COMMON ETHICAL VIOLATIONS AND ETHICAL ACTION PATTERNS AMONG TURKISH MENTAL HEALTH PROFESSIONALS AND THE FACTORS THAT INFLUENCE THEM

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SOSYAL BİLİMLER ENSTİTÜSÜ
PSİKOLOJİ YÜKSEK LİSANS PROGRAMI

YARD. DOÇ. DR. ZEYNEP ÇATAY
2011

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Türkiye Ruh Sağlığı Çalışanlarınca Gerçekleştirilen Etik İhlaller, Etik Davranış Biçimleri ve Bunları Etkileyen Faktörler

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Tezin Onaylandığı Tarih : 22/09/2011

Toplam sayfa sayısı: 102

Anahtar Kelimeler (Türkçe)	Anahtar Kelimeler (İngilizce)
1) Ethical dilemma	1) Etik ikilem
2) Ethical violations	2) Etik ihllaler
3) Ethical decision-making	3) Etik karar alma
4) Ethical knowledge	4) Etik bilgi
5) Mental health professionals	5) Ruh sağlığı çalışanları

Thesis Abstract

Common Ethical Violations and Ethical Action Patterns Among Turkish Mental Health Professionals and the Factors That Influence Them

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The aim of the present study was to investigate the way mental health professionals think about and make decisions on how to act under different ethical dilemma situations and the factors that influence both their decision about how to respond to others' unethical behaviors and the frequency of their own unethical behavior. 140 mental health professionals who actively work in the field as therapists participated in this study by filling out online survey. Survey consisted of questions concerning demographic, educational and professional characteristics of the professionals, ethical knowledge, action tendencies in ethical violation situations as well as the frequency of their own unethical behavior. The results of the study indicated that the lack of supervision, the degree of education and stressful work environments contributed much to the professionals' unethical behavior. Moreover, the kind of action they took under ethical violation situations was determined by the kind of violation situation. When the violation situation was a serious one such as a breach of confidentiality, the professionals preferred to take more serious actions like warning to report to the Ethics Committee if the situation continues. However, on sexual misconduct and multiple relationship issues, the

professionals seemed to be surprisingly less sensitive. The most common type of ethical misconduct they reported were also related to engaging in multiple relationships with their clients as well as competence issues. The implications of these findings suggest that further training is necessary whether as in the form of graduate education or as professional seminars on ethics. Furthermore, in line with the findings, the professionals –especially training therapists- should be encouraged to take supervision in order to pursue ethically healthy practice in the field of psychotherapy.

Tez Özeti

Türkiye Ruh Sağlığı Çalışanlarınca Gerçekleştirilen Etik İhlaller, Etik Davranış Biçimleri ve Bunları Etkileyen Faktörler

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Bu çalışmanın amacı ruh sağlığı çalışanlarının etik ikilemlerle ilgili düşüncelerini, böyle durumlarda nasıl davranacaklarına ilişkin karar verme süreçlerini ve hem başkalarınca gerçekleştirilen etik dışı davranışlara nasıl tepki vereceklerine ilişkin karar alma süreçlerini hem de kendi etik dışı davranış sıklıklarını etkileyen faktörleri araştırmaktır. Alanda aktif olarak çalışmakta olan 140 profesyonel internet üzerinden anket doldurarak çalışmaya katılmıştır. Anket, katılımcıların demografik, eğitimsel ve profesyonel özellikleri ile etik bilgi düzeyleri, etik ihlal durumlarını ele alış biçimleri ve etik dışı davranış sıklıklarını ölçen sorulardan oluşmaktadır. Çalışmanın sonuçları süpervizyon ve yüksek eğitim almamış olmak ile stresli ve talepkar bir ortamda çalışıyor olmanın etik dışı davranışlarda bulunmakla ilişkili olduğunu göstermiştir. Ayrıca, etik ihlal durumlarında profesyonellerce tercih edilen eylemlerin ihlal türüne göre belirlendiği bulunmuştur. İhlal durumu gizliliğin ihlali gibi ciddi olduğunda, profesyonellerin bu davranış devam ettiği takdirde Etik Kurul'a şikayet etme konusunda ihlalciyi uyarmak gibi daha ciddi eylemlerde bulundukları görülmüştür. Ancak, çalışmaya katılan profesyonellerin cinsel kötüye kullanım ve çoklu ilişkiler gibi ihlal alanlarında daha az duyarlı davrandığı

görülmüştür. Ayrıca en sıklıkla rapor ettikleri ihlaller arasında yetkinlik ve çoklu ilişkilerle ilgili ihlaller bulunmaktadır. Tüm bu bulgular yüksek eğitim veya mesleki seminerlerle etik konusunda eğitimi sürdürmenin gerekliliğini göstermiştir. Ayrıca, özellikle psikoterapi alanında yeni yetişmekte olan terapistlerin etik açıdan sağlıklı bir çalışma hayatı sürdürebilmek için süpervizyon almaya teşvik edilmelerinin önemi görülmüştür.

Acknowledgements

I would like to express my sincere appreciation to my thesis advisor Asst. Prof. Dr. Zeynep Çatay for her valuable contributions and support throughout the thesis process. At every stage of this process, but especially when I decided to change my thesis subject after months of work due to sample problems, I felt her support and belief in what I was doing. I am grateful for her encouragement and understanding as well as her systematic approach which enabled this thesis to appear with less anxiety on my part.

I am also grateful to Assoc. Prof. Dr. Yeşim Korkut who made special contributions to this study with her knowledge and experience about ethical issues by accepting my request to be my third advisor. She was always eager to allow her time to me in her busy schedule opening up new ways of thinking and of approaching to the field of ethics. I am really thankful to her for sharing her valuable insights and knowledge. I would also like to thank to Dr. Ryan Wise for his sincerity and helpfulness. His voluntary dedication of time to think about my study and to generate different viewpoints about the statistical analyses was invaluable to me. I am very pleased to have a chance to study with him in this core part of my thesis. I am also thankful to Prof. Dr. Diane Sunar for her interest in my thesis. Her valuable comments especially on the bureaucratic process for conducting a thesis research enhanced my work.

I am also grateful to a special person for me, Cihan Koçak, without whom this thesis would not have been written with less chaos. He made very special indirect contributions to this study with his continual emotional

support and understanding. Especially throughout the process when I decided to change my thesis subject, his encouragements and motivations enabled me to come through this process with much ease. I owe him a great deal for his trust and genuine affection.

I would like to express my gratitude to my friends and cousins who helped me to balance my study and relaxation times enabling me to effectively manage my thesis sharing all my happiness and worry. I also want to thank my classmates for their encouragements since they themselves experienced the same stages of anxiety and depression which are characteristics of the thesis process.

Specially, I wish to express my love and thanks to my family for their support and caring. From the beginning of my graduate education process, at every stage I have felt their belief in me and in what I can do. Their unconditional love and encouragements contributed heavily on this study. To them I would like to dedicate my thesis.

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Chapter 1: Introduction

1. 1. What is Ethics?

Ethics has long been an issue of philosophical discussions from the ancient times onward. It is a field of philosophy which focuses on understanding and constructing criteria for right actions and moral evaluation. It generally deals with the rightness of a given action and the points that make it right. Moral theories deal with rendering moral direction to any action as well as granting constant evaluation about the morality of that action since individuals often quest for justifying their acts (Driver, 2007). This evaluation takes place in three steps. First, the focus of philosophical ethics is on the issue of how people should behave toward one another. Then, a judgment about the value of that behavior is made, that is, whether it is an act to be approved or punished. And finally, having made a judgment, some principles are established in order to justify that choice (Kitchener, 2000).

Ethics, in psychology, denotes a framework composed of previously defined, professionally endorsed standards which aim to ensure the best interests of those who obtain psychological help as an individual or as a group. It is not a one-way process, though. Ethics also safeguard the interests of those who provide psychological service by allowing for a safe area in their professional practice. Taken together, constitution of ethical

standards in the field of psychology serves to enable the progression of the psychology/psychotherapy profession (Banyard & Flanagan, 2005).

What differentiates such ethics from morality which entails guiding behavior according to personal beliefs about right and wrong, good and bad, acceptable and unacceptable? Perhaps the most important difference lies in the issue of self-interest since morals are unique personal values whereas ethics imply more general level standards which are granted as relevant guiding principles by all the professionals in a given field (Kitchener, 2000). That is, in order to introduce an order to the chaos of subjective and lenient decisions, ethics aims to establish high professional standards -in an accepted written format- which are beyond simple morals for the sake of both parties; clients and therapists.

