "the word of the fathers" (p. 342); it cannot be doubted or challenged and it demands our unconditional allegiance. By contrast, "**internally persuasive discourse**" is comprised of the process whereby the inner dialogue between different voices is increasingly integrated and retold in the subject's own emerging and independent voice. The development of "moral authority" accordingly entails

appropriating, transforming and "populating" the words and voices of inner others with one's own "accents" and intentions.

Examples of "authoritative discourse" emerged in the following three excerpts. Commenting on the code of ethics to which he had been exposed as a postgraduate student, David suggests in the first excerpt suggests that obedience and strict adherence to "the rules" concerned had not necessarily fostered independent thinking or "internally persuasive discourse". Instead the "authoritative" word of the Professional Board for Psychology had been accepted as "a name that must not be taken in vain" (p. 342):

> *... the Psychology Board and Health Professions Council, their rules of ethics hung over as the grand daddy of behave yourself, and it was just accepted that you go and read that and you obey those rules ... And no one realised that ... creating a culture of ethics was not about reading the riot act, it was actually about engendering a way of thinking about what's right ... why it's not a good thing to breach boundaries, what that means ... for your patient (Interv.* ***2****, p. 31, 35-41).*

The second excerpt provides an example where "authoritative discourse" appears to have exacted the research participant's unquestioning allegiance without either evoking the desire "to understand the reasoning behind the rules" (Allphin, 2005, p. 44) or eliciting the altruistic concern for the harm the patient may have suffered that is characteristic of an ethical attitude (Solomon, 2003b):

> *Well ... I have not ...* ***ever*** *thought that I was breaking a code in terms of the Professional Board that would ... endanger my registration ... but if I thought that ... this was a rule that was part of being registered as a psychologist ... then I wouldn't have done it ... because ... I'm not prepared to put my livelihood at risk (Interv.* ***4****, p. 149, 14-23).*

Gillian's supervisor considered that the family matrix shared by the patient and the therapist was physically and emotionally distant enough not to impinge on therapeutic progress. Gillian's response in the fourth excerpt provides a sobering example of lived allegiance to "authoritative discourse":

> *... but, ja, ,I mean I think that I do tend to ... go, go with the authoritarian or the authority which was like, Ray, my first supervisor, in this case, it's okay (Interv.* ***3****, p. 103, 41-43).*

While principle ethics traditionally focuses on ethical choices and actions and on the question „What ought I to do?', virtue ethics concentrates on the ethical agent or actor and on the question of „Who shall I be?' (Jordan & Meara, 1990). Yet these approaches are not

mutually exclusive but exist rather in "mutual symbiosis" (Jordan & Meara, 1990, p. 109). Applying ethical principles appears to presuppose traditional virtues including, for example, the capacity for courage, prudence (or the ability to reason wisely) and integrity (or the consistent commitment to moral principles even under adverse conditions). "Virtuous" practitioners on the other hand may equally deploy principles and standards to illuminate the process of ethical decision-making and action (Kitchener, 2000). The five fragments below suggest that research participants' subjective concerns embraced both questions concerned:

> *I sat with [the dilemma] … I sat with it for about four days and then said to my [partner] there is a boundary issue and I don't know what to do about it (Interv.* ***1****, p. 13, 1-3).*
>
> *… this one … I was faced with my own professional dilemma, do I need to respond? Do I, you know, it's a colleague, do I need to do something? Never mind the patient, is it right that I say something? (Interv.* ***2****, p. 39, 40-42).*
>
> *And so I … was very thrown … and didn't quite know what to do (Interv.* ***3****, p. 79, 17-18).*
>
> *… this driving force of is this the best thing? Is this the right thing? Is this a useful thing? That … continuous questioning … would be the link to my … ethical consciousness … these multiple role moments … would throw out the question … and I would go again in my head, is this actually okay? (Interv.* ***6****, p. 227, 37-48; p. 228, 1-2).*
>
> *… my mind was going, sort of racing all over the place … is this legal? Is it illegal? Is it sex? Is it just fun? … What do I do? (Interv.* ***5****, p. 176, 6-9).*
>
> *… my strongest fantasy was … actually a confrontation with [the abuser] in the Psychoanalytic Society … And* ***somewhere*** *in that confrontation… somebody came up in my fantasy as one of the visiting analysts, who would cast some thoughtfulness and wisdom, like an older person who would take it over, so I would have some release and say, okay, now it's in the parents' [hands] … to, to take the burden away from me about what to do (Interv.* ***2****, p. 41, 28-38).*

Research participants' subjective concerns seemed to highlight the apparent paucity of ethically significant "internally persuasive discourses". At the time of the research interviews in 2003, for example, not one participant possessed or had read the *South African Ethical Code for Professional Conduct* (2002) for psychologists. Hewitt (2003) contends that the therapist's countertransference constitutes "the single most important conceptual link to ethical practice" (p. 35). Yet no current supervisor or personal therapist had

apparently explicitly raised any "voice" pertaining to the ethical as opposed to the theoretical dimensions of participants' countertransference responses to the dilemmas which had confronted them. Exploring the inner "voices" she had drawn on to help her through a real-life dilemma, Theresa, for example, made the following discovery:

> *I don't know, I don't remember learning about that, I can't say that there's a specific voice when it comes to that … I can't say that I have* ***any voice*** *around multiple roles (Interv.* ***6****, p. 225, 39-46).*

Authoring an authentic moral account or perspective presupposes dialogue not only with "internally persuasive discourses" but also a relational context with an empathic external other (Tappan, 1991). For Solomon (2003c), it is particularly the third person of the supervisor who helps to restore the therapist's capacity for thoughtfulness through the former's active provision of a third area of reflection. Hence Solomon (2003c) writes that the manifestation of Britton's (1998) "triangular psychic space", a third position in mental space, "is quintessentially present in the supervisory or consultative relationship. Here, two people, the analyst and the supervisor, are linked in relation to a third, the patient" (p. 173).

Through the provision in supervision of a third area of reflection, supervisor and supervisee may work together to integrate possibly conflictual inner moral "voices" created by, for example, psychoanalytic theory, codes of ethics, legal constraints or unethical interjections derived from the therapist's unconscious aggression or narcissism. When internalised as a thoughtful, benevolent member of the "inner moral audience", the supervisor may both provide an ethically attuned inner voice as well as potentially modifying the shaming superego, which appeared at least partially responsible for the abrasive denting of participants' professional self-esteem and which was often apparently projected onto colleagues and professional societies. Internalisation of such a benevolent object may constitute one core component in the evolution of a morality dominated not by threat and the talion principle but by parental prohibitions experienced as "protective caretaking injunctions that provide safety in the face of potential object-related dangers" (Ogden, 1986, p. 97).

The issue of professional resources is addressed in detail in a later chapter. At this stage of interest is that not only did participants appear to struggle to locate helpful "internally persuasive discourses" but they also apparently identified an absence of ethically attuned

external professional spaces capable of providing a sustained third area of reflection. This seemingly unmet need emerges in the following extracts:

> *... it's occurring to me ... how helpful it would've been to have ... somebody to go through, in this kind of detail ... all the bits and pieces ... at that time ... which I realize I missed, it would've been nice to do that (Interv.* ***2****, p. 46, 43-44; p. 47, 1-3).*

> *... [the research interview] has opened up ... different dimensions which I hadn't really thought about ... in terms of unconscious motivations and ... unconscious kinds of hindrances to the process (Interv.* ***3****, p. 108, 47-48; p. 109, 1-2).*

> *... it was interesting ... to reflect on [the dilemma] ... so I hadn't really done that before, like this (Interv.* ***4****, p. 136, 31-32).*

> *... but the biggest mistake was that I didn't actually consult anybody ...my level of discomfort was very ... high ... and in that 'high' I should've reflected ... that I was feeling very uncomfortable and* ***that*** *would have been an indication that I [should] confer with somebody ... there would've been a sense that I was sharing it, I wasn't holding it on my own (Interv.* ***1****, p. 9, 41-42; p. 22, 12-24).*

> *... through your questioning ... I've had to think about certain things and ... things feel clearer for me ... at times, ... I felt quite anxious ... I came away feeling* ***rattled****, oh, shooh, revisiting all that stuff and „mess'! So, it's been varied but, ultimately, useful (Interv.* ***6****, p. 235, 10-17).*

3.3. Fantasies, Images and Metaphors

Vivid fantasies, images and metaphors arose in the descriptions provided by interviewees of their grappling to resolve real-life dilemmas. These often seemed to be suffused with a sense of threat and persecutory anxiety, suggesting once again that for the most part the paranoid-schizoid mode continued to prevail across the body of text. Evidence for the latter observations is apparently provided by the excerpts below. One research participant breached confidentiality to a patient's significant other, "loading" the latter with an "awkward" and "difficult" situation. Apparent projection of an aggressive self representation generated the following fantasy in which the significant other, like a retaliatory "amoeba", threatened to spread incriminating information about this frame break and to expose the interviewee as a deficient professional:

> *... there was an awkwardness about ... having loaded this onto Heather ... I particularly like her ... and ... putting her in a difficult situation,* ***that*** *was the initial difficulty. Then I started realising that ... it could become like this growing amoeba (laughs), with this spreading out with everybody knowing about the therapy ... (Interv.* ***1****, p. 21, 10-18).*

> *... I wasn't ... in control anymore. I have this image of this amoeba growing, growing, growing ... that was the fantasy (Interv. **1**, p. 12, 1-3).*

Exploring the sexual abuse of a gay patient by his former therapist, the participant's image of a snail's feeler connotes the acute anxiety and feeling of being endangered that suddenly suffused the supervisory space:

> *... the supervision almost felt like a, like a, like a snail's feeler, when you touch it, it recoils, that **the vibe** in the supervision became suddenly very tentative ... very cautious ... very careful, as if **both of us** were ... touching something quite dangerous and without the courage to go to the edge of what needed to be thought about, of what needed to be dealt with (Interv. **2**, p. 52, 37-45; p. 53, 1-2).*

Feeling menaced by "the war zone" which surrounded him, Riaan elaborated on possibly realistic fears of gang retaliation (Interv. **5**, p. 170, 26-31). Fantasies also emerged of violent attacks perpetrated against family members (Interv. **5**, p. 176, 17-20) or against himself by child patients who would in the future reappear as retaliatory adults threatening legal action:

> *... one of the fantasies ... was that ... [the patient] was traumatised and it had an impact on her ... adult life, that (sighs) ... she could then take legal action against me for having not ... supported her the whole way (Interv. **5**, p. 174, 28-31).*

Defensive splitting in the next two excerpts appears to have effected a separation between devalued and idealised sets of object relationships. Thus the following fantasy reveals the feared presence of "the psychoanalytic police", a projected and endangering part-object representation, that appears intent on punishing and shaming the fearful self who has concealed his rebellious transgressions of the psychoanalytic frame:

> *I'd a lot of fear ... I had fantasies that I was going to get ... „foundout' by the '**psychoanalytic police**' and I'd be shamed or ostracised or frowned upon ... like in conversation with members of the [Psychoanalytic] Society ... I would want to say something and then ... I'd choose not to because I'd think whoah! ... I'd better not say anything „cause I'd be afraid of the judgments (Interv. **4**, p. 131, 42; p. 132, 1-34).*

Juxtaposed against this negative set of self and object representations were the participant's references to exclusively male fraternities, including Organisation B, a potentially idealised paternal part object representation that offered apparently unique opportunities for male mentorship (Interv. **4**, p. 140, 24-29; p. 142, 11-26). The organisation was ostensibly charged with the spiritual mission of reclaiming "the sacred masculine" (Interv. **4**, p. 125, 10) in contemporary times:

> *The most support I got was from **non-psychologists** ... more **spiritual** people who were saying, listen, the work that you're doing ... in Organisation B ... is **bigger** than you ... **beyond** you ... you're, you're a channel of consciousness that is hungry to be born and ... even if you wanted to, you couldn't stop this ... the psychoanalytic model is **too small** for what you're doing (Interv. **4**, p. 133, 25-34).*

Key to processing the disturbing countertransference anxieties that may emerge in the wake of an ethical dilemma is access to "an ethical space" (Wiener, 2003, p. 130). The concept of "ethical space" refers to an internal site of moral struggle, a third area of reflection from which to view the conflict between, for example, ethical and unethical desires or the relationship between codes of ethics and subjective ethical attitudes. From this interaction, Wiener (Wiener, 2001) suggests, new meaning and thinking regarding ethical decision-making and action may arise. Similarly, Solomon (2003a) comments that maintaining an analytic attitude and ensuring a stance of non-enactment in the context of the emotionally charged therapeutic relationship is contingent upon the act of processing or thinking which transpires in the "internal protected space" (p. 5) of the therapist's mind. Providing a contrast with "ethical space" (Wiener, 2003) and "sustained triangular space" (Solomon, 2003c) was imagery offered by participants which was suggestive of compromised or attenuated reflective space. The Listening Guide method (Gilligan, Spencer, Weinberg and Bertsch, 2003) discussed in earlier chapters (see Chapter 4) facilitated the construction of "I poems"; the latter "poems" foregrounded participants' first-person voice and their subjective experiences of reflective space. What emerged were four striking metaphors which suggested that attenuated reflective space had arisen in the context of either a failed container, such as that provided by ethically derelict supervision, or as a result of professional isolation.

In the following fragment, the spatial metaphor of a room graphically illustrates the breakdown of the boundary between the realms of personal and professional life. The therapeutic space seems to be invaded by domestic stresses and relationships. In a context marred by apparent professional isolation, the therapist's capacity to assert her professional identity and to create "ethical space" or a "third area of reflection" appears to have been eroded by unprocessed countertransference pressures:

> *I only have room ... to write up notes quickly, **I don't have room to think**. Not like I used to ... a room meaning room in terms of space and time ... so many utterly stupid things ... have got to be sorted out, when [my partner] works in the office my stuff gets moved out of the way and then I can't find*

> *my stuff … there's no space for me … to be respected as a professional … And … my professionalism was **really** on the line … **now this** has happened … and I **have to think** about it (Interv. **1**, p. 17, 24-34; p. 18, 9-18).*

In paranoid-schizoid mode, object relatedness does not take the form of experiencing others as subjects who can be hurt or injured but rather as objects which are prized or hated according to what they can do for or to one (Ogden, 1989). In the context of repeated engagement with several dual role relationships, the following excerpts again highlight the absence of a generative consultative or supervisory space. The participative yet reflective stance characteristic of the analytic attitude (Gabbard & Lester, 1995) appears to have given way to an unretrieved therapist driven enactment of "pioneering in the Wild West". This latter image seems to suggest of a compromised reflective space wherein the therapeutic well-being of patients has been forfeited in order to gratify the unconscious need to be seen and admired as an iconoclastic "risk-taker" (Interv. **4**, p. 137, 25-34) or powerful "warrior-leader" (Interv. **4**, p. 138, 21):

> *I guess Wild West is not a bad term ‚cause … what I was doing was, I don't know if I could say the word „pionœring' … but I was in territory where few have trodden and I was … without much guidance … I remember even thinking … supervision-wise, who could supervise me on this really? (Interv. **4.** p. 133, 15-19).*

> *But there **were** moments in which … I thought of myself as … **a maverick in the room** … my fantasy [was] let them [the patients] think … that their therapist was … pioneering in some way or … **a risk-taker**, something like that (Interv. **4**, p. 137, 23-34).*

If others are experienced in the paranoid-schizoid mode as prized or hated objects, the self too is experienced not as a subject but as an object "buffeted by thoughts, feelings and perceptions as if they were external forces or physical objects … bombarding oneself" (Ogden, 1989, p. 21). The following images of a tightly buckled briefcase and of a cooker under pressure suggest participants' temporary collapse under the emotional duress exerted by real-life dilemmas in the direction of the paranoid-schizoid mode of experience. Thus the two descriptions appear to provide continuing evidence of interviewees' subjective experiences of an impoverished reflective space that is assailed by "stuff", by paralysing headaches and by an accretion of "undigested" emotionally draining experiences:

> *Describe it? … sometimes … where there's been a lot of that kind of stuff, I'll have stuff … I need to do … I'll come home on … Friday evening and my leather briefcase will stay closed until Monday … I **block** it out, **close** it off … it's an **emotional** thing, I **don't** want to … open the briefcase, all that [stuff] is inside there … leave it there, leave it closed – buckled up. Pack it*

*away, close it away and leave it there … **I don't, I don't want to go there** (Interv. **5**, p. 189, 23-40).*

*How to describe the tension? … like a headache, something paralysing. When, when, when there are various forces pulling one simultaneously … it's difficult … to be clear and confident about the decision … there's so many demands and voices … [there's] **no, no, no** … **outlet**, a lot of **stuff** going in … **too much**, … like a pressure cooker and that pressure builds up … things just accumulate and accumulate … one incident after the next … added to the pot and … maybe there was too much pressure and not, not an adequate outlet (Interv. **6**, p. 229, 11-28).*

4. ETHICAL DECISION-MAKING AND THE WOUNDED-HEALER MODEL

The wounded-healer model provides a useful metaphor which potentially enlivens debate on the process of professional decision-making as it transpires in the therapeutic space. Fundamental to the concept lies the interplay between the polarities constituted by health and illness (Groesbeck, 1975; Miller & Baldwin, 1987; Sedgwick, 1994; Wakefield, 1995). In the context of the model, the therapist is identified at the outset with the role of the healthy, charismatic healer who is "wise, insightful, caring, and possessed of healing powers" (Ivey 1995, p. 356). By contrast, the patient, who is identified with sickness and weakness, stands in need of curing. In object relations terms, the model of the wounded-healer accordingly suggests that the patient projects an idealised object representation into the therapist while the latter in turn responds with projective counteridentifications pertaining to disavowed affects, vulnerabilities and narcissistic injuries.

Contemporary ethical decision-making models (Corey, Corey & Callanan, 1998; CPA, 2000; Keith-Spiegel & Koocher, 1985; Kitchener, 1984; Rest, 1984; Steere, 1984) are arguably largely congruent with the identification of the therapist as the powerful "healer-redeemer" (Groesbeck, 1975) since the emphasis lies on the latter's apparently healthy capacity for rational analysis and the dispassionate weighing of competing ethical principles. As discussed in earlier chapters, linear models of ethical decision-making may take insufficient account of the clinician's susceptibility to the enactment of "countertransference pathology" (Ivey, 1992) and may not capture fully the emotional vicissitudes of real-life dilemmas. Alternative models are thus "needed that account for factors that lead clinicians away from ethical practice" (Betan, 1997, p. 350).

What the data reveal is that the theme of the wounded-healer emerged through research participants' frequent references to physical and psychological scars, trauma, the lancing of

wounds, pus, the onset of cancer and to the corresponding process of healing. The discussion in the previous chapter on "Avowed vs Lived Values" suggests that the ethical principles of beneficence and Gilligan's (1982) ethic of care were prominently foregrounded as dominant ethical values. The following excerpts accordingly suggest that for the most part participants were strongly identified with a professional image of themselves as authoritative, beneficent caregivers who expertly tended to patient wounds:

> *I saw a [patient] ... who was ... **badly scarred**, ... this **really** horrible looking scar ... When [the patient] came into the session, the first time ... [the patient] held [the body] at just the right angle so that I couldn't see [the scar] ...like not too much and not too little ... So the first thing that I said ...was, I said ... nicely, ... I see you are holding your [body] in a way that I can't see how ugly your scar is ...and [the patient] was delighted ... very, very grateful ... it was the beginning of a very good therapy ... Now that was a **physical** thing, but I applied the same thing to **internal** things ... [to patients'] very deep, difficult wounds ... (Interv. **2**, p. 33, 26-44; p. 34, 3-4).*
>
> *... of all these cases ...the benefits to me ... were (pauses) really only to see the **healing** of the person ... Bear witness ... to the healing of the person ... there was no other value to me ... (Interv. **4**, p. 154, 2-14).*
>
> *... often what happens is ... once patients have disclosed to me and ... ninety per cent of the time, I'm the person that they disclose these things to, that same [night] they'll talk to [others] about it ... It's kind of like the, the **wound** is lanced and **the pus** comes out ... (Interv. **5**, p. 173, 23-27).*
>
> *Within myself, I felt very clear ... very clear around my role, who I am, the work that I'm doing and, despite the mess that [the patient] was bringing in and the attempt to sabotage the space ... I felt **very clear** about what I was doing ... what was being projected ... into me, ... what was ... transpiring between the two of us, ja (Interv. **6**, p. 209, 15-22).*

When the therapist struggles to acknowledge impairment or narcissistic vulnerability (Wakefield, 1995), the likelihood increases that the latter "feels himself to be the strong healer; the only wounds are those of the patients, while he himself is secure against them; the poor creatures known as patients live in a world completely different from his own" (Guggenbühl-Craig, 1971, p. 2). Gabbard (1998) notes that there is often "a kernel of reality" (p. 447) to the patient's assignment of internal object projections to particular individual carers. Thus the nature of the therapist's pre-existing inner conflicts and self-object-affect constellations will determine whether patient projections are likely to find a convenient "hook" in the clinician concerned (Gabbard, 1995). In the following fragments, research participants' psychodynamic formulations of patients' emotional difficulties

seemed to occur in the absence of any corresponding acknowledgement by the therapist of his/her own possible contributions to the countertransference enactments concerned. This may suggest the unconscious enlisting of the patient as the carrier of the therapist/healer's disavowed self or object representations:

> *I … have a sense of [the patient] as a person who was not connected to her feelings and … the deeper parts of herself … I suppose the term is dissociation … she's quite, I think, a dissociated person … very scared of reaching just those parts of her which have been traumatised … the connections between people were very, let's say, broken for her … she doesn't have a family that can hold her … I suppose [another patient] might've said, hey … we're cousins, maybe I should look for another therapist and we should go and have tea together (Interv.* ***3****, p. 87, 45-46; p. 88, 6-31).*

> *What, what approach did [my own analyst] adopt? I suppose she gave meaning to … the kind of projective identifications … where, ja, I felt like there was something* ***really*** *being put into me and* ***twisted*** *… at an* ***abdominal*** *level and … my sense of having been* ***violated*** *… I had* ***very*** *strong reactions and I think [my analyst] helped to normalise those and to … hand them back, to be able to say you know what? This stuff belongs to you, the patient … to just clarify that distinction, that was quite useful (Interv.* ***6****, p. 225, 7-13).*

> *… the concept of projective identification … is used unethically by a lot of therapists … To avoid owning their own stuff around the relationship … with the patient. So they'll see someone they'll … call them „borde·line' … So they'll say …I feel overwhelmed in the room … but it's because of this projective identification going on „cause this person's a very disturbed borderline … Now … the piece* ***missing*** *is does that mean* ***everyone*** *is going to feel overwhelmed in the room with this person and, if not, then how come* ***you're*** *feeling overwhelmed? … what is it about* ***you*** *…* ***it's the*** *…* ***countertransference piece*** *… that gets skipped which I don't think is true to the concept but … that's how it's used. It's used defensively … (Interv.* ***4****, p. 123, 11-28).*

Anomalies evident in the following two quotes by the same interviewee apparently lend weight to Bennet's (1987) claim that when the therapist's impairment is consistently denied, the patient carries a double burden of woundedness, his own and the healer's:

> *… the major reparation for me was around [the patient] developing a similar … erotic transference with me and [my] holding that and containing that. So that [the patient] had a chance to repeat the … falling in love with the therapist story and that I managed to hold that … and [he] then could work through that with … a responsible, thoughtful person who understood his needs (Interv.* ***2****, p. 61, 21-26).*

> *In terms of … his erotic transference to me … I killed that very early, I interpreted it very early and I stopped it very early (Interv. **2**, p. 48, 18-20).*

While the clinician's professional persona is authoritative and ostensibly well-qualified, the wounded-healer model confronts us with the uncomfortable notion that the therapist's unresolved wounded polarity or personal disturbance constitutes the covert and unconscious aspect of the "healer-redeemer" (Groesbeck, 1975). Therapist woundedness is, however, complex and double-sided in nature (Ivey, 1992; 1995; Miller & Baldwin, 1987; Wakefield, 1995). As Haumann (2004) writes "The „wound' primes the therapist to do the work of therapy by leading to the development of an exquisite sensitivity to the unconscious needs of others and the ability to subjugate his own needs and desires in order to meet those of others" (p. 98). Therapist woundedness thus provides the ground for the eventual development of an "agapaic capability" which seems "to be connected with concern, patience and a capacity to remain-in-being for his patient. It is a combination of eros, humane feeling and respect, together with a freedom from G-d-almightiness" (Lambert, 1981, p. 24). Although ethical decision-making appeared to transpire largely in the paranoid-schizoid mode, the data also revealed repeated instances of research participants' "agapaic capability" or feelings of empathy, concern and guilt. Patients were thus acknowledged not as part objects to be appropriated for narcissistic use in the internal world of the healer but as subjects who "can be hurt or injured" (Ogden, 1989, p. 22). The following examples offer glimpses of participants' remorse, concern and non-defensive openness:

> *I felt that I'd let [my patient] down … I felt that I'd betrayed her and [the patient's significant other] … somehow, **both** of them were victims of my … ineptitude (Interv. **1**, p. 11, 16-23).*

> *Should I be working with this person at all? Is it appropriate … knowing the problems that come with (pauses) working in this **kind** of environment … where there's a high risk of these kind of boundaries becoming blurred or challenged or threatened? Is it actually **safe** enough to work with? That's my question, is it safe enough to work with this person? And in retrospect, I don't think it was … (Interv. **6**, p. 210, 42-48).*

> *She's a little girl, she's a young, she's twelve, a little, little twelve. A little, tiny little girl, vulnerable and she told me that she'd been raped … (Interv. **5**, p. 175, 36-38).*

> *The consequences? … my decision not to be involved might be that this [rapist] might've got off the hook … if I'd been [a] more **active** agent, it might've been different … (Interv. **5**, p. 191, 37-43).*

Therapist woundedness may conversely destructively colonise the therapeutic space. What is immoral and unethical may then unconsciously be "lived out in projection, using and abusing the other as a vehicle for holding the bad aspects of the self" (Solomon, 2003b, p. 23). "Neurotic countertransference" represents a professional hazard not because the therapist experiences infantile and primitive responses within himself but because the latter may be prone to projecting and enacting unresolved countertransference difficulties which have been insufficiently emotionally integrated (Lambert, 1972). In the South African context, Ivey (1992) bluntly avers that "The uncomfortable truth is that [therapists'] interventions are very often unconscious attempts … to gratify their own contextually inappropriate needs and alleviate the anxiety related to the interactional emergence of both their patients' and their own psychopathology" (p. 38).

What the data in the previous chapter (see Chapter 5) suggest is that participants apparently often struggled to entertain the maleficent or iatrogenic aspects of their therapeutic interventions. Nonmaleficence and countertransference management accordingly appeared to constitute "neglected" ethical values. Professional self-esteem and participants' seemingly strong identification of themselves as beneficent caregivers were consequently apparently shaken by their encounters with real-life ethical dilemmas and by their experience of challenging research interviews. The narcissistic need "to bask" (Haumann, 2004) in the satisfying glow cast by the inflated image of ourselves as a charismatic "healer-redeemer" represents an apparently common countertransference difficulty (Anonymous, 2005; Groesbeck, 1975). The quotes below convey, by contrast, the corresponding painfulness and feelings of anger or vulnerability that may follow the reluctant uncovering of "festering" (*Interv*. **5**. p. 184, 8) countertransference wounds:

> *… I mean that [the dilemma's] very difficult to talk about, the question is **why** is it difficult to talk about, what's the difficulty, does one feel **exposed**, does one feel **vulnerable**, does one feel, somehow, one's part of [the] ethical dilemma and therefore responsible for it, you know? (Interv. **2**, p. 53, 27-32).*

> *… part of me is quite apprehensive because this, this is **messy** stuff and it feels like **failed work** … that just ended abruptly, that I feel … I didn't manage adequately … So, it's, … it's difficult to talk about … I find it quite exposing and maybe doesn't reflect very well on **me** as a clinician. (Interv. **6**, p. 215, 11-16).*

> *Well, I think it's all about building one's self as a professional … the challenge [in the research interview was] … getting in touch with feelings*

and being able to articulate them ... I feel a bit challenged ... just asking questions about whether or not I feel there might be ... unconscious resistance on [the patient's] part ... I have felt ... tense, more kind of anxious ... this ... has felt more stressful because it does, you know, it's, it's, I think, it's ... it wasn't okay ... (Interv. ***3****, p. 109, 19-20; p. 110, 1-25).*

That of all these ... cases, there was no financial benefit to me ... so the benefits to me ... were (pauses) really only to see the healing of the person ... if that's wrong then, you know, I'm, I'm in the wrong profession! (Interv. ***4****, p. 154, 1-15).*

Groesbeck (1975) comments that when mutual unconscious projections continue to reign, then "no movement to a real cure occurs though outward remedies, physical and psychological, are applied" (p. 128). Holding one another in thrall, the therapist and the patient may unconsciously attempt to coerce each other to conform to mutual inner needs for dominance and childish dependency respectively (Guggenbühl-Craig, 1971). In psychoanalytic object relations terms, Ivey (1995) writes that the patient's idealising transference fantasies and the therapist's unmet archaic needs for narcissistic affirmation may potentially create a stable union. In such a scenario, the therapeutic relationship defends against shared narcissistic insecurities and may be conceived of as a mutually reinforcing "positive narcissistic symmetry" (Ivey, 1995, p. 352).

Only when the therapist withdraws and integrates his/her disavowed projections can the "narcissistic symmetry" be dissolved and the healing process once more be resumed. The therapist's ensuing emotional freedom may then be used in the service of "objective" rather than "neurotic countertransference" (Racker, 1957; Stein, 1984), receiving and metabolising the patient's "wounds" or projective identifications and returning these in a form that the patient can use (Bion, 1962; Wakefield, 1995). As Guggenbühl-Craig (1971) notes, genuine wounded healers "recognise time and again how the patient's difficulties constellate his own problems and vice versa, and he therefore works openly not only on the patient, but also on himself. He remains forever a patient as well as a healer" (p. 129).

Far from being characterised by rational choice and an emotionally uncontaminated capacity for abstract reasoning, the process of ethical decision-making often appears to engage deeply with the therapist's own woundedness or "blind spots" (Freud, 1912, p. 116). The unexpected force of strong affects arising in the therapeutic space may "unhitch" or "dislodge" the therapist from the analytic attitude or from the capacity for sustained reflection on the meaning of the emotional vicissitudes engendered by therapeutic pair

(Solomon, 2003a). The vignette below seems to illustrate the enduring magnitude of unresolved countertransference affects which seemingly continued to suffuse the ethical dilemma concerned and to "dislodge" the research pair nearly four years after the termination of the relevant case.

In the context of describing the real-life ethical dilemma posed by collegial sexual misconduct, the participant's unexpected request in the course of the research interview to switch off the tape recorder (*Interv.* **2**, p. 45, 20-28) and his offer to look at photographs had the unsettling effect of relocating us from the research space to the „keyhole' of the erring practitioner's personal apartments. The capacity for reflection or the "otherness of the observing object" (Britton, 1998, p. 45), symbolised by the tape recorder and a public record in the form of a transcribed interview text, was thus abruptly erased or "switched off". Carried out in virtual silence, the mutual enactment of looking through photographs featuring the former therapist's dwelling occurred „off the record', thereby generating a prurient sense of „spying' on the latter's private life. The tape recording was eventually resumed but the incident remained unlanguaged and "undigested" as neither the research participant nor I spoke of what had silently transpired between us.