The history of first professional ethical principles might be rooted in the Hippocratic Oath written thousands of years ago which consists of the doctors' promise not to misuse their abilities and judgment while treating their patients (Koocher & Keith-Spiegel, 1998). The first ethical code for psychologists was implemented after World War II when psychology began to be defined as a distinct profession. First by American Psychological Association (APA) in 1948 and later by psychologists of the several countries, serious formal steps were taken to establish the ethics code for psychologists. First codes of ethics briefly tapped on nonmaleficence, responsibility and competence in a descriptive manner (Allan & Love, 2010; Korkut, 2010). It was only towards the end of 1990's that first attempts about ethical issues were made in Turkey via publications on ethical

principles of publishing, research and practical applications of psychology (Dağ, 2003). The Ethics Committee Branch of the Turkish Psychological Association (TPA) reviewed the Ethic Codes of American Psychological Association and European Federation of Psychologists' Association (EFPA) and offered some main points that they considered to be included in the Turkish Ethic Code. They focused on developing a unique code which is consistent with both international codes and cultural characteristics. These efforts finally brought about the Ethics Code of the Turkish Psychological Association in 2004 which includes ethical principles that psychologists should follow in order to ensure the progression of their profession as well as the well-being of those to whom they provide psychological service (TPA, 2004). The necessity to engage in this process was confirmed by the results of a small survey by Korkut, Müderrisoğlu and Tanık (2006) which rendered some useful information about ethical dilemmas; the type, the frequency and how they become violations in the lack of an ethics system. The results showed that competence and its limitations as well as beneficence/maleficence and responsibility should be the major principles to be involved in the developing code of ethics (Korkut, 2010; Korkut et al., 2006).

1. 2. Ethical Dilemma

Across their professional lives, clinicians encounter various troubling situations where they have to arrive at the right judgment in a very limited time. Sometimes they have to choose one action among many

alternatives at the expense of another right course of action. Ethical dilemmas are such cases when the psychologists have to act in line with one ethical principle although another right –but perhaps conflicting- principle might also apply (Kitchener, 2000). In order to clarify this definition, an example is necessary. A minor girl, who got pregnant and had an abortion without the knowledge of her parents, tells these experiences to her therapist (Pope & Vetter, 1992). This is a good example of an ethical dilemma since the therapist has to choose an ethical principle to act on between two conflicting ones: Either to keep the client's confidentiality or to inform her parents since she is under 18 years of age.

Throughout their career, clinicians have to deal with their decisions in dilemma situations where their choice of acting on a certain principle might mean being unethical in light of another widely accepted principle (Tribe & Morrissey, 2005). In such situations, some professionals depend upon their own ideals and opinions or even upon commonsense and intuitions. However, these personal judgments might not necessarily be valid or appropriate for other professionals in the field and they might even be immoral for most people. Therefore, decision-making requires more profound attention in ethical processes since it is important to identify the facets of the troublesome situation, to evaluate the pros and cons of the possible course of action the clinician considers and to finally accept the full responsibility of that choice (Pope & Vasquez, 2007). As in the above example with the minor girl, the therapist has to consider all aspects of the situation and decide which principle should be more privileged in that case.

1. 3. Ethical Decision-Making

Pursuing a profession in line with ethical guidelines is difficult. As far as the profession of psychology/psychotherapy is concerned, the professionals in that area often have to reach quick and fair judgments and base their decisions on those.

In general, when a person is faced with a problem, the prompt reaction is identified based on personal beliefs, knowledge about the problem and encompassing conditions of that problem. When it comes to ethics, ethical dilemma situations lead the clinicians to make their immediate decisions on the basis of their previous knowledge about ethical issues as well as their experiential background. Soon after an immediate moral judgment about the issue is formed, the clinician is ready to look through the information about dilemma situation to reach the final verdict (Kitchener, 2000).

Is this final verdict always the right one? Pope and Vasquez (1999) indicated that it is not necessarily the case! When faced with a complex situation, some professionals tend to disregard some of the main ethical principles to get themselves out of this problematic situation as quickly as possible. On the other hand, behaving in this manner they also did not want to be perceived as unethical in the eyes of their colleagues or friends, therefore they often come up with some rationalizations to vindicate their positions. Stevens (2000) also pointed out Pope and Vasquez's (1999) list of common rationalizations and argued that, unfortunately, clinicians often rely on them to excuse their unethical professional conduct. Some important

items in the list show that clinicians do not view a conduct as unethical, “if there are also other colleagues who would behave the same in that situation”, “if nobody files a legal complaint against the clinician”, “if they are sure that ethic code developers are unaware of the contextual conditions in the practical applications of the profession” or “if they convince themselves that it is what the client needs and it is nothing to be exaggerated” (Pope & Vasquez, 1999).

Pope and Vasquez (2007) identified some useful steps in ethical decision-making, helping clinicians find their ways in complex dilemma situations. Those steps include considering the ways in which to react to dilemmas, taking proper actions and taking the responsibility for these actions. First, the clinician should identify the situation within the scope of ethics and try to foresee those who will be affected by the decision he/ she makes. Then, the clinician should engage in introspection, figure out the adequacy of his/ her own knowledge, skill and expertise in handling the situation. The clinician should, of course, examine in detail the applicable formal standards of ethics and consider their relevancy and possible outcomes. Then, he/she should regard whether his/her own feelings, personal issues or prejudices impose negative outcomes. And if they do, consultation, supervision and personal psychotherapy are among the major options to be considered. If the solutions the clinician comes up with are overwhelmingly difficult to implement, alternative ways of action should be developed and evaluated in line with the previous stages of decision-making regarding the situation from the client’s perspective. Having made the

decision and implementing proper actions, the clinician should finally assume full responsibility for the consequences of that choice (Pope & Vasquez, 2007).

Francis (2009) argued that dilemmas and subsequent unethical behaviors result from lack of knowledge and experience as well as well-defined ethical codes. Therefore, he offered three means to evaluate dilemma cases. As the first way, he suggested that these situations should be regarded in line with key principles such as psychologists' duty to not cause harm to the clients. Another option is to consider them under the lights of accepted ethical codes of professional conduct and make a decision based on these previously defined principles. Third way focuses on some specific issues in looking at dilemma situations such as whether there is a deficiency in terms of ensuring the privacy of clinical records or keeping bodily contact with the client under control (Francis, 2009). Witnessing unethical behavior of a colleague, psychologists' reactions might vary. Viewing the given behavior as a one time only type of fault, engaging in bystander kind of reactions waiting for some other people to handle the situation and hoping that eventually the violator will pay the penalty for unethical conduct are among the major rationalizations of colleagues to rid themselves of their professional duties. In our country, a study by Korkut et al. (2006) showed that 41% of the psychologists who observed ethical violations in the field thought that no actions were being taken about those issues. As the reasons for this "no action" attitude, the participants stated that there were no professional chamber, no proper guidelines, lack of knowledge and control

mechanism. On the other hand, Rusch (1981, as cited in Koocher & Keith-Spiegel,1998) found that many psychologists prefer not to take any action to intervene in the situation unless the violation is of a serious kind. They are more likely to neglect small and less severe violations (Koocher & Keith-Spiegel, 1998).

Is the severity of the violation the sole factor in determining to take any action? Bernard, Murphy and Little (1987) displayed that even in severe cases like sexual misconduct, psychologists might do less than what they should do when the violator is a close friend/colleague. They also found that there were not any significant differences in terms of demographic characteristics between the clinicians who would do what they should do and those who would not. Therefore, they concluded that personal values of the clinicians are influential in determining whether to report an ethical violation. Smith, McGuire, Abbott and Blau (1991) supported these findings by demonstrating that even though mental health professionals are aware of the ethical guidelines they should follow, they are more likely to rely on personal values and practical solutions while dealing with ethical dilemmas.

Some researchers agreed on the effects of personal qualities on ethical decision-making process. Gilligan (1982) indicated that gender is one such characteristic. She proposed that women attend more to relational consequences of acts while evaluating a certain situation under the lights of ethics whereas men value matters of justice. From that line on, Haas, Malouf and Mayerson (1988) deepened their investigation on personal factors that affect decision-making on ethical issues. Acknowledging that

there is a general sense of baseline professional ethics among clinicians, Haas et al. (1988) indicated that gender is not as influential as Gilligan (1982) claimed. Rather, experienced therapists, regardless of their gender, are alike in terms of their reactions and reasoning styles in ethically complex situations. Moreover, their focus on work settings revealed that differences in terms of where clinicians work are not determinant in their responses, neither are the amount of training they received in ethical issues. However, they found significant differences in terms of experience such that more experienced clinicians remain less active preferring to do nothing or act indirectly while dealing with ethical dilemmas during their practice whereas less experienced therapists believed that they should actively intervene to protect third parties. They proposed that it might be due to burn-out or heightened cynicism of the clinicians who spent many years in the profession (Haas et al., 1988).

Haas et al.'s (1988) findings about less experienced therapists' active stance on ethical issues are not surprising as the ethical zeitgeist is considered. During 1980'-90's, American Psychological Association's (APA) ethic codes make it mandatory for the psychologists to directly handle and actively intervene in violations by colleagues. If these interventions do not work, the psychologists are encouraged to reach an ethics committee (APA, 1981). Beginning from 1992 code, if the situation is beyond the generation of any informal solutions, psychologists are obliged to contact the committee and put in formal complaints (APA, 1992). Not surprisingly, this might be perceived as costly and risky on the complainant

side. However, the gains are much higher than the costs for both the violator colleague, the clients he/she provides services and the profession in general (Koocher & Keith-Spiegel, 1998).

1. 4. Ethical Violations

Psychologists often maintain professional conduct characterized by actions that conflict with the general principles as well as the ethical standards of their profession. These unethical acts are defined as ethical violations. In this section, those violations will be explained in detail based on their deviation from the ethical standards defined in ethics codes of both APA and TPA (APA, 2002; TPD, 2004). These principles lead the psychologists to strive for ethically highest degree in their professional practice. Among them, in our country, competence, beneficence, responsibility and psychological evaluation are the major areas in which ethical violations are observed in the field (Korkut et al., 2006).

1. 4. 1. Competence Issues

Not only limited to the context of psychotherapy, in general, people seek help from those others who are more competent and knowledgeable when faced with an overwhelming situation. However, when the profession of psychotherapy is considered, this poses a necessity thus, it is the foundation of ethical practice for psychotherapists (Pope & Vasquez, 2007).

Competence is basically conceptualized under two headings: intellectual and emotional competence. The former refers to knowing –as a psychologist- what you know, in other words, it denotes the psychologist's ability to evaluate, conceive and implement suitable treatment alternatives for the client and his/her problem. The latter is defined as the psychologist's ability to become aware of the psychological processes of both himself and the client as well as to digest the raw clinical data presented by the client while recognizing his own shortcomings in pursuing his profession. In other words, it also entails being aware of both what you do not know and what you are not capable of (Koocher & Keith-Spiegel, 1998).

APA (2002) puts high emphasis on competence issues in the psychologists' code of conduct. Boundaries of competence are defined as well as the principles of emergency interventions. In addition, psychologists are warned to be alert about their own problems and psychological processes that might interfere with healthy progression of the client's treatment. Likewise, in our ethics code (TPA, 2004), competence is placed as the first (and perhaps the most important) general principle. Similar to APA code, the Turkish ethics code assigns to psychologists the duty to evaluate their own competence, to recognize their limits and to preserve their competence while keeping in mind the interfering factors. In sum, they are expected to have some degree of ethical awareness which is characterized by knowing ethical principles, deciding how to act on them in dilemma situations and seeking for professional guidance when the situation is complex and beyond their competence.

At this point, it is crucial to illustrate what is meant by a competence violation. Since competence is concerned with psychologists' use and nonuse of what they do and do not know in terms of their profession and their capacity to evaluate their own competence, violation in this area simply encompasses the use of a therapy technique, an assessment tool, etc. for which they do not have the formal proper education as well as the maintenance of therapeutic relationship in the presence of interfering personal factors. For example, consider a therapist who has had some personal problems lately and relies on drinking hoping that it will ease his life. However, his professional practice becomes impaired, his clients cancel their appointments due to the fact that he often arrives late to his sessions and does not seem to be there emotionally during those sessions. This therapist's behavior provides an instance of an ethical violation in the competence area since he continues to carry out his profession even though his problems impair his work (Wise, 2008). Moreover, accepting a client who needs sex therapy even though you are not equipped with this therapy method or using a psychological assessment tool by reading its manual despite the fact that you do not have its formal training can be counted as other instances of competence violations (Haas et al., 1988).

Korkut et al. (2006) asked professionals who work in the field to state the kind of ethical violations that they often observe in the field of psychology: in areas of education, research, evaluation, psychotherapy and practical applications. The findings of their study revealed that violations about competence and limits of competence are the most widely observed

ones the field (66%). In depth, they stated that the professionals in the field think that the profession of psychotherapy is conducted by those who are not competent in that area. They discussed that this situation is related to a lack of legally accepted written regulations and law governing the profession of psychology in Turkey (Korkut et al., 2006). Violations in the area of competence do not seem to be unique to our country, though. Pope, Tabachnick and Keith-Spiegel (1987) showed that one quarter of their participants stated that they seldom or at times carried out their professional practice in areas/cases beyond their competence. These findings demonstrate the necessity of continuing professional training since competence is not a static trait (Wise, 2008). Professionals in the field should keep up with new improvements germane to their area of practice in order to preserve their competence (Allan & Love, 2010).

1. 4. 2. Human Relations Issues

Looked at in the simplest way, therapist-client relationship is a human contact. However, it differs in some fundamental ways from ordinary human relations holding some special rules which aim to protect each party in that relationship. The first and the most important rule for psychologists is to avoid bringing any harm to those whom they provide services to. Psychologists are obliged to take proper actions in order to safeguard their clients, students, supervisees, etc. and to minimize the risk if harm can be anticipated (APA, 2002). Moreover, this unique relationship has to be limited to the therapy room; if it exceeds this limit, multiple role

relationships are the subject. That is, if the psychologist is involved in another role with a client (or her close contacts) with whom he also maintains the professional conduct OR at the most extreme, if there is a multiple relationship which also involves sexual or nonsexual misconduct, violations are more severe (APA, 2002).

Smith and Fitzpatrick (1995) commented on multiple relationships via the term 'treatment boundaries'. They argued that the therapeutic frame, which entails forming a relationship with time, money and place limitations with a mental health professional, is the determining factor in treatment outcome. If these boundaries and the frame are blurred, serious boundary violations are likely. There are four types of boundary violations: dual relationships, self-disclosure, nonerotic contact and sexual involvement.

1. 4. 2. 1. Dual Relationships

Dual relationships might occur in therapy if the therapist -with his professional identity- is involved in a nonprofessional relationship (friendship, business partnership, etc.) with his clients. Pope and Vetter (1992) with their significantly wide sample demonstrated that the dual relationship issue was among the most serious ethical problems among American clinicians. A few years before them, Borys and Pope (1989) conducted a nation-wide survey with psychologists, social workers and psychiatrists and arrived at surprising findings. First, they found that these three groups were not significantly different from each other on the basis of

engaging in dual relationships. However, psychologists were more frequently responding (positively) to special invitations from clients whereas psychiatrists considered dual relationships as less ethical than the other two groups. When deeply investigated, theoretical orientation seemed to make a difference. Psychodynamically oriented professionals regardless of their profession reported dual relationships less frequently compared to those of other orientations and considered them as unethical. And finally, gender-related findings revealed that male clinicians were involved in dual relations more frequently than female clinicians and also they considered this behavior as more ethical (Borys & Pope, 1989).

1. 4. 2. 2. Self-disclosure

With a humane instinct, therapists might sometimes want to share their own experiences with those clients who go through same processes hoping that it would normalize and reassure the clients about their current problems. This self-disclosure, if it is done for the best interest of the client within therapy context, might help her to surmount the blockages in therapeutic process (Smith & Fitzpatrick, 1995). However, if therapists rely on self-disclosure for self-seeking and exploitative purposes, disclosure by the therapist might bring ethical violations into picture. These purposes might vary from sharing of personal problems and fantasies about clients to talking about sexual or economic situations that they are in. As can be seen, self-disclosure is a powerful tool which –if used properly- can change the progression of the therapeutic relationship, but at this point, the question is

to consider the content, context and the reasons why the therapist chooses to self-disclose in order to determine the ethicality of that behavior (Gutheil & Gabbard, 1995). Peterson (2002) warned the psychologists to seriously regard the issues of doing good and avoiding harm to the clients as well as the contextual conditions under which they want to disclose.