Renik (1993a; 1996) argues that countertransference awareness emerges retrospectively after countertransference enactment. In the context of the research interview, the enactment concerned bore the characteristic hallmark of initially bypassing consciousness. It was only understood retrospectively with the aid of supervision which created the observing "meta level" (Stokoe, 2000) and requisite mental freedom needed for sustained reflection about "a third, whether [that] third is an individual, a couple …, or an idea or aspect within the therapist … that is relevant to their clinical work" (Solomon, 2003c, p. 174). From this perspective, the enactment may be construed as possibly indicative of unprocessed oedipal dynamics and as the interviewee's imaginative projection of himself into the intimate, lived spaces of a valued senior male. The participant ascribed the wound of suffering from very early unmet needs for fathering to his sexually abused patient (*Interv.* **2**, p. 50, 7-8; p. 61, 25-27). But analysis of the data raised the additional possibility that the sustained decision over three years (*Interv*. **2**, p. 34, 23), to desist from confronting the abuser/mentor may in part have been unconsciously informed by the healer's own unacknowledged need to protect from contamination an idealised paternal part-object representation.

The foregoing description of a principally therapist driven enactment suggests that the unresolved countertransference affects which swept over the research pair temporarily disrupted independent access to Britton's (1998) "triangular psychic space" (p. 13). Comprehension of the impact of the therapist's disavowed woundedness on the process of ethical decision-making accordingly appeared to demand assistance from external supervision which provided the requisite third area of reflection. Repeated observations during the research process regarding the need to establish a third area of reflection helped to construct a psychoanalytically informed model of decision-making. The model is presented and discussed in a later chapter.

5. SUMMARY

Three areas of interest were outlined in the introduction to this chapter. With regard to the first area, the four levels of decision-making, the data suggest that unconscious determinants and unprocessed countertransference affects often appear to drive earlier prereflective phases of ethical decision-making. Conscious, rational cognitions may initially exert comparatively little influence on those real-life ethical dilemmas which revive the therapist's archaic needs and disavowed self and object representations. In such a scenario, instead of privileging the patient's best interests, ethical decision-making seemingly collapses in the direction of a paranoid-schizoid mode of functioning. Ensuing ethical decision-making enactments appear to be organised around the need to keep Meissner's (1994) "unconscious determinants" or Stern's (1983) "disturbing glimmers of meaning" out of conscious awareness. While the paranoid-schizoid mode appeared to predominate, glimpses of mature ethical decision-making and depressive position functioning emerged in the research interviews. These were apparently predicated on external consultation or dialogue with an empathic other which helped to establish an ethically attuned "third area of reflection" (Solomon, 2003c, p. 174).

Data analysis focused, secondly, on examination of inner moral "voices", counter-transference fantasies, images and metaphors. Research participants' reported phenomenological experience provided supportive evidence for Day's (1991) notion of an "inner moral audience". But in contrast to Day's (1991) depiction of its members as comprised of exemplary inner others, interviewees described conflictual relationships with inner presences who on occasion urged frankly unethical conduct and who often appeared to be unhelpful, harsh and condemnatory. Tappan (1991) writes that "authoring" an

authentic moral account presupposes dialogue with "internally persuasive discourses" as well as a relational context with an empathic external other. Hampering research participants' efforts to resolve real-life dilemmas was an apparent paucity of readily available "internally persuasive discourses", including those that might have arisen through the internalisation of a relevant code of ethics as well as ethically attuned personal analysis or supervision.

Lack of an accredited South African training in psychoanalysis or psychoanalytic psychotherapy (Gibson, 2002; Haumann, 2004) renders the individual therapist's current efforts to attain increased objectivity through self-analysis a relatively problematic practice at this stage. The latter approach assumes that the therapist concerned is largely familiar with his/her own biases and "blind spots" (Freud, 1912, p. 116) as a result of intensive supervision and personal analysis. By contrast, the research endeavour seems to lend empirical support for the attainment of a "relative objectivity" (Gabbard, 1997). Solomon (2003c) notes that the analyst as a trainee is optimally embedded in different sets of triangular relationships. The trainee thus consistently internalises the expectation that "there is always a third space created in which he or she as a patient or as a supervisee will be thought about by another supervisor-practitioner pair" (p. 175). Similarly, participants inadvertently forged a reflective link with the research space which was then used for the retrospective examination of unconscious dynamics that had potentially animated the original therapeutic dyad and appeared integral to the dilemma concerned. This triangular relationship was itself held and thought about by two often contrasting supervisory spaces which enhanced a greater, if not an absolute, objectivity through the accrual of ethically informed additional and different points of view (Louw & Pitman, 2001). This suggests that regular peer supervision or consultation offers a potentially viable local option that may be useful in the identification and rectification of "blind spots" and ethical decision-making. Vivid imagery accordingly arose which suggested that interviewee's efforts to resolve ethical quandaries transpired largely in the context of deeply impoverished or compromised reflective spaces.

The final area of interest explored the relevance to ethical decision-making of the wounded-healer model. The model provides a compelling theoretical illustration of the notion that countertransference may function as "a virtue" but also as "a vice" (Louw & Pitman, 2001). When countertransference is mobilised "as a virtue", the double-sided nature of therapist

woundedness allows the latter to use his/her well developed capacity for empathy to gain valuable ingress to the patient's internal object world. Detailed discussion of a therapist driven enactment that occurred during the research interview seemingly provided evidence for the enduring force of unresolved countertransference affects and a contrasting example of countertransference when it is mobilised "as a vice". Thus the data continued to suggest that therapist-driven ethical decision-making enactments may arise as a result of the healer's repeated efforts to ward off threatening countertransference feelings or thoughts.

As a didactic tool, the wounded-healer model exerts heuristic appeal through its theoretical and clinical relevance to a varied professional audience (Miller & Baldwin, 1987). The model's pragmatic delineation of the inevitable mobilisation of the healer's unresolved, wounded aspects may assist in legitimising a sorely needed professional space wherein to engage more publicly with the unethical, destructive and self-interested dimensions of our therapeutic interventions. In foregrounding countertransference as a central organising concept, the wounded-healer paradigm provides a useful additional theoretical tool to decision-making models that emphasise a rational, step-by-step approach to the resolution of ethical dilemmas.

Difficulties in resolving ethical dilemmas were compounded not only by the therapist's susceptibility to enacting his/her personal countertransference but also by lacunae that characterised much of the wider professional matrix. Reaching out for support and help, participants often encountered problematic professional ethics training, supervision and personal analysis. The following chapter thus tracks participants' subjective accounts of their efforts to utilise professional resources.

CHAPTER 7

ABSOLUTION, PENANCE OR EXCOMMUNICATION: PARTICIPANTS' PERCEPTIONS OF PROFESSIONAL RESOURCES

1. INTRODUCTION

The professional resources that were consulted by the six participants are embedded in a post-apartheid society that continues to experience rapid legislative, political and professional change. Contemporary South African psychotherapy may additionally be influenced by postmodern thinking which eschews the theoretical certainties espoused by "the sovereignty of reason, rationality, objectivity and empiricism" (Snyman & Fasser, 2004, p. 73). The latter author's claim that the lack of objective "set facts" and the ensuing uncertainty results in the postmodern therapist taking increased responsibility for the influence on the therapeutic relationship of his/her own biases, interventions, personal values and decisions (Snyman & Fasser, 2004). In the following excerpt, Patrick situates the discussion of available resources against a broader backdrop of interprofessional rivalry, the introduction of new legislation and the impending breakdown of traditional divisions governing the specialist practices of the different professions concerned. A sense of profound uncertainty appears to pervade not only psychology but also the contemporary practice of psychotherapy in South Africa:

> *Well, I think psychology and psychotherapy ... the whole psychological intervention field across the board in South Africa at the moment, I think is in a tremendous state of flux, of change and transformation ... there's an identity crisis ... lots of power plays ... new legislation's coming out ... the restrictions about counselling, the move to a PhD for psychologists, the idea of restricting doctors from doing therapy ... the move of psychologists to try and prescribe medication, I mean* ***all*** *these happen within a very short space of time and I think that the community is tremendously anxious as a whole ... not just the psychology community, I would say the* ***psychotherapy*** *community ... counsellors who are counselling without being registered ... social workers, psychiatrists ... no one knows what, what the future looks like ... and as a result* ***ethics*** *is ... like the* ***doing*** *as a response to the anxiety. It's like what* ***should*** *we do, what we should do is we should make sure that we are, you know, behaving properly ... And I don't think this anxiety was present some years ago ... some years ago ... everyone was quite clear on ... where you stood ... everyone knew ... their place and they knew how to behave ... (Interv.* ***4****, p. 117, 17-43; p. 18, 2-6).*

While research studies have documented the nature and frequency of common ethical dilemmas (Lindsay & Colley, 1995; Pettifor & Sawchuk, 2006; Pope & Vetter, 1992),

further insight is needed into how "practitioners, when recognizing an ethical dilemma, sort through the complex considerations involved in making ethical decisions" (Welfel & Lipsitz, 1983, p. 321). The discussion which follows explores a variety of professional resources that were available to assist research participants with professional decision-making. The chapter considers, firstly, several current debates pertaining to the issue of professional training in ethics as well as participants' own perceptions of their former ethics instruction. This is followed, secondly, by participants' further accounts of accessing (or avoiding) the South African Ethical Code of Professional Conduct (2002), the Professional Board for Psychology, PsySSA, the law, supervision, personal therapy and peer consultation. Three potential risk factors pertaining to compromised ethical decision-making emerged and are summarised at the end of this chapter.

2. POSTGRADUATE ETHICS TRAINING

Comprehensive ethics training is widely endorsed as critical for helping postgraduate psychology students to engage effectively with the ethical dilemmas and decision-making processes they will encounter as future therapists, researchers or theoreticians (Abeles, 1980; Bernard & Jara, 1986; Eberlein, 1987; Fine & Ulrich, 1988; Handelsman, 1986b; Scherrer, Louw & Möller, 2002). The issue apparently no longer revolves around whether ethics education should be included in masters and doctoral curricula but on how best to teach it (Pettifor & Pitcher, 1982).

Despite evident consensus, sparse information is available regarding the form, content and short and long-term outcomes of graduate ethics training programmes (Eberlein, 1987; Welfel, 1992). Their characteristic variability may contribute to clinical psychologists' later inconsistent decision-making practices (Tymchuk, Drapkin, Major-Kingsley, Ackerman, Coffman & Baum, 1982). In the context of overcrowded teaching schedules, arguments abound as to whether ethics should constitute a separate formal module or whether it is best taught as it arises „naturally' during theoretical coursework or clinical supervision (Fine & Ulrich, 1988; Gawthrop & Uhlemann, 1992; Pettifor & Pitcher, 1982; Snyman & Fasser, 2004; Tymchuk et al., 1982). Handelsman (1986b), for example, argues that teaching ethics informally "by osmosis" in supervision remains "a dangerous practice" which is constrained by the supervisor's potentially limited awareness of ethical issues and which does not systematically promote the skill of ethical thinking nor the ability to generalise beyond individual cases.

While an apparent need exists for more detailed information regarding graduate ethics courses, the relationship between ethics training and the implementation of actual ethical behaviour is not necessarily causal or "linear" (Scherrer et al., 2002). Research attempting to demonstrate the efficacy of formal ethics instruction yields seemingly contradictory results (Slack, 1997); thus the evidence available remains inconclusive as to whether such training positively enhances ethical behaviour with clients (Welfel & Lipsitz, 1984). Gawthrop and Uhlemann (1992) argue, for example, that undergraduates who received ethics instruction showed a significantly better quality of ethical decision-making than did control participants who received no training. The authors concede that ethics taught within the confines of a classroom may well not generalise to real-life ethical dilemmas encountered in clinical practice. Haas, Malouf and Mayersen (1988) by contrast observe that hours of formal ethics training did not apparently exert any marked effect on psychologists' preferred choice of action in the context of hypothetical vignettes. Commenting on a number of different studies, Bersoff (2004) similarly observes that ethics training does not apparently ensure that trainees who complete the programmes concerned will act ethically as professionals.

Apparently contradictory results regarding the efficacy of ethics education may point to "competing feelings or interests that can interfere with a therapist's willingness to act ethically" (Betan & Stanton, 1999, p. 295). Repeatedly observed discrepancies between intellectual comprehension as opposed to the actual implementation of ethical knowledge (Bernard & Jara, 1986; Bernard, Murphy & Little, 1987; Smith, McGuire, Abbott & Blau, 1991) may well reveal the lack of courage to act (Rest, 1984) or "elements of expediency and opportunism" (Smith, McGuire, Abbott & Blau, 1991, p. 238). The disjunction identified cannot simply be reduced to arguments suggesting that ethical principles provide too little guidance or are too vaguely formulated (Bernard & Jara, 1986). Accounting for observed discrepancies between ethical knowledge and action may devolve not only on the adequacy of rational analysis but also on the need to identify "the personal and professional risk factors that can come between [ethical] decisions and their implementation" (Gawthrop & Uhlemann, 1992, p. 41). Additional ethical guidelines, examples and casebooks alone will probably not resolve the complexities entailed in ethical decision-making (Smith et al., 1991) nor necessarily encourage ethical "resoluteness" or the willingness to follow through and to actually implement ethical action (Betan & Stanton, 1999). As Bernard and Jara (1986) conclude "[The] problem is not how to communicate ethical principles to students

more effectively, but rather how to motivate them to implement principles that they apparently understand quite well" (p. 315).

Traditional training approaches appear to rely on the reasoned application of ethical principles and theories to ethical dilemmas (Eberlein, 1987; Gawthrop & Uhlemann, 1992; Tymchuk, 1986). Bersoff (2004) proposes, for example, that acting ethically derives from the integration of didactic knowledge including thorough familiarity with formal ethics codes and their underlying potentially competing philosophical principles, an understanding of decision-making models and personal attributes such as maturity, discretion and wisdom. Offering a different perspective on how to enhance ethical motivation in postgraduate clinical psychology students, Betan and Stanton (1999) claim that practising psychologists make inadequate decisions partly as a result of poor attunement to their own emotions, values and contextual concerns. The traditional training emphasis on ethical principles and reasoning processes therefore needs to be supplemented by encouraging student awareness of how motivation and decision-making may be powerfully affected by the "emotional pulls and subjective concerns" experienced by the individual decision-maker (Betan, 1997, p. 299). Context, personal values and feelings of, for example, shame, anxiety, compassion or empathy may accordingly act as "barriers" or, alternatively, as "prompts" to furthering ethical resoluteness and action (Betan & Stanton, 1999, p. 300). While acknowledging the primacy of emotions and contextual concerns, Betan and Stanton (1999) do not consider the role of unconscious phenomena in promoting or hindering ethical commitment and decision-making.

Shifting the focus from individual trainees, Abramovitch (2006) suggests that stimulating ethical awareness during training encompasses not only individual candidates but also necessarily pervades the collective or group life of each institute or society. Similar observations are advanced by Kitchener (1992) who argues that training ethical professionals goes beyond discrete theoretical modules and remains the responsibility of the entire staff. Even when excellent ethics instruction is offered, unethical conduct by educators insidiously compromises ethical motivation by contradicting the explicit messages conveyed by course content. This provides a less than optimal model, or psychoanalytically speaking, source of "identification" (Laplanche & Pontalis, 1980) for students' later professional practices. Of relevance to research participants' descriptions of their ethics education is the specific caution advanced by Slimp and Burian (1994) regarding social or

multiple-role relationships. These authors comment that training staff who embark on dual relationships with current supervisees need to consider that the marked power differential and possible transference-countertransference dynamics at play carry a high potential for exploitation of the supervisee concerned and for negatively impacting on the group dynamics of both staff as well as students. Incorporating various suggestions from the professional literature, Wassenaar (2002) writes that "the creation of a climate of ethical sensitivity" (p. 222) necessitates that ethics education is grounded in formal structures or response systems that are publicly perceived to be capable of processing at remedial and disciplinary levels actual instances of academic dishonesty or ethical misconduct between staff and students. Additional strategies that might help to imbue academic departmental life with a sense of lived ethicality include regular staff-student ethics colloquia, the consensual designation of particular staff members prepared to develop a specialist interest in furthering ethics education and the active encouragement of students to openly share ethical concerns derived from their "personal experience, their training experiences or … their interactions with or observations of their peers, teachers or supervisors" (Wassenaar, 2002, p. 222).

In South Africa an apparent neglect of ethics education in professional psychology training programmes is evident (Slack, 1997). Acknowledging that data collected in 1995 pertaining to the training of South African psychologists in professional ethics may be dated, Wassenaar (2002) concludes that prior to his study "Essentially, no reliable data [appeared] to exist on the teaching of professional ethics in South African psychology programmes, let alone information on what, why and how effectively it is taught" (p. 63). While professional ethics constitutes a mandatory 10% of the CPD points every registered psychologist is annually required to accumulate (HPCSA, CPD, Guidelines for Psychologists and Registered Counsellors, 2001), the evident lack of clarity regarding graduate ethics training may well extend to postqualified South African psychologists practising as analysts and as psychoanalytic psychotherapists. At the time of writing, no published South African studies were available which detail the design, content or perceived efficacy of postqualifying mandatory ethics educational activities including those offered in the context of analytically oriented societies, institutes or reading groups. Of relevance to participants' reports of the compromised supervision of common ethical dilemmas conducted by local accredited Jungian analysts, is Abramovitch's (2006) observation that an international IAAP[1] survey of ethics training in over 50 societies (Wahba, 2005, cited in Abramovitch, 2006) reveals no

[1] International Association for Analytical Psychology

consensus on what or how ethics should be taught and failed to elicit any response from SAAJA[2], an affiliated Cape Town based training institute (personal communication).

For South African graduate ethics training to be relevant to prospective professional practice, it needs to ensure that it "embraces both the views of the complaining public [as well as] the anxieties of practitioners themselves" (Wassenaar, 2002, p. 218). In the context of graduate ethics courses, case discussions might accordingly address the most pressing complaints lodged against South African psychologists including, for example, the management of fee issues, child custody work, child abuse reporting, incompetence and improper behaviour (Scherrer, Louw & Möller, 2002; Wassenaar, 2002). Contrasting real-life ethical dilemmas which could be incorporated and which most frequently trouble South African practitioners themselves include confidentiality concerns, non-sexual dual relationships and collegial misconduct (Slack & Wassenaar, 1999). While acknowledging the need to systematically teach ethical decision-making skills, Wassenaar (2002) notes that the emotional dimension of professional decision-making did not comprise a focus of his study. A further limitation pertains to Wassenaar's (2002) related survey of 26 South African masters and internship psychology programmes which omitted to obtain clarity on whether and what ethical decision-making models are used by South African training universities. The ostensible scarcity of local data regarding South African preprofessional ethics training may extend not only to the issue of ethical decision-making frameworks but also to whether and how awareness is raised with respect to the potential impact of countertransference phenomena on graduate students' decision-making practices.

2.1. Perceptions of Postgraduate Ethics Training

The length of post-qualifying experience amongst the participants at the time of the 2003 research interviews ranged from between 4 to 12 years. All six participants underwent postgraduate clinical or educational psychology training at various South African universities between 1991 and 1999. The foregoing outline of current debates in the domain of professional ethics training is used to deepen an understanding and interpretation of participants' lived experience as they identified the following seven difficulties which apparently affected the extent, quality and perceived relevance of their graduate ethics training.

[2] South African Association of Jungian Analysts

In the context of participatory, process-oriented ethics training, students are encouraged to consult with colleagues, to challenge each other's ideas and values and to go beyond ethical codes to probe underlying principles and ethical theories (Abeles, 1980; Eberlein, 1987; Fine & Ulrich, 1988). In contrast with this apparently lively sense of student engagement, Wassenaar (2002) found that most respondents in his 1995 survey of South African psychology Masters programmes expressed dissatisfaction with the quality and relevance of their ethics training. Across the interview texts, recollections of graduate ethics education were similarly characterised by feelings of boredom, poor recall and a perceived lack of relevance. Participants' original exposure to ethical issues in the context of their professional training thus comprises the initial difficulty:

> *I found it unbelievably boring and not very relevant ... I think it was because I hadn't started practising ... and I think it would only really make sense to me once I'd got into the real world, rather than a student looking at it in a very theoretical way and not seeing it as kind of a very applicable here and now issue (Interv. **1**, p. 5, 37-41).*

> *I don't remember any ethics training (laughs) actually ... I don't really remember it, it actually didn't make much impression. I know we **had** it ... [but] it was quite theoretical (Interv. **3**, p. 75, 20-33).*

> *... I wasn't conscious of links between those two experiences [ethics training and this real-life dilemma] ... no, absolutely no links ... Not from the ethics training ... no, not from that input, no (Interv. **6**, p. 225, 21-26).*

This ostensible lack of enthusiasm may derive from student perception that ethical thinking and decision-making do not comprise a valued core skill that is integral to the analytic attitude and to competent clinical practice:

> ***P:** When I did my training, I wanted more **tools** ... for me [ethics] was by the way ... I was so hungry for skills [and] the training is so short ... My feeling was I wanted more and more and more skills ...*
>
> ***R: … ethics didn't seem to fall into the …***
>
> ***P:** Skills thing, skills, no (Interv. **5**, p. 165, 8-19).*

The apparent lack of prominence accorded to ethics in academic departments may stem from educators' own discomfort and lack of expertise in teaching ethics courses (Handlesman, 1986b). The following comments by David suggest that perceived low levels of staff interest, commitment and expertise comprise a second difficulty that may potentially compromise the quality of South African graduate ethics education:

> *... my interpretation of an absence of ethics was ... I don't think that a lot of the ... academics and tutors had any real training themselves or interest,*

> *and the … Psychology Board and Health Professions Council, their rules of ethics hung over as the grand daddy of behave yourself, and it was just accepted that you go and read that and you obey those rules … no one recognised that … creating a culture of ethics was **not** about reading the riot act, it was actually about engendering a way of **thinking** about what's right … so that was the one dynamic, that the ethos wasn't there (Interv. **2**, p. 31, 33-42).*

Handlesman's (1986b) criticism of teaching ethics "by osmosis" has earlier been noted. In the context of different South African training universities, participants recollected exposure to both informal ethics teaching as well as to formal ethics modules. The following comments highlight a third difficulty, the risk that when ethics teaching is left to chance, it may be omitted entirely or merely added as an appendage or "short footnote … to the subject matter of various courses" (Fine & Ulrich, 1988, p. 542):

> *… I don't remember at university (long pause) doing a specific course on ethics … I can't remember any specific lecture we had on ethics (Interv. **4**, p. 115, 37-37).*

> *… ethics was always an **adjunct** to, to doing interpretation [so] what are the ethics of interpretation or we're talking about transference and what are the ethics of transference or … what is the ethics of the **setting** of the room … (Interv **4**, p. 116, 33-36).*

Even when participants were exposed to formal ethics modules, these appear to have been experienced as discrete and isolated entities rather than as a foundational and integrated component of graduate training:

> *[Ethics] could have been more … than something in isolation – well, this is the book, this is the reading and we'll discuss it and have a few seminar discussions around different issues (Interv. **5**, p. 165, 25-27).*

> *… my training as a clinical psychologist … definitely had some input on ethics … I suppose the difficulty I had … was that it wasn't integrated … it didn't **feel** integrated into the rest of our training. It was something that came in a bit of a vacuum … kind of handed over and then … left for us to [integrate] with practice and with the rest of our training, it felt … out of context … It didn't really have **roots** … Ja, sorry, I feel like I'm really straining to remember … how it proceeded (Interv. **6**, p. 201, 24-25; p. 202, 22-29).*

In the following extract, Riaan advocates adopting an approach to ethics education wherein theory and prospective practice are presented as integrated and interrelated components of an ongoing ethics education. Ethics should additionally be systematically taught not only in the form of a specific introductory module but should also consistently be borne in mind as a constant dimension of clinical case material:

> *To me [ethics] could be the **introductory** thing, when we started off, we said this is the framework and this is … **pervasive** and we need to deal with this for everything and when we do these **other** things, let's try and be alert to those, it'll come up like…you're doing an assessment with a child, I want you to be aware of [the ethics of] **that**, make comment on **that** (Interv. **5**, p. 165, 21-25).*

The professional literature suggests that postgraduate ethics training should optimally be comprised of 25 hours of study time; Wassenaar (2002) wrote that the surveyed average of 9 hours allocated by South African training universities was regarded as insufficient by most of his respondents. Qualitative research results appear congruent with these latter findings in that lack of time constitutes a fourth factor which similarly contributed to participants' primarily negative evaluation of their ethics education. When asked about the extent of their exposure to professional ethics training, participants' responses included the following replies:

> *None (Interv. **2**, p. 31, 29).*

> *… we went basically right through [Steere's (1984)] book … but that's all we had (Interv. **1**, p. 5, 31-32).*

> *… there wasn't an enormous amount of focus placed on that … I **imagine** it was probably not more than two mornings, two hours of two mornings … it was unlikely to have been more than that (Interv. **6,** p. 201, 26; p. 202, 1-3).*

In the context of professional practice, four of the six participants describe the sustained enactment of dual role relationships. Interviewees' could not, however, recall any "voice" (*Interv. **6,** p. 225, 45-46)* or ethical framework from their former graduate ethics training that spoke to the asymmetrical power relations and potential for harm that might be entailed. Difficulties in identifying the potent role of self-interest in motivating participants' „decisions' to engage with dual relationships were arguably compounded by their earlier exposure as students to the confusing "modelling" proffered by teaching faculty. As Kitchener (1992) notes, the most influential ethical attitudes learnt or internalised by students may come not from explicit course instruction but from observation of inappropriate boundary crossings by faculty members. Participants' recall of seemingly irregular "modelling" or implicit promotion of dual relationships by hospital and academic staff thus comprises the fifth difficulty that apparently compromised the quality of their ethics training:

> ***P**: I don't know, I don't remember learning about that, I can't say that there's a specific „voice' when it comes to [multiple relationships] …*

R**: **Where do you think you came across that concept first?

***P**: (Long pause) I think probably my training, like working in a hospital … where I might run a group, see the person for individual therapy, maybe do another process, so multiple roles within a therapeutic … milieu, therapeutic ward, ja (Interv. **6**, p. 225, 39-40; p. 226, 1-3).*

*I … remember that there wasn't a problem even if you were being lectured by your therapist, like at „Varsity …a lot of the therapists, the lecturers in the Department, their patients are students (Interv. **4**, p. 146, 21-23).*

*… I knew that it wasn't against **professional** ethics as a psychologist … to refer [my] patient to [my] workshop … I knew that was okay … because I remembered … the head of the hospital that I trained at … telling us that … they actually teach [therapists] to give … a book list … like you go to therapy, your therapist says I want you to read these books, and [then the therapist] refers them to workshops and … therapists would run the workshop that their patient is **in**, so I want you to … come and … do my workshop … it would be good for you (Interv. **4**, p. 146, 1-11).*

Gaps in participants' current ethical sensitivity and basic ethical knowledge comprise a sixth difficulty. The next excerpts suggest a lack of systematic didactic input pertaining to core reference texts including, for example, exposure to the ethical principles and standards of the APA (1992) ethics code as well as the local South African code first published by Steere and Wassenaar (1985):

*At that stage [of the ethical dilemma] … I was not even aware that there was [a code of ethics] on hand. You know, in our training, we'd never been provided with such (Interv. **4**, p. 145, 46-48).*

*… when does one get [a code of ethics], when you register? … I've got a file full of stuff … so verbose and wordy … I don't think I have a current code of ethics, I would have to apply to get it, wouldn't I? (Interv. **3**, p. 99, 21-27).*

In the context of participants' recall of key ethics texts, Riaan's quote strikes a solitary positive note; Steere's (1984) book on ethics in clinical psychology is recalled as a helpful and still relevant resource:

*… we had a book by somebody … can't remember the name now but I know I'd …lent it to people who would make photocopies of my photocopy because … it's excellent … it's a very comprehensive little book on ethics (Interv. **5**, p. 164, 41-43).*

While the relationship between ethics training and professional practice is not necessarily "linear" (Scherrer et al., 2002), the data suggest that the perceived irrelevance of ethics education, irregular staff "modelling" and seemingly low levels of expertise, lack of time

and erratic exposure to ethical issues may combine to undermine participants' subsequent clinical proficiency and competence. In the following extract, for example, the participant concerned struggles to identify the presence of common ethical dilemmas:

> *... when you think of ethical dilemmas, you think of ...* ***big*** *difficult things, someone comes to you and they've committed a crime ... what do you do? ... so when I mentioned [the case] around sexual harassment ... there* ***was*** *a sexual boundary violation [between therapist and patient] but it wasn't very bad, I mean it was bad but it could've been worse ... The other [dual role relationship] I suppose I, I wasn't* ***sure*** *whether it was an ethical dilemma or not (Interv.* ***3****, p. 76, 10-12; p. 77, 23-27).*

Core reference texts appear to be conflated. In the following excerpt, the bare legal provisions of Act 56 of 1974 (Government Gazette, 1974) are erroneously confused with the then available but apparently unread ethics code for clinical psychologists (Steere & Wassenaar, 1985):

> *When we ... registered as intern psychologists, we were given this Code ... I remember going through it ... and some things popping up that surprised me like "How you can advertise", I mean, I found this quite quirky but what, what's acceptable in terms of advertising, you know, a business card and a plaque outside your house ... . So, I remember being quite taken ... by the breadth of what was covered in terms of ethical issues (Interv.* ***6****, p. 222, 22-29).*

Justification for ethical decisions has traditionally been based on four levels of ethical reasoning consisting of ethical theories, principles, rules and judgments (Fine & Ulrich, 1988). In the apparent absence of early professional ethics training which emphasised decision-making frameworks and the importance of reflective space or a third point of view (Britton, 1998), reliance is currently placed for ethical judgments on impulsive "gut" feelings or prereflective "intuitive" levels of moral thinking (Kitchener, 1984):

> *... ethics for me has been ... sort of common sense stuff, I kind of had a* ***gut*** *feeling for what was right and wrong ... there's the law ... the formal stuff, this is what you can and can't do and then these other times when you deduce ... [what's] in the interest of the patient, what's best for the patient ... that's my own opinion about it all (Interv.* ***5****, p. 165, 3-12).*

The lack of training opportunities to explore the potential role of emotions and other countertransference phenomena in ethical decision-making comprises a final difficulty. Steiner (2006) observes that enactments in the analytic setting are inevitable but that their usefulness is contingent on understanding their meaning in relation to the patient's habitual object relationships. Each therapist thus needs to develop sensitivity to those areas in which

"enactments are most likely to occur and this requires self-observation and self-knowledge on the part of the analyst" (Steiner, 2006, p. 315). Inadequate emphasis in graduate ethics courses on the countertransference dimension of ethical decision-making may increase students' vulnerability to initiating future unretrieved enactments, leaving them inadequately prepared to engage with dilemmas that forcibly evoke, for example, sexual attraction to clients or feelings of hate, fear and anger (Pope, Keith-Spiegel & Tabachnik, 1986; Pope & Tabachnik, 1993; Stevenson, 1999).

In the context of South African academic psychology, Ivey (1992) contends that clinical training and supervision have long been dominated by humanistic and cognitive behaviourist orientations, both of which ignore the transference-countertransference dimension of therapeutic interaction. Intergenerational and institutionalised countertransference blindness and the ensuing absence of psychoanalytically oriented training and supervision may render students particularly prone to the later enactment of malignant "countertransference pathology" (Ivey, 1992, p. 34). Haumann (2004) objects that these unsubstantiated assertions are essentially speculative in nature and that no published research currently exists which determines more precisely what "specific theoretical paradigms [are] adhered to by psychology departments at South African universities or … how this may relate to countertransference problems and enactments among South African psychologists" (p. 5). However, detailed examination of data in the preceding chapter (see Chapter 6) apparently supports the contention that the postgraduate ethics training from 1991 to 1999 of six experienced psychologists failed to heighten awareness of idiosyncratic countertransference vulnerabilities that routinely appeared to play a role in the process of ethical decision-making as it transpired within and across the research interviews. Certainly the ready acknowledgement of the potential impact of countertransference phenomena on ethical judgment is absent from participants' accounts of their former ethics training and from their subsequent understanding of their own ethical decision-making practices. This suggests that if we are to heed Steiner's (2006) caution regarding the need to sensitise clinicians to those areas in which they may be vulnerable to iatrogenic boundary violations, then the systematic and early identification of personal countertransference responses should be considered as integral to ethics education and to the teaching of the core skill of ethical decision-making. As Epstein and Simon (1990) point out, normalisation and frank discussion of countertransference phenomena including erotic countertransference should be repeatedly emphasised in both graduate and continuing ethics

education “as a reminder of the perils involved in our work and as a preventive safeguard” (p. 450).

3. PERCEPTIONS OF THE ETHICAL CODE OF PROFESSONAL CONDUCT, THE PROFESSIONAL BOARD, THE PSYCHOLOGICAL SOCIETY OF SOUTH AFRICA (PSYSSA) AND THE LAW

Clinical practice is situated within a framework of normative ethics which is comprised of a series of documents defining acceptable ethical behaviour (Abeles, 1980). At the time of the 2003 research interviews, applicable documents included the first legally enforceable national Ethical Code of Professional Conduct adopted in 1999 by the Professional Board (HPCSA, CPD, Guidelines for Psychologists and Registered Counsellors, 2001). Since the data (Interv. **6**, p. 226, 21-29) reveal that Act 56 of 1974 (Government Gazette, 1974) was mistaken for a professional ethics code, the latter Act arguably constitutes a second statutory benchmark. Devised for the protection of the public, the Act’s spare legal injunctions do not provide effective guidelines for complex ethical dilemmas but they do stipulate “which actions by psychologists might lead to disciplinary action ... [it is thus] constructed as a catalogue of potential offenses” (Allan, 1997, in Wassenaar, 1998, p.135). A third document pertains to statutory rape and concerns the Child Care Act 74 of 1983 which obligates the treating therapist to report suspected child abuse (Allan, 2001). While these texts constitute a necessary statutory and ethical framework for the dilemmas concerned, the data suggest that participants were apparently unaware of their existence, their differences and their purposes.

3.1. Perceptions of the South African Ethical Code of Professional Conduct

Ethical codes offer a set of guidelines or ethical rules that establish the parameters of acceptable practice and attempt to secure competent and professional behaviour (Louw & Edwards, 1998). The provision of aspirational ethical principles protects the public interest by encouraging the individual practitioner to strive for optimal levels of practice (Pettifor & Sawchuk, 2006). At the very least, codes may encapsulate minimum standards representing the “bottom line below which … practice should not go” (Lindsay & Colley, 1995, p. 448). Excessive outside interference by state bodies is accordingly pre-empted by the profession’s autonomous attempts to regulate itself (Steere, 1984) and to enforce disciplinary action against behaviour which violates acceptable standards of conduct (Pettifor & Sawchuk, 2006).

Mere exposure to ethical code items is, however, widely agreed to be "woefully inadequate" (Gabbard, 1996, p. 318) in fostering ethical behaviour (Clarkson, 2000; Handelsman, 1986b; Scherrer et al., 2002). Missing from the APA's (1992) and CPA's (2000) ethics codes is the explicit recognition accorded by APsaA (2003)[3] to countertransference phenomena and the related need identified in the latter association's professional code to vigorously monitor "behaviours that are likely to misuse the power differential of the transference-countertransference relationship to the detriment of patients" (p. 2). The current South African ethics code for psychologists similarly does not factor in the potential influence on ethical decision-making of "blind spots" (Freud, 1912, p. 116) or of unconscious phenomena. As Gabbard (1996) argues, however, even if therapists do not practice dynamic psychotherapy, "transference and countertransference issues will always be present in the therapy whether or not the therapist acknowledges their existence" (p. 318). In contrast with the CPA (2000), the usefulness of the present South African ethics code is arguably constrained not only by the absence of explicit decision-making guidelines but also by any cautionary statement alerting practitioners to the possibility that ethical decision-making potentially represents a time-consuming emotionally distressing endeavour that can forcibly mobilise "personal biases, stresses or self-interest" (CPA, 2000, p. 4). Without the assistance of basic decision-making steps, practitioners may encounter increased difficulties regarding the obligation to remain professionally accountable and thus to engage "in an ethical decision-making process that is explicit enough to bear public scrutiny" (CPA, 2000, p. 4).

The following excerpts highlight participants' seeming ambivalence towards professional ethics codes. At the time of the 2003 research interviews, no participant had consulted the *South African Ethical Code of Professional Conduct* (2002) or was apparently even aware of its existence:

> *I'm just trying to picture it, kind of bring it into my mind … No, I didn't consult the Code … to be honest, I haven't … gone and sat with that document for a long time (Interv.* ***6****, p. 226, 13-19).*
>
> *No, no, I don't even know where it is (Interv.* ***5****, p. 185, 8).*
>
> *No, I didn't consult the Code of Ethics … I'm really very out of touch with the … bureaucracy of the professional (Interv.* ***3****, p. 98, 35-37).*

[3] The American Psychoanalytic Association

> *... I didn't even know that there was a document that I could have in my possession (Interv.* ***1,*** *p. 15, 21-22).*

The general domain of „ethics' appears to be perceived as the province of dry officialdom and tedious bureaucracy. Rather than being syntonic with everyday professional practice, the current code seemed to represent a distant and split off entity that inspired only ambivalence, avoidance or dismissiveness. When asked to describe their relationship with past and current ethics codes, participants gave the following replies:

> *Ambivalent, „cos on the one hand it's quite clear and though it's very clear ... this is what you might do and this is what you might not do ... it offers no guidance (Interv.* ***2****, p. 55, 35-37).*

> *... the ethics that we got ... is so abstract ... it feels like a very* ***dry*** *background part of things ... [My relationship] at this point, very distant ... It feels extremely distant (Interv.* ***3****, p. 98, 39-41; p. 99, 30-35).*

> *I imagine that the Code ... existed in a sphere that was* ***beyond****, that was* ***elsewhere*** *... my feeling was that* ***this*** *dilemma [involving dual role relationships] was so sensitive ... that no* ***document*** *could give me answers ... it didn't occur to me to even look ... it didn't occur to me that it would have anything to offer ... of any value (Interv.* ***6****, p. 226, 32-45).*

At times, the unread Code seems to take on an actively persecutory guise. Fuelled by ignorance of its contents, participants' transference relationship to the Code is on occasion suffused with fear and panic:

> ***Fear*** *... because I don't* ***know*** *enough about it, because I feel* ***vulnerable****, because there's ... there's uncertainty (Interv.* ***5****, p. 184, 40-43).*

> *"****Fear*** *... ah, fear ... my sense is that ... it's a* ***rule*** *book, it's not really a ... mentoring guide, that's my projection ... it's a rule book and there's like police that police it ... on a feeling level, I'm afraid, I'm afraid ... I'm afraid that ... I'll be basically* ***applied*** *to a set of rules and ... be seen to fall outside of those rules ... and then be punished accordingly (Interv.* ***4****, p. 147, 16-32).*

When the constraints and caution sounded by the current Code in relation to multiple relationships were explored, fear and anxiety alternate with escalating anger:

> *I've got a little bit of a paranoid-schizoid feeling ... I feel angry ... because if ... this* ***is*** *breaking some professional [rule] of conduct and that would mean I wouldn't be able to do it anymore ... it* ***feeds*** *my sense of* ***mistrust*** *and* ***judgment*** *of ...* ***the constructors*** *... of this Code ... like what I'm doing is being measured against the Code and I feel ... angry about that ... people can't see what the hell's going on here! (Interv.* ***4****, p. 153, 33-37; p. 154, 30-33).*

Analysis of the data suggests that research participants felt isolated and alienated from their graduate ethics training and from the current ethics code; neither professional resource was perceived as offering support or guidance with the resolution of common ethical dilemmas.

3.2. Perceptions of the Professional Board and PsySSA

The Professional Board for Psychology was originally formed in 1974 and is a statutory body whose primary aim remains the protection of the public and the safeguarding of minimum standards of education and training for psychologists (Wassenaar, 1998). The Board is empowered to take disciplinary action against any psychologist who may be guilty of unprofessional conduct including withdrawal of the latter's registration and right to practice (Wassenaar, 1998). By contrast, the Psychological Society of South Africa (PsySSA), founded in 1994, carries no statutory powers and to date represents the predominant voluntary professional association in this country (Wassenaar, 1998). Paramount aims include the promotion of the mental health of all South Africans in a post-apartheid society, the safeguarding of ethical standards and the provision of supportive and advisory services to its membership (PsySSA website[4]).

At the time of the research interviews, no participant was a member of PsySSA. Imagery evident in the interview texts portrays the formidable difficulties of penetrating the perceived institutional armour of both organisations in frustrated attempts to find within a humane and helpful voice. Once again key professional resources are depicted as remote from the daily concerns and conflicts of practice on the ground. When asked whether they would consider approaching PsySSA or the Board for help with ethical dilemmas, participants' answers reflect collective feelings of frustration, anger and mistrustfulness:

> ***No**, I wouldn't ... I wouldn't do that, I wouldn't put myself at risk. Not a chance ... I don't have **any trust** ... at all in the powers that be in psychology. **Zero trust** (Interv**. 4**, p. 147, 36; p. 148, 34-35).*
>
> *I've an image of waiting on the other end of the phone and it not being answered ... being passed from pillar to post, not getting the right person ... being quite frustrated (Interv. **1**, p. 15, 32-34).*
>
> *I'm not a member of PsySSA, I was a member ... but basically all I was doing was paying a fee and I didn't feel that there was any value that I was getting from it (Interv. **4**, p. 148, 13-14).*

[4] www.psyssa.com

> *Where are they? The Professional Board? ... trying to contact them ... long-distance calls and you're on the phone and you hear music ... Mozart or* ***whatever*** *... there's a switchboard that somebody will get back to you and (sighs)* ***no, never, never!*** *... you can't get through to them ... they're on lunch or they're on tea or they've gone home already (Interv.* ***5****, p. 185, 18-30).*

David similarly described struggling with a dilemma involving collegial sexual misconduct between 1997 and 1999. Structural changes affecting the profession of psychology during this period saw the amendment in 1999 of the name of the original controlling body, the South African Medical and Dental Council (SAMDC), to the new title of the Health Professions Council of South Africa (HPCSA) (Scherrer et al., 2002). Formerly excluded from service on the SAMDC, the professional Board for Psychology is today one of twelve Boards which are represented on the HPCSA and which enjoy considerable autonomy with regard to ratifying decisions affecting the different professions concerned (Mokhuane, 2006). In the following excerpt, David refers to the original SAMDC which he too experienced as unsupportive of the everyday struggle to foster ethical practice in the context of the therapeutic space:

> *... the man basically said ... listen, it's up to you ... we can do nothing unless you lay a formal complaint ... it's your pillow and you must lie on it ... I sort of felt ... switched off by [that] ... like if* ***that's*** *their attitude towards it, I'm not going to get any support from them ... now I'm kind of* ***on my own*** *... they are not very enhancing of encouraging practitioners* ***to feel*** *ethical. I mean my sense of it was ... ag, why bother because they're not going, they've no intention of supporting me ... [It was] like trying to find your way to the right person to speak to ... (laughs) where I [had] to* ***fight*** *my way in, really to be heard. „Cos really what I ... wanted [was] to just talk to somebody on the Ethics Board, with whom I could dialogue my dilemma, that was my need (Interv.* ***2****, p. 54, 30-42; p. 55, 1-4).*

The Council's apparently brusque rejoinder that they could play no role outside the lodging of a formal complaint is followed by David's reasoned appeal for the creation by statutory bodies of a knowledgeable, user-friendly ethics advisory service that would be widely available for informal consultation. Such a service would optimally be thoroughly attuned to practitioners' need for support and to their anxieties regarding the implications both of remaining silent as well as of speaking out about collegial misconduct. The next excerpt thus highlights the need for professional bodies to adopt an experience-near and more invitational approach to anxious professionals seeking guidance on ethical dilemmas:

> *... what would've been nice is ... if I'd phoned the [Council] and the person ... said, look, let me first do this for you, let me fax you the relevant*

> *paragraphs of the Medical and Dental Council's Code of Ethics … come back to me … and we can discuss it … **Then** they said … you don't have to reveal the person's name … but just give me the facts and let me give you an opinion about how we would view this … **Then**, **if** you wanted to activate something … **if** there's some kind of … preliminary hearing, that we would need to interview you … and if the thing should go forward for a complaint, this is how you will be involved and this is what we expect from you … we have a … view that we encourage practising professionals … to speak up … around this kind of misdemeanour and what we recommend is that you phone the [health professional] … mention that you've called us and that it's appropriate for you to have a meeting with him and hear his side of the story first hand … **That** would've been helpful to me, „œs that's what I would do, if I was supervising somebody now who's in a dilemma, what I would want them to know is what is the infrastructure … the locus in which this all exists and what are the implications for you, as a practising professional, to remain silent **and** to speak up … **That** would've been useful for me (Interv. **2**, p. 53, 37-48; p. 54, 1-26).*

The data provide only a single instance where the Board and PsySSA were perceived to have offered constructive assistance with the resolution of a dilemma. Although Theresa acknowledged that she too did not consider approaching the latter organisations for guidance with regard to troubling multiple relationships, she offered the following anomalous description:

> *Well, subsequently through my experience of a psychoanalytic reading group, they've been involved in an incident around a colleague and it suddenly brought those bodies one step closer, that they **are** bodies that can be consulted, they're people … not just concepts that belong to a document in Pretoria. So, in the last say, six to eight months … I've become more conscious of them around ethical issues (Interv. **6**, p. 227, 9-14).*

3.3. Perceptions of the Law as a Professional Resource

The practice contexts that are disproportionately most likely to attract public complaints against South African psychologists include child custody work, adult psychotherapy and work with minors. This finding foregrounds the "conclusion that Complaints are much more likely to arise at the interface of ethical and legal domains of professional practice" (Wassenaar, 2002, p. 216). Clinicians are adjured to improve the quality of their work by attaining a sound understanding of the relevant legal rules which intersect with their professional activities and practices (Allen, 2001). But by virtue of finding themselves in the potential role of witness or accused, the "uneasy" relationship which prevails between clinical psychology and the law may well arouse "resentment towards the legal profession in the hearts of many clinical psychologists" (Steere, 1984, p. 75). Rather than being perceived as a "big benevolent force" (Interv. **5**, p. 189, 1), the following excerpt suggests that, on the

contrary, the law often seemed to be regarded as a mistrusted and not necessarily ethical adversary:

> *And the **whole** issue at play in that workshop [on the law and psychotherapy] was not what are the ethical issues in terms of what's **moral** or what's **right**, it's more about what are the issues in terms of what will get you in trouble (pauses) legally (Interv. **4**, p. 117, 4-6).*

Abramovitch (2006) writes of Primo Levi's "grey zone" in extermination camps wherein the polarities of ethical and unethical are redefined by context and behaviours customarily accepted as unethical (including lying, stealing and cheating) may come to constitute ethical virtues. Breaking the structure of confidentiality by compliance or "blind obedience" (Slack, 1997, p. 21) to legal injunctions including mandatory reporting laws similarly does not necessarily secure an optimally therapeutic or ethical course of action (Bollas, 1999). Professional ethics codes may thus accord explicit recognition to the paradox that refusal to abide by legal injunctions may on occasion constitute the most ethical course of action (APsaA, 2005; CPA, 2000). In the highly aversive circumstances generated by collegial misconduct, for example, "defensive psychotherapy" (Clarkson, 2000, xviii) may serve to discharge various legal obligations yet still leave the sexual misconduct concerned unchallenged and the dilemma unresolved from an ethical and countertransference perspective:

> *[The law] … offered me … clarity that … I'd done everything necessary to discharge my practical responsibility … I needed to inform the parents … I made an attempt to contact the colleague … I recorded that in my notes. So, from that point of view, no-one could point a finger at me and say you **should** have done X, Y and Z … the legal thing … gave me certainty … that there was nothing more I needed to do actually (Interv. **2**, p. 56, 10-24).*

Apart from helping to avoid potential law suits, not a single quote emerges that suggests that the legal domain was perceived to be an ethical ally or professional resource that might aid the resolution of the dilemmas concerned. Descriptions veer from conceiving South African law primarily as a mistrusted adversary to, alternatively, perceiving it as a profoundly compromised and corrupt institution:

> *The law was unjust … the law doesn't protect (pauses) the person who has been raped, the law doesn't protect **me** as a professional person … the law will protect the rapist, the law will protect the person who gets put in jail … the law **doesn't** protect the policeman … policemen are **prizes**, you know, you kill a cop, you go up in … status in the gang. Ja, the law, ja, the law, the law doesn't work (Interv. **5**, p. 186, 1-8).*

Not only is the law perceived as failing to address the legitimate security concerns of both the professional as well as the raped patient, but the very act of enlisting its aid and of mobilising its procedures may well elicit an unwelcome secondary source of trauma:

> *… it just feels like it all went roughshod over the little girl … I don't know what the forms are called but … there's an A130 that's been completed, the report from the social worker on the B22 … **that** kind of state bureaucracy stuff … and the person's lost, ja … there's **an absence** of the person, of the little girl … I suppose these people are doing a good job but … this doesn't **feel gentle** to me … I just wonder if there was **a format**, you know, rape victim comes in … let them tell their story over and over … work through their feelings, „work through their feelings' in inverted commas, whatever that means … see them for four sessions, terminate … and then **guilt** on my side… I … criticise, but what did **you** do? (Interv. **5**, p. 182, 4-40).*

The data thus far disconcertingly suggest that graduate ethics training, the current ethics code, the statutory and voluntary professional bodies concerned and the law were to a very large extent not perceived by participants as professional resources that could be profitably accessed to guide ethical decision-making and action.

4. PERCEPTIONS OF PEER CONSULTATION, CLINICAL SUPERVISION AND PERSONAL THERAPY

The difficulties inherent in reaching out to colleagues and research participants' evident reticence regarding exposure of their professional lapses have previously been identified in „Avowed vs Lived Values'. In the following excerpt, for example, David continues to reflect on the apparent lack of hospitable professional space wherein therapists can speak freely without shame of their ethical concerns and anxieties:

> *[It's difficult to] find a working space where people don't talk theory but people can actually talk about what they **really** do without … the persecution that you are going the right thing, you **have** to do the right thing or **make** the right interpretation … if you look at the sort of primary defence … of educated people … with some kind of university degree, the first inclination is to use intellect to cover up … I think it's an almost automatic response … and I think it's got to do with shame (Interv. **2**, p. 30, 25-43).*

Collective covert pressure to conform to a cerebral, highly intellectualised ego ideal which quotes "the right page in the right articles" (Interv. **2**, p. 31, 19) actually functions to seal over countertransference difficulties and clinicians' "real inside experience of their work" (Interv. **2**, p. 67, 32). Should this ego ideal be transgressed, David argues, the archaic superego of the professional community finds talionic expression through shaming, isolating, excommunicating or labelling the „transgressor' as mad, maverick or crazy

(Interv. **2**, p. 31, 1-12). In the context of contemporary South African psychoanalytic psychotherapy, David's comments regarding professional peers again seem to highlight the perceived absence of benevolent third others who might have aided participants' efforts to resolve the dilemmas concerned.

During the time in which the ethical dilemmas arose, two participants reported avoiding supervision. The four remaining participants reported contact with five different supervisors. The theoretical orientation of all supervisors, barring one who adopted a non-analytic pragmatic style of case management, was described as psychoanalytic or as Jungian.

Gabbard (1996) notes the inadequacy of the individual clinician's reliance on introspection or on the internal self-monitoring of primitive transference-countertransference dynamics. Such scrutiny "will always be subject to the vagaries of countertransference, bias, denial, and unconscious wishes for the patient to meet the therapist's needs" (p. 316). While novice and experienced clinicians alike are thus encouraged to access ongoing consultation or a third point of view (Dewald & Clark, 2001; Gabbard & Lester, 1995; Ivey, 1992), the data disconcertingly suggest that receiving regular supervision even from experienced or analytically attuned clinicians does not necessarily offer an effective antidote to incompetent professional practice. When asked how effectively supervisors were able to assist with the processing and understanding of common ethical dilemmas, participants' reservations show evidence of anxiety, uncertainty or outright disappointment:

> *I have a slight worry that if my supervisor ... reads [this thesis] ... I just feel a bit anxious ... because ... perhaps we didn't explore it enough at the time ... and I sort of feel anxious that she might feel criticised or something like that (Interv.* ***3,*** *p. 72, 11-16).*
>
> *... it was pretty useless supervision, ...* ***never*** *get into* ***anything*** *to do with how I felt ... In retrospect, ... the supervisor was ...* ***shocked*** *and undone and* ***he*** *probably needed supervision ... actually, that was my disappointment ... he was paralysed, didn't know really what to say ... (Interv.* ***2****, p. 40, 27-29; p. 52, 14-18).*
>
> *Unfortunately, my supervision ... didn't feel (laughs) very satisfying ... I had very ... little input and input that didn't feel ... that useful, not that helpful ... I probably would've benefited ... from outside supervision ... this [case] is about ... detailed, very powerful psychoanalytic work ... transference and countertransference and projective identification ... it ...*

> *didn't feel like **they** had **a place** in my supervision (Interv. **6**, p. 208, 3-18; p. 224, 16-21).*

Apparently torn between mandatory reporting laws governing statutory rape and the need to consider the potentially disruptive effects on the therapeutic process of breaching confidentiality, Riaan's following description provides the single exception to participants' generally negative evaluation of the efficacy of supervision:

> *Well, I think [the supervisor] addressed my needs which were around the legal/ethical issues ... just clarifying my role ... as therapist as opposed to forensic counsellor [or] investigator and that ... I don't have training in that kind of work (Interv. **5**, p. 183, 32-38).*

Mills (2005) writes that relational psychoanalysis courageously acknowledges the primacy of the analyst's phenomenology in analytic work and offers candid accounts of the latter's intimate countertransference experiences. Relational approaches thus profoundly challenge the traditional emphasis on interpretation and insight and forge a new "clearing for honest discourse on what we actually do, think, and feel in our analytic work … breaking the silence and secrecy of what actually transpires in the consulting room" (Mills, 2005, p.156). Yet shame, fear of verbal censure and superego projections onto the supervisor apparently continue to lead to the supervisee's omission of critical clinical material and to inhibit the latter's self-disclosures regarding his/her feelings and interventions with patients (Gabbard & Lester, 1995). Gabbard (1996) thus suggests that the training of novice therapists needs to actively promote normalisation of intense countertransference feelings in an effort to lessen resistance to sharing such „forbidden' affects with the supervisor concerned. Beginner therapists need to learn that "those aspects of their thoughts, feelings, or actions that they would most like to keep secret from the supervisor are precisely the issues which should be openly discussed in supervision" (Gabbard, 1996, p. 317). The following quotes suggest that anxiety about appropriate supervisory intervention but also fear of possible judgment and censure were instrumental in postqualified clinicians' apparent guardedness and avoidance of self-disclosure in the supervisory space:

> *I was quite uncertain as to how **much** to reveal if I'm **really** struggling with the case. So what I'd do is I'd bring [the supervisor] stuff that was ... processed ... refined and thought through ... I wouldn't come with **huge** questions ... **huge** difficulties, I'd ... work on it…on my own (Interv. **6**, p. 223, 49-51; p. 224, 1-3).*

> *... the feeling ... about not ... feeling professional in my space ... I don't think I formulated any thought about it consciously ... but I still didn't think of going to colleagues ... the feeling of having made a mistake at the*

beginning would have just made me more reticent about going to speak ... about it, because it's ... as though nothing can be done about it now ... if I'd taken it to supervision, I feel very ***safe*** *in my supervision ... I've risked more ... than this before so I can't explain why [I didn't go] (Interv.* ***1****, p. 20, 17-20; p. 21, 3-5).*

It felt like ... I was managing and so I ***„didn't need'*** *supervision. But if I think about that, it wasn't so much that I didn't need but ... I was ... anxious that the supervisor would ... act against it ... I was worried that they would not* ***support*** *what I was doing ... and I didn't want to risk that (Interv.* ***6****, p. 142, 43-46; p. 143, 1-4).*

Additional difficulties which beset the supervisory space echoed compromised postgraduate teaching practices and included, for example, "rushed" supervision and the irregular „modelling' or acceptance of dual role relationships. Moreover, current supervisory practices often retained an apparent emphasis on pragmatic case management at the expense of discussing the ethical and countertransference dimensions of the dilemma concerned. The following quotes suggest that Eberlein's (1987) observation that few supervisors spend sufficient time exploring the ethical implications of their student supervisees' interventions may also pertain to well qualified clinicians' subjective experiences of the supervisory space:

... we didn't have enough time really to explore this [dual role] dimension ... because ... there is a ... crisis ... about whether or not [the patient] breaks up with her boyfriend ... I would've been interested to get, but I didn't ask my supervisor ... it was a bit ***rushed*** *... whether* ***he*** *thought there was an ethical issue around this [dual role relationship]? (Interv.* ***3****, p. 93, 46-48; p. 94, 1-7).*

... because of her time and my time we'd sometimes not see each other ... so ... I've had less supervision than I would have liked ... often I've ended up having more ***management supervision*** *than ... where you're* ***really*** *tracking a case. So I might come ... with ... what must I* ***do*** *about* ***this*** *and then ... maybe looking at someone else (Interv.* ***3****, p. 75, 1-10).*

The dual role relationships which form the context for the following three quotes have each been described in detail at the outset of the „Results' section. In the initial scenario, the participant questions whether the supervision of a troubling dual role relationship is itself potentially contaminated by a supervisor who apparently unquestioningly provides irregular „modelling' through her own engagement with multiple relationships. In the second scenario, two different analytically oriented supervisors are apparently "unfazed" by the therapeutic impasse wherein the participant concerned is both the patient's therapist as well as her cousin:

> *... I have supervision with my boss once a week ... I think in [my supervisor's] relationship with [my patient], „œause they're **also** colleagues ... it felt like things were ... again contaminated because she had her own experience of [my patient] which might've coloured her perceptions and her capacity ... to supervise me (Interv. **6**, p. 200, 27; p. 224, 3-7).*

> *Well [my first supervisor's] attitude was ... fairly straightforward, it was about ... [the patient's] not in your immediate environment ... it's all quite distant so ... it should be okay ... it wasn't explored an enormous amount in that supervision ... it was also ... what feelings do I have ... the feelings that had come up ... had been quite intense ... So perhaps ... I was **surprised**, I felt there would've been more ... shock ... it was ... downplayed ... I think that that felt a little surprising to me (Interv. **3**, p. 95, 13-24; p. 96, 7-10).*

> *... my [new] supervisor ... didn't appear shocked ... about my seeing a ... cousin ... he seemed to take it ... in his stride ... we didn't really explore that dimension ... but this morning ... I had the thought that ... [the patient] told me about going to family gatherings ... and it feels like there's an extra dimension of interest thinking about those people because ... my family would know about [them] ... I mean to what extent it enters the therapy I suppose is the question and I'm not sure whether it does or not (Interv. **3**, p. 92, 15-32).*

Underpinning the teaching of mental health professionals lies the core ethical principle of competence (*Journal of Nervous and Mental Disease*, Editorial, 1980, in Wassenaar, 2002). Perhaps the most troubling aspect of derelict supervisory practices is the seeming unawareness of the personal countertransference component apparently driving supervisees' ethical decision-making and chronic boundary violations. The data raises the contentious question of whether local analytically oriented supervisors are currently adequately equipped to identify the presence and possible countertransference ramifications of common ethical dilemmas. Wassenaar (2002) observes that competence as an academic or as a practitioner does not necessarily secure competence as a supervisor; this suggests that the competent supervision of ethical dilemmas may require the future development of training programmes for supervisors which have as their primary focus the issue of ethics education.

From the perspective of psychoanalytic psychotherapy, Steiner (2006) observes that countertransference enactments frequently allow the analyst to evade uncomfortable psychological truths either about him/herself or about the patient. Enactments may thus represent what is split off and projected "because it is too disturbing to be talked about" (Steiner, 2006, p. 327). A stance of non-enactment derives from the establishment of "triangular space" (Solomon, 2003, p. 174) and from the capacity for reflection on the

transference-countertransference pressures mobilised by the analytic relationship and setting. The protection afforded to the patient's subjectivity by constraining the therapist's impulse to react or to retaliate without thought comprises the analytic attitude which, Solomon (2003) argues, is therefore quintessentially ethical in nature. The data pertaining to analytically oriented supervision, however, seems to support Ivey's (1992) contention that having an analytic orientation "does not immunise its adherents or guarantee them insight into their countertransference issues" (p. 43). General difficulties integral to identifying countertransference phenomena may well be augmented by the lack of supervisory awareness of the countertransference dimension of ethical decision-making. These latter instances of countertransference blindness apparently contributed to the pervasive collapse of "triangular space" evident in the supervision of the following dilemmas and to the seeming evasion of supervisees' disturbing countertransference enactments.