The issue of self-disclosure gets more complicated given the spreading use of social networking websites in which members share personal information about their lives. Personalized information might vary from your religious views and marital status to your favorite TV shows or quotes. Clients might view your photos with friends or family members. All the personal details that you refrain from sharing with your clients might be a click away. This kind of 'involuntary' self-disclosure obviously brings some problems like receiving friend requests from your former or current clients. A recent survey by Levahot, Barnett and Powers (2010) revealed that graduate student participants in their study frequently use social networking sites (%81). While some of them employed restricted security settings for people other than friends, a significant portion of them did not. Taylor, McMinn, Bufford and Chang (2010) survey revealed similar results for the excessive use of social networking sites by graduate students. On the other hand, they found that experienced psychologists in their study rarely use these sites, but this situation might limit their supervisory guidance to graduate students about controlling students' disclosure of personal information via websites. Therefore, they warned the graduate programs to

consider following new technological advances and address these issues in their curriculum.

1. 4. 2. 3. Nonerotic Contact

Touch is a vital part of human development as attachment studies have shown. If the baby human (or animal) lacks physical contact while growing, bodily processes are negatively affected resulting even in death (Harlow, 1971). In some cultures, culture-specific qualities also encourage the use of physical contact in human interactions. Hugging, kissing or touching on hands or shoulder while talking are perceived as acceptable in our culture or French and Canadian cultures (Smith & Fitzpatrick, 1995). However, when it comes to psychotherapy profession, -even it is nonerotic in nature- touching might lead to misinterpretations on behalf of the clients. Holub and Lee (1990) discussed that psychologists should carefully analyze their intentions, needs and consequences before engaging in touching behavior. However, they warned that even it is used for therapeutic purposes, it should not be forgotten that for male therapists, nonerotic contact with female clients precedes engaging in sexual relationship with them. As theoretical orientation is considered, Holroyd and Brodsky (1977) found that 30% of therapists with humanistic orientation considered touching as serving for the benefit of clients whereas only 6% of the dynamically oriented therapists thought so.

Pope et al. (1987) reported three types of physical contact within therapy setting. Kissing was viewed as the least acceptable and the most unethical kind of contact. Therefore, it was found to be practiced with the rarest frequency. Next, hugging was viewed as unquestionably unethical and it was practiced with much lower frequency. The last kind of contact, handshaking, was viewed as more acceptable and ethical, and it was the most commonly practiced form.

1. 4. 2. 4. Sexual Involvement

Without any doubts, sexual involvement with clients is the most serious and detrimental boundary violation that a therapist can make. Bouhoutsos, Holroyd, Lerman, Forer and Greenberg (1983) conducted a study with psychologists who were the subsequent therapists of the clients who were sexually involved with their former therapists. Their reports revealed that 90% of their clients who had sexual involvement with their therapists described negative effects varying from difficulty in trusting subsequent therapists to suicide. These therapists also argued that this kind of relationship was especially more damaging if it began in the early stages of the therapeutic relationship when trust is tried to be established. However, ten percent of the subsequent therapists reported that their clients did not get adversely affected or even profited from that experience (Bouhoutsos et al., 1983).

In spite of the fact that it is clearly forbidden as indicated by APA (2002) ethics code to become sexually involved with current and former clients, prevalence results showed that male therapists engaged in sexual intimacies with female clients more than did female therapists with male clients (Holroyd & Brodsky, 1977). Similarly, in ethics code of Turkish psychologists, engaging in sexual relations with clients is strictly forbidden. Korkut et al.'s (2006) findings have shown that the second and third most frequent ethical violations were observed in the areas of emotional and sexual misconduct as well as other types of misuses such as in financial affairs, etc.

Apart from these 4 types of boundary violations, violations about the financial issues are also important to consider in this area. Chodoff (1996) argued that sometimes two contrasting roles are found together in some therapists: healer and business person. Therapists might go back and forth between their ethical responsibilities toward clients and their self-interests. Finance-related premature terminations or demanding high prices for sessions in that sense are ethically inappropriate situations.

As another instance of economic misuse, accepting expensive gifts appears as an ethical problem due to the high probability of client exploitation. That is, it alters the therapeutic relationship because the therapist, being now aware of the disproportionate power relations, might make distorted decisions about the therapeutic process. For example, he might be more lenient toward those clients who gave gifts, such as giving

make-up sessions when they missed a session (Gerig, 2004). Brown and Trangsrud (2008) investigated therapists' acceptance and decline of client gifts. They found that therapists tended to accept gifts which had relatively low price, had cultural value for the client and were given at the termination phase with feelings of appreciation toward the therapy work. Moreover, they tended to turn down those gifts which were valuable, were given during the course of therapy and had emotional or manipulative intentions behind them. Interestingly, only two therapists out of forty explained that their refusal to accept gifts was due to ethical guidelines that prohibit gift-taking.

Taken together, it is clear that boundary issues are the regular parts of therapeutic process, and they are often presented as ethical dilemmas to the attention of therapists. Smith and Fitzpatrick (1995) argued that clients come to therapy with some initial needs which serve for their adaptation to therapy and they often expect that their needs will be met by the therapist. On behalf of therapist, any endeavor to gratify these needs might bring boundary issues. As Gutheil and Gabbard (1995) notified, even a small, well-intended attempt might lead to bigger unethical behavior. This 'slippery slope' phenomenon indicates that minor boundary crossings evolve into major boundary violations which might alter the therapeutic process altogether. Therefore, for the healthy progression of the therapeutic relationship, it is necessary to regard the intentions and motives behind the clients' needs and actions and to make their final judgments accordingly.

1. 4. 3. Privacy/Confidentiality and Assessment Issues

When a client is admitted for therapy, -especially if she is unfamiliar with the psychotherapy process-, beginning from the very first session she would like to make sure that what she will tell is going to stay as a secret between her and her therapist. It is only after some sessions which will finally make the client feel convinced about the privacy and confidentiality of the therapy room that a working alliance and trust will be developed (Younggren & Harris, 2008).

Koocher and Keith-Spiegel (1998) have remarked that the confidentiality and privacy are the key elements in helping professions. What they meant by confidentiality is the psychologists' professional duty to not to confide in anyone else about what a client discloses during therapy sessions. And, privacy entails the clients' right to determine the extent to which the information that they disclose can be communicated to others. Taken together, this ethical standard requires the therapist not to disclose what the clients say in therapy without their consent (Fisher, 2008).

In the APA ethics code (2002), the importance of ensuring confidentiality in therapy and the conditions under which there might be exceptions in terms of maintaining it were emphasized. In addition, principles about recording (i.e., 4.03 Recording), disclosure (i.e., 4.05 Disclosures) and use of confidential information for educational purposes as well as consultation (i.e., 4.07 Use of Confidential Information for Didactic and Other Purposes) were presented to professionals in the field. The TPA ethics code (2004) has similar principles. According to this code,

psychologists have to ensure the confidentiality of information that they derive from their clients and inform them about the limits of confidentiality beforehand (i.e., 3.2 Maintaining Confidentiality). Psychologists can violate the rule of confidentiality under two circumstances: 1) if the client brought or will bring harm to herself, her psychologist and/or other people, 2) if the client is a minor, a mentally disabled person or mentally incompetent elderly and maleficence is the subject. Moreover, in the principles 3.3 and 3.4 in the TPA code, the maintenance of confidential records and use of them for other purposes are clearly described. If the psychologists wish to take a video or audio record of the session, they have to obtain permission from the client. If they wish to share confidential information about the client with others (for educational purposes, consultation or supervision), they must obscure the characteristic details from which others might infer the identity of the client (TPA, 2004).

As mentioned above, it is not surprising that every rule also has some exceptions. In terms of the confidentiality rule, exceptions comprise some situations which require the disclosure of confidential client data without permission. For example, if there is a case of abuse, suicide or domestic violence, in order to ensure the safety of the client, psychologists have to report and share confidential information with authorities (Fisher & Oransky, 2008; Kitchener, 2000; Younggren & Harris, 2008). Besides these context-specific sharing of information, there are laws that require psychologists to breach confidentiality such as reporting a colleague who carries out unethical practice by risking others' lives (Fisher, 2008).

Breaches of confidentiality are often observed in the assessment area, which is why these two issues are held together for the sake of continuity and clarity. APA code (2002) warns the psychologist to not to share the records of raw and scaled scores as well as client responses with either clients or their families to prevent misuse. Thus, inability to ensure the confidentiality of test records constitutes a violation. Moreover, it is common in graduate assessment courses to bring sample test data in order to facilitate comprehension by students. However, this understandable and educative procedure might turn into an ethical violation if the professors do not obscure client identity while making it available to their students (Kitchener, 2000).

Confidentiality and assessment related violations were reported by the participants of Korkut et al. (2006) study as being observed in the field. Similarly, confidentiality violations are common in American sample, too. Haas et al. (1987) identified the confidentiality issue as one of the two most serious problems considered by American psychologists. Pope and Vetter (1992) asked the psychologists to report ethical dilemmas that they or their colleagues have encountered during their professional practice. Most frequently reported dilemmas were related to confidentiality (18%). When deeply investigated, situations about confidentiality dilemmas in their reports involved maleficence risk to third parties, child abuse or violence. In addition, related dilemmas regard the disclosure of confidential information and the decisions about whom they should be disclosed.

1. 5. Factors That Precipitate Ethical Violations

1. 5. 1. Lack of ethical knowledge

An important part of being an ethical professional is knowing the ethical rules and regulations. Koocher and Keith-Spiegel (1998) argued that most of the psychologists who are involved in unethical behavior do so because they are not provided with sufficient knowledge about ethical principles and professional standards. Once they are informed about these standards, minor violators with no formal ethical education assure that this behavior will not recur in future practice. In that sense, Barnett (2008) stressed the importance of knowing ethical standards and guidelines especially in ethical decision-making process. He provided two dilemma examples and explained how the therapists in those situations handled the issue. Regardless of the nature of dilemma situation (custody issues or being attracted to a client), therapists firstly reviewed parts of the ethics code pertinent to the dilemma that they were in to decide how they should proceed on the basis of formal guidelines.

Korkut et al. (2006) also argued that not all mental health workers are equipped with the skills that enable them to make distinctions regarding which conduct is ethical and which is not. Because they do not know in detail the ethical standards and guidelines as well as the authorized offices to report observed violations, those professionals act upon their will and personal judgment while dealing with ethical dilemmas by often

normalizing them. This situation is not unique to our country, though. A recent study by Qian, Gao, Yao and Rodriguez (2009) showed that Chinese mental health clinicians are also faced with ethical dilemmas in their professional practice and their lack of knowledge and of proper training about ethical issues often bring about violations particularly in the areas of dual relationships and confidentiality. They argued that some of these professionals are not even aware that they violate an ethical standard or what they should do when an ethical dilemma arises (Qian et al., 2009). To overcome such problems, Korkut et al. (2006) proposed that, in order to introduce mental health professionals to ethical standards, short-term educative seminars might be implemented. Doing so, they will be able to recognize the ethical pitfalls in their practice and the ways they can deal with them.

1. 5. 2. Not Taking Supervision and/or Personal Therapy

Clinical supervision defines the professional relationship in which the supervisor takes on more than one role: teacher, mentor, evaluator and sometimes parent. These roles all serve to increase ethical knowledge and awareness of the clinical trainee/supervisee as well as to help develop competency and maximize professional functioning (Koocher & Keith-Spiegel, 1998).

The presence of a supervision relationship in a professional's life, especially in the early years of his/her career, is important for developing

personal and professional competency since one of the supervisor's duties is to ensure this in that dyadic relationship. During the supervision relationship, the supervisor has to make sure that the trainee knows and applies ethical guidelines in his/her practice so that the supervisor can determine the credibility of the trainee in terms of client care. The supervisee can also determine his/her own competence and limits through supervisory interaction which enables regular self-assessment (Falender & Shafranske, 2007).

Supervisors contribute to the development of a supervisee's professional practice through teaching how to monitor his/her feelings and behaviors. It enables the supervisee to freeze the moment and examine his/her intentions, motivations and inner processes at a deeper level. Not surprisingly, being in this kind of relationship which relies on regular exploration of every single detail about therapeutic process acts as a risk management system for reducing ethical violations since it equips the beginner trainee with necessary skills to detect any pitfalls beforehand (Walker & Clark, 1999). On the other hand, even the professionals who are in their mid-careers might fall into ethical traps and not take proper actions. Handelsman (2001) argued that after years of work, psychologists in their midcareer can be more ignorant of the necessity to continue ethical training and also be professionally isolated, which decrease their chances of carrying out professional and ethical scrutinizing process. Therefore, it is important to be open to exploration and supervision when needed.

Personal therapy is also a significant element in this picture. Like supervision, personal therapy enables the therapist to realize his/her personal strengths and weaknesses and how they might pose pitfalls in terms of professional functioning (Pope & Vasquez, 2007). By continuous self-evaluation, personal therapy contributes to personal and professional growth as well as to the ability to empathize with the clients since the therapists themselves would now assume the role of being a client (Cross & Papadopoulos, 2001). Pope and Tabachnick's (1994) survey results were interesting in that sense. They revealed that most therapists (70%) considered that personal therapy should be mandatory for training psychologists as a part of graduate education. However, in reality, they found that only a small group of therapists received mandatory therapy. Aside from these findings, they showed that compared to old therapists (over 40 years-of-age), young therapists had higher rates of entering therapy whereas 34% of the older group had never been in therapy in their lives (Pope & Tabachnick, 1994). Even though most of the graduate programs do not mandate personal therapy for their students, APA ethics code (2002) warns the therapists to be alert about their personal problems interfering in the therapeutic process and assigns the responsibility to take supervision or therapy, to terminate therapy, to consider referring to a colleague when there are such factors.

1. 5. 3. Workplace strains/future anxiety

Tjeltveit and Gottlieb (2010) recognized that current therapists might work in highly stressful settings where they should be alert and quick in making ethically correct decisions. Sometimes, workplaces put the professionals at a difficult position in which it is hard to make the right decision. Pope and Vasquez (2007) talked about the situation that trainees are in while working at hospital settings. Most of the trainees are introduced to the clients as doctors although they have not completed their graduate degrees. This situation jeopardizes the honesty of the clinician, and if not explained to the client, implies deception.

Examples might vary. Some institutions can expect multiple roles to be performed by therapists. Especially in special education centers in Turkey, psychologists are expected to be teachers as well as family counselors bringing about engaging in multiple roles with the same client. Furthermore, this kind of education might also entail more physical contact due to the very nature of special needs of the retarded children such as motoric guidance. Still other institutions might expect a trainee to take full responsibility for a high case load without providing supervision.

Orme and Doerman (2001) survey showed that almost half of the participants, who work in the United States Air Force, experienced conflictual ethical dilemma situations across their professional lives. But fortunately, only in a few of these incidents did army psychologists have to behave in ways that they thought of as being unethical. These areas particularly covered the use of techniques and materials without formal

training, testimonials about security permissions based on previous psychologist's notes, etc. In these cases, it was clearly shown that dilemmas and subsequent ethical violations were products of organizational demands of superiors in the chain of command. Additionally, Knapp and VandeCreek (2006) also stressed the issue of confidentiality in military settings. The psychological assessment and other records of the clients, who are also members of the military, can be deciphered in response to military pronouncements. They also argued that state hospitals might discharge the psychiatric patients even if their therapists did not think that they are ready to be in the community.

Overall, it seems vital to regard work place strains on the professionals due to economic reasons. Most of trainees as well as the professionals in the field face unemployment or work at less decent jobs. Therefore, being ethically sensitive- especially if these ethics clash with the expectations of the institution- and opposing the imposed violations might mean putting their jobs at risk.

1. 5. 4. Psychologists' Personal Attitudes and Behaviors

While facing an ethical dilemma, there is a repertoire of actions that are available to therapists. Some professionals might remain inactive because they think either there is nothing wrong with the given situation or it is none of their business to actively intervene in someone else's work. Others might prefer to inform the violator and suggest personal therapy and

supervision. Still others might warn the violator, giving the indication of reporting the unethical act to Ethics Committee whereas others directly tend to report to the committee without any warning or other actions. What are the factors that might bring those different action alternatives?