The first example which follows shows a supervisor's apparent resistance to openly confronting both his own as well as his supervisee's countertransference reactions regarding collegial homosexual misconduct. The second scenario highlights a supervisor's apparent failure to consider the possible meanings of the participant's reticence to disclose his affective responses and of the same interviewee's ensuing „decision' to passively desist from reporting, following up or handing over the statutory rape of a young patient:

> *... I think [collegial sexual misconduct] was a difficult situation for anybody to think about ... supervision became suddenly very tentative ... as if **both** of us were ... touching something ... dangerous and without the courage to just go to the edge of what needed to be thought about ... I think **that** was my supervisor's experience ... this information ... made him **tense** ... his **anxiety** around dealing with a topic like this was activated and therefore he couldn't serve me as a supervisor effectively (Interv. **2**, p. 52, 42-45; p. 53, 1-23).*
>
> *... immediately after the [research] interview, I felt quite emotionally disturbed ...' Cause I generally never talk much in that way about my work ... [in] supervision, I try and ... cram as many [cases in] ... it's quite limited ... it's about sessional notes and discussion ... then moving on ... but ... this [interview] ... made me think about my own vulnerability ... also my emotion, in terms of my work, my emotional neediness (Interv. **5**, p. 178, 17-27).*
>
> *... last week after we ... explored [the dilemma] ... that was the first time I really, on an affective level, explored it (Interv. **5**, p. 184, 14-15).*

Personal therapy and supervision are acknowledged as the two primary influences which are brought to bear on the professional development of a psychotherapist (Gabbard, 1996; Ivey, 1992; Solomon 2003). Within the intimate context of a personal therapy, the therapist hopefully familiarises him/herself with key defensive patterns and conflicts around which countertransference enactments are most likely to occur (Gabbard, 1996; Steiner, 2006). At the time of the research interviews, three participants reported attending regular analytically oriented personal therapy. When participants turned to their own therapists for help, the latter's interventions revealed difficulties around basic ethical knowledge similar to those evidently experienced by the supervisors concerned. The following quotes suggest, for example, that the personal therapists involved failed to identify the specific ethical dilemma at stake. Moreover, in the context of participants' sustained enactments around dual role relationships over periods ranging from 18 months to nearly two years (Interv. **4**, p. 128, 23; Interv. **6**, p. 208, 21), core countertransference difficulties including narcissistic self-interest and separation anxieties remain apparently unchallenged and unrectified. Finally, rather than helping to establish "triangular space", personal therapists appeared to blur the boundary between therapy and supervision and are perceived by participants as offering either "covert encouragement" or, alternatively, absolution of responsibility for chronic boundary violations by erroneously locating the site of disturbance solely within the patient's internal object world:

> *My therapy was ... at that time ... about three times a week on the couch ... [it] was the **primary** place of processing **everything,** including any ... stuff associated with my practice, so if you go back to that previous question, what resources did I tap on ... my therapist [was] there with me thinking ... that was a dominant ... **very** powerful influence was my therapist ... a qualified analyst ... I **never** had any negative sense about [the dual role relationship] from him ... I ... remember (pauses) like ... covert encouragement (laughs) ... really covert encouragement ... and every now and then an overt encouragement (Interv. **4**, p. 144, 4-18).*

> *... this current therapist has ... had an analytic training ... [I'm in therapy] twice a week ... What approach did she adopt? ... she gave meaning to my experiences, to the ... projective identifications ... where I felt ... something **really** being put into me and **twisted** ... at an abdominal level ... my frustration, my anger ... my sense of having been **violated** ... she helped to normalise those and to ... hand them back ... to be able to say you know what? This stuff belongs to you, the patient ... just [to] clarify that distinction that was ... useful (Interv. **6**, p. 201, 1-4; p. 225, 7-13).*

The data reveal that supervision was avoided by two participants. The sample of six participants included one practitioner who remained professionally isolated throughout the

duration of the dilemma. The remaining five participants approached a combined total of five supervisors and three personal analysts for help with processing common ethical dilemmas. Analysis of the descriptions pertaining to the combined eight supervisory and personal therapy contacts suggests a possible ethics hiatus in the way clinical cases may be processed in the field of contemporary South African psychoanalytic psychotherapy. Solomon (2003b) reminds us that an ethical dimension is constantly present in the consulting room and that an ethical attitude, which constitutes the core of the analytic attitude, is integral to all our professional activities as clinicians, supervisors and as colleagues. Despite the smallness of the sample, the repeated omission by analytically oriented supervisors and personal therapists of the ethical dimension (including the countertransference component) of the clinical material concerned seems to suggest that „ethics' is currently perceived as detached from daily professional practice and can be relegated to a formal "set of rules that can be forgotten as long as they are not contravened" (Solomon, 2003a, p. 167). The data thus raises the possibility that postqualifying ethics education not only of analytically oriented supervisors but also that of personal therapists remains a neglected area of continuing professional development.

Introspection and the therapist's own self-observations require the additional corroboration offered by ongoing individual or peer supervision and psychotherapy. Personal and professional isolation is fertile soil for chronic boundary violations (Epstein & Simon, 1990; Gabbard, 1996). However the preceding data analysis seems to highlight participants' perceived alienation from a variety of valuable professional resources. In the excerpts which follow an ensuing sense of pervasive isolation appeared to emerge both within and across the interview texts as a heightened risk factor for compromised ethical decision-making:

> *There aren't any resources, I mean, who does one speak to about this? (Interv.* ***5****, p. 52, 37-39).*
>
> *... the biggest mistake was that I didn't actually consult anybody ... I tend to deal with things alone ... I ... find it difficult to reach out (Interv.* ***1****, p. 9, 42; p. 14, 45-46).*
>
> *... my experience of the supervision was that it left me feeling even* ***more*** *alone in managing the dilemma. I mean I had a hope that that would be the place, but it wasn't to be so (Interv.* ***2****, p. 52, 37-39).*
>
> *... in conversation with members of the [Psychoanalytic] Society ... there would be times in which I would want to say something ... about this*

*[dilemma] ... and then I'd choose not to ... „cause I'd be afraid of the judgments ... something like that (Interv. **4**, p. 132, 30-34).*

*...in this particular case, I had very ... very little input ... it was difficult ... finding myself carrying [the dilemma] alone ... that's my personal „stuff', that I land up just doing it myself and doing it on my own (Interv. **6**, p. 208, 16-17; p .224, 37-40).*

5. WHEN ETHICAL DECISION-MAKING IS COMPROMISED: CONTEXTUAL AND SUBJECTIVE RISK FACTORS

Complex ethical dilemmas are unlikely to be resolved by the practitioner in isolation. The professional literature widely endorses the need for consultation (APsaA, 2005; CPA, 2000; Dewald & Clark, 2001; Gabbard, 1996; HPCSA, 1999; Jennings, Sovereign, Bottorff, Mussell & Vye, 2005; Norris et al., 2003). The preceding data analysis, however, repeatedly reveals the felt absence of professional resources or benevolent third others who might be called upon to aid decision-making. The third other may be envisaged as comprised of postgraduate ethics training, professional organisations, ethics codes, supervisors or peers. Interview texts reflect collective anxieties that exposure of countertransference difficulties will elicit a mainly punitive third, resulting in labelling, censure, shame, cancellation of registration, loss of professional identity and earnings or even complete excommunication by the analytic community. As a consequence, „ethics' may be defensively dismissed as distant, dry and irrelevant and relegated to the confines of ignored or forgotten official documents. Alternatively, since its guise is construed as fundamentally punitive in intent, „ethics' may be feared and actively avoided. In either event, „ethics' emerges as detached from everyday professional practice and as comprising a mostly unacknowledged and silenced dimension of clinical work. This apparent severance affected not only participants but also their educators, supervisors and personal therapists.

Research participants' reported alienation from the ethical dimension of clinical practice provides a contrast with Etchegoyan's (1991) claim that a failure of ethics invariably leads to technical failure as the "basic principles [of psychoanalysis], especially those that structure the setting, are founded upon ethical concepts of equality, respect and search for truth" (p. 32). The apparent severance, in the present sample, of ethics from the praxis of psychoanalytic work raises the ongoing question of how to foster collectively "a climate of ethical sensitivity" (Wassenaar, 2002, p. 66) or benevolent ethicality that might inform daily professional activities. Conscious integration of the ethical dimension of clinical work might translate locally into useful new practices. This could include increased recognition of the

ethical aspects of clinical material presented in supervision or in professional contexts dedicated to continuing professional development. Consistent establishment of "ethical space" (Wiener, 2003), identification of counter-transference phenomena elicited by ethical dilemmas, and regular examination of anti-analytic wishes or impulses may contribute to creating safer public forums wherein practitioners' anxieties and ethical concerns could be openly discussed with less fear of peer censure or judgement.

The following discussion uses the preceding data analysis of professional resources to identify three risk factors for compromised ethical decision-making. Strategies are suggested which may aid the integration of ethics into everyday professional practices. These include consideration of how „ethics' might attain a more „user-friendly' professional profile as well as a recognition among psychoanalytically oriented practitioners that ethical decision-making which interrogates countertransference phenomena remains a core skill which is integral to the establishment and maintenance of the analytic attitude.

5.1. First Risk Factor: Compromised Postgraduate Ethics Training

When participants confronted real-life ethical dilemmas, they appeared unable to summon their earlier ethics training as an effective resource that might help to resolve the dilemma concerned. Boredom, poor recall, perceived irrelevance and the unintegrated nature of ethics training effectively alienated participants from their former ethics education. South African graduate ethics curricula may need to adopt teaching strategies that perceptibly enliven course content and that materially strengthen perceived relevance by establishing more direct linkages between training and prospective clinical practice.

Multifaceted teaching approaches might include values confrontation (Abeles, 1980), stimulating ethical sensitivity by reading accounts given by victims of ethical violations (Anonymous, 2005; Gabbard & Lester, 1995), the use of role play and simulations to process ethical complaints (Abramovitch, 2006) and enlisting the cross-disciplinary services of philosophy departments to facilitate the integration of ethical theories and principles with clinical practice (Fine & Ulrich, 1988). Given the apparent alienation of participants from the Professional Board and PsySSA, additional guest lecturers might be recruited from the ethics committees of the latter statutory and voluntary professional bodies (cf. Handelsman, 1986b). Such a strategy might ease graduate students' later consultation of these key but apparently underused professional resources. Course content could be further enlivened by

presenting the "Exploitation Index", an innovative self-assessment questionnaire that could be used to alert students to the issue of boundary violations and therapist exploitiveness in key areas of professional practice including eroticism, narcissism, power seeking and enabling behaviors (Epstein & Simon, 1990). Prescribed reading might include discomforting professional literature highlighting the issue of ethical motivation and the discrepancies identified between knowing and doing the ethically correct course of action. A range of well-known surveys provide a challenging context for trainees to reflect upon personal ethical motivation and how they themselves might engage with prospective dilemmas (Bernard & Jara, 1986; Bernard et al., 1987; Betan & Stanton, 1999; Smith et al., 1991). The latter surveys discuss challenging data indicating that significant numbers of graduate clinical psychology students and practising clinicians are well aware of what they ethically should do but they simply won't do it!

Direct linkages between training and professional practice could be established by adopting Wassenaar's (2002) recommendation that postgraduate ethics training should include the study of local patterns of public complaints as well as of the real-life dilemmas which preoccupy practitioners both locally and internationally (Pettifor & Sawchuk, 2006; Slack & Wassenaar, 1999). Current gaps in practising professionals' basic ethical knowledge could be reduced by continuing to focus systematically on the traditional four levels of ethical reasoning. These include general ethical frameworks or philosophical ethical theories, ethical principles and their application, ethical rules as expressed in professional ethics codes and ethical judgements or decision-making processes (Fine & Ulrich, 1998).

Qualitative data generated by this study appear to support Betan and Stanton's (1999) conclusion that more traditional teaching approaches need to be supplemented by heightening student awareness of how emotions and contextual concerns can profoundly influence ethical decision-making. Of central important to this thesis, however, is the additional finding that while the avowed principle of beneficence ostensibly drove participants' ethical performance, the latter's undetected personal countertransference arguably continued to organise ethical judgement and action. Regardless of the theoretical persuasion of prevailing teaching paradigms, qualitative data thus suggest that ethics education might usefully address the following three areas where countertransference phenomena allow for a confluence of ethical and clinical concerns. These include erotic

transference and countertransference, the issue of boundaries and boundary violations and trainees' introduction to new and supplementary ethical decision-making frameworks.

Slack and Wassenaar (1999) write that collegial misconduct comprised the fourth largest category of ethical conflict reported by South African clinical psychologists and that most respondents "described [such a] scenario as so aversive as to be consistently avoided" (p. 183). Qualitative data from the present study similarly highlight practitioners' apparent reticence in confronting collegial homosexual boundary violations and in publicly discussing, in local psychoanalytic societies and reading groups, the loaded issue of erotic transference. As an early preventive measure, Gabbard (1996) therefore advocates encouraging novice therapists to openly discuss countertransference feelings of love and sexual desire for patients "and [to] accept whatever feelings may arise [so that] they may develop a sense that their human struggles are largely ones shared by other therapists and thus be less reticent to discuss them with colleagues" (p. 319). In addition to teaching ethical principles, ethics courses could potentially enhance prospective ethical performance by deepening trainees' understanding of the need to reflect on and to contain the transference-countertransference configurations (including those of an eroticised nature) which inevitably emerge through the re-enactment of the internal object relations of both members of the therapeutic dyad.

Boundary difficulties are confined neither to the setting of private practice nor to the "bad" apples in the professional barrel but are common to all clinical practitioners regardless of their theoretical persuasion (Norris et al., 2003). Breaches of therapeutic boundaries (as occurred, for example, when the participant concerned sought out social contacts and business deals involving patients) constitute direct actions which point to ethical decision-making enactments and to the potential mobilisation of personal countertransference. Ethics instructors could thus, secondly, educate trainees on the necessity and purpose of boundary maintenance. This might include exploration of the differences between being a therapist and a parent or lover, highlighting the circumstance that repetitive departures from the boundaries of the therapeutic frame (as emerged in participants' sustained enactments around dual role relationships) reflect countertransference errors that gratify the therapist's unconscious emotional needs but that are consciously rationalised as actions that best serve the patient's interests (Gabbard, 1996). Finally, the presentation of a psychoanalytically oriented ethical decision-making model, which includes examination of countertransference

phenomena, may prove a useful addition to trainees' exposure to traditional frameworks which conceive of professional decision-making as a fundamentally rational process of ethical analysis.

Beyond individual ethics courses, formal procedures that publicly process trainees' ethical conflicts, concerns or instances of misconduct provide meaningful structures which frame and contain students' subjective experiences of their graduate ethics education (Kitchener, 1992; Wassenaar, 2002). If Solomon (2003b) is correct in asserting that clinicians draw on their internalised experience of the analytic attitude as conveyed by their own personal therapists and supervisors, then students' lived experience of their educators and of the collective ethical life of the teaching department concerned is arguably a foundational component or source of identification for the latter's burgeoning professional ethicality and capacity for appropriate ethical decision-making.

5.2. Second Risk Factor: Clinical Supervision and the Collapse of Triangular Space

When supervisors want to be perceived as "nice people", they may be reluctant to offer "the insult" of confronting their colleagues with dubious ethical behaviour (Handelsman, 1986b). Supervisory reluctance may additionally extend to their supervisees' therapeutic interventions. Rather than bluntly confronting the supervisee with the need to discontinue repetitive breaches of the therapeutic frame, supervisors may opt rather to adopt a conciliatory stance of "empathic understanding" towards the latter's countertransference difficulties (Gabbard, 1996).

Analysis of the data in this study suggests that local supervisory practices may be compromised in both spheres of professional activity. Participants reported, for example, supervisory resistance to exploring the meaning of confronting collegial homosexual boundary violations as well as an apparent incapacity to challenge supervisees' repeated frame deviations in the context of sustained non-sexual dual role relationships. Data interpretation is admittedly constrained by the small size of the sample and by the caveat that research participants' predominantly negative evaluation of supervision remains their individual construal of the events concerned. However, accumulative accounts across the research interviews of compromised supervisory and personal therapy practices suggest the defensive privileging of theory, technique and pragmatic case management at the expense of

the confrontation and careful exploration of the ethical and countertransference dimensions of the clinical material concerned.

The challenge for local supervision may be twofold. Rather than the easy offering of "covert encouragement" (*Interv. **4**, p. 144, 17-18)* or skirting strong affective responses (*Interv. **3**, p. 95, 13-24; p. 96, 7-10; Interv. **5**, p. 184, 14-15*), competent supervision of ethical dilemmas demands the uncomfortable probing of the countertransference dimensions of the supervisee's ethical decision-making and „ruder' or more forceful confrontation of the latter's early relatively innocuous boundary "crossings" (Gabbard & Lester, 1995). Thus the first challenge confronting local psychoanalytically orientated supervisors may be that informed exploration of their supervisees' ethical dilemmas presupposes a confident grasp of relevant ethical knowledge. This includes, for example, the capacity to identify common dilemmas, thorough coverage of traditional problem-solving approaches to ethical dilemmas (Eberlein, 1987) as well as engagement with the familiar four levels of decision-making (Fine & Ulrich, 1988) described earlier in this chapter.

The second challenge may not yield as easily to the systematic coverage of relevant content areas. This consists of helping to restore the primary function of supervision which arguably remains the sustained provision of "triangular" or reflective space. Educative efforts may thus be directed to actively attempting to establish an ethos of "ubiquitous triads" (Solomon, 2003, p. 176), including not just the supervisee, the patient and the supervisor but also the latter's regular discussions with a consultant about his/her own work with supervisees. Competent supervision may entail re-visiting, with the consultant concerned, the issues of supervisory resistance and countertransference and how these dynamics may be mobilised in the course of supervising troubling ethical dilemmas. Exposure to postqualifying ethics education may arguably heighten local supervisors' awareness not only of the ethical dimension of clinical material but also of the impact of countertransference phenomena on their own as well as on their supervisees' ethical motivation, judgement and action.

Local supervisors may need to learn to supervise ethical dilemmas more competently but supervisees may also need to be taught how to use the supervisory relationship more effectively. Given participants' reticence and even fear regarding disclosure of countertransference difficulties in the supervisory space, Gabbard (1996) suggests that a useful precept to be ingrained is the principle that secrecy and therapist reluctance to discuss

„special' thoughts, feelings and actions constitute a major risk factor and may herald the beginnings of a descent "down the slippery slope" of chronic boundary violations (p. 312). Awareness of the following risk factors previously identified by Norris, Gutheil and Strasburger (2003) may also alert the postqualified supervisee to the need for increased consultation. Congruent with the latter authors' observations, the data generated by the present study suggest that predisposing risk factors include therapist loneliness and the precipitation of role reversal, excessive self-disclosure in the place of exploration of the transference relationship, narcissistic difficulties which endorse the belief that the therapist concerned is not subject to the usual "ground rules" (Langs, 1982) of the analytic frame and denial that repeated breaches of frame boundaries are harmful to the patient concerned.

5.3. Third Risk Factor: Professional and Personal Isolation

Challenging ethical dilemmas can generate a slew of troubling countertransference responses. The *South African Ethical Code of Professional Conduct* (2002) accordingly advises that practitioners should "consult with another psychologist knowledgeable about ethical issues, with an appropriate national psychology ethics committee, or with another appropriate authority in order to make the proper decision" (p. 34-35). What the data highlight, however, are participants' contrasting experiences of aloneness and their estrangement from core texts, statutory bodies, professional societies, each other and even from their own avowed values. Relationships with underused professional resources were often suffused with anxiety, disappointment, anger and fear of censure or punishment. Many of the excerpts previously quoted in this study appear to confirm that "it [is] difficult to reach out" (*Interv. **1**, p. 14, 46*) and that participants consequently felt under duress to successfully resolve complex dilemmas alone. Professional isolation and the largely fruitless search for robust supervisory space capable of resolutely processing supervisees' unresolved personal countertransference emerge as key findings and as a heightened risk factor for compromised ethical decision-making.

Psychoanalytic psychotherapy necessarily occurs in the privacy of the therapeutic space but the very isolation of the setting simultaneously creates the predisposing circumstances for boundary violations (Gabbard & Lester, 1995). Consistent relational connections including regular collegial contact and the avoidance of professional isolation thus emerged as the most important ethical value for 10 master therapists and as central to their maintaining competence as practising professionals (Jennings, Sovereign, Bottorff, Mussell & Vye,

2005). The importance of relational connections in limiting ethical violations is similarly reinforced by Gabbard (1996) who observes that colleagues need to talk to one another either in a one-to-one context or in group supervision about difficult cases and about their current ethical concerns. One advantage of ongoing peer supervision, for example, is that colleagues' familiarity with each other's work facilitates the ready identification or "spotting" of early countertransference difficulties (Gabbard & Lester, 1995).

Sexual boundary violations are a flagrant expression of therapist exploitiveness but also provide a telling example of professional isolation. Qualitative data generated by this study appear to support local survey research regarding the formidable difficulties of breaking and confronting collegial isolation and misconduct (Slack & Wassenaar, 1999). Gabbard (1996), nevertheless, insists that when a therapist advocates or is perceived to conduct troubling unorthodox practices, his/her colleagues "must … be willing to sit down and talk with the therapist who raises concerns, long before a complaint comes to the ethics committee or licensing board" (p. 320). Thus designated members of the ethics committees of local institutions or societies could be called upon to respectfully talk through with the colleague concerned the preliminary appearance of boundary crossings, hopefully before these develop into entrenched boundary violations.

This extension of concerned caring in the context of intimate collegial relationships recalls Gilligan's (1982) ethic of care and its claim "that everyone will be responded to and included, that no one will be left alone and hurt" (p. 63). Rather than the defensive privileging of theory and technique, analytic societies, reading groups and collegial networks that actively promote a genuine ethic of care may contribute to bettering the quality of professional relationships. The process of generating a more benevolent 'third' potentially entails risking confrontation with group projections and countertransference dynamics, but may eventually ease the isolated practitioner's efforts "to reach out" to peers and to disclose shameful or „forbidden' affects elicited by common dilemmas. Giving voice to an aspirational ethic of care and to the increased integration of ethics into daily professional practices, David points a possible way forward:

> *I think that I do a disservice ... to **not** inform the colleague who's not functioning or practising at least adequately ... they don't get the feedback ... from their colleagues, ... we don't gather together as a group supporting each other in an open and honest manner ... there are things that people might do that are kind of borderline in a particular way, and ... we should*

> *talk to each other ... so, you know ... you're discussing a matter with a colleague who gets very hot under the collar and very charged emotionally about a matter, does one say ... to that colleague, you know, when we were talking about the case of X, my perception was that you were drawn in, in a very powerful way and you need to think about that, you need to think about what the charge is for you. And that can be done in a ... very generous and giving way. (Interv.* ***2****, p. 63, 13-45).*

Finally, although only speculatively supported by interviewees' data, the professional literature highlights the importance of intimate relationships in the prevention of boundary violations. This includes the need to actively attend to self-care and to the avoidance of personal isolation. The legitimate gratification of personal needs may go against training and supervisory experiences which from early on inculcate an attitude whereby the therapist consistently attempts to selflessly put aside his/her own needs in favour of attunement to the patient's internal object world (Gabbard & Lester, 1995). The incipient dangers of self-neglect may be exacerbated by, for example, career disillusionment, ageing, illness, discord in intimate relationships and alienation from the professional community. Such life events and a deeply ingrained professional attitude of selflessness may together render the therapist vulnerable to „deciding' to turn to the patient for excitement or solace (Norris, Gutheil & Strasburger, 2003). The achievement of a fulfilling personal life which includes the appropriate gratification of emotional and sexual needs is arguably indispensable to maintaining competence as a psychoanalytic psychotherapist. Gabbard (1996) concludes that "Therapists who make no time for a personal life will ultimately look for personal gratification in a professional context" (p. 321).

6. SUMMARY

This chapter explored research participants' use of professional resources in the resolution of real-life ethical dilemmas. Analysis of the data is sobering, suggesting as it does that in the main participants reported feeling disillusioned, isolated and alienated from key professional resources. These included their graduate ethics training, professional codes, voluntary and statutory bodies and their peers.

In general, participants expressed dissatisfaction with the content, relevance and length of their postgraduate ethics education. Recollections of ethics training included clear descriptions of boredom, poor recall, irregular staff modelling, low levels of academic expertise, lack of time and erratic or no exposure to core reference texts, including national and international ethics codes. Ethics was additionally perceived as a discrete entity, largely

unintegrated with the theory and practice components of professional training. In particular, participants' accounts suggested the lack of training opportunities to examine different decision-making frameworks and to explore the potential role played by emotions and by enactment phenomena in the ethical decision-making process. When subsequently confronted with the problem of resolving real-life ethical quandaries in professional practice, interviewees appeared unable to summon their earlier ethics training as a potentially benevolent resource or "internally persuasive discourse" (Tappan, 1991). Participants' primarily negative experience and evaluation of their postgraduate ethics education apparently comprises a possible first risk factor for compromised professional decision-making.

The absence of an ethically attuned robust supervisory space emerged as a key finding and as a second risk factor for compromised decision-making. Derelict supervisory practices included "rushed" supervision, irregular modelling of dual role relationships and seeming unawareness of the ethical dimension of clinical material. The data suggest that supervisors were equally unaware of, and did not pursue, supervisees' personal countertransference which was apparently deeply implicated in repeated frame deviations and in the decision-making process. Not a single instance emerged wherein the supervisor concerned demonstrated the capacity to bluntly confront the ethical and countertransference dimensions of the unfolding dilemma. Research participants accordingly consistently reported feelings of disappointment in the perceived capacity of their supervisors to assist with the identification, processing and resolution of common dilemmas. The data raises the pertinent question as to whether local analytically orientated supervisors are themselves adequately trained to conduct supervision which is sufficiently probing of enactments and of their supervisees' countertransference responses to disturbing dilemmas. This suggests that competent ethically attuned supervision may require the future development of comprehensive ethics education programmes.

Professional isolation and the portrayal of a seemingly punitive professional matrix unexpectedly emerged in this as in previous chapters as a consistent theme. Ethics codes, the law, professional bodies and collegial networks often appeared to induce mistrust and fearfulness rather than the hope of emotional support and deepened insight. Excerpts quoted thus apparently confirm earlier impressions that participants repeatedly experienced difficulties in "reaching out" and in exposing their doubts, ethical concerns and

countertransference enactments. Thus reticence and apparent fears of peer or supervisory censure or shaming apparently often drove interviewees to conceal frame deviations and countertransference difficulties and to attempt to resolve complex dilemmas alone. This group dynamic ironically only served to entrench the third risk factor of professional isolation, heightening the potential for continued involvement in enduring therapist-driven decision-making enactments.

Various strategies have been proposed in previous chapters that may be useful in normalising discussion of the therapist's often anti-analytic countertransference responses provoked by charged ethical dilemmas. In relation to the ethical decision-making process, a further strategy entails the presentation of a supplementary framework which both addresses the use of ethical principles as well as subjective and unconscious determinants that may influence ethical performance.

The next and final results chapter accordingly presents a psychoanalytically informed ethical decision-making model. The model integrates principle-based ethical decision-making with an exploration of countertransference phenomena elicited by dilemmas arising in the context of analytic space.

CHAPTER 8

TOWARDS A PSYCHOANALYTIC ETHICAL DECISION-MAKING MODEL

1. INTRODUCTION

Numerous accounts of ethical decision-making models appear in the professional literature (Corey, Corey & Callanan, 1998; CPA, 2000; Eberlein, 1987; Forester-Miller & Davis, 1996; Garfat & Ricks, 1995; Gottlieb, 1993; Steere, 1984). Yet relatively few empirical studies have apparently been conducted on either models or processes of ethical decision-making. Cottone and Claus (2000) thus critique the many "hodge-podge" (p. 281) practice-based frameworks available as lacking philosophical and theoretical grounding.

Common aids or "decision-bases" (Woody, 1990, p. 134) used in the resolution of ethical dilemmas include decision-making models, statutory laws as well as professional ethics codes and principles (Allan, 1997; Betan, 1997; Neukrug & Lovell, 1996). It has been argued throughout this study that these latter resources fail to take sufficient cognisance of the unconscious dimension of the therapeutic relationship and of the primitive affective arousal that often appears to mark the clinician's engagement with real-life ethical dilemmas. Even psychoanalytic ethics codes (American Psychoanalytic Association, 2005; British Psychoanalytic Society, 1991; Canadian Psychoanalytic Society, 1993; International Psychoanalytic Association, 1998) fail to provide decision-making models which accord due recognition to irrational or unconscious determinants that potentially drive ethical decisions and actions (Meissner, 1994, 2004). Data analysis in previous chapters (see chapters 5-7) suggests, however, that only once subjective countertransference phenomena have been truthfully confronted and processed, can rational dialogue with universal ethical principles and professional ethics codes begin.

This chapter presents preliminary work towards the building of a psychoanalytic model of ethical decision-making. The proposed model forms an integral part of the research study and is directly based on the detailed analysis of the preceding chapters (see chapters 5-7) of psychoanalytic psychotherapists' accounts of subjective countertransference responses and ethical decision-making processes in the context of real-life dilemmas. The model hopefully provides a pragmatic decision-making framework that could be used to help resolve

common ethical quandaries encountered in the therapeutic space. It thus aims to facilitate exploration of the potentially unconscious dimension of familiar dilemmas recognised by established ethics codes (APA, 1992; CPA, 2000; South African Ethical Code of Professional Conduct, 1999) and categorisation systems (Pope & Vetter, 1992; Slack & Wassenaar, 1999) as well as additional professional situations subjectively construed as dilemmatic by the practitioner concerned.

Countertransference "blind spots" ensure "that we can never be entirely certain how our unconscious reactions to the patient are affecting clinical judgment" (Gabbard, 1995, p. 117). When the ethical dilemma revives the therapist's own repressed "self-object-affect constellations" (Gabbard, 1995, p. 477), data from this study support the contention that the countertransference phenomena apparently underpinning decision-making remain largely impervious to attempts at self-scrutiny. This chapter thus opens with discussion of the need to situate the model squarely within the context of ethically attuned supervision or consultation. Juxtaposed against research participants' descriptions of impoverished reflective space (see chapter 6), the model proposes that the ethically attuned supervisory or consultative context optimally provides containment and additionally fosters the capacity for ethical reflection. The issue of containment and its role in promoting thinking is discussed in relation to Bion's (1962) concept of the "container-contained". Balancing containment with the need for reflection (Frosh, 1997), the model describes further the relevance for ethical decision-making of Britton's (1989, 1998, 2003) notion of a third position in mental space or "triangular psychic space" wherein the dilemma's emotional vicissitudes are taken up by the supervisory pair as an object of thought (Solomon, 2003c).

The second part of the chapter presents a proposed psychoanalytic model based directly on the previous analysis of participants' oscillating four levels of thinking and capacity for ethical decision-making (see chapter 6). Five distinguishing features may be discerned. The proposed model assumes, firstly, the primacy of multiple unconscious determinants. It thus accords recognition to the heat of the clinical moment and to the repeated shifts between paranoid-schizoid and depressive position functioning (Bion, 1963; Ogden, 1989; Solomon, 2003; Steiner, 1992) that may occur in the course of engaging with the dilemma concerned. The CPA' s (2000) well-known ethical decision-making steps foreground the practitioner's subjectivity once only; step 3 thus encourages "Consideration of how personal biases,

stresses, or self-interest might influence the development of or choice between courses of action" (p. 4). The proposed psychoanalytic model elaborates on this third step, highlighting the importance of holding open the space between the original identification of the dilemma and the subsequent implementation of action. In this intermediate area between unconscious fantasy and potentially precipitous action, the model considers how the impact on ethical decision-making of countertransference phenomena including enactments and projective identification may be tolerated, thought about and given meaning.

Secondly, the model is situated within a contemporary understanding of countertransference. Involving unconscious contributions from both the therapist and the patient, a contemporary understanding thus "emphasizes the interactional nature of the therapist-patient relationship, be that as it is applied in work with individuals, couples, families, groups or institutions. This emphasis is most clearly demonstrated by the clinical centrality of the analysis of the transference–countertransference relationship." (Ruszczynski, 1998, p. 34). Thirdly, the data suggest that under the impact of raw affective arousal, the capacity for rational thinking and for achieving "relative" or "greater" objectivity (Gabbard, 1997; Louw & Pitman, 2001) may temporarily be lost and must be wrested back again. The model thus argues for the critical need to establish, in supervision, a third perspective or area of reflection from which to view the therapist's subjectivity and the unconscious dimension of the therapeutic relationship. Fourthly, the model proposes that mature ethical decision-making involves engagement with the dialectic comprised by the two poles of subjective experience and universal ethical principles, or between the particularity of subjective countertransference phenomena and objective professional ethical standards (Betan, 1997; Wiener, 2001). Finally, the model accords prominence to the analytic attitude and hence to the need for truthful self-examination or the "unending search for … personal, emotional truth" (Grotstein, 2004, p. 1094) in order to effect decision-making that is fiduciary in nature and that prioritises the patient's analytic journey.

Since the proposed model integrates the CPA's (2000) ten ethical decision-making steps with the psychoanalytic notion that ethical judgments may be organised by unconscious determinants, it arguably constitutes a synthesis of previous points of view and offers a third, different, perspective. Drawing this final results chapter to a close, a summary sets out the main findings pertaining to the individual decision-maker's need for engagement with

the objective and subjective poles (including the psychoanalytic dimension) of the ethical decision-making process.