Haas et al. (1988) stressed the importance of requisite ethical knowledge. However, some other factors might also be involved. First may be the type of ethical violation. Haas et al. (1988) found in their study that psychologists highly agree on breaking confidentiality where the lives of others are at stake. However, when the violator is a close friend and colleague, the therapists might do less than what they are expected to. Bernard et al. (1987) showed that in those cases, therapists might remain less active in taking the appropriate steps in involving in the solution of a friend's dilemma. That is, if the situation requires the reporting to a committee, they might cooperate in disguising it. Also, a study by Handelsman (2001) revealed surprising findings on the relationship between professional experience and ethical practice. The study showed that experienced psychologists, who were expected to be ethically more knowledgeable and more sensitive in terms of sustaining ethical practice, turned out to be less sensitive. Taken together, these findings are in line with Bernard and Jara's (1986) study which argued that neither training nor knowledge of ethical guidelines alone suffice to account for professional ethical conduct.

Cultural background of the therapist is also an important factor determining how he/she behaves when faced with an ethical dilemma. This

might be especially relevant in explaining boundary crossings and violations. In some cultures, personal boundaries are highly valued whereas in others strict devotion to those is interpreted as discourtesy (Sonne, 2006). Especially about non-erotic physical contact, some cultures perceive such behaviors as acceptable and ordinary whereas it might be a violation on the basis of ethical codes of conduct (Smith & Fitzpatrick, 1995).

Theoretical orientation might also pose some differences in terms of the actions taken in a dilemma situation. Borys and Pope (1989) found that therapists with psychodynamic orientation were less likely to become involved in dual relationships with clients both socially and financially compared to cognitive and humanistic therapists. They also posited that among these psychodynamic, cognitive and humanistic orientations, adherents of the last approach had the highest frequency of dual relations. In this study they also found that, in general, less experienced therapists (under ten years of experience) evaluate the social, financial relationships with the clients as ethically more acceptable than more experienced therapists (more than 30 years).

1. 6. Present Study

Ethics is an important issue which is recently gaining importance in our country with personal and collective efforts of the mental health professionals, both academicians and clinicians. Since clinical psychology as a profession was only recently recognized in law codes, the criteria of

expertise are not firmly in place. Therefore, psychotherapy and related mental health services are often in the hands of incompetent people (Korkut et al., 2006).

It is clear that the importance of knowing ethical values and principles should be implemented in the curriculum of M. A. and PhD programs as well as undergraduate education (as beginner-level lectures) because most of the new graduates do not continue to further education and begin to work in the field with their limited knowledge. Disseminating the awareness on ethical issues will contribute to raising competent and ethically-sensitive professionals.

The goal of this study was to examine the way psychologists think about and make decisions on how to act under different dilemma situations, which factors influence their reactions to violations and the frequency of their own unethical behaviors. There were very few studies conducted in this area in Turkey (Korkut et al., 2006). Previous studies in the U.S. literature showed that lack of knowledge on ethical issues, not taking supervision/personal therapy as well as workplace strains were important factors that determine the (un)ethical attitudes and behaviors of the therapists (Koocher & Keith-Spiegel, 1998; Pope & Vasquez, 2007; Walker & Clark, 1999). Therefore, in this study, those variables were deeply investigated in order to determine the extent to which they contribute to the therapist reactions and behaviors in the face of an ethical dilemma. Based on prior research in the field, the following hypotheses have been formulated:

A. Relationship between professionals' own ethical misconduct and other factors

1. It was expected that those participants who lacked adequate knowledge on ethical guidelines and regulations would report more ethical violations on the violation checklist.

2. It was predicted that participants who did/ do not take supervision would report more violations. Moreover, the more the months of supervision taken, the less would be the reported violations.

3. It was expected that participants who did/ do not take personal therapy would report more violations. Moreover, the more the months of therapy taken, the less would be the reported violations.

4. Years of professional work might differentially affect ethical behavior. It was expected that, in this study, as years of experience increase, ethical insensitivity as measured by violation frequency might increase. However, it was expected that experienced professionals would be more knowledgeable about ethical issues compared to their less experienced counterparts.

5. Participants, who reported increased work place strains, such as being exposed to employer expectations that were in conflict with ethics codes, were expected to report more ethical violations.

6. In general, clinicians with psychoanalytic/psychodynamic orientation were thought to be more sensitive about ethical issues. Thus, in this

study, psychoanalytically-oriented therapists were expected to report less violation compared to therapists with other theoretical orientations.

7. Education level and ethical knowledge level were expected to be positively correlated. It was expected that as years of education of participants increased, the level of ethical knowledge would also increase. However, as the degree of the participants' education increases, the frequency of violations they report would decrease.

B. Relationship between ethical action patterns in response to others' violations and educational and professional factors as well as the kind of ethical violation

8. As the ethical knowledge of the mental health professionals increased, they were expected to take more serious actions in the face of a colleague's ethical violation. As the ethical knowledge of the individual increases, "no action" answers on the ethical behavior questionnaire were predicted to decrease.

9. Courses of action that are taken by the professionals were expected to be differentially impacted by their degree of education. Professionals with only undergraduate education were predicted to be more lenient towards violation situations, thus they were expected to give more "no action" responses whereas those with M.A. education or PhD were expected to take more serious actions in the same situations.

10. Actions taken by the mental health professionals were predicted to differ regarding their theoretical orientation. Professionals with

psychoanalytic orientation were expected to give less "no action" responses compared to the professionals with other orientations.

11. Kind of ethical violations might differentially impact the actions taken by the therapists. We expected serious actions (warning to report to Ethical Committee or reporting to Ethical Committee) in the cases of sexual misconduct. Violations in the area of competence might bring less serious actions. Reactions to multiple relationships and privacy were also explored to identify participants' action tendencies in such cases.

In addition to these hypotheses, demographic (age, gender, etc.), occupational and professional variables and the way they are related to ethical violations among mental health professionals in Turkey were also investigated.

Chapter 2: Method

2. 1. Participants

The participants of the study were composed of mental health professionals such as psychologists, counselors, psychologists with M.A. or PhD in clinical, developmental and forensic psychology as well as counselors with M.A. degree in guidance and psychological counseling who actively work in the field as clinicians. They were contacted via online e-mail lists. In total, 140 participants consisting of 19 males, 120 females and 1 person who did not indicate gender contributed to the study and were included in the statistical analyses. Their ages ranged from 23 to 56, with a mean of 29.67 (SD= 6.04). 57 % of the sample was single, 37% of the sample was married and the remaining 6% was either divorced or was living apart (See Table 1, p. 37).

In terms of the educational profile of the sample, 10 % of the sample had a PhD degree, 62.1 % had a master's degree, and 27.9 % had a B.A. degree. The majority of the participants had undergraduate degree in psychology (65.7 %), only 10.7 % of the participants had a B.A. degree in psychological counseling and the remaining part held different undergraduate degrees. In terms of master's degree education, 27.9 % of the participants did not have M. A. education, 47.1 % of them had a clinical psychology degree, 9.3 % of them had M. A. counseling degree, 7.1 %

Table 1

Demographic, Educational and Professional Characteristics of the Sample

Characteristics	N	M (SD)	Percentages
Gender (%)			
Male	19	-	13.6
Female	120	-	85.7
Missing	1	-	.7
Total	140	-	100
Age (Years)	135	29.67 (6.04)	-
Marital Status (%)			
Single	80	-	57.1
Married	52	-	37.1
Divorced	6	-	4.3
Living Apart	1	-	.7
Missing	1	-	.7
Total	140	-	100
Degree (%)			
Undergraduate	39	-	27.9
Graduate	87	-	62.1
PhD	19	-	10.0
Occupation (%)			
Counseling Center	33	-	23.6
Education	26	-	18.6
State Hospital	20	-	14.3
Private Hospital	13	-	9.3
Special Education & Rehab.	12	-	8.6
State Institution	16	-	11.4
Other	19	-	13.6
Professional Experience (months)	138	62.41(56.87)	-

Table 1

Demographic, Educational and Professional Characteristics of the Sample (cont'd)

Characteristics (cont'd)	N	M (SD)	Percentages
Theoretical Orientation (%)			
Psychoanalytic	37	-	26.4
Cognitive-behavioral	68	-	48.6
Humanistic	7	-	5.0
Other	27	-	19.3
Supervision (%)			
Yes	97	-	69.3
No	43	-	30.7
Duration of Supervision (months)	140	18.31(25.10)	-
Personal Psychotherapy (%)			
Yes	81	-	57.9
No	59	-	42.1
Duration of Psychotherapy (months)	140	15.42 (28.94)	-

had forensic psychology M. A. degree whereas 6.4 % had different another M. A. degree. A substantial number of participants did not have a PhD degree (90 %), 4.3 % of the participants had a PhD in clinical psychology, 2.1 % in psychological counseling, 1.4 % in forensic psychology and 2.1 % in different related fields.