2. SITUATING THE PSYCHOANALYTIC MODEL WITHIN THE SUPERVISORY SPACE

The emotional vicissitudes generated by real-life ethical dilemmas apparently found only attenuated containment in the contexts of research participants' supervision and personal analysis. Evocative metaphors pertaining to, for example, pressure cookers or "buckled up" briefcases emerged, suggestive of compromised reflective spaces crowded with "undigested" mental and bodily events (see chapter 6). Commonly thought of as referring only to the activity of processing the patient's intense feelings, Gabbard (1999) points out that „containment' equally applies to those mental processes geared towards understanding the nature of the therapist's unconscious contributions to the therapeutic interaction. Several of these latter processes are incorporated into the later discussion of the psychoanalytic ethical decision-making model and include analysis of the patient's internal object world, self-examination and restoration of the capacity for reflection.

Real-life ethical dilemmas do not, however, necessarily incur heightened countertransference affects. The following scenarios, for example, are reminiscent of the first ethical decision-making pathway which is discernible in the professional literature and was discussed in an earlier chapter (see chapter 3). The scenarios suggest the retention of analytic poise and the capacity for internal containment; thus the therapist's empathic observation of the transference relationship continues without primitive affects apparently being discharged into premature ethical decision-making enactments:

> *... there are other dilemmas that we can have in psychotherapy ... one goes to a movie and one is sitting in front of a patient, what does one do? One can think about it ... it isn't a shock ... one can really* ***think*** *about what does one do and [what] does one say ... (Interv.* ***2****, p. 45, 1-4).*

> *... I've come across ... less powerful issues which ... have given me cause to call another therapist and say, can you let me know what's going on here ... and then I'm glad for ... having the internal containing space to say you don't have to react ... you're not activated in an acting out way ... (Interv.* ***2****, p. 66, 39-43).*

The next excerpts, in contrast, reveal an apparently unmet need for "a sanctuary" (Britton, 1992) or container wherein psychotherapists can safely explore deeply disorienting

transference-countertransference dynamics specific to the real-life ethical dilemma concerned:

> *… my level of discomfort was … high, dipped and then was very high … and in that high I should've reflected … that I was feeling very uncomfortable and* ***that*** *would've been an indication that I could reach out and … confer with somebody … to create a kind of holding space … for myself … to know that I can share this dilemma (Interv.* ***1****, p. 22 , 12-22).*
>
> *I suppose some part of me … is wanting [further processing] that's why I … volunteered to participate in the research but I [feel] apprehensive … this is* ***messy*** *stuff … **failed** work … that just ended abruptly … so, it's … difficult to talk about … (Interv.* ***6****, p. 215, 11-15).*
>
> *… I was saying that I hadn't considered … referring [my relative] on … now I'm thinking that the possibility of exploring [the referral] … could've been part of the therapeutic process … the same way as one explores the transference – countertransference or the intersubjective space, whatever you … call it … that this … is an area that* ***could*** *be explored (Interv.* ***3****, p. 105, 27-34).*

Bion (1959; 1962a) summarises his "container-contained" model of thinking thus: "I shall abstract for use as a model the idea of a container into which an object is projected and the object that can be projected into the container, the latter I shall designate by the term „contained' " (1962b, p. 90). In Bion's terms, projective identification may be conceived of as an interpersonal elaboration of an intrapsychic splitting process. Chaotic, irrational feeling states or "beta elements" (1962a) are projected into the containing object who, via reverie, uses "alpha function", a hypothetical transformative agency (Grotstein, 2004), to tolerate and transform the projected contents into "alpha elements" or meaningful experience. This is then reintrojected by the infant or patient who regains not just the previously split off aspect of self but also the crucial experience of containment and capacity for "alpha-function" or for thinking about him/herself.

Between the original often somatically based identification of the ethical dilemma and the action implemented, the data suggest that painful affects or disturbing incipient thoughts were precipitously evacuated and evaded rather than tolerated and thought about. Failures of external and internal containment, including the absence of any thoroughly internalised or "digested" ethical decision-making model, thus often appeared to have resulted in participants seeking relief from escalating countertransference anxieties in premature decision-making enactments:

*... the first mistake I made was to make the decision too quickly about what I was going to do. I didn't think it through enough ... and [I hadn't] used other resources available (Interv. **1**, p. 15, 5-15).*

*... I remember phoning [the supervisor] ... telling her I've just decided to go ahead ... it was more or less, ja, it's okay, I feel I can contain the feelings, it's not going to be something that intrudes ... if I think about it now, I can see that it could've been explored more ... thinking about it now, retrospectively ... but at the time it felt ... it's not ...a big deal (Interv. **3**, p. 95, 20-24, p. 96, 1-4).*

*Now here I am, I'm going to facilitate on this workshop and this ... new patient [has registered] ... this created for me ... **anxiety**, that ... this person would have this extra-therapeutic contact with me ... On the other hand ... I thought this guy [was] very appropriate ... . So, there was nothing really to do other than to just go ahead and see what would happen (Interv. **4**, p. 125, 32-37; p. 126, 4-7).*

*... I wasn't having supervision that often ... in a way, in the hurly-burly of your work, you say, okay, I'm gonna make this decision and I don't think we always give, with every decision, the amount of time it should take (Interv. **3**, p. 109, 26-29).*

The preceding extracts are congruent with previous data analysis (see chapter 6) which suggests that participants were consistently unable to access the psychoanalytic dimension of ethical decision-making through "internal supervision" (Casement, 1985) or solitary self-examination. What appeared to be lacking was a competent supervisory space or container which offered "a cooling off period" (Varghese & Kelly, 1999, p. 110) wherein to engage with an appropriate ethical decision-making model. Distressing countertransference responses could arguably have then been safely received, mentally "digested" and progressively transformed from "unthinkable" bodily and emotional events into a retrospective understanding of the meaning of the principally therapist-driven decision-making enactments which had been provoked by the dilemmas concerned.

The containment provided by Bion's model allows the recipient (in this case, the supervisee) to experience him/herself as a direct participant and beneficiary of the container-contained process (Ruszczynski, 1998). But containment needs to go beyond the holding of distressing subjective experiences to an active engagement with insight and understanding (Frosh, 1997). As discussed in earlier chapters, it is the supervisory or consultative relationship that is envisaged as the quintessential external manifestation of Britton's (1989; 1998) internal triangular state. It is here that the necessary opportunity is created "for analytic reflection, where two people work together to think about a third,

whether the third is an individual, a couple … or an idea or aspect within the therapist … that is relevant to their clinical work" (Solomon, 2003c, p. 174). The protection given to the therapeutic dyad by the supervisory provision of triangular space helps to maintain the analytic attitude, to guard against chronic ethical decision-making enactments and to consistently ensure that the therapeutic needs of the patient are foregrounded. As such, Solomon (2003a) argues, the analytic attitude is essentially ethical in nature.

In summary, the supervisory space in which the psychoanalytic ethical decision-making model is situated may be characterised by its capacity for containment of the supervisee's emotionally charged countertransference arousal. Additionally, the supervisory context provides a third area of reflection wherein the unconscious dimension of decision-making, including maleficent, unthinkable or unethical impulses, may be normalised, reflected upon and given meaning. Thus the ethically attuned supervisory space may be metaphorically likened to Bion's seventh servant or "truth drive" (Grotstein, 2004) which helps to turn attention to internal psychic reality and facilitates processing of the supervisee's counter-resistance and acceptance, rather than the unconscious evasion, of personal emotional truths.

3. TOWARDS A PSYCHOANALYTIC ETHICAL DECISION-MAKING MODEL

The following model elaborates the CPA's (2000) third step. Clarification of commonalities and differences between the CPA's ten decision-making steps and the psychoanalytic model's eight levels of enquiry are summarised in Table 1 below. Through its consideration of the influence of the therapist's subjectivity, the proposed psychoanalytic model may extend contemporary understanding of the psychological processes underpinning ethical decision-making. As Mills (2005) comments "… all ethical decisions are filtered through the subjective lens of our own personalities, developmental histories, unconscious conflicts, transference proclivities, and emotional dispositions. It is from this standpoint that we must necessarily engage our own internal processes when confronting the ethical" (p. 240). Presented as a possibly conservative conceptual framework that aims to secure maximum psychological protection for the patient, the model's eight levels of enquiry are derived from detailed textual analysis of participants' fluctuating capacity for reflection and for ethical decision-making.

Table 1: Comparison of CPA and Psychoanalytic Ethical Decision-Making Models

The CPA's (2000) Code of Ethics: 10 ethical decision-making steps (abbreviated)	**The Psychoanalytic ethical decision-making model: 8 levels of enquiry**
	1. Prereflective identification of ethical dilemmas. 2. Naming countertransference arousal.
1. Identification of … individuals and groups potentially affected by the decision. 2. Identification of ethically relevant issues and practices, including the interests, rights, and … relevant characteristics of the individuals and groups involved and of the system … in which the ethical problem arose.	3. Identification of the nature of the dilemma and its relational context.
3. Consideration of how personal biases, stresses, or self-interest might influence the development of or choice between courses of action.	4. Ethical decision-making enactments: ascertaining patient and therapist contributions. 5. Decision-making as behavioural expression of the patient's internal object world. 6. Analysis of therapist-driven decision-making enactments.
4. Development of alternative courses of action.	7. Maintaining the capacity for reflection. 8. Resumption of the CPA's decision-making framework.
5. Analysis of … short-term, ongoing, and long-term risks and benefits of each course of action on the individual(s)/group(s) involved … 6. Choice of course of action after conscientious application of … principles, values, and standards. 7. Action, with a commitment to assume responsibility for the consequences of the action. 8. Evaluation of the action. 9. Assumption of responsibility for consequences of action, including correction of negative consequences … or re-engaging in the decision-making process if the ethical issue is not resolved. 10. Appropriate action … to prevent future occurrences of the dilemmas … .	

Although written as a coherent sequence, the model's eight levels are not intended to imply an orderly linear ethical decision-making process. What the data suggest is that, in the presence of an empathic other, ethical decision-making potentially evolves from somatically based countertransference arousal to include a third area of reflection which fosters understanding and "multiple points of view" (Louw & Pitman, 2001, p. 749) pertaining to the unconscious determinants animating the dilemma concerned. While current trends in

relational psychoanalysis suggest enactments are "co-constructed via the intersubjective melding of patient and analyst's transferences to each other" (Ivey, 2007, p. 5), the data disconcertingly highlight that the ethical decision-making enactments considered in the present study were saturated primarily with unconscious therapist factors. Countertransference is understood, however, to represent "a joint creation" (Gabbard, 1995, p. 481) and the model necessarily allows for the exploration of ethical decision-making processes fuelled by both the patient's projective identifications and role response pressures as well as by therapist-driven enactments. Each of the psychoanalytic model's eight levels of enquiry are presented and discussed below. Use of the model alone may not in itself augment ethical motivation. As Rest (1984) writes "… the production of moral behaviour is an exceedingly complex phenomenon and no single variable and no major psychological theory is sufficiently comprehensive to represent the phenomenon alone" (p. 27).

3.1. Prereflective Identification of Ethical Dilemmas

Heightened countertransference arousal often in the form of somatic states may initially announce the advent of the dilemma concerned. At these prereflective or initial levels of decision-making, the psychological implications of strong countertransference reactions are apparently not yet cognitively grasped. Anxieties provoked by idiosyncratic pre-existing conflicts may continue to be expelled into bodily states or inhibited emotional responsiveness, signalling "counter-resistance" (Ivey, 1999) or the therapist's ongoing defensive need to keep "undigestable" thoughts and feelings out of conscious awareness.

Kitchener (1984) identifies an immediate prereflective or "intuitive" level of moral reasoning which is comprised of our "ordinary moral sense" and is "based on the sum of [an individual's] prior ethical knowledge and experience" (p. 44). This intuitive level is often deployed to resolve immediate everyday ethical decisions. Moral intuition may not however necessarily lead to defensible ethical choices; Rest (1984) thus cautions that initial "gut feelings" and strong affective arousal optimally need to be interpreted and understood before ethical judgment is implemented. At these levels participants experienced, for example, nausea, disturbed sleep, bodily pain, and sensations of blankness, sinking and shock (see chapter 6).

3.2. Naming Countertransference Arousal

In the context of an ethically attuned and empathic other, the therapist's emotional arousal is identified and its various components are differentiated and languaged. Unconscious determinants of ethical decision-making may continue to lie outside awareness. Retrospective countertransference awareness may also include descriptions of "the slippery slope" phenomenon (Gabbard & Lester, 1995) involving boundary violations and already realised ethical decision-making enactments. Although the multiple meanings of countertransference arousal were not yet accessible, feelings of, for example, anxiety, fear, anger, sadness and loss were retrospectively named by the participants concerned (see chapter 6).

3.3. Identification of the Nature of the Dilemma and its Relational Context

The professional practice and interpersonal contexts which comprise the physical and psychological setting for the ethical dilemma are clarified and the specific interactional trigger responsible for the therapist's original countertransference arousal is located. In following a decision-making path, early difficulties that may derail the psychoanalytic practitioner include the initial failure to detect the presence of an ethical dilemma as well as compromised ethics training or "ill-preparedness" to engage with the ethical dimensions of professional practice (Rest, 1984).

Empirical examples include the context of private practice wherein the therapist concerned reacted sharply to a new patient's history and to the dawning recognition that the latter was also her relative (see „Introduction to Third Research Interview'; also, chapter 6). A second participant, also in private practice, confirmed that his original countertransference arousal stemmed from the moment his patient disclosed sexual abuse by a former therapist who was a known colleague (see „Second Pilot Interview'; also, chapter 6). Ethically attuned supervision or consultation presupposes a competent grasp of relevant ethics codes and should help to conceptualise the foregoing dilemmas as comprising, for example, a nonsexual dual role relationship and collegial misconduct respectively (Pope & Vetter, 1992).

3.4. Ethical Decision-Making Enactments: Ascertaining Patient and Therapist Contributions

The following two levels of enquiry (levels 5 and 6) specifically address whether and how countertransference has been enacted through the medium of premature ethical decision-making and intervention. As discussed in earlier chapters, countertransference enactment may be understood as the patient actualising "an internal scenario within the analytic relationship that results in the analyst's being drawn into playing a role scripted by the patient's internal world" (Gabbard, 1995, p. 481). Alternatively, enactments may refer to countertransference interpreted in the narrow sense of unconscious idiosyncratic conflicts or pathological "experiences from the analyst's past that are revived in the interaction with the patient" (Gabbard, 1999, p.10). Offering an intersubjective approach for understanding ethical decision-making, Varghese and Kelly (1999) propose seeing countertransference "as a spectrum encompassing projective identification on the one hand … countertransference enactment on the other … [and] the two as interacting with each other" (p. 105). Whereas the previous perspectives foreground the patient or the therapist's unconscious contributions respectively, the intersubjective approach holds that the subjectivities of both parties are mutually and equally embroiled in the generation or co-construction of unconscious countertransference enactments (Levine & Friedman, 2000).

Drawing on data analysis as well as on Varghese and Kelly's (1999) theoretical model, the continuation of the psychoanalytically informed decision-making pathway set out below turns to exploration of the relative contributions of both the patient and the therapist to potential ethical decision-making enactments.

3.5. Ethical Decision-Making as the Behavioural Expression of the Patient's Internal Object World

Countertransference feelings evoked in the therapist are widely regarded as a valuable source of information about the patient's internal object world (Gabbard, 1999). The patient's projective identifications are understood as exerting interpersonal pressure on the therapist; the projected contents thus "nudge" (Spillius, 1992), "hook" (Gabbard, 1995) or "bully" (Symington, 1990) the analyst into playing out the patient's intolerable affects and regressive object relational patterns.

Data analysis pertaining to real-life dilemmas yields little supporting clinical evidence for ethical decision-making enactments driven principally by either the patient's unconscious

contributions or by "the intersubjective melding of patient and analyst's transferences to each other" (Ivey, 2008, p. 25). However, in the relational context constituted by euthanasia or physician-assisted suicide, Kelly, Varghese and Pelusi (2003) demonstrate, through the use of the following hypothetical scenario, the thoroughly interactional nature of patient-induced end-of-life decision-making enactments.

A terminally ill despairing patient expresses a wish to die. Via interpersonal pressure and the process of projective identification, the patient induces in the caregiver a corresponding despair and an identification with the patient's wish that he/she should die. Kelly, Varghese and Pelusi (2003) point out that the physician's decision to hasten death can thus become the forum for the enactment of countertransference feelings without the true origins of the affects concerned ever becoming apparent. In the preceding vignette, for example, the physician's countertransference response and decision to expedite death could be construed as based on the latter's predisposing object relational configurations and on an unacknowledged concordant identification (Racker, 1957) with the patient's projected self-representation.

To effect emergence from disorienting but potentially useful boundary "crossings" and identification with the patient's internal object world, the following questions, sourced from analysis of the transcripts as well as from Gabbard (1999), Epstein and Simon (1990) and Ivey (1998) may help to illuminate possible linkages between patient-induced countertransference phenomena and the process of ethical decision-making. Given the context of a real-life ethical dilemma, a supervisor could, for example, encourage the supervisee to interrogate the following aspects of his/her subjective experience:

1. **What sort of role do I feel myself pulled into and what sort of emotional characteristics (e.g., hostile, flattering, sadistic, despairing) do I feel "pressured" into taking on in relation to this patient at this specific point in time?**
2. **What subjective needs, conflicts or stresses have been mobilised for me by this ethical dilemma which may predispose my playing out roles derived from the patient's internal familial drama?**

3. **Are my countertransference reactions potentially based on identification with a concordant self-representation within the patient or on an identification with a disavowed complementary object-representation?**
4. **Given the context of this real-life dilemma, what potential linkages or meanings exist between my current „decision-making' and elected course of action and the patient's habitual object relational patterns, personality structure and current support systems or life circumstances?**

3.6. Analysis of Therapist-Driven Ethical Decision-Making Enactments

Data from this study appear congruent with the unsettling observation that, while carefully cultivating a sense of self as a caring figure, the psychoanalytic practitioner's countertransference is not necessarily benign and includes narcissistic, self-interested, hating and malicious feelings (Betan, 1997; Epstein & Simon, 1990; Martinez, 2000; Varghese & Kelly, 1999). Similarly, in his discussion of the four components of moral reasoning, Rest (1984) suggests that in choosing between alternative courses of action, competing nonmoral motives (e.g., the acquisition of money or self-serving ambition) may be ascendant and thus "it is not unusual for nonmoral values to be so strong and attractive that a person chooses a course of action that pre-empts or compromises the moral ideal" (p. 25).

Participants' countertransference arousal has been extensively discussed. The data suggest that multiple instances of „ethical decision-making' could arguably be construed as therapist-driven enactments or as comprising the behavioural expression of the latter's unresolved emotional difficulties revived in the charged atmosphere of the ethical dilemma concerned. The following summary is not exhaustive but highlights ten different examples of ethical decision-making enactments that were revealed by analysis of the data within and across the eleven research interviews.

In the context of numerous triangular relationships (see „First Pilot Interview'; also chapter 5), the unprocessed countertransference responses of the participant concerned appeared to have resulted in the gratification and concealment of unconscious hostility through the enactment or "intuitive" prereflective "decision" (Kitchener, 1984) to, firstly, breach confidentiality to a nonanalytic third party and, secondly, to engage with the latter in a social dual role relationship. Textual analysis of three different research interviews revealed

additionally that „decisions' to engage in prolonged nonsexual dual role relationships apparently serviced therapist self-interests for the accrual of money, the negotiation of business deals, the inappropriate gratification of friendship needs and for the narcissistic heightening of professional status and self-esteem at the expense of heeding the patient's request to terminate (see chapters 5-6). Brown (in Steere, 1984) cautions against using the patient as a means "to work out the therapist's personal dynamics in relationship" (p. 40). Further examples of therapist-induced ethical decision-making enactments arguably included using an ex-patient in the posttermination phase of an in-depth therapy to effect role reversal wherein the latter in a closed group assumed the burden of caring for his former caregiver (see „Introduction to Fourth Interview'; also chapter 5). Engaging in regular therapeutic contact over two years with a patient/relative, one participant appeared unconsciously to strive to re-establish familial and emotional intimacy apparently assuaging unresolved childhood feelings pertaining to loss, family dispersal and death (see „Introduction to Third Interview'; also chapter 6). Underpinning an interviewee's seeming avoidance of confronting collegial sexual misconduct lay unprocessed „decisions' which functioned to help maintain an idealised paternal object representation of a respected mentor (see „Second Pilot Interview'; also, chapter 5). A final example suggests that repeated „decisions' to refrain from following up the rape of a minor, leaving the latter exposed to possible future abuse, appeared to be organised by the practitioner's unconscious identification with an overwhelmed parental object who had failed to extend protection in the therapist's own childhood context of family violence (see „Introduction to Fifth Interview'; also, chapters 5-6).

Given a real-life ethical dilemma, the following questions may help to clarify the therapist's prevailing psychological mode of functioning, to identify dominant "voices" in the "inner moral audience" (Day, 1991; see chapter 6) and to consider the practitioner's possible contributions to potential or already realised decision-making enactments:

1. **In what ways does the patient or particular characteristics of the latter (e.g., greediness, vulnerability, neediness, sexual seductiveness) remind me of myself or significant others or events in my (childhood) past? Given the context of this real-life dilemma, what subjective fears, fantasies, images or conflicts are stirred up in my interaction with this patient?**

2. **In trying to resolve this dilemma, what inner moral "voices" of, for example, previous therapists, supervisors, colleagues, lecturers, family members or significant others am I "hearing" that might be influencing my „decision-making' and choice of action? What "voices" emanate from legal or theoretical sources? More specifically, what are these "voices" saying? Are they empathic, shaming and condemnatory or frankly unethical and self-interested? Have any "voices" been silenced or muted? What feelings and attitudes might these "voices" evoke in me?**
3. **Is the current ethical dilemma or interpersonal situation with the patient reminiscent of any other conflictual or emotionally charged situation in my present life circumstances?**
4. **Of the courses of action potentially available to me, what do I feel I *ought to do,* ethically? What *have* I done or what do I think I *will actually* do? What competing self-interested or possibly exploitative factors might this ethical dilemma activate that could account for discrepancies between what I know I *ought* to do and what I actually *want* to do?**
5. **Given the preceding questions and my original countertransference arousal, what potential linkages or meanings exist between my current „decision-making' and elected course of action and my present understanding of my own needs, anxieties and defences?**

3.7. Maintaining the Capacity for Reflection

This level of ethical decision-making involves ongoing processing of the emotionally charged experience of countertransference arousal, tolerating "the inherent ambiguity … of ethical matters in psychotherapy" (Betan, 1997, p. 361) and living with the understanding that "acting ethically does not always lead one to feel good" (Kitchener, 1986, p. 307). As participants aver, ethical decision-making may leave in its wake "moral traces" (Nozick, 1968, in Kitchener, 1984) or feelings of regret, dissatisfaction, guilt and concern.

At this level, the data suggest that the individual decision-maker increasingly experiences him/herself as an interpreting subject capable of thinking about the meanings or possible linkages between his/her idiosyncratic object relational world and his/her proposed or already realised ethical decision-making and course of action. Responsibility is assumed for

the consequences of possibly repeated countertransference enactments. Previously unconscious possibly painful determinants driving ethical decision-making and action are clarified and integrated. Where the consequences of enactments carry iatrogenic implications, the therapist can, in conjunction with the supervisor, thoughtfully consider how to re-engage with the ethical decision-making process. This may entail thinking about alternative courses of action and how to address and redress the issue of the therapist's contribution to the original decision-making enactment concerned.

Empirical examples include: participants' thoughtful reflections in the later research interviews on the possibly negative consequences of, and alternative courses of action to, non-essential dual role relationships; the inadvertent breach of confidentiality; and failure to confront collegial sexual misconduct. The data suggest further that the creation of a third area of reflection which remains critical to mature ethical decision-making is not a permanent achievement but may be rapidly disestablished under the impact of fresh anxieties generated by renewed shifts between depressive position and paranoid-schizoid functioning.

3.8. Resumption of the CPA's Ethical Decision-Making Framework

Based on increased understanding of the meanings of his/her original countertransference arousal, the therapist hopefully experiences relief and relative freedom from countertransference pressures. This freedom may see a new level of self-observing ethical vigilance emerge and restraint of the impulse to actualise decision-making enactments and boundary violations.

Thoughtful consideration of the CPA's (2000) remaining ethical decision-making steps may be resumed, including the development, choice, implementation and evaluation of the optimal course of action (see Table 1 above). Mature levels of ethical decision-making accordingly include active engagement with "the dialectic of the universal and the subjective of human relations, in which each informs the other … the task is not, and cannot be, simply to apply principles a priori, but instead to work toward an understanding of how the principles fit within the context, the alternatives, and the interpersonal demands of a particular ethical situation" (Betan, 1997, p. 356). Having worked through and clarified possible "unconscious determinants" (Meissner, 1994), the ethical decision-making process may increasingly focus on the universal or objective pole of the decision-making dialectic.

The attention of the supervisory pair thus shifts to critically considering the rational application of ethical principles, values and standards housed in professional codes of ethics or decision-making models.

In addition to consulting the CPA's (2000) rank ordered ethical principles, proposed ethical actions may be evaluated in the light of Kitchener's (1984) "three tiers [ethical rules, principles and theories] of increasingly general and abstract forms of justification" (p. 45). Eschewing ethical absolutism, Kitchener (1984) argues, as do Knapp and VandeCreek (2007), that absolutising any one principle or any one ordering of ethical principles is not practically viable across all ethically problematic situations. The five ethical principles of autonomy, beneficence, nonmaleficence, justice and fidelity are accordingly considered by Kitchener (1984) to be not absolute but "*prima facie*" binding or "always morally relevant" (p. 52) to the dilemma at hand. Resolution of the dilemma, Kitchener (1984) argues, should thus be sought in carefully evaluating and interpreting which of the five potentially competing principles should be accorded priority and the greatest weighting in the context of the dilemmatic situation concerned. Providing a pragmatic illustration of the latter perspective, Kelly, Varghese and Pelusi (2003) observe, for example, that professional debate pertaining to euthanasia typically ignores the particularities of the interpersonal context constituted by the specific doctor-patient relationship, privileging instead the general principle of autonomy or the patient's right to suicide. Cautioning against any simplistic application of the principle of autonomy, the authors emphasise the need to explore the interpersonal meaning of the patient's request for hastened death and suggest that the physician's projected nihilism, need for control and disgust with suffering may engender in the patient what at first sight appears to be the latter's rational and autonomous exercise of the „right' to die.

The hard work entailed in traversing the „subjective-objective' dialectic or continuum of ethical decision-making may still leave the formidable challenge of actually implementing and evaluating the course of action finally chosen. Faltering ethical motivation may yet scupper the combined efforts of the supervisory pair to negotiate the emotionally distressing and time-consuming vicissitudes involved in ethical deliberation. Thus the success of the ethical decision-making endeavour finally devolves on the individual therapist's capacity for persistent fiduciary concern wherein the virtues of "Perseverance, resoluteness,

competence, and „character' " (Rest, 1984, p. 26) are actively mobilised in the service of implementing the course of action most likely to promote the patient's analytic journey.

4. SUMMARY

Integration of the professional literature with detailed analysis of research participants' real-life dilemmas suggests that the process of ethical decision-making optimally includes both the interpretation of subjective countertransference phenomena and the thoughtful application of objective ethical principles and standards. When emotionally charged dilemmas animate the therapist's repressed self and object representations, unprocessed countertransference responses may translate into repeated ethical decision-making enactments that impede the patient's therapeutic progress. By definition, such countertransference enactments are difficult to subject to self-scrutiny. The proposed psychoanalytic model thus counters the prevailing notion that ethical decision-making is logical, reasonable and sequential in nature and that it is effected by a principally solitary and rational agent. Based directly on analysis of empirical data, the proposed model suggests instead that ethical decision-making encompasses multiple shifts between paranoid-schizoid and depressive position functioning and that understanding of unconscious, irrational and potentially self-interested determinants is best sought in an ethically attuned and containing supervisory or consultative context.

Guided by examination of participants' thickly textured accounts of ethical decision-making, the proposed psychoanalytic model differentiates eight evolving levels of enquiry. Earlier levels focus on the identification and interpretation of subjective countertransference phenomena. The final levels of enquiry promote active engagement with the objective pole of the ethical decision-making continuum and involve consideration and the possible application of the CPA's rank ordered ethical principles and standards to the dilemma at hand.

Since the data are strongly suggestive of the influence of personal countertransference on ethical decision-making, the psychoanalytic model has retained an emphasis on processing and understanding therapist-induced ethical decision-making enactments. Limitations of the proposed model include the observation that its theoretical and pragmatic viability remain in doubt until further research demonstrates or disproves its utility and validity across a range of common dilemmas. Moreover, contemporary study of ethical decision-making

frameworks is as yet "immature" (Cottone & Claus, 2000). The preliminary status of this psychoanalytic model leaves open the possibility that self-selecting factors pertaining to choosing to participate in this study are largely responsible for the pre-eminence of therapist-driven decision-making enactments. Further empirical work may yield clinical data that persuasively supports a thoroughly intersubjective understanding of the phenomenon of ethical decision-making enactments.

While the problems attendant on application of the proposed model require acknowledgement, the creation of a psychoanalytic ethical decision-making model hopefully contributes to professional dialogue pertaining to the development and evaluation of empirically based decision-making frameworks. More specifically it may provide a potentially helpful conceptual framework for engaging with the unconscious dimension of ethical decision-making. It may thus usefully supplement the traditional emphasis on the reasoned application of normative ethical principles and standards. In legitimising examination of self-interested or unethical aspects of the therapist's countertransference experience, the model may help to secure both ethical decision-making which is grounded in the analytic attitude and a therapeutic space which, unencumbered by chronic enactments, resonates principally with the sounds of the individual patient's unfolding story.

CHAPTER 9

CONCLUSION AND RECOMMENDATIONS

1. OVERVIEW OF MAIN FINDINGS

Ethical dilemmas arising in the interpersonal context of the therapeutic space confront the psychoanalytic practitioner with the complex and challenging task of ethical decision-making. It has been argued throughout this study that contemporary theoretical and empirical literature, ethics codes, most decision-making models and training curricula rely on an overly rational approach to the appraisal and addressing of ethical dilemmas. Unanticipated real-life ethical quandaries arguably demand that professional attention extends beyond codes of conduct and current models to include "… the inner realities of motivation, intention … and attitudes of the person … making the decision" (Abramson, 1996, p. 195). The literature appears to lack theoretically informed accounts, grounded in empirical data, of individual practitioners' subjective experience of grappling with ethical decision-making challenges in the therapeutic space. This study has thus sought to explore and to construct an interpretive account of the subjective, irrational and unconscious dimension of the ethical decision-making process. This final chapter summarises the principal findings and draws out their possible implications for improved ethical decision-making guidelines, ethics education and future research initiatives.

The theoretical framework informing the present study included principle-based ethical decision-making approaches as well as contemporary psychoanalytic debates on countertransference enactments. Principle-based systems and psychoanalytic perspectives were related to Gilligan's (1982) moral voices of justice and care and comprised the objective and subjective poles of the ethical decision-making process respectively. Examination of the well-traversed objective pole included a review of empirical survey research, the uses and limitations of professional ethics codes and seminal principle-based ethical decision-making models.