In terms of workplace categorization, 23.6 % of the participants were working in private counseling centers, 18.6 % in education sector, 14.3

% in state hospitals, 9.3 % in private hospitals, 8.6 % in special education, 11.4 % in governmental institutions such as social services, prisons, etc and the remaining part as freelance. Their mean years of clinical experience was 5.20 (SD= 4.74) ranging from 0 to 30 years.

2. 2. Materials

Demographic Information Questionnaire: This questionnaire is designed to obtain basic information about the participating clinicians. It involves questions about age, marital status, education, theoretical orientation, occupation, the duration of work experience as a therapist, personal psychotherapy and supervisions taken as well as possible workplace strains (See Appendix B, p. 74- 75).

Ethical Behavior Inventory: 8 cases of ethical violations are provided and the participants are asked to indicate their choice of action among five options in the face of such ethical violation cases (See Appendix C, p. 76- 80). This inventory was developed by the author based on the most frequent violation categories among Turkish professionals revealed by Korkut et al. (2006) study. Ethical violations in four domains were found to be more common among Turkish psychologists: misconduct (mainly sexual misconduct), competence-based violations, multiple relationships and invasion of privacy. Two case examples are provided for each kind of ethical violation comprising the total inventory with eight cases.

Bernard and Jara (1986) argued that the mental health professionals' knowing of the ethical principles did not necessarily mean that they would

be put into action. They found that half of the graduate student participants in their study reported that they would do less than they knew they should when they witness a peer violating an ethical principle. In addition, Bernard et al. (1987) demonstrated similar findings with clinical psychologists working in the field and concluded that it might be a matter of individual values which determines how they respond to such cases. From that line on, the author aimed to address in which ways the professionals respond to the situations that necessitate action and generated some action tendencies. In this questionnaire the respondents were asked to choose one among the five ethical action options provided for each scenario. These options were developed based on Bernard's (1987) findings. The first option indicates taking no action because the clinicians themselves do not see any problem in the given situation, and second option includes taking no action because the clinicians believe that it is none of their business to get involved with the given situation. These two "no action" answers were later combined in the analysis as one "no action" category. Third option emphasizes explanation and suggestion of supervision when faced with hypothetical violation situations whereas the fourth one focuses on warning to report to Committee if the violation situation continues. The last group option indicates that the person would file a complaint and to report the violation and the violator directly to the Ethics Committee.

Ethical Violations Inventory: This inventory was developed to measure the participants' degree of knowledge about ethical codes. Short paragraphs of samples of ethical dilemmas/violations are provided which

were inspired by İhsan Dağ's (2007) translations from the book by Koocher and Keith-Spiegel (1998). In this book, violation case examples were derived from APA Ethics Committee's case vignettes, court records, license board decisions as well as authors' own observations in the field. Those case examples were carefully considered, ten main examples were chosen, some basic changes were made and cases were elaborated in order to constitute the violation inventory. The participants are asked to indicate their opinion whether this case is an example of a violation or not, as well as why they think it is a violation and in which area (See Appendix D, p. 81-88). Participants' answers on items a and c in each case are conceptualized as comprising the ethical knowledge level of the participants. Correct answer was given 1 point and incorrect answer 0 point. The lowest and the highest possible scores were 0 and 20, respectively.

At the end of this inventory, some open-ended questions were provided to the participants in order for them to indicate whether they personally experienced any of these situations during their professional lives. And if some of them happened to themselves, they were asked to indicate these cases and what they did in those situations.

Unethical Behavior Checklist: A list of unethical therapist behaviors was presented to identify the frequency of unethical professional conduct. Items were selected by the author based on the four common violation categories given before: sexual/nonsexual misuse, competence-based violations, multiple relationships and invasion of privacy (See Appendix E, p. 89). This checklist, coupled with the open-ended questions at the end of

the ethical violations inventory, was designed to get a glimpse of the participants' personal experiences in terms of similar ethical violation situations throughout their professional career.

2. 3. Procedure

The overall survey was composed of four parts. The first part asked the participants to indicate their demographic, educational and professional characteristics. The second part investigated the action tendencies of the participants when faced with hypothetical dilemma situations. The third part looked at the participants' level of knowledge about ethical issues. The last part investigated the frequencies and kinds of violations that participants have made throughout their career. Survey began with an informed consent page which briefly describes the aim of the study and asks for volunteer participation (See Appendix A, p.73). Taken together, on average, it took 20 to 30 minutes to complete the whole survey.

The survey was created via computer software called Webropol (2002). The secure online link of the survey coupled with brief informing statements about the aim and scope of the study was sent to mental health professionals' e-mailing lists. Mails were reposted every week during five weeks to obtain more participation. Final sample of 140 participants filled out the questionnaires this way.

Chapter 3: Results

3. 1. Description of the Sample

Overall, 140 participants filled out the survey and thus were included in the final analyses. Their demographic, educational and professional characteristics were presented in detail in the previous section (See Table 1, p. 37-38).

In terms of work setting problems, participants were asked to indicate whether they experienced any clashes between institutional expectations and professional responsibilities. More than half of the sample indicated not having such problems (n=86, 61.4%) whereas 37.9% indicated having these conflicts (n=53). Furthermore, 21.4% of the sample (n=30) indicated that the institution they worked at expected them to serve the best interest of the institution even at the expense of client benefit. 76.4% of the sample indicated not experiencing such insistence (n=107). When their reactions to such situations were investigated, 80.7% of the participants indicated that they would challenge those institutional demands (n=113), 7.9% indicated that they would try to conciliate in order not to lose their jobs (n=11) and 8.6% of them indicated having "other" reactions such as making their decisions case by case (n=12).

3. 2. Participants' Report of Own Ethical Violations

Participants were asked to indicate whether they had experienced situations similar to the violation cases in the *Ethical Violations Inventory*. 52.1% of the sample stated that they had not experienced such cases whereas 47.1% indicated having experienced similar ones.

When the violation frequency was investigated through the 12-item violation checklist, it was shown that the mean frequency of violation incidence reported was 1.03 (SD=1.08) with a range from 0 to 5 violations throughout their career. The most frequently reported violation areas were using a technique or an assessment tool without taking proper formal education (n=32, 22.9%), sharing client data at setting outside supervision (n=27, 19.3%), being in a dual relationship with a client (n=24, 17.1%) and applying redundant assessment procedures to clients (n=22, 15.7%). The least frequently reported violation areas were accepting expensive gifts from clients (n=1, 0.7%), confessing ones's emotional and physical attraction to clients (n=1, 0.7%) and demanding high therapy fees from affluent clients (n=3, 2.1%) (See Table 2, p.45).

Table 2

The Distribution of Reported Ethical Violations

Unethical Behaviors	*N*	Percentage (%)
Accepting expensive gifts	1	.7
Redundant testing	22	15.7
Engaging in multiple relationships	24	17.1
Asking help for personal issues	4	2.9
Confessing emotional and physical attraction	1	.7
Testing without training	32	22.9
Sharing confidential data outside supervision	27	19.3
Social networking with clients	12	8.6
Crying in front of the clients	8	5.7
Keeping audio records of the sessions without client permission	5	3.6
Sharing raw data of testing with clients	5	3.6
Demanding high fees from affluent clients	3	2.1
Total Unethical Behavior (mean/ standard deviation)	-	1.03/ 1.08

3. 2. 1. Relation Between Reported Ethical Violations, Knowledge about Ethics, Taking Supervision and Personal Therapy and Professional Experience

Relations between ethical violation frequency scores and certain continuous variables were investigated with Pearson correlation. These variables are ethical knowledge (total score of the participants in *Ethical Violations Inventory*), duration of supervision (total months of supervision that the participants took), duration of therapy (total months of personal psychotherapy that the participants took) and duration of professional experience.

We initially hypothesized that the mental health professionals who lacked adequate knowledge about ethical issues would be more likely to report more violations. However, no statistically significant correlation between ethical knowledge (M= 15.09, SD= 3.02) and total number of ethical violations (M= 1.03, SD= 1.08) was found, r (138) = -.112, $p > .05$. Then, the data was split into two categories based on reported violations as "no violation reported" and "violation(s) reported" and these two were compared based on their ethical knowledge. An independent samples t-test revealed no significant difference, t (138) = 1.03, $p > .05$, indicating that the 54 participants who reported no violations (M= 15.43, SD= 2.61) were not significantly more knowledgeable than those 86 participants who reported any violations (M= 14.88, SD= 3.26). The idea that more elaborate knowledge (knowing the kind of violation) about ethical guidelines leads to a lesser number of violations was also tested. A Pearson correlation between

more elaborate ethical knowledge (M= 6.44, SD= 1.7) and violation frequency also yielded no significant correlation, r (138) = -.097, $p > .05$.