The literature review confirmed that emphasis has traditionally been placed on linear decision-making steps and on the dispassionate and logical application of ethical principles to the resolution of ethical dilemmas. The impact of therapist subjectivity on professional ethical decision-making has received comparatively little formal acknowledgment. Thus a

critique of the familiar ethical decision-making model presented in the CPA's (2000) code highlighted, for example, that only its third step encourages conscious evaluation of the influence exerted on real-world dilemmas by the practitioner's personal biases, self-interests and needs. The South African Professional Board's current ethics code (2002) assumes "a logical, linear, and cognitively explicit process in resolving ethical dilemmas" (Burke et al., 2007, p. 114) and likewise does not refer to the irrational and emotionally charged dimension of professional decision-making. Well-known practice-based ethical decision-making models (Corey, Corey & Callanan, 1998; Keith-Spiegel & Koocher, 1985; Welfel, 1998) similarly present clearly defined linear steps of ethical deliberation; these seemingly presuppose a consistently rational moral agent whose motives are self-transparent and axiomatically beneficent in intent. Even psychoanalytic ethics codes (American Psychoanalytic Association, 2005; British Psychoanalytic Society, 1991; Canadian Psychoanalytic Society, 1993; International Psychoanalytic Association, 1998) fail to incorporate ethical decision-making models that recognise the unconscious and often anti-analytic determinants that may drive ethical judgment and intervention.

Formal ethics codes, principles and decision-making models provide essential normative guidelines for navigating the ethical decision-making process. International surveys and empirical studies discussed in earlier chapters nonetheless repeatedly demonstrate that the rational comprehension of available codes, principles and standards is necessary but often insufficient to secure ethical action. Therapists may well continue to engage with unethical behaviours that result in public complaints against them (American Psychological Association, 2004; Scherrer, Louw & Möller, 2002) and that violate the integrity of the therapeutic space. This study has argued that greater understanding of the widely observed judgment/action discontinuity includes consideration of both the objective as well as the subjective poles of ethical decision-making, thus integrating the distinctive ethical concerns articulated by the voices of justice and care respectively. In-depth interviews and qualitative data analysis accordingly explored the competing interpersonal pressures, anxieties, disavowed motivations and impulses that comprised the subjective pole of professional decision-making. This helped to identify possible risk factors that may deflect the practitioner away from the pursuit of ethical practice.

Frequent, albeit brief, allusions are made in the professional literature focusing on principle-based decision-making to prereflective responses, primitive "gut feelings", nonmoral values

and ethical "blind spots". The relative absence of persuasive theoretical accounts that address the influence of irrational and prereflective phenomena on ethical judgment has been noted. Based directly on empirical data generated by open-ended research interviews, this study, in contrast, offers a psychoanalytically orientated account of the nature of the unconscious linkages potentially forged between the therapist's subjectivity and the unfolding ethical decision-making process.

In contrast to principle-based approaches, different psychoanalytic schools of thought portray the therapist not as a consistently rational agent but as one who remains unwittingly susceptible to the "evocative power" (Chused, 1991, p. 617) of countertransference enactments. Kleinian, classical and relational perspectives view enactments as alternatively initiated by the patient's projective identifications, by the analyst's personal countertransference or by equal unconscious contributions from both members of the therapeutic dyad. Enactment phenomena are thus construed as placing interpersonal pressure on the therapist to cross the boundary between thought and behaviour, often by actualising a role derived from the patient's early object relations. "Acute" enactments are usually benign single incidents that are retrospectively "caught" by the therapist, thoughtfully examined and openly discussed with the patient in an effort to further understanding of the transference relationship. "Chronic" analyst-centred enactments mobilised by the therapist's own unresolved emotional difficulties by contrast typically find behavioural expression in repeated boundary violations that are not brought to consciousness nor subjected to post-enactment scrutiny. When the unconscious meaning of chronic therapist-induced enactments fails to emerge, the risk of harmful consequences to the patient is correspondingly heightened.

The notion of an "ethical decision-making enactment" emerging from this study is based on both psychoanalytic theory of countertransference enactments as well as on detailed analysis of ethical decision-making processes evident in the interview texts. This notion addresses the influence exerted by subjective and unconscious determinants on the ostensibly rational ethical decision-making process. Confronted by stressful dilemmas, therapist "decisions" to resolve the ethical quandary at hand may, on examination, reveal evidence of unconscious dynamics that structure countertransference enactments in general. As such, the notion of an "ethical decision-making enactment" offers a useful conceptual vantage point from which to grasp how even experienced psychoanalytic practitioners may

on occasion be dislodged by charged real-life dilemmas from their customary reflective stance and adherence to aspirational ethical principles. The collapse or restoration of reflective space was proposed as the critical pivot which engendered discrete pathways of ethical deliberation and which determined whether an ethical decision-making enactment emerged as an analytically useable or exploitative process. While relational psychoanalysis holds that countertransference enactments are mutually co-constructed by equal unconscious contributions from both members of the therapeutic dyad, this study's disconcerting data, on the contrary, suggest that the ethical decision-making enactments identified were primarily saturated with unconscious therapist factors.

Contemporary psychoanalytic theory on countertransference enactments and the construct of an ethical decision-making enactment were integrated and used in the analysis of data pertaining to participants' fluctuating capacity for appropriate ethical judgment. "Thick description" (Geertz, 1973) of engagement with real-life ethical dilemmas suggested repeated shifts across the body of text between prereflective, often somatically based levels of decision-making and mature phases of ethical deliberation characterised by depressive position functioning.

Experience-near accounts of earlier levels of ethical decision-making were replete with descriptions of unprocessed "gut" reactions, unformulated thoughts, declamatory inner moral "voices" and unintegrated childhood memories. Strong visceral reactions often accompanied the prereflective identification as well as the later recall of the ethical dilemma concerned. Feelings of anxiety, shock, sickness, blankness, sleeplessness, headaches, bodily pain or arousal were common to all accounts. The psychological meanings of the latter "unspeakable" reactions were, at these levels of thinking, not yet apparently cognitively grasped. Subjective experiences of wrestling with ethical dilemmas were additionally suffused with a sense of threat and immersion in a seemingly persecutory professional matrix. A stream of fantasies coursing through the text included, for example, feared "psychoanalytic police", vindictive colleagues, retaliatory adult and child patients, endangered supervisory spaces and hostile superego "voices". Evocative metaphors suggested that the therapeutic container was alternatively crowded by domestic strife, cookers under pressure, buckled up briefcases and reckless pioneering in the Wild West. These images similarly suggested that ethical dilemmas had transpired for the most part in the context of profoundly impoverished reflective space. Research participants reported that

the analytic frame was accordingly consistently assailed by the "stuff" (Interv. **6**, p. 229, 11-28) of multiple "undigested" psychological and bodily events. Without sufficient consideration of the possible unconscious determinants of the therapist's behaviour, nor the impact on the therapy, radical modifications to traditional therapeutic boundaries have been vaunted as comprising "humane" and ethical interventions (Lazarus, 1994). The data suggested that, on the contrary, frame deviations provoked by charged dilemmas typically saw the emergence of boundary violations which gratified, for example, inappropriate therapist needs for business dealings, friendship, the re-establishment of lost familial intimacy or for heightening professional self-esteem at the expense of heeding the patient's request to terminate therapy.

While „Beneficence' and „Integrity in Relationships' were the most strongly endorsed ethical principles, data analysis revealed significant discontinuities between aspirational ethical principles and lived professional practices. Avowed ethical principles often unravelled under the impact of real-world dilemmas, giving way to enduring ethical decision-making enactments of which the majority lasted for over a year. „Nonmaleficence' and the management of personal countertransference by contrast received minimal acknowledgement and emerged as the most "offended" (Knapp & VandeCreek, 2007) or neglected ethical values.

These findings appeared congruent with the observation that interviewees were clearly identified with the compelling professional image of a beneficent, authoritative caregiver or "wounded-healer" (Bennet, 1987; Miller & Baldwin, 1987). The model of the wounded healer argues that the therapist's personal disturbance or capacity for maleficence constitutes the hidden and covert aspect of the wise and charismatic "healer-redeemer" (Groesbeck, 1975; Groesbeck & Taylor, 1977). This suggests that the therapist may be prone to rescuing and to "healing" those disavowed aspects of him/herself that are projected into the ostensibly wounded and needy patient. As Solomon (2003b) avers, what is disavowed or unethical can unconsciously be "lived out in projection, using and abusing the other as a vehicle for holding the bad aspects of the self." (p. 23).

Ten different examples emerged from the eleven research interviews of ethical decision-making enactments. Impaired internal and external containment apparently saw participants seeking relief from escalating countertransference pressures through precipitate decision-

making involving ethically compromised behaviours. Psychodynamic formulations of patients' emotional difficulties often appeared to occur in the absence of any corresponding acknowledgement by therapists of their own unconscious contribution to the enactments concerned. As one interviewee succinctly suggested, the sometimes unpalatable "countertransference piece … gets skipped" (Interv. **4**, p. 123, 11-28). This suggests that when the psychoanalytic practitioner appears thoroughly identified with the principle of beneficence and with the related professional image of a beneficent healer, he/she may struggle to consider the maleficent or iatrogenic aspects of their therapeutic interventions.

In short, this study argues that initial levels of ethical decision-making seemingly collapsed in the direction of a paranoid-schizoid mode of functioning predominantly structured by projective identification and by the defensive need to keep "disturbing glimmers of meaning" (Stern, 1983, p. 92) out of conscious awareness. The data suggest that the six real-life ethical dilemmas were thus characterised by multiple therapist-driven enactments; these were construed as comprising the overt behavioural expression of participants' unresolved emotional difficulties that were revived in the charged atmosphere of the ethical quandary concerned.

Later phases of mature ethical decision-making appeared relatively free of countertransference pressures and saw the research interviews function as an empathic reflective space. Participants' disturbing countertransference experiences were "digested", thought about and a measure of insight into the nature of the unconscious determinants driving the ethical decision-making process was occasionally achieved.

A generative ethical decision-making pathway in the context of analytic space apparently partakes of "a state of double consciousness" (Gabbard, 1999, p. 18). Earlier unwitting participation in the transference-countertransference matrix is optimally succeeded by "the mental freedom" (Britton, 1998, p. 42) characteristic of "triangular psychic space" (Britton, 2003, p. 98) or of mature phases of the ethical decision-making process. In this triangular space, the therapist, in the company of a benevolent other, takes up a third position from which it becomes possible to view the object relationships involved, to interact with ideas and alternative points of view, and to think retrospectively about the meanings of the ethical decision-making enactment at hand. Central to mature ethical decision-making is the extension of the role of containment from the familiar activity of processing the patient's

intense affects to apprehending and analysing the nature of the therapist's own unconscious contribution to the countertransference enactment concerned (Gabbard, 1999).

An array of professional resources were available for consultation at the time of the ethical dilemmas. Data analysis foregrounded inadequate postgraduate ethics training, derelict supervisory practices and professional isolation as major risk factors for compromised professional decision-making. In general, interviewees expressed dissatisfaction with the content, duration, intensity and perceived relevance of their postgraduate ethics education. Boredom, poor recall, staff disinterest, lack of exposure to ethics codes and the unintegrated nature of ethics training effectively alienated participants from their former ethics instruction. Confronted by everyday ethical dilemmas, research participants appeared unable to summon their graduate ethics training as a potentially helpful resource. Experience-near descriptions suggested moreover that isolated ethics modules were not apparently situated within training institutions that were perceived to actively foster "a climate of ethical sensitivity" (Wassenaar, 2002, p. 222) wherein students, their peers, academic staff and internship supervisors felt free to discuss and to address their ethical conflicts and concerns.

Apart from Wassenaar's (2002) work, no recent reliable data are available regarding the content, methods used, duration and perceived efficacy of pre-professional ethics instruction in psychology programmes at South African universities. South Africa is a multicultural society that includes eleven official languages and a prevalent "African cosmology" (Burke et al., 2007, p. 114). Over 90% of clinical psychologists are white and they appear mostly unskilled in the African languages used by the majority of the population (Pillay & Kramers, 2003). Despite these conditions, no clarity presently exists as to whether or how cultural and diversity considerations have been integrated into postgraduate ethics education. This lack of information extends to whether and what ethical decision-making models are taught and how awareness is raised with respect to the impact of countertransference phenomena on the decision-making process. At the time of writing, there are similarly no publications that discuss what and how ethics is taught in the context of the Professional Board's postqualifying mandatory ethics educational activities. The present study argues that research participants' primarily negative experience and evaluation of their postgraduate ethics instruction comprises a first major risk factor for compromised professional decision-making.

Impaired supervisory practices emerged as a second risk factor. Compromised practices included "rushed" supervision, irregular modelling or unquestioning acceptance of dual role relationships and the seeming unawareness of the ethical dimension of clinical practice. Data analysis suggested that personal countertransference was deeply implicated in enduring ethical decision-making enactments. Yet not a single instance wherein the supervisor bluntly confronted the unethical or countertransference aspects of their supervisees' therapeutic interventions emerged from the data. When asked to comment on their supervisors' perceived capacity to assist with the resolution of troubling dilemmas, interviewees reported avoiding supervision or, alternatively, of being left feeling directionless, disappointed and frustrated. The apparent imperviousness to the ethical dimension of clinical practice by most analytically orientated supervisors and personal therapists in this study suggests that "ethics" may currently be construed as a discrete entity and as separate from daily professional practices. The data raise the question as to whether local supervisors are themselves adequately trained to recognise the presence of ethical dilemmas and to conduct supervision that actively probes the ethical and countertransference aspects of their supervisees' decision-making practices and interventions.

Data analysis confirmed a pervasive sense of professional isolation that comprised the third risk factor for compromised ethical decision-making. This stands in contrast with previous studies which found that supportive professional connections and informal collegial networks were highly valued by master therapists and psychologists as enhancing the ability to practice ethically, as assisting with ethical decision-making and as the most effective resource in guiding professional behaviour (Haas, Malouf & Mayerson, 1986; Jennings et al., 2005; Pope, Tabachnik & Keith-Spiegel, 1987). The key phrase "It's difficult to reach out" (Interv. **1**, p. 14, 46) succinctly captured a common theme, reflecting participants' aloneness and estrangement from the relevant ethics code, the law, professional bodies and their colleagues. Relationships with the latter underused professional resources often appeared to be suffused with mistrust, anger and fears of shaming, censure or punishment. Ironically, these dynamics only served to seal over countertransference difficulties, entrenching professional isolation and continued involvement in chronic therapist-driven enactments.

Review of the relevant professional literature revealed numerous accounts of ethical decision-making frameworks. Cottone and Claus (2000) comment, however, that relatively few appear to be both empirically and theoretically grounded. Based on the literature and on data generated by real-life ethical dilemmas, a pragmatic psychoanalytically oriented ethical decision-making model was constructed. The proposed model integrates the CPA's (2000) principle-based ethical decision-making steps with the psychoanalytic notion that ethical judgments are impacted additionally by irrational and unconscious determinants. The latter ethical decision-making framework thus synthesises previous points of view and offers a third or alternative perspective.

Under the impact of raw affective arousal, the data suggest that the psychoanalytic practitioner's capacity for rational thinking and ethical functioning may temporarily be lost and must be wrested back again. Since attempts at self-scrutiny are likely to be clouded by countertransference "blind-spots", the proposed model argues for the need to create a reflective space with the aid of peer supervision or consultation. In the presence of an empathic other, the model's eight levels of enquiry hopefully progressively transform "unthinkable" bodily and emotional events into a retrospective understanding of the unconscious dynamics animating the dilemma concerned. Specific questions are directed at assisting the psychoanalytic practitioner to explore and to think about intense and irrational feeling states, including those that derive from patient-induced or therapist-driven ethical decision-making enactments. The model thus proposes "a cooling off period" (Varghese & Kelly, 1999, p. 10) wherein unethical, maleficent or anti-analytic impulses can be normalised, reflected upon and given meaning. Since the model aims to restore the therapist's customary reflective stance and to protect the patient's psychological growth, it is congruent with the analytic attitude which, Solomon (2003a) suggests, is at its core essentially ethical in nature.

Use of a psychoanalytic model may not in itself augment ethical motivation or ensure ethical action. However, it offers a contribution to professional debate and represents a preliminary empirically based framework that may help the psychoanalytic practitioner engage more effectively with the unconscious dimension of professional decision-making. Mature ethical decision-making is apparently predicated upon engagement with the two interdependent poles of subjective experience and universal ethical principles. Acknowledging the influence on ethical decision-making of both the particularity of

subjective countertransference experience as well as the need for objective ethical principles, the unitary approach adopted by the proposed psychoanalytic model integrates the ethical concerns articulated by the moral voices of justice and care respectively.

2. LIMITATIONS OF THIS STUDY

The findings of this study are subject to several limitations. Firstly, the lack of a culturally and racially diverse participant sample is acknowledged. As reported in chapter 4, all six participants in the study were white, middle-class psychologists working as psychoanalytic practitioners. Secondly, and perhaps more pertinent, however, is the possibility that the sample was skewed by the fact that participants were effectively self-selected. This could conceivably have resulted in, for example, suitable subjects declining to participate because they had already successfully resolved charged ethical dilemmas with little or no interference from countertransference phenomena. On the other hand, potential participants may have been involved in ethical decision-making enactments but declined to participate either because they were less concerned about ethical dilemmas and/or infractions or because they did not wish to be exposed to the external scrutiny inevitably involved in such a research study. However, without available data it is not possible to go beyond conjecture around the factors that impeded or facilitated participation in this study. It may seem therefore, given both this lack of clarity as well as the small and predominantly homogeneous nature of the sample, that the findings are open to the criticism that they are confined to a particular emotionally troubled subgroup and are thus limited in scope. These possible objections to the generalisability of the present findings may be countered by the following observations.

The type of ethical dilemmas presented by research participants in this study included confidentiality concerns, non-sexual dual role relationships and collegial misconduct. It is therefore likely that the present findings are of wider relevance since these ethical dilemmas are of the type identified as „traditional' by Lindsay and Colley (1995) and are amongst those most frequently reported in local and international studies of both psychotherapists' and psychologists' ethical concerns (Colnerud, 1977; Lindsay & Clarkson, 2000; Pettifor & Sawchuck, 2006; Pope & Vetter, 1992; Report of the APA Ethics Committee, 2000; Slack & Wassenaar, 1999; Wassenaar, 2002). Additionally, the recurring need expressed implicitly or explicitly by research participants for improved ethical guidelines, training and supervision, arising out of their experience of significant inadequacies in these areas,

appears congruent with the findings and recommendations made by many researchers and theorists (see chapters 2 and 7).

More importantly, however, this study has assumed that there is little need to establish the fact that ethical violations and related judgment/action discrepancies occur within communities of psychological practitioners – the studies reviewed previously (see above and chapter 2) provide ample evidence in this regard. The focus of this study has therefore not been on the incidence of such violations but rather on the aspiration that a theoretically-informed analysis of psychoanalytic practitioner accounts of grappling with ethical dilemmas may helpfully contribute to a deeper and more detailed understanding of how and why ethical violations arise in the therapeutic space. It has been assumed, therefore, that the dynamics involved in the latter accounts are likely to be similar, with specific contextual variations, to those arising in comparable situations in which such violations occur. In this way, potential „universal' veracity has been sought through an in-depth exploration of the particular. Given this intent, and the appropriate qualitative methodology that gave effect to it, the question of whether, or to what extent, the countertransference dynamics identified actually do occur in the wider practitioner community is not within the scope of this study and could be addressed in future research.

A further criticism of this study could involve questioning the reliability of participant accounts given the tendency in self-report studies for subjects to give what they believed to be socially desirable responses to the resolution of ethical dilemmas (Pope & Tabachnik, 1993). However, the emergence of multiple ethical decision-making enactments in the interviews (see chapter 8) suggests that the data largely escaped being heavily compromised by such „self-censored' responses. Indeed the detailed, nuanced and often distressed accounts offered by participants appeared to be singularly honest and forthright descriptions of subjective countertransference experiences and difficulties that they encountered in their efforts to resolve ethical quandaries.

Another potential criticism that should be acknowledged involves other role-players in the provision of professional resources. This study focused on foregrounding research participants' subjective "voices" and perspectives in their recall of encounters with professional resources and the resolution of real-world ethical quandaries. The lack of specific knowledge of the construction of the present South African ethics code as well as

about postgraduate and postqualifying ethics education has been noted. A further limitation is thus also the absence in this study of the "voices" of ethics educators, supervisors and Professional Board ethics committee members in describing their own efforts, struggles and resources in responding to the needs of trainees and supervisees with respect to engaging with, and satisfactorily resolving, ethical dilemmas arising in the therapeutic setting. Thus this study did not attempt to elicit the opinions and perspectives of supervisors and ethics educators as to how, for example, an ethically attuned and responsive learning environment might be cultivated or what factors might be salient in improving current ethical guidelines and ethics training programmes.

A final point concerns the possibility of idiosyncratic interpretation of the data. However, the researcher has tried as far as possible to describe the data analysis process in a transparent and rigorous way, in the hope that a second reader might be potentially able to replicate the interpretation. Until such a reading is ever done, however, the researcher cannot guarantee that the analysis is free of such idiosyncratic bias.

3. RECOMMENDATIONS

Original taken-for-granted assumptions that the real-life ethical dilemmas presented by research participants would eventually be resolved through the thoughtful use of available professional resources were belied by the data. Descriptions of lived ethical dilemmas unexpectedly highlighted a mistrust of professional bodies, a seemingly persecutory collegial matrix and a wealth of disturbing, unprocessed subjective countertransference experience. Based on these findings, the following recommendations include suggestions for the revision of the current South African ethics code, the improvement of postgraduate and postqualifying ethics education and the building of more benevolent relational connections in the psychoanalytic community.

3.1. The Professional Board of Psychology's code of ethics

Research participants' relationship to the ethics code of the HPCSA Professional Board for Psychology (2002) was characterised by a sense of perceived irrelevance and alienation. Rather than being seen as a valuable professional resource, professional ethics codes aroused little interest and apparently represented dry, official, experience-distant documents of which interviewees were either unaware or which went unused. On occasion, the unread code seemed to take on an actively persecutory guise, provoking fear and further avoidance.

These findings suggest that a revised South African code of ethics should optimally provide a practitioner-friendly and relevant document that was easy to teach, conceptually cohesive and that would open up a professional space for debate around diverse points of view.

An alternative and revised code could follow the example of the Canadian Psychological Association (CPA) process in which the "collective wisdom" of psychologists in relation to ethical issues and ethical decision-making was integrated into their code of ethics (Sinclair, 2000). The Preamble to the CPA's (2000) ethics code unambiguously states that its four ethical principles are anchored in the analysis of actual responses given by the CPA membership to hypothetical ethical dilemmas. Pope and Vetter (1992) similarly observe that the original APA (1952) ethics code was based on actual descriptions of real-life ethical dilemmas offered by a representative sample of APA members.

In contrast, the Professional Board of Psychology's current code contains no equivalent statement as to how the present code came into being. This absence invites speculation that an "armchair approach" was adopted whereby a committee of experts devised the "authoritarian" (Burke et al., 2007) code presently in use. A revised code might therefore include research initiatives actively geared to soliciting real-life ethical dilemmas faced by a representative sample of South African psychologists practising on the front lines of a multiracial, multicultural and multilingual society. Following the example provided by the Canadian model, the latter research initiative could conceivably distil dynamic ethical principles from actual practice that could subsequently be used in the construction of an experience-near and relevant code of ethics. As Wassenaar (1998b) writes, the challenge then would be "to develop ethical standards which are relevant to local communities and indigenous values, and which remain simultaneously compatible with international standards in psychology" (p. 241).

Previous discussion (see chapter 2) argued that the efficacy of the current ethics code for guiding the resolution of ethical dilemmas is additionally hampered by its lack of conceptual cohesiveness. No apparent rationale thus appears to inform the overall organisation or content of the text concerned. The Professional Board's ethics code thus fails to identify explicitly its "ethical foundation" (Welfel & Kitchener, 1992, p. 180) or the full range of philosophical ethical principles upon which it is based. This necessarily carries

consequences for the code's capacity to function as an empowering educative tool and to offer pragmatic assistance in the ethical decision-making process.

The "vague and brief" (Burke et al., 2007) ethical decision-making guidelines set out in the South African code under "Resolving Ethical Issues" (chapter 11) provide neither rank-ordered ethical principles nor any reference to widely cited decision-making models. Revision of the present code could correct these omissions by including an ethical decision-making framework which acknowledges hierarchical principles and which additionally raises awareness of the irrational and emotionally charged dimension of professional decision-making. The publication of an educative manual, such as the *Companion Manual to the Canadian Code of Ethics for Psychologists* (Sinclair & Pettifor, 2001) or the *Ethics Casebook of the American Psychoanalytic Association* (Dewald & Clark, 2001), could illustrate the practical application of the ethical principles and decision-making model concerned to contemporary ethical dilemmas drawn from the lived experience of South African practitioners. Hypothetical and disguised actual vignettes presented in the manual could stimulate ethical sensitivity and group debate around common ethical concerns and controversies. The foregoing measures might play a role in increasing the perceived relevance and sense of ownership of a revised national code of ethics.

3.2. Postgraduate and Postqualifying Ethics Education

Efforts to foster an ethical attitude as an essential aspect of professional practice include redressing the quality of ethics education available to both trainees and qualified professionals. The data reveal that the troubling split between professional practice and the misconception that ethics is a discrete entity which consists "mainly [of] slavish attention to professional and research ethics codes" (Davidson, Garton & Joyce, 2003, p. 220, in Falender, 2006) may be inculcated early on in professional training. Clearly further research is therefore needed to supplement the available sparse information and to ascertain more accurately when, what and how ethics instruction is integrated into South African psychology undergraduate, graduate and continuing professional development programmes. Literature outlining relevant debates on professional ethics training was reviewed in chapter 7. While devising detailed ethics curricula lies outside the scope of this thesis, the following recommendations elaborate the relevance of the main findings of the present study for local ethics instruction.

Lack of ethical sensitivity and deficient role modelling by statutory bodies, supervisors and personal therapists (see chapter 7) apparently contributed to the prolonged non-confrontation of collegial sexual misconduct and to participants' continued involvement in dual role relationships. This suggests that academic departments, training institutes, psychoanalytic societies and reading groups need to provide an ethically responsive professional context that models an empathic and humane alertness to ethical issues and decisions. As Kitchener (1992) avers, the training of ethically competent practitioners transcends the content of any discrete theoretical module and becomes the responsibility of the entire staff. Even excellent ethics instruction may be insidiously undermined by the unethical conduct of educators and supervisors. Thus the collective life of academic departments, institutes and psychoanalytic societies needs to remain ethically congruent with the explicit messages conveyed by ethics training programmes. Frank and open discussion of ethical concerns and conflicts arising from trainees' personal experiences with patients, peers, supervisors and educators needs to be encouraged. Additional strategies include the establishment of regular conferences and staff-student ethics colloquia as well as the designation of particular institute or staff members who are prepared to develop ethics education as a specialist interest. If Solomon (2003b) is correct that clinicians draw upon their internalised experience of the analytic attitude as conveyed by their supervisors and personal therapists, then trainees' lived experience of their educators and of the collective ethical life of the teaching department similarly functions as a key source of identification for students' burgeoning professional ethicality and capacity for appropriate ethical decision-making.

Deficits in basic ethical knowledge and applied problem solving skills were revealed by textual analysis of psychoanalytic practitioners' responses to real-life ethical dilemmas. This suggests that thorough familiarity with legal frameworks, ethical theories, formal ethics codes, principles and standards as well as competence in the application of seminal ethical decision-making models comprise the *sine qua non* of ethics instruction at postgraduate and postqualifying levels (Fine & Ulrich, 1988). Wassenaar (2002) recommends that postgraduate ethics training should include the study of local patterns of public complaints as well as of the ethical dilemmas that preoccupy practitioners locally and internationally. A thorough grasp of these several but interdependent components of an ethics curriculum would hopefully promote linkages between the theoretical knowledge of

codes, principles and standards and their practical application to teaching vignettes and real-life ethical quandaries.

Within these broad parameters, the professional literature is replete with innovative training suggestions that might perceptibly enliven course content. Multifaceted teaching approaches previously discussed (see chapter 7) have highlighted the creative use of case studies and values confrontation (Abeles, 1980), experiential training including role-play and simulation (Abramovitch, 2007) and drawing on guest lecturers from statutory and voluntary professional bodies (Handelsman, 1986b). Challenging self-assessment questionnaires are offered by Epstein and Simon (1990) and by Falender (2006) respectively. These could be used to stimulate group debate around the issue of boundary violations and therapist exploitiveness in key areas of professional practice or to encourage reflection about the nature of the supervisor-supervisee relationship and the reasons why trainee self-disclosures may be censored or suppressed. The foregoing training initiatives may help to develop a professional "membership [which is] capable of making sophisticated judgments about which course of action may be ethical in situations in which no one behaviour seems entirely ethical or unethical" (Welfel & Lipsitz, 1984, p. 31).

Data analysis foregrounded the extent to which unresolved personal countertransference impeded and structured the ethical decision-making process. The need for improved training in the management of countertransference is supported by local research. Investigating sexual attraction to clients, Stevenson (1999) concludes that "Qualitative data volunteered by many subjects indicate that they find psychoanalytic concepts and theory, including the therapeutic frame and transference and countertransference, useful in understanding their sexual attraction, their clients as well as in facilitating the therapeutic process. This argues for the inclusion of these topics in training programmes" (p. 108). Gabbard (1996) similarly argues that, even if therapists do not practice dynamic psychotherapy, "transference and countertransference issues will always be present in the therapy whether or not the therapist acknowledges their existence" (p. 318). This suggests that ethics education might arguably help to enhance prospective ethical performance and reduce ethical violations by encouraging trainees and psychoanalytic practitioners alike to interrogate irrational countertransference pressures so that these helpfully inform, rather than hamper, the therapeutic process.

Complex ethical dilemmas are unlikely to be resolved in isolation and the professional literature widely endorses the need for consultation (APsaA, 2005; CPA, 2000; Dewald & Clark, 2001; Gabbard, 1996; Sonne, 1994). Data analysis repeatedly revealed the felt absence of professional resources or benevolent third others who might be called upon to aid the ethical decision-making process. The third may be envisaged as consisting not only of postgraduate ethics training but also of ethics codes, professional bodies, supervisors and colleagues. Four practical educative strategies for encouraging changed ethical decision-making practices and for depathologizing embarrassing or shameful ethical decision-making enactments emerged from the different chapters of this study and are summarised below. Each strategy attends to the need to implement at postgraduate and postqualifying levels the normative practice of examining emotionally loaded, unethical or anti-analytic countertransference pressures which routinely arise in the therapeutic relationship and which are likely to deflect novice and experienced therapists alike from optimal ethical functioning.

Qualitative data confirmed that beneficence was the aspirational ethical principle most strongly endorsed by participants. The present study has argued, however, that the first strategy of redressing the neglected status of nonmaleficence paves the way for considering both competing ethical principles as well as the countertransference dimension of professional decision-making. When beneficence is foregrounded as the primary ethical principle governing the therapist's conscious ethical choices, this does not nullify the obligation to limit or to prevent harm by examining repeated frame deviations from the counterpoles of nonmaleficence and personal countertransference. Peer and collegial discussion of unconscious "blind spots" and the sometimes self-serving aspects of ethical decision-making may assist in dismantling the idealised notion of the unrelentingly beneficent caregiver and help to confer meaning upon disavowed countertransference pressures seeking potential or already realised behavioural expression in boundary violations and ethical decision-making enactments. These observations appear congruent with Zelen's (1985) comments that raising awareness of the practitioner's countertransference vulnerabilities may "enable the helping professions to drop the false model of omniscience and omnipotence" (p. 184).

The wounded-healer model, reconfigured from an object relations perspective, offers a second strategy and a compelling metaphor for illustrating how countertransference may

function as "a virtue" and as "a vice" (Louw & Pitman, 2001). When countertransference is mobilised as a virtue, the therapist's woundedness allows the latter to use his/her well-developed capacity for empathy to gain entry into the patient's internal object world. When countertransference "blind spots" are, by contrast, mobilised as a vice, unretrieved therapist-driven ethical decision-making enactments may arise as a result of the healer's efforts to ward off threatening and disavowed countertransference feelings and thoughts. The model's pragmatic delineation of the inevitable mobilisation and ensuing need to process the healer's projections and unresolved personal countertransference may once again assist in legitimising a much needed professional space wherein to discuss the possible impact of countertransference and enactment phenomena on ethical performance. In foregrounding countertransference as a central organising concept, the wounded-healer model provides an additional educative tool that usefully supplements ethical decision-making models emphasising a rational and linear approach to the resolution of ethical dilemmas.

Compromised supervisory practices revealed by the data suggest that the development of ethics education programmes for psychodynamically oriented supervisors may comprise a needed and useful area in South Africa for continuing professional development. A third strategy relates to the recurring argument set out in the present study that the establishment or restoration of reflective space remains central to the resolution of real-life ethical dilemmas. Confident exploration by supervisors of their supervisees' responses to complex ethical quandaries presupposes a thorough grasp of the basic components of ethical knowledge described earlier as comprising the *sine qua non* of ethics education. Going beyond the need to increase supervisory awareness of the ethical dimension of clinical practice, the third strategy widens the notion of reflective space as encompassing the supervisor, the supervisee and the patient to the broader ethos of establishing "ubiquitous triads" (Solomon, 2003; Solomon, 2004). The latter practice would include the supervisor's regular discussion with a consultant about his/her own work with supervisees. The ripple effect of creating "ubiquitous triads" thus affords the supervisor a useful opportunity for reviewing his/her own potential resistance and countertransference dynamics which may have emerged in the course of supervising troubling ethical dilemmas. Such an attitude of openness, non-defensiveness and thoughtfulness is then more likely to be internalised by supervisees as an integral aspect of the analytic attitude. Discussing South African clinical psychologists' responses to sexual attraction, Stevenson (1999) similarly argued for "an

ethos of consultation and supervision seeking, so that when problems arise therapists will feel free to get help before they act on feelings of sexual attraction" (p. 107).

Construction of a pragmatic psychoanalytic model of ethical decision-making comprises the fourth and final strategy to promote engagement with the unconscious dimension of professional decision-making. The model has been extensively discussed and may provide a practical tool that the psychoanalytic practitioner can use to explore disturbing countertransference feelings. The model may thus usefully supplement the more traditional application of ethical principles and standards to the resolution of complex dilemmas.

The collective task of engendering a non-judgmental ethical consciousness appears to begin with practical efforts to construct benevolent professional spaces. Each of the foregoing strategies may play a role in raising awareness of and in normalising distressing or shameful countertransference experience by encouraging freer and more open disclosure of shared ethical conflicts and concerns. This collegial "reaching out" may, over time, foster a genuine ethic of care and help to modify the persecutory superego apparently abroad in at least some local psychoanalytic societies and reading groups.

4. FUTURE RESEARCH

Several directions for future research are suggested by the present findings. This research study was limited to exploring and understanding the subjective experiences of a small pool of white, middle class psychoanalytic practitioners who encountered ethical dilemmas in the therapeutic space. Earlier discussion (see chapter 2) noted that Western liberal ideologies that privilege individual autonomy are at variance with the ethical values and decision-making practices of different cultural and ethnic groups. As part of the revision of the current ethics code, surveys could attempt to elicit a wider and more representative sample of real-life ethical dilemmas drawn from practitioners with diverse linguistic, religious, cultural and ideological backgrounds and worldviews.

Based on the experience of the present study, future qualitative research investigating a different range of real-life ethical dilemmas might anticipate the evocation of subjective distress and unresolved trauma in veteran and novice psychoanalytic practitioners alike. Using the "ethics as process" research model (Ramcharan & Cutcliffe, 2001), informed consent procedures could include the offer of debriefing facilities conducted by a competent

counsellor. Such research might also usefully provide further opportunities for research participants to evaluate and to correct the researcher's portrayal of their self-understandings and their descriptions of real-life ethical dilemmas.

The need for further research into South African ethics education at postgraduate and postqualifying levels has been noted. The data in this study additionally suggest that research is needed into the training and development of ethically competent psychotherapy supervisors. As Clarkson and Lindsay (2000) observe, both experienced and novice therapists may consistently avoid engaging with particular aspects of their therapeutic interventions. It is then the responsibility of the supervisor to draw attention to any problematic ethical and professional practice dimensions of the work at hand. An absence of information currently prevails in South Africa regarding supervisors' prior ethics education, the state of their current ethical knowledge (including familiarity with ethics codes and decision-making models), their subjective conflicts, perceived needs and what professional resources are accessed when doubts about supervisory interventions arise. Evaluation by supervisees of the perceived capacity of their supervisors to aid the resolution of ethical dilemmas is equally lacking but appears to offer a fruitful area for research.

Given that the construction of a psychoanalytic ethical decision-making model has been proposed as a practical strategy for enhancing professional decision-making, its utility and efficacy could be piloted and evaluated. It is suggested, for example, that small groups of graduate students or practitioners could receive instruction in the use of both the psychoanalytic model as well as the CPA (2000) ethical decision-making framework. Alternative groups might receive instruction in the use of the CPA framework alone. Subsequent group discussion of selected case vignettes might provide an opportunity for evaluating whether exposure to the psychoanalytic model facilitated greater confidence and competence in countertransference management and fewer ethical decision-making enactments. Strengths and weaknesses of the psychoanalytic model could be identified and used to increase its relevance and utility.

5. CONCLUDING COMMENTS

This study has sought to respond to the challenge of identifying, describing and understanding the irrational and emotionally charged dimension of professional decision-making. Description and interpretation have repeatedly been woven together to create the

text of individual chapters. Each chapter has played an integral part in contributing to a hopefully nuanced and coherent understanding of the ethical decision-making process as it unfolds in the often turbulent therapeutic setting. In particular, attention has been drawn to countertransference phenomena and how these may unconsciously structure ethical decisions and interventions. In the end, every psychoanalytic practitioner confronts the personal struggle and life-long task of engendering his/her own ethical perspective and thus takes or abandons responsibility for the ongoing monitoring of disorienting thoughts, feelings and actions so frequently evoked by real-life ethical dilemmas. The final interpretive account set out in this study has hopefully contributed a conceptual framework for reflecting anew on the unconscious underpinnings of ethical judgment and the basis for advancing practical changes in the psychoanalytic psychotherapist's everyday ethical decision-making practices.

REFERENCES

Abeles, N. (1980). Teaching ethical principles by means of value confrontations. *Psychotherapy: Theory, Research and Practice, 17*(4), 384-391.

Abramovitch, H. (2007). Stimulating ethical awareness during training. *Journal of Analytical Psychology, 52*, 449-461.

Abramson, M. (1996). Reflections on knowing oneself ethically: Toward a working framework for social work practice. *Families in Society: The Journal of Contemporary Human Services, 77(4)*, 195-202.

Addison, R.B. (1989). Grounded interpretive research: An investigation of physician socialization. In M. J. Packer & R. B. Addison (Eds.). *Entering the circle: Hermeneutic investigations in psychology* (pp. 39-57). Albany, NY: State University of New York Press.

Addison, R. B. (1992). Grounded hermeneutic research. In B. F. Crabtree & W. L. Miller (Eds.). *Doing qualitative research: Research methods for primary care, Vol. 3* (pp. 100-124). London: Sage Publications.

Addison, R. B. (1999). A grounded hermeneutic editing approach. In B. F. Crabtree & W. L. Miller (Eds.). *Doing qualitative research* (2nd ed., pp. 145-162). London: Sage Publications.

Allan, A. (2001). *The Law for Psychotherapists and Counsellors.* Second Edition. Somerset West: Inter-Ed Publishers.

Allphin, C. (2005). An ethical attitude in the analytic relationship. *Journal of Analytical Psychology, 50,* 451-468.

Anonymous (2005). The unfolding and healing of analytic boundary violations: personal, clinical and cultural considerations. *Journal of Analytical Psychology, 50(5),* 661-91.

APA - American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist,* Retrieved 10 August 2001, from PsycNET.

APA - American Psychological Association. (2001). Report of the ethics committee, 2000. *American Psychologist, 56(8),* 680-688.

APA - American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57(12),* 1060-1073.

APA - American Psychological Association. (2004). Report of the ethics committee, 2003. *American Psychologist, 59(5),* 434-441.

APsaA - American Psychoanalytic Association (2001). *Principles and standards of ethics for psychoanalysts.* Retrieved 16 June 2005, from http://www.apsa.org/

Attwood, R. D. & Stolorow, G. E. (1984). *Structures of subjectivity: Explorations in psychoanalytic phenomenology.* Hillsdale, NJ: The Analytic Press.

Baldick, T. (1980). Ethical discrimination ability of intern psychologists: A function of training in ethics. *Professional Psychology: Research and Practice, 11,* 276-282.

Baranger, M. & Baranger, W. (1966). Insight and the analytic situation, In R. Litman (Ed.). *Psychoanalysis in the Americas*. New York, International Universities Press.

Barnett, J. E., Rosenthal, S. L., Behnke, S. H., & Koocher, G.P. (2007). In case of ethical dilemma, break glass: Commentary on ethical decision-making in practice. *Professional Psychology: Research and Practice, 38(1),* 7-12.

Beauchamp, T. L. & Childress, J. F. (1994). *Principles of biomedical ethics* (4th ed.). Oxford: Oxford University Press.

Bennet, G. (1987). The wound and the doctor. Healing, technology and power in modern medicine. M. Secker and Warburg.

Benatar, D. (2002). *Ethics for everyday*. New York, McGraw-Hill.

Bernard, J. L., & Jara, C. S. (1986). The failure of clinical psychology graduate students to apply understood ethical principles. *Professional Psychology: Research and Practice, 17 (4)*, 313-315.

Bernard, J. L., Murphy, M., & Little, M. (1987). The failure of clinical psychologists to apply understood ethical principles. *Professional Psychology: Research and Practice, 18 (5)*, 489-491.

Bersoff, D. N (2003). Ethical Conflicts in Psychology. (3rd Ed). Washington, American Psychological Association.

Betan, E. J. (1997). Toward a hermeneutic model of ethical decision making in clinical practice. *Ethics and Behavior, 7(4)*, 347-365.

Betan, E. J. & Stanton, A. L. (1999). Fostering ethical willingness: Integrating emotional and contextual awareness with rational analysis. *Professional Psychology: Research and Practice, 30 (3)*, 295-301.

Bion, W. R. (1957). Differentiation of the psychotic from the non-psychotic personalities. *International Journal of Psychoanalysis, 38,* 266-275.

Bion, W. R. (1959). Attacks on linking. *International Journal of Psychoanalysis, 40,* 308-315.

Bion, W. R. (1962). A theory of thinking. *International Journal of Psychoanalysis, 43, (4-5)*, 110-119.

BMA – British Medical Association (1991). *Report of the Psycho-Analysis Committee.* Handbook September 1991.

Bollas, C. (1999). On the loss of confidence in psychoanalysis. [Originally published in the *International Psychoanalytical Association (IPA) Newsletter, 8(2)*] Retrieved 10 March 2003, from http://www.academyprojects.org/leboll1.htm

Borkan, J. (1999). Immersion/Crystallisation. In B.F. Crabtree & W.L. Miller (Eds.), *Doing qualitative research* (2nd ed).(pp. 179-195). London: Sage Publications.

Brenner, C. (1985). Countertransference as compromise formation. *Psychoanalytic Quarterly, 54 (2)*, 155-163.

British Psychoanalytic Society (1991). *Ethical code and ethical guidelines*. Retrieved on 10 October 1999, from http://www.psychoanalysis.org.uk/

Britton, R. (1989). The missing link: Paternal sexuality and the Oedipus complex. In R. Britton, M. Feldman, & E. O'Shaughnessy, *The Oedipus complex today: Clinical implications* (pp. 83-103). London: Karnac Books.

Britton, R. (1992). Keeping things in mind. In R Anderson, (Ed.), *Clinical lectures on Klein and Bion.* (pp. 102-112). London: Tavistock/Routledge.

Britton, R. (1998). Subjectivity, objectivity and triangular space. In R. Britton, *Belief and imagination: Explorations in psychoanalysis* (pp. 41-58). London: Routledge.

Britton, R. (2003). *Sex, death and the superego: Experiences in psychoanalysis*. London: Karnac Books.

Brookes, S, & Hodson, P. (2000). The invisible matrix. In S. Brookes & P. Hodson (Eds.). *The invisible matrix: An exploration of professional relationships in the service of psychotherapy,* (pp. 11-22). London: Rebus Press.

Brown, L.M., & Gilligan, C. (1991). Listening for voice in narratives of relationship. In M. Tappan & M. Packer (Eds.), *Narrative and storytelling: Implications for understanding moral development. New directions for child development* (Vol. 54, pp. 43-62). San Francisco: Jossey-Bass.

Brown, L. M., Tappan, M. B., Gilligan, C., Miller, B. A. & Argyris, D. E. (1989). Reading for self and moral voice: A method for interpreting narratives of real-life moral conflict and choice. In M. J. Packer & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigations in psychology* (pp. 141-164). Albany, NY: State University of New York Press.

Brown, L.M., Debold, E., Tappan, M., & Gilligan, C. (1991). Reading narratives of conflict and choice for self and moral voices: A relational method. In W. Kurtines & J. Gerwirtz (Eds.), *Handbook of moral behavior and development. Volume 2: Research* (pp. 25-46). Hillsdale, N. J.: Lawrence Erlbaum Associates.

Burian, B. K. & Slimp, A. O. (2000). Social dual-role relationships during internships: A decision-making model. *Professional Psychology: Research and Practice, 31(3),* 332-338.

Burman, E. (1991). Interviewing. In P. Banister, E. Burman, I. Parker, M. Taylor and C. Tindall. (Eds.), *Qualitative methods in psychology, A research guide* (pp 49-71). Buckingham: Open University Press.

Burke, A. Harper, M. Rudnick, H. & Kruger, G. (2007). Moving beyond statutory ethical codes: Practitioner ethics as a contextual character-based enterprise. *South African Journal of Psychology, 37(1),* 107-120.

Canadian Psychoanalytic Society (1993). *Principles of ethics for psychoanalysis.* Retrieved 13 July 1999, from http://www.psychoanalysis.ca/

CPA - Canadian Psychological Association. (2000). *Canadian code of ethics for psychologists.* (3rd Ed). Ontario: Author.

Casement, P. (1985). *On learning from the patient.* London: Tavistock Publications.

Cassorla, R. S. (2005). From bastion to enactment: The „non-dream' in the theatre of analysis. *International Journal of Psychoanalysis, 86,* 699-719.

Cassorla, R.S. (2001). Acute enactment as a „resource' in disclosing a collusion between the analytical dyad. *International Journal of Psychoanalysis, 82,* 1155-1170.

Charmaz, K. (1995). Grounded Theory. In J. A. Smith, R. Harrè and L.V. Langenhove (Eds.), *Rethinking Methods in Psychology* (pp. 27-49). London: Sage Publications.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.). (pp. 509-536). London: Sage Publications.

Chused, J. F. (1991). The evocative power of enactments. *Journal of the American Psychoanalytic Association, 39,* 615-639.

Clarkson, P. (2000). Preface: Ethics, the heart of the matter. In P. Clarkson, *Ethics: Working with ethical and moral dilemmas in psychotherapy (pp. xiii -xviii).* London: Whurr.

Clarkson, P. & Lindsay, G. (2000). Ethical dilemmas in supervision, training and organisational contexts. In P. Clarkson, *Ethics: Working with ethical and moral dilemmas in psychotherapy (pp. 173-190).* London: Whurr.

Colnerud, G. (1997). Ethical dilemmas of psychologists – a Swedish example in an international perspective. *European Psychologist, 2(2),* 164-170.

Cottone, R. R. (2001). A social constructionism model of ethical decision making in counseling. *Journal of Counseling and Development, 79 (1),* 39-45.

Cottone, R. R., and Claus, R. E. (2000). Ethical decision-making models: A review of the literature. *Journal of Counselling and Development, 78,* 275-283.

Corey, G., Corey M. S. & Callanan, P. (1998). *Issues and ethics in the helping professions* (5th ed). Pacific Grove, CA: Brooks/Cole.

Cottone, R. R. & Tarvydas, V. M. (1998). *Ethical and professional issues in counseling.* Colombus, OH: Merrill/Prentice Hall.

Crabtree, B. F. & Miller, W. L. (1999). Introduction. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research* (2nd ed). (pp. xi-xvii). London: Sage Publications.

Da Silva, G. (2003). Confidentiality in psychoanalysis: A private space for creative thinking and the work of transformation. In C. Levin, A. Furlong, & M. K. O'Neil (Eds.). *Confidentiality: Ethical perspectives and clinical dilemmas*, (pp. 151-165). Hillside, N.J.: Analytic Press.

Davies, J. M. (1994). Love in the afternoon: A relational reconsideration of desire and dread in the countertransference. *Psychoanalytic Dialogues, 4,* 153-170.

Day, J. M. (1991). The moral audience: On the narrative mediation of moral "judgement" and moral "action". In M. B. Tappan and M. J. Packer (Eds.). *Narrative and storytelling: Implications for understanding moral development (pp. 27-42).* Anne Arbor, Michigan: Jossey-Bass Inc.

Dewald, P. A. & Clark, R. W. (2001). *Ethics casebook of the American Psychoanalytic Association.* New York, American Psychoanalytic Association.

Dove, W. R. (1995). Ethics training for the alcohol/drug abuse professional. *Alcoholism Treatment Quarterly, 12,* 19-30.

Durrheim, K. and Wassenaar, D. (1999). Putting design into practice: writing and evaluating research proposals. In M. Terre Blanche and K. Durrheim (Eds.), *Research in practice: Applied methods for the social sciences (pp. 29–54).* Cape Town: University of Cape Town Press.

Eberlein, L. (1987). Introducing ethics to beginning psychologists: A problem-solving approach. *Professional Psychology: Research and Practice, 18(4),* 353-359.

Epstein, R. S. & Feiner, A. H. (1988). Countertransference: The therapist's contribution to treatment. In B. Wolstein (Ed.), *Essential papers on countertransference* (pp. 282-303). New York: New York University Press.

Epstein, R. S., Simon, R. I. (1990). The exploitation index: An early warning indicator of boundary violations in psychotherapy. *Bulletin of the Menninger Clinic, 54(4),* 450-465.

Etchegoyan, R. H. (1991). *The fundamentals of psychoanalytic technique*. London: Karnac Books.

European Federation of Psychologists' Association (EFPA). (1995). *Content of ethical codes of member associations.* Retrieved 24 July 1999, from http://www.efpa.be

Falender, C. (2006). Ethics in the practicum and internship. Paper presented at the 114th Convention of the American Psychological Association, New Orleans.

Feldman, M. (1992). Splitting and projective identification. In R. Anderson, (Ed.), *Clinical lectures on Klein and Bion* (pp. 74-88). London: Tavistock/Routledge.

Fine, M. A. & Ulrich, L. P. (1988). Integrating psychology and philosophy in teaching a graduate course in ethics. *Professional Psychology: Research and Practice, 19(5),* 542-546.

Forrester-Miller, H. & Davis, T. (1996). A practitioner's guide to ethical decision-making Retrieved 15 March 2000, from http://www.counseling.org/resources/pracguide.htm

Frayn, D. H. (1996). Enactments: An evolving dyadic concept of acting out. American *Journal of Psychotherapy, 50(2),* 194-207.

Freud, S. (1912). *Recommendations to physicians practising psycho-analysis.* S. E., 12, 109-120. London: Hogarth Press, 1953.

Freud, S. (1917). A difficulty in the path of psycho-analysis. S.E., 17, 135-145. London: Hogarth Press, 1955.

Frosh, S. (1997). *For and against psychoanalysis.* London: Routledge.

Furlong, A. (2005). Confidentiality with respect to third parties: A psychoanalytic view. *International Journal of Psychoanalysis, 86,* 375-394.

Gabbard, G. (1989). Splitting in Hospital Treatment. *American Journal of Psychiatry, 146, 4,* 444-451.

Gabbard, G. (1994). Sexual excitement and countertransference love in the analyst. *Journal of the American Psychoanalytic Association, 42(4),* 1083-1105.

Gabbard, G. (1995). Countertransference: the emerging common ground. *International Journal of Psychoanalysis, 76,* 475-485.

Gabbard, G. (1996). Lessons to be learned from the study of sexual boundary violations. *American Journal of Psychotherapy, 50(3),* 311-322.

Gabbard, G. (1997). A reconsideration of objectivity in the analyst. *International Journal of Psychoanalysis, 78,* 15-26.

Gabbard, G. (Ed.). (1999). *Countertransference issues in psychiatric treatment.* Review of Psychiatry Series, Vol 18, No 1. Washington, DC: American Psychiatric Press.

Gabbard, G. (n.d.). But is it love? An interview with Glen Gabbard. *New Therapist 29.* Retrieved 25 May 2007, from http://www.newtherapist.com/29gabbard.html

Gabbard, G. & Lester, E. (1995). *Boundaries and boundary violation in psychoanalysis.* New York, Basic Books.

Garfat, T. & Ricks, R. (1995). Self-driven ethical decision-making: A model for child and youth care. *Child and Youth Care Forum, 24*(6), 393-404.

Garvey, P. (2003). Whose notes are they anyway? In C. Levin, A. Furlong, & M. K. O'Neil (Eds.). *Confidentiality: Ethical perspectives and clinical dilemmas* (pp. 167-181). Hillside, NJ: Analytic Press.

Gawthrop, J. C. & Uhlemann, M. R. (1992). Effects of the problem-solving approach in ethics training. *Professional Psychology: Research and Practice, 23(1),* 38-42.

Geertz, C. (1973). Thick description: Toward an interpretative theory of culture. In C. Geertz (Ed.), *The interpretation of cultures* (3-32). New York: Basic Books.

Gibson, K. (2002). *Politics and emotion in work with disadvantaged children: Case studies in consultation from a South African clinic.* Unpublished doctoral thesis. Cape Town: University of Cape Town.

Gillespie, S. (1992). Historical notes on the first South African psycho-analytic society. *Psycho-analytic Psychotherapy in South Africa. 1,* 1-6.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, M.A.: Harvard University Press.

Gilligan, C., & Wiggins, G. (1987). The origins of morality in early childhood relationships. In J. Kagan & S. Lamb (Eds.), *The emergence of morality in early childhood*. Chicago: University of Chicago Press.

Gilligan, C. , Spencer, R., Weinberg, K.M., & Bertsch, T. (2003). On the Listening Guide: A voice-centred relational model. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 157-172). Washington, DC: American Psychological Association.

Glass, L. (2003). The gray areas of boundary crossings and violations. *American Journal of Psychotherapy, 57(4),* 429-444.

Glaser, B. G. & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* London: Weidenfeld & Nicholson.

Groesbeck, J. C. (1975). The archetypal image of the wounded healer. *Journal of Analytical Psychology, 20*, 122-145.

Groesbeck, J.C. & Taylor, B. (1977). The psychiatrist as wounded physician. *The American Journal of Psychoanalysis, 37*, 131-139.

Grosz, E. (1994). Lived bodies: phenomenology and the flesh. In E. Grosz, *Volatile bodies: Toward a corporeal feminism* (pp. 86-111). Bloomington: Indiana University Press.

Grotstein, J. S. (2004). The seventh servant: The implications of a truth drive in Bion's theory of „O'. *International Journal of Psychoanalysis, 85,* 1081-1101.

Guggenbühl-Craig, A. (1982). *Power in the helping professions*. Dallas, Texas: Spring Publications.

Gutheil, T.G. (2005). Clinical Concerns in Boundary Issues. *Psychiatric Times, 16(8).* Retrieved 24 June 2006, from http://psychiatrictimes.com/p990857.html

Gutheil, T. G. & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *American Journal of Psychiatry*, *150(2),* 188-196.

Gutheil, T. G. & Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry*, *155(3),* 409-414.

Haas, L. J., Malouf, J. L. & Mayerson, N. H. (1986). Ethical dilemmas in psychological practice: Results of a national survey. *Professional Psychology: Research and Practice, 17 (4)*, 316-321.

Haas, L. J., Malouf, J. L. & Mayerson, N.H. (1988). Personal and professional characteristics as factors in psychologists' ethical decision making. *Professional Psychology: Research and Practice, 19 (1)*, 35-43.

Hadjistavropoulos, T. (1999). Ethical principles of the American Psychological Association: An argument for philosophical and practical ranking. *Ethics & Behaviour, 9(2),* 127-141.

Hadjistavropoulos, T. & Smythe, W. E. (2001). Elements of risk in qualitative research. *Ethics & Behaviour, 11(2),* 163-174.

Hamburger, T. (1992). The Johannesburg Psycho-analytic Psychotherapy Study Group: A short history, *Psycho-analytic Psychotherapy in South Africa. 1,* 62-71.

Handelsman, M. M. (1986). Problems with ethics training by osmosis. *Professional Psychology: Research and Practice, 17 (5),* 371-343.

Haumann, H. J. (2004). *An intersubjective perspective on the role of personal therapy in being a psychotherapist.* Unpublished Doctoral thesis, Rhodes University.

Heimann, P. (1960). Counter-transference. *British Journal of Medical Psychology, 33,* 9-15.

Henwood, K. & Pidgeon, N. (2003). Grounded theory in psychological research. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology:*

Expanding perspectives in methodology and design (pp. 131-156). Washington, DC: American Psychological Association.

Hewitt, P. (2003). Ethics: the higher nature and the ego ideal. In H. M. Solomon & M. Twyman (Eds.), *The Ethical Attitude in Analytic Practice (pp 31-38).* London: Free Association Books.

Hill, A. (1999). Oedipal issues and enactment in couple psychotherapy. *Society of Psychoanalytical Marital Psychotherapists, Bulletin, 6.*

Hirsch, I. (1998). The concept of enactment and theoretical convergence. *Psychoanalytic Quarterly, LXV11,* 78-100.

Holloway, W and Jeffersen, T. (2002). *Doing qualitative research differently: free association, narrative and the interview method.* London: Sage.

International Psychoanalytic Association. (1998). *Ethical principles and procedures.* Retrieved on 2 April 2002, from http://www.ipa.org.uk/

IUPsyS - International Union of Psychological Science (2005). *Universal Declaration of Ethical Principles for Psychologists: Draft Proposal.* Unpublished manuscript.

Ivey, G. (1992). Countertransference pathology in South African psychotherapy. *Psycho-analytic Psychotherapy in South Africa, 1,* 31-45.

Ivey, G. (1995). Interactional obstacles to empathic relating in the psychotherapy of narcissistic disorders. *American Journal of Psychotherapy, 49 (3),* 350-370.

Ivey, G. (1998). *Countertransference: Understanding, managing and using it.* Unpublished manuscript.

Ivey, G. (1999). Thoughts on the „analytic attitude'. *Psycho-analytic Psychotherapy in South Africa, 7(1),* 1-18.

Ivey, G. (2004). Critiques of projective identification: A critical evaluation. *Psycho-analytic Psychotherapy in South Africa, 12(2),* 1-20.

Ivey, G. (2008). Enactment controversies: A critical review of current debates. *International Journal of Psychoanalysis, 89,* 19-38.

Jacobs, T. J. (1993). The inner experiences of the analyst: Their contribution to the analytic process. *International Journal of Psychoanalysis, 74,* 7-14.

Jacobs, T. J. (1999). Countertransference past and present: A review of the concept. *International Journal of Psychoanalysis, 80,* 575-594.

Jordan, A. E. & Meara N. M. (1990). Ethics and the professional practice of psychologists: The role of virtues and principles. *Professional Psychology: Research and Practice, 21, 107-114.*

Jennings, L., Sovereign, A., Botorff, N., Mussell, M. P. & Vye, C. (2005). Nine Ethical Values of Master Therapists. *Journal of Mental Health Counselling, 27(1)* 32-47.

Kantrowitz, J. L. (2006). *Writing about patients: Responsibilities, risks and ramifications.* New York: Other Press.

Kast, V. (1995). How to handle unethical behaviour in an ethical way. In L. Ross & M. Roy (Eds.), *Cast the first stone: Ethics in analytical practice* (pp. 75-81*)*. Wilmette, IL: Chiron Publications.

Keith-Spiegel, P. & Koocher, G. P. (1985). *Ethics in psychology: Professional standards and cases.* New York: Erlbaum.

Kelly, K. J. (1994). *Hermeneutics in Psychotherapy: A study of interpretation in the context of the psychotherapeutic dialogue.* Unpublished Doctoral Dissertation, Rhodes University.

Kelly, K. J. (1999a). From encounter to text: Collecting qualitative data for interpretive research. In M. Terre Blanche & K. Durrheim (Eds.), *Research in action: Applied methods for the social sciences* (pp. 379-397). Cape Town: UCT Press.

Kelly, K. J. (1999b). Hermeneutics in action: Empathy and interpretation in qualitative research. In M. Terre Blanche & K. Durrheim (Eds.), *Research in action: Applied methods for the social sciences* (pp. 398-420). Cape Town: UCT Press.

Kelly, K.J . (1999c). Calling it a day: Reaching conclusions in interpretive research. In M. Terre Blanche & K. Durrheim (Eds.), *Research in action: Applied methods for the social sciences* (pp. 421-437). Cape Town: UCT Press.

Kelly, B. J., Varghese, F. T. & Pelusi, D. (2003). Countertransference and ethics: A perspective on clinical dilemmas in end-of-life decisions. *Palliative and Supportive Care, 1,* 367-375.

Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counselling psychology. *The Counselling Psychologist, 12(3),* 43-55.

Kitchener, K. S. (1986). Teaching applied ethics in counsellor education: An integration of psychological processes and philosophical analysis. *Journal of Counseling and Development, 64,* 306-310.

Kitchener, K. S. (1992). Psychologist as teacher and mentor: Affirming ethical values throughout the curriculum. *Professional Psychology: Research and Practice, 23(3),* 190-195.

Kitchener, K. S (2000). Beyond ethical decision making. In K. S. Kitchener (Ed.), *Foundations of ethical practice, research and teaching in psychology* (pp. 42-54). Mawah: Lawrence Erlbaum.

Knapp, S. & VanderCreek, L. (2007). Balancing respect for autonomy with competing values with the use of principle-based ethics. *Psychotherapy: Theory, Research, Practice, Training, 44(4),* 397-404.

Kohlberg, L. (1981). *Essays in moral development. Voume 1: The philosophy of moral development.* San Francisco: Harper & Row.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing.* Thousand Oaks, CA: Sage.

Kymlicka, W. (1990). Feminism: An ethic of care. In W. Kymlica, *Contemporary political philosophy: An introduction* (pp. 238-292). Oxford: Clarendon Press.

Lacovics, M. (1983). Classification of countertransference for utilization in supervision. *American Journal of Psychotherapy, 37(2),* 245-257.

Lambert, K. (1972). Transference/counter-transference: talion law and gratitude. In *Technique in Jungian Analysis, The Library of Analytical Psychology: Volume 2* (pp. 303-327). London: Heinemann.

Langs, R. (1982*). Psychotherapy: A basic text.* Northvale: Jason Aronson.

Laplanche, J. & Pontalis, J. B. (1980). *The language of psychoanalysis.* London: Hogarth Press.

Lazarus, A. A. (1994). How certain boundaries and ethics diminish therapeutic efficiency. *Ethics and Behaviour, 4,* 255-61.

Lear, J. (2003). Confidentiality as a virtue. In C. Levin, A. Furlong, & M. K. O'Neil (Eds.), *Confidentiality: Ethical perspectives and clinical dilemmas* (pp. 167-181). Hillside, NJ: Analytic Press.

Levin, C. Furlong, A. & O'Neil, M. K. (Eds.). (2003). *Confidentiality: Ethical perspectives and clinical dilemmas*. Hillside, NJ: Analytic Press.

Levine, H. B. & Friedman, R. J. (2000). Intersubjectivity and interaction in the analytic relationship: A mainstream view. *Psychoanalytic Quarterly, 69(1),* 63-80.

Levenson, E. A. (2006). Response to John Steiner. *International Journal of Psychoanalysis, 87,* 321-4.

Lindén, E. & Rådeström, J. (2008). *Ethical dilemmas among psychologists in Sweden and South Africa.* Unpublished Masters thesis. Linkoping University, Sweden.

Lindsay, G. & Colley, A. (1995). Ethical dilemmas of members of the society. *The Psychologist, 18,* 448-451.

Lindsay, G. & Clarkson, P. (2000). Ethical dilemmas of psychotherapists. In P. Clarkson, *Ethics: Working with ethical and moral dilemmas in psychotherapy (pp. 1-16).* London: Whurr.

Louw, F. & Pitman, M. (2001). Irreducible subjectivity and interactionism: A critique. *International Journal of Psychoanalysis, 82,* 747-765.

Mabe, A. R. & Rollin, S. A. (1986). The role of a code of ethical standards in counselling. *Journal of Counseling and Development, 64(5),* 294-297.

Maguire, D. C. & Fargnoli, A. N. (1991). *On moral grounds: The art/science of ethics.* New York: Crossroads.

Malloy, D. C. & Hadjistavropoulos, T. (1998). A philosophical value analysis of the Canadian code of ethics for psychologists. *Canadian Psychology, 39(3),* 187-193.

Martinez, R. M. (2000). A model for boundary dilemmas: Ethical decision-making in the patient-professional relationship. *Ethical Human Sciences and Services, 2(1),* 43-61.

McLaughlin, J. T. (1981). Transference, psychic reality and countertransference. *Psychoanalytic Quarterly, 50,* 639-664.

McLaughlin, J. T. (1991). Clinical and theoretical aspects of enactment. *Journal of the American Psychoanalytic Association, 39,* 595-614.

Meissner, W. W. (1994). Psychoanalysis and ethics: Beyond the pleasure principle. *Contemporary Psychoanalysis, 30,* 453-472.

Meissner, W. W. (2002). The problem of self-disclosure in psychoanalysis. *Journal of the American Psychoanalytic Association, 50(3),* 827-867.

Meissner, W. W. (2004). What if there is an ethical dimension in psychoanalysis? *Journal of the American Psychoanalytic Association, 55(2),*

Miller, W. L. & Baldwin, D. (1987). Implications of the wounded healer paradigm for the use of the self in therapy. *Journal of Psychotherapy and The Family, 3(1),* 139-151.

Miller, W. L. & Crabtree, B. E. (1999a). Clinical research: A multimethod typology and qualitative roadmap. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research* (2nd ed). (pp. 3-30). London: Sage Publications.

Miller, W. L. & Crabtree, B. E. (1999b). Depth interviewing. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research* (2nd ed). (pp. 89-107). London: Sage Publications.

Miller, W. L. & Crabtree, B. E. (1999c). The dance of interpretation. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research* (2nd ed). (pp. 127-143). London: Sage Publications.

Mills, J. (2005a). A critique of relational psychoanalysis. *Psychoanalytic Psychology, 22(2),* 155-188.

Mills, J. (2005b). On moral countertransference. *International Journal of Applied Psychoanalytic Studies, 2(3),* 236-248.

Mitchell, S. A. (1988). *Relational concepts in psychoanalysis: An integration.* Cambridge, MA: Harvard University Press.

Mokuane, E. M. Q. (Chairperson) Structure of the Professional Board for Psychology: HPCSA. Retrieved on 30 May 2006, from http://www.hpcsa.co.za

Neukrug, E. & Lovell, C. (1996). Employing ethical codes and decision making models: A developmental process. *Counselling and Values, 40(2),* 98-105.

Norris, D. M., Gutheil, T. G. & Strasburger, L.H. (2003). This couldn't happen to me: Boundary problems and sexual misconduct in the psychotherapy relationship. *Psychiatric Services, 54,* 517-522.

Nozick, R. (1968). Moral complications and moral structure. *Natural Law Forum, 13,* 1-50.

Ogden, T. (1979). „On projective identification'. *International Journal of Psycho-Analysis, 60,* 357-373.

Ogden, T. (1986). *The matrix of the mind: Object relations and the psychoanalytic dialogue.* Northvale, NJ: Jason Aronsen.

Ogden, T. (1989). *The primitive edge of experience.* Northvale, NJ: Jason Aronsen.

O'Leary, Z. (2004). *The essential guide to doing research*. London: Sage Publications.

Packer, M. (1989). Tracing the hermeneutic circle: Articulating an ontical study of moral conflicts. In M. J. Packer & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigations in psychology* (pp. 95-117). Albany, NY: State University of New York Press.

Packer, M. J. & Addison, R. B (1989a). Introduction. In M. J. Packer & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigations in psychology* (pp. 95-118). Albany, NY: State University of New York Press.

Packer, M. J. & Addison, R. B (1989b). Evaluating an interpretive account. In M. J. Packer & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigations in psychology* (pp. 275-291). Albany, NY: State University of New York Press.

Palmer, R. E. (1969). *Hermeneutics: Interpretation theory in Schleiermacher, Dilthey, Heidegger and Gadamer.* Evanston, IL: Northwestern University Press.

Peel, M. S. (1998). *A study of informal breaches of confidentiality among a sample of South African clinical, counselling, and educational psychologists in the light of aspects of*

ethical education and of countertransference phenomena. Unpublished masters thesis. University of Natal.

Petersen, B. S. (2002). Indeterminacy and compromise formation: Implications for a psychoanalytic theory of mind. *International Journal of Psychoanalysis, 83,* 1017-1035.

Pettifor, J. L. (2001). Are professional codes of ethics relevant for multicultural counselling? *Canadian Journal of Counselling, 35,* 26-35.

Pettifor, J. L. (1998). The Canadian code of ethics for psychologists: A moral context for ethical decision-making in emerging areas of practice. *Canadian Psychology, 39(3),* 231-238.

Pettifor, J. & Pitcher, S. (1982). Ethics training in Canadian graduate schools of psychology. *Canadian Psychology, 23(4),* 235-242.

Pettifor, J. L., Sawchuk, T. R. (2006). Psychologists' perceptions of ethically troubling incidents across international borders. *International Journal of Psychology, 41(3),* 216-225.

Pillay, A. L. & Kramers, A. L. (2003). South African clinical psychology, employment (in)equity and the "brain drain". *South African Journal of Psychology, 33,* 52-60.

Pillay, A. L., Wassenaar, D. R. & Kramers, A. L. (2004). Attendance at psychological consultations following non-fatal suicidal behaviour: an ethical dilemma. *South African Journal of Psychology, 34,* 350-363.

Pope, K. S. & Bajt, T. R. (1988). When laws and values conflict: A dilemma for psychologists. *American Psychologist, 43,* 828-829.

Pope, K. S. & Bouhoutsos, J. L. (1986). *Sexual intimacy between therapists and patients.* New York: Praeger.

Pope, K. S. Tabachnik, B. & Keith-Spiegel, P. (1987). Ethics of practice: the beliefs and behaviours of psychologists as therapists. *American Psychologist, 42,* 993-1006.

Pope, K. S. & Tabachnik, B. G., (1993). Therapists' anger, hate, fear and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal complaints and training. *Professional Psychology: Research and Practice, 24 (2),* 142-153.

Pope, K. S. & Vetter, V. A. (1992). Ethical dilemmas encountered by members of the American Psychological Association: A national survey. *American Psychologist, 47 (3),* 1397-1411.

Professional Board for Psychology (2002). *Ethical code of professional conduct.* Pretoria: HPCSA.

Rachels, J. (2003). Feminism and the Ethics of Care. In J. Rachels, *The Elements of Moral Philosophy* (4th ed., pp. 160-172). Boston: McGraw-Hill.

Racker, H. (1957). The meanings and uses of countertransference. *Psychoanalytic Quarterly, 26,* 303-357.

Ramcharan, P. & Cutcliffe, J. R. (2001). Judging the ethics of qualitative research: considering the „ethics as process' model. *Health and Social Care in the Community, 9(6),* 358-366.

Renik, O. (1993a). Countertransference enactment and the psychoanalytic process. In M. Horowitz, O., Kernberg, & E. Weinshel (Eds.). *Psychic structure and psychic change* (pp. 135-158). Madison: International University Press.

Renik, O. (1993b). Analytic interaction: Conceptualizing technique in the light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly, 62,* 553-571.

Renik, O. (1996). The analyst's self-discovery. *Psychoanalytic Inquiry, 16(3),* 390-400.

Renik, O. (1998). The analyst's subjectivity and the analyst's objectivity. *International Journal of Psychoanalysis, 79,* 487-497.

Renik, O. (2004). Intersubjectivity in psychoanalysis – with comments by E. B. Spillius. *International Journal of Psychoanalysis, 85,* 1053-64.

Rest, J. R. (1984). Research on moral development: Implications for training counseling psychologists. *The Counseling Psychologist, 12(3),* 19-29.

Ruszczynski, S. (1998). The „marital triangle': Towards „triangular space' in the intimate couple relationship. *Journal of the British Association for Psychoanalysis, 3(1).*

Sandler, J. (1976). Countertransference and role-responsiveness. *International Review of Psycho-Analysis, 3,* 43-47.

Scherrer, R., Louw, D.A. & Möller, A. T. (2002). Ethical complaints and disciplinary action against South African psychologists. *South African Journal Psychology, 32(1),* 54-64.

Searles, H. F. (1959). Oedipal love in the countertransference. *International Journal of Psychoanalysis, 40,* 180-190.

Sebek, M. (2002). Some critical notes on Solomon's paper „The ethical attitude – a bridge between psychoanalysis and analytical psychology'. *Journal of Analytical Psychology, 47,* 195-201.

Seidman, I. E. (1991). *Interviewing as qualitative research: A guide for researchers in education and the social sciences.* New York: Teachers College Press.

Seitz, J., & O'Neill, P. (1996). Ethical decision-making and the code of ethics of the Canadian Psychological Association. *Canadian Psychology, 37 (1),* 23-30.

Sevenhuijsen, S. (2003). *Principle ethics and the ethic of care: can they go together?* Unpublished manuscript.

Siegelman, E. (1990). Metaphors of the therapeutic encounter. *Journal of Analytical Psychology, 35,* 175-191.

Sinclair, C. & Pettifor, J. (Eds.). (2001). *Companion manual to the Canadian code of ethics for psychologists* (3rd ed.). Canadian Psychological Association.

Sinclair, C. Poizner, S. Gilmour-Barrett, K. & Randall, D. (2001). The development of a code of ethics for Canadian psychologists. In C. Sinclair & J. Pettifor (Eds.), *Companion manual to the Canadian code of ethics for psychologists (3rd ed., pp. 1-12).* Canadian Psychological Association.

Sinclair, C. (2001). Nine unique features of the Canadian code of ethics for psychologists. In C. Sinclair & J. Pettifor (Eds.), *Companion manual to the Canadian code of ethics for psychologists. (3rd ed., pp. 13-27).* Canadian Psychological Association.

Slack, C. M. (1997). *Ethical dilemmas in psychological practice: A survey of clinical psychologists.* Unpublished masters thesis. University of Natal, Pietermaritzburg.

Slack, C. M. and Wassenaar, D. R. (1999). Ethical dilemmas of South African clinical psychologists. *European Psychologist, 4(3),* 179-186.

Slochower, J. A. (2003). The analyst's secret delinquencies. *Psychoanalytic Dialogues, 13(4),* 451-470.

Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harrè & L. V. Langenhove (Eds.), *Rethinking Methods in Psychology* (pp. 9-26). London: Sage Publications.

Smith, T. S., McGuire, J. M., Abbott, D. W. & Blau, B. I. (1991). Clinical ethical decision making: An investigation into the rationales used to justify doing less than one believes one should. *Professional Psychology: Research and Practice, 22 (3),* 235-239.

Snyman, S. & Fasser, R. (2004). Thoughts on ethics, psychotherapy and postmodernism. *South African Journal of Psychology, 34(1),* 72-83.

Solomon, H. M. (2001). Origins of the ethical attitude. *Journal of Analytical Psychology, 46,* 443-454.

Solomon, H. M. (2003b). The ethical attitude: a bridge between psychoanalysis and analytical psychology. In H. M. Solomon & M. Twyman (Eds.), *The Ethical Attitude in Analytic Practice (pp 21-30).* London: Free Association Books.

Solomon, M. H. (2003c). The ethics of supervision: developmental and archetypal perspectives. In H. M. Solomon & M. Twyman (Eds.), *The Ethical Attitude in Analytic Practice (pp 167-177).* London: Free Association Books.

Solomon, H. M. & Twyman, M. (Eds.). (2003a). Introduction: the ethical attitude in analytic practice. In H. M. Solomon & M. Twyman (Eds.), *The Ethical Attitude in Analytic Practice (pp 3-12).* London: Free Association Books.

Sonne, J. L. (1994). Multiple relationships: Does the new ethics code answer the right questions? *Professional Psychology: Research and Practice, 25(4),* 336-343.

Spillius, E. B. (1992). Clinical experiences of projective identification. In R. Anderson (Ed.), *Clinical lectures on Klein and Bion* (pp. 59-73). London and New York: Tavistock/Routledge.

Spillius, E. B. (2004). Comments on Owen Renik „Intersubjectivity in psychoanalysis''. *International Journal of Psychoanalysis, 85,* 1053-64.

Spence, D. (1989). Rhetoric vs. evidence as a source of persuasion: a critique of the case study genre. In M. J. Packer & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigations in psychology* (pp. 205-221). Albany, NY: State University of New York Press.

Steere, J. & Wassenaar D. R. (1985). *Ethical guidelines for clinical psychologists.* Stellenbosch: Universiteits-Uitgevers.

Steere, J. (1984). *Ethics in clinical psychology*. Cape Town: Oxford.

Steere, J. & Dowdall, T. (1990). On being ethical in unethical places: The dilemma of South African clinical psychologists. *Hastings Center Reports, 20(2),* 11-15.

Stein, M. (1984). *Power, shamanism and maieutics in the countertransference.* Chiron Publications.

Steiner, J. (1992). The equilibrium between the paranoid-schizoid and the depressive positions. In R. Anderson, (Ed.), *Clinical lectures on Klein and Bion* (pp. 102-112). London: Tavistock/Routledge.

Steiner, J. (2006). Interpretative enactments and the analytic setting. *International Journal of Psychoanalysis, 87,* 315-20.

Stern, D. B. (1983). Unformulated experience: From familiar chaos to creative disorder. *Contemporary Psychoanalysis, 19(1),* 71-99.

Stevenson, R. (1999). *A forbidden zone: Sexual attraction in psychotherapy.* Unpublished masters thesis, University of Natal, Pietermaritzburg.

Stokoe, S. (2000). Holding the boundaries. In S. Brookes & P. Hodson (Eds.), *The invisible matrix: An exploration of professional relationships in the service of psychotherapy* (pp. 23-40). Rebus Press: London.

Stokoe, P. (2003). *Some thoughts about the ethics of psycho-analytic psychotherapy.* Unpublished manuscript.

Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* London: Sage Publications.

Strydom, H. & Delport, C. S. L. (2002). Sampling and pilot study in qualitative research. In A. de Vos (Ed.). *Research at grass roots: For the social sciences and human service professions* (pp. 333-338). Pretoria: Van Schaik Publishers.

Swartz, L. (1988). Some comments on the draft ethical code for South African clinical psychologists. *South African Journal of Psychology, 18 (1),* 17-20.

Symington, N. (1990). The possibility of human freedom and its transmission (with particular reference to the thought of Bion). *International Journal of Psychoanalysis, 71,* 95-106.

Tappan, M. B. (1991). Narrative, authorship, and the development of moral authority. In M. B. Tappan and M. J. Packer (Eds.), *Narratives and Storytelling: Implications for understanding moral development.* Jossey-Bass Inc.

Tarvydas, V. M. (1998). Ethical decision-making processes. In R. R. Cottone & V. M. Tarvydas (Eds.), *Ethical and professional issues in counselling* (pp.144-155). Upper Saddle River, NJ: Prentice-Hall.

Terre Blanche, M. & Durrheim, K. (1999). Social constructionist methods. In M. Terre Blanche & K. Durrheim (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 147-177). Cape Town: University of Cape Town Press.

Terre Blanche, M. & Kelly, K. (1999). Interpretive methods. In M. Terre Blanche and K. Durrheim (Eds.), *Research in practice: Applied methods for the social sciences (pp. 123-146).* Cape Town: University of Cape Town Press.

Trent, C. S. & Collings, S. J. (1998). *Clinical psychologists' attitudes towards and practices regarding erotic and non-erotic physical contact with clients.* Paper presented at 3rd Annual Congress of PSYSSA, Durban, South Africa.

Treurniet, N. (1997). On an ethic of psychoanalytic technique. *Psychoanalytic Quarterly, LXVI,* 596-627.

Twyman, M. (2003). Ethical themes in analytic practice. In H. M. Solomon & M. Twyman (Eds.), *The Ethical Attitude in Analytic Practice (pp 15-20).* London: Free Association Books.

Tylim, I. (2004). Ethical notes on disrupted frames and violated boundaries. *Psychoanalytic Psychology, 21(4),* 609-613.

Tymchuk, A. J., Drapkin, R. S., Major-Kingsley, S., Ackerman, A. B., Coffman, E. W. & Baum, M. S. (1982). Ethical decision making and psychologists' attitudes towards training in ethics. *Professional Psychology: Research and Practice, 13 (3),* 412-421.

Van Hooft, S. (2006). *Understanding virtue ethics.* Chesham, Bucks: Acumen.

Varghese, F. T. & Kelly, B. (1999). Countertransference and assisted suicide. In G.O. Gabbard (Ed.), *Countertransference issues in psychiatric treatment* (pp. 85-116). Washington, DC: American Psychiatric Press.

Wakefield, J. (1995). Am I my brother's keeper? In L. B. Ross & M. Roy (Eds.), *Cast the first stone: Ethics in analytic practice* (pp. 82-91). Wilmette, IL: CHiron.

Wassenaar, D. R. (1998a). A history of ethical codes in South African psychology: An insiders view. *South African Journal of Psychology, 28(3),* 135-145.

Wassenaar, D. R. (1998b). Ethical codes in South African Psychology: Contribution to the Canadian code. *Canadian Psychologist, 39(3),* 240-241.

Wassenaar, D. R. (2002). *Ethical issues in South African psychology: Public complaints, psychologists' dilemmas and training in professional ethics.* Unpublished doctoral thesis. University of Natal, Pietermaritzburg.

Wassenaar, D. R. & Mamotte, N. Ethical issues and ethics reviews in social science research. Social Science & Medicine, doi: 10.1016/j.socscimed.2008.02.006

Welfel, E. R. (1992). Psychologist as ethics educator: Successes, failures and unanswered questions. *Professional Psychology: Research and Practice, 23(3),* 182-189.

Welfel, E. R. & Kitchener, K. S. (1992). Introduction to the special section: Ethics education – an agenda for the 90's. *Professional Psychology: Research and Practice, 23(3),* 179-81.

Welfel, E. R. & Lipsitz, N. E. (1983). Wanted: A comprehensive approach to ethics research and education. *Counselor Education and Supervision, 22,* 320-332.

Welfel, E. R. & Lipsitz, N. E. (1984). The ethical behaviour of professional psychologists: A critical analysis of the research. *The Counseling Psychologist, 12,* 31-41.

Wharton, B. (1998). „What comes out of the consulting room?' The reporting of clinical material'. *Journal of Analytical Psychology, 43(2),* 205-23.

Weiner, J. (2003). Finding a space for ethical thinking about matters of confidentiality. In H. M. Solomon & M. Twyman (Eds.), *The Ethical Attitude in Analytic Practice* (pp 123-135). London: Free Association Books.

Wilson, T. (2007). How do you know? The centrality of Bion's container/contained concept in developing the capacity to think and know. *Psycho-analytic Psychotherapy in South Africa, 15(2),* 19-37.

Winnicott, D. W. (1949). Hate in the counter-transference. *International Journal of Psychoanalysis, 30*, 69-74.

Woody, J. D. (1990). Resolving ethical concerns in clinical practice: Toward a pragmatic model. *Journal of Marital and Family Therapy, 16,* 133-150.

Zeddies, T. J. (1999). Becoming a psychotherapist: The personal nature of clinical work, emotional availability and personal allegiances. *Psychotherapy, 36(3),* 229-235.

Zelen, S. L. (1985). Sexualization of therapeutic relationships: The dual vulnerability of patient and therapist. *Psychotherapy, 22(2),* 178-185.

Zoja, L. (2007). *Ethics and analysis: Philosophical perspectives and their application in therapy.* College Station: Texas A & M University Press.

APPENDICES

APPENDIX A

Dear Colleague

Research Project: Psychoanalytic psychotherapists' experiences of ethical dilemmas encountered in professional practice

As part of a doctoral degree in psychotherapy, I am about to undertake a research project that explores psychoanalytic psychotherapists' experiences of real-life ethical dilemmas encountered in their therapeutic work. I am looking for registered psychologists who practise psychoanalytic psychotherapy and who are willing to participate in this research. The following information outlines the basic aims of the research and addresses issues that may be of concern to potential participants.

International research into ethical dilemmas encountered in professional practice has often been conducted through anonymous surveys and based on hypothetical vignettes. In South Africa little research has been initiated in the areas of either ethics education/training or the actual dilemmas experienced by practising psychotherapists. In documenting individual accounts, this research study aims to explore how psychoanalytic psychotherapists engage with and attempt to resolve real-life ethical dilemmas. The data gathered will be of a sensitive nature as participants will be involved in talking about their personal experiences of ethical dilemmas, and any related conflicts, in the context of their work as psychotherapists.

It is essential that research participants feel as safe and comfortable as possible and that anonymity remains a priority. The following steps will be taken to safeguard both confidentiality and anonymity. The interview, at which participants will be invited to talk about an ethical dilemma encountered in practice, will last between one and half to two hours. It will be held at a mutually suitable time and place. The interview will be tape-recorded and transcribed using pseudonyms and with all identifying details removed or disguised. Transcription will be completed with the help of a trusted and reliable assistant. Raw data will be kept throughout the research process under secure conditions. On completion of the project all interview transcripts will be shredded and audio cassettes will be erased or returned to participants at their request. Participants may of course withdraw from the study at any time. The final thesis will be lodged in the university library but it will not include interview transcripts. Should they wish, participants may read the completed thesis and a copy will be made available for this purpose.

The research interview should create a valuable opportunity to share and to reflect upon personal experiences of real-life ethical dilemmas as well as contributing to professional debate around ethical issues and concerns in this country.

Potential participants are welcome to contact me by telephone or email to discuss any part of this research study (please remember to leave your contact details). I will gladly return any initial phone calls from participants who live outside Cape Town and would also conduct the interview concerned in the participant's home city.

Your interest and co-operation are greatly appreciated.

Yours sincerely

I, the undersigned, have read the letter outlining the aims of this research project and agree to participate in the study on a voluntary basis.

Participant:

Name(print):……Contact address:…….

Signature:…… ……

Contact no:…… Cell no:…….

Email
address:……..

APPENDIX B

INTERVIEW GUIDE

WARM-UP QUESTIONS

- Before we begin, are there any questions you'd like to ask?

  Before we proceed to the main questions, there are a few details about your experience as a therapist that I'd like to clarify….

- How long have you been registered as a clinical psychologist and how long, would you say, have you been practising as a psychoanalytic psychotherapist?
- Can you tell me about your work setting: in what settings do you work and what sorts of patients do you see on a day to day basis? (Individual/couple/group)
- Since starting to work as a psychoanalytic psychotherapist, what kinds of therapy and supervision experiences have you had?

  Do you have supervision / therapy at the moment?

  How often are you going at the moment?
- During your postgraduate professional training in South Africa, what kind of ethics education and training did you receive?

  Yes – please describe…

  No – any thoughts or feelings about this?
- After qualifying, what sorts of professional opportunities have presented themselves for exploring and learning about ethical issues and concerns?
- What motivated you to take part in this study?
- What do you believe are the core ethical principles or values that inform your everyday practice as a psychoanalytic psychotherapist?

We're about to go on to the 3 main questions: is there anything you'd like to add to what we've just been talking about?

Can you describe as fully as possible an ethically challenging or troubling dilemma that you've encountered in practice over the past 24 months where you weren't sure what you should do?

Prompts:

- What was it about this situation that made it an ethical dilemma or conflict for you?
- Can you recall any actual dialogue, anything that was actually said, between people in this situation?
- CT feelings, physical responses, thoughts
    - Feelings evoked in you?
    - Feelings about others involved?
    - Professional/personal concerns and anxieties for yourself and others?
    - Physical/bodily responses to these events?
    - Images/fantasies?
    - Thoughts occurring to you?
- How did you first identify or become aware of this ethical conflict? What first alerted you to its presence?
- From the point when you first became aware of this dilemma, can you describe what struggles you encountered in yourself?

  What shifts or changes, if any, occurred in your feelings or thoughts *before* you reached the point of deciding what to do?
- Most difficult aspects of this situation?
- At the time of the dilemma, can you describe how your feelings and thoughts may have affected your behavior or attitude towards your patient?

  While engaged with this ethical dilemma, were you aware of any shifts or changes in the patient's responses to you?
- Records and documentation
    - Any kept?
    - Any that you feel may be relevant to our discussion and that you'd be prepared to talk about?

You've described the ethical dilemma and we've talked about what encountering it was like for you. I'd like to explore a new question:

Can you describe in as much detail as possible how you processed this ethical dilemma and what professional resources you used to help you?

Prompts:

- **Did you struggle alone or consult with others?**
    - Alone – thoughts and feelings?
    - Consulted – who with? What was helpful/disappointing?
- **Code of Ethics for Psychologists**
    - Familiar with it?
    - Consult it at the time of this dilemma?
    - What approach did you feel the Code adopts regarding how to address the ethical dilemma?
    - What are your feelings about the statutory Code of Ethics? How would you describe your relationship with it?
- **PsySAA and the Professional Board for Psychology**
    - Ever consider approaching them for help with this situation?
    - Feelings/thoughts these structures evoke for you regarding assistance with ethical dilemmas?
- **Supervision and personal therapy**
    - What role, if any, did supervision play in processing this dilemma?
    - Personal therapy or analysis?
- **Role played by the law,** or your thoughts about the law, in processing these issues?
- **Core ethical principles/values** mentioned at the start
    - Can you describe their influence, if any, on the processing of this dilemma?
- **Countertransference experience**
    - What sense or understanding do you have regarding your feelings, thoughts and responses at the time of the dilemma?
- **One's approach to understanding and addressing an ethical dilemma** may be informed by a number of perspectives, for example, the statutory Code of Ethics, your adherence to a psychoanalytic way of working and your own ethical values.
    - What sorts of conflicts or tensions, if any, did you experience between these different perspectives?

We've been speaking about how you worked with and processed the ethical dilemma. We're coming to the last part of the interview, which has to do with ethical decision-making.

Could you describe what your final decision was and how you implemented it?

Prompts:

- In thinking about what to do, what kinds of different opinions, actions or interventions did you consider?
- Reasons that determined your decision?
  Strongest reason/factor?
- How do you perceive your feelings/thoughts to have helped or hindered you in deciding what to do?
- How confident were you about following through and implementing your final decision? What anxieties, if any, did you experience?
- Consequences of your decision for yourself and for the others involved?
- Looking back, do you think you did the right thing? Did you do what you believed you *should* do?
- In what ways, if any, has this experience of encountering an ethical dilemma affected you professionally or personally?
- If this dilemma should happen again, what might you do differently?
- What do you feel you've learnt from this experience?

Closure / Ending Off

- We're coming to the end of this interview. I'm wondering what this experience of speaking about this ethical dilemma has been like for you?
- Is there anything you'd like to add, or to return to, before we finish this interview?

APPENDIX C

INTERVIEW 1: I – POEM
(p.17, 18-38; p.18, 8-18)

I don't know
I don't know
I've found it difficult
to balance home and work life.
I've been over burdened
and haven't had room for my practice.
I've been dealing
dealing with *it* internally
But I've not really, haven't really spoken about it
I think that might've come into it.

I hadn't room to think
only room to write up notes quickly
I don't have room to think.
Not like I used to
a room meaning room in terms of space and time,
if I'm not apparently working
my life, my other life will intrude.
I can't shut myself out
just to sit and think
Because it doesn't like work from the outside.

So many utterly stupid things to be sorted out
when *he* works in my office
my stuff gets moved out of the way
I can't find my stuff
there's no space for me, as a professional
And I think
my professionalism was really on the line.

I haven't had time
for my practice
I haven't been putting thought
into my practice
And *now* this has happened
I feel absolutely dreadful
And I *have* to think about it.

INTERVIEW 4: I POEM
(p.133, 15-20; p.142, 29-46; p.143, 1-7)

Well, I guess
Wild West is not a bad term
I felt
I don't know if
I could say "pioneering"
I'm sure it's been done before but
I was in territory
where few have trodden and without much guidance.
I mean
I remember thinking
supervision-wise
who could supervise me, who, whose had this experience?

I suppose
the supervision I did take it to
wasn't formal
where I sat for an hour
and took the case
and da, da, da
I guess there was the sense
I was on top of it
I was managing
I "didn't need" supervision

But I think
it wasn't I didn't need but more
I was anxious
the supervisor would act against it.
I was worried
they would not *support*
what I was doing
And I didn't want to risk that.
Because I felt
I felt
I was right.
I felt
what I was doing
it was *bigger*
than psychology and psychotherapy
a powerful *new* development in consciousness.

INTERVIEW 5: I POEM
(p.177, 25-36; p.188, 9-28; p.189, 23-40)

I, I *should* be in therapy
two weeks ago
I kind of broke down.
I grew up
where there was violence,
I mean, the scar
in the end hasn't gone away.

this previous hour
I thought
two things,
it doesn't help to report
and guilt, ja, well, you're doing the same.
I suppose, feeling
there isn't a big, benevolent force out there.
I mean
I didn't *think* it at the time but
I'm just wondering whether
I didn't report
evoked guilt
for doing the same as people have done when
I was in that position myself.

What I *do* know is
I'll come home Friday
and my briefcase will stay closed
until Monday morning
I'll open it up again.
I block it out, close it off
it's an *emotional* thing,
I *don't* want to open
my briefcase,
leave it, leave it closed, buckled up.
Pack it away, close it away and leave it there.
I don't,
I don't want to go there.
It's exhausting, nerve-wracking, anxiety provoking.
I think that's why
I don't want *to open*
that briefcase,
there are times
I'll think
I can think *clearly* now, it's not *that* bad,
I thought why not?
Just Saturday mornings,
just a few phone calls,
a few calls,
but I don't,
I don't want *to go* there.