It was expected that participants who did not take supervision at all would report more violations. An independent groups t-test compared the mean violation frequency for the no supervision group (M= 1.35, SD= 1.04) with that for the supervision group (M= 0.89, SD= 1.07). This test was found to be statistically significant, t (138) = 2.38, $p < .05$, indicating that participants who had never received supervision during their professional lives reported more violations. Moreover, there was also a statistically significant negative correlation between total number of ethical violations and the duration of supervision (M= 18.31, SD= 25.10), r (138) = -.227, $p < .05$, indicating that mental health professionals who had more months of supervision reported less ethical violations.

In a similar vein, it was predicted that the professionals who took personal psychotherapy would report less violations. An independent groups t-test was conducted in order to compare the mean violation scores for no therapy group (M= 1.07, SD= 1.22) with that for the therapy group (M= 1.00, SD= 0.98). Contrary to supervision group, this difference was not found to be statistically significant, t (138) = .37, $p > .05$, indicating that taking personal psychotherapy did not have any effect on reducing ethical violations. There was also no correlation between total number of ethical violations and the duration of personal psychotherapy (M= 15.42, SD= 28.94), r (138) = .114, $p > .05$.

We hypothesized that as years of experience increase, violation frequency might also increase. A Pearson correlation between total number of ethical violations and duration of professional experience (M= 62.41, SD= 56.87) yielded no significant correlation, r (136) = -.153, $p > .05$. We also predicted that experienced professionals would be more knowledgeable about ethical issues. However, there was no correlation between ethical knowledge and professional experience, r (136) = -.037, $p > .05$, indicating that being more experienced did not predict being ethically more knowledgeable.

3. 2. 2. The Relationship Between Ethical Violations and Professional, Educational and Occupational Factors

We hypothesized that professionals who experienced more work strain would report more violations. Therefore, participants were asked whether they were asked to engage in professional conduct outside of boundaries of their competence by their employer. According to their responses, they were compared in terms of violation frequency. An independent groups t-test revealed no significant relationship, t (137) = -.82, $p > .05$, indicating that participants who experienced workplace strains in terms of competence issues (M= 1.13, SD= 1.08) did not report more violations compared to their counterparts who did not experience such strains (M= .98, SD= 1.08). Similar analysis was carried out to reveal the relationship between violation frequency and the workplace strains to serve for the best interest of the institution at the expense of client benefit.

Participants were again divided into two groups, those who reported that they were asked by their employer to serve the interest of their institution such as conducting unnecessary tests and those who were not. An independent groups t-test showed a significant relationship, t (135) = - 3.29, $p < .05$, indicating that participants, who were asked to guard the best interest of the institution even if this meant to cause harm to the client, reported more violations in general (M= 1.60, SD= 1.33) compared to those who did not do so (M= .89, SD= .96).

In order to investigate whether theoretical orientation of the professional had an effect on reducing ethical violations, a one-way analysis of variance (ANOVA) was conducted which compared the mean violation scores of analytically-oriented, cognitive-behaviorally-oriented, humanistically-oriented and other-oriented participants. This test was found to be statistically not significant, F (3, 135) =.817, $p > .05$. This result indicated that contrary to hypotheses, participants with psychoanalytic orientation (M= 1.08, SD= 1.06) did not report less violations compared to those with cognitive-behavioral (M= .93, SD= .97), humanistic (M= 1.57, SD= 1.90) or other theoretical orientations (M= 1.04, SD= 1.13).

In order to investigate the relationship between the degree of education and ethical knowledge, one way ANOVA was conducted to compare mean knowledge scores of participants across three degrees: undergraduate, master's and PhD. It yielded no significant relationship F (2, 137) = 1.153, $p > .05$, indicating that there is no difference in terms of the level of ethical knowledge across three degrees. However, in order to

reveal the relationship between the level of education and the frequency of reported violations, one way ANOVA was conducted. This test was found to be statistically significant, F (2, 137) = 3.09, $p < .05$, indicating that degree of education is related to ethical violation frequency. Post hoc LSD tests showed that the participants who had undergraduate degree (M= 1.36, SD= 1.27) reported significantly more violations than did those who had M. A. degree (M= 0.94, SD= 1.00) and those with PhD degree (M= 0.64, SD= 0.75). There was no significant difference between the means for the M. A. and PhD groups.

3. 2. 3. The Relationship Between Ethical Action Patterns and Ethical Knowledge, Violation Type, Educational and Professional Characteristics

A general picture of the participants' ethical action patterns revealed that the mental health professionals in this study heavily relied on preferring to give "supervision advice" (47.18%) to a colleague in a hypothetical situation where they witness him/her engaging in unethical behavior. They also showed a trend toward "warning" (22.7%) a colleague in that situation followed by choosing "no action" (17.52%) and complaint (12.6%) (See Table 3 for detailed information, p.51).

We hypothesized that a relationship might exist between ethical knowledge and the kinds of ethical actions taken by the mental health

Table 3

The Distribution of Ethical Action Tendencies

	Ethical Action Tendencies			
	No Action	Supervision Advice	Warning	Complaint
Percentages (%)	17.52	47.18	22.7	12.6
Total Number of Responses	196	528	254	141

professionals when they witness a colleague's unethical behavior, namely, as the knowledge of the professional about ethical issues increased, the likelihood of "no action" answers to unethical cases would decrease. In order to investigate that relationship, a Pearson correlation between ethical knowledge and frequency of no action answers (M= 1.40, SD= 1.50) was conducted. It yielded no significant correlation, r (138) = -.136, $p > .05$, indicating that as people become more knowledgeable about ethical issues, their tendency to remain actionless in the face of violations does not decrease.

In a similar vein, it was also predicted that professionals with higher education would take more serious actions such as warning to report or directly reporting to Ethics Committee when their opinions are asked on ethical violation cases. In order to investigate the relationship between the

degree of education and 4 different action tendencies, one way ANOVA was conducted to compare mean action scores of participants across three degrees of education. This test was found to be statistically nonsignificant for all action tendencies; F (2, 137) = 0.32, $p > .05$ for no action, F (2, 137) = 2.48, $p > .05$ for supervision advice, F (2, 137) = 2.03, $p > .05$ for warning and F (2, 137) = 0.49, $p > .05$ for complaint. These results indicated that as the education level of the professionals increases, they do not necessarily prefer to take more serious actions in violation cases.

Professionals with psychoanalytic orientation were expected to give less "no action" responses compared to the professionals with other orientations. A one-way ANOVA compared the no action responses across theoretical orientation categories. This test was found to be statistically significant, F (2, 137) = 2.03, $p < .05$. Post hoc LSD tests showed that the participants who are psychoanalytically oriented (M= 0.73, SD= 0.84) tended to give less "no action" answers compared to cognitive-behaviorally oriented therapists (M= 1.51, SD= 1.53) and those with "other" orientation (M= 1.96, SD= 1.87).

Lastly, it was predicted that there would be differences in terms of which course of action participants would take (i.e., no action, supervision advice, warning and complaint) toward a colleague's unethical behavior based on the kind of violation (i.e., competence, privacy, multiple relations and sexual misconduct). A 4X4 chi-square test was applied and was found to be statistically significant, χ^2 (9, N = 979) = 242.89, $p < .01$. First of all, we expected that since competence is the least clearly defined and

understood area in Turkey, less serious actions such as “no action” or “supervision advice” would be more likely. The results of the chi square analysis showed that as expected participants were more likely to respond with “supervision advice” (60.22%) when presented with violation cases in the competence area. However, contrary to expectations, participants were found be less likely to give “no action” (8.24%) response in competence violations. On privacy issues, we found that participants were more likely (38.57%) to warn the violator and remind him/her that they can report to Ethical Committee if the situation continues. In addition, participants were more likely to give “supervision advice” responses (28.57%) followed by more “complaint” responses (20.36%). This finding might be related to the fact that privacy is the widely held area for mental health professionals, thus more serious actions such as “warning” to report and filing a “complaint” against the professionals became more likely responses. On sexual misconduct, as expected, participants were less likely to give “no action” responses (0.71%). Surprisingly, they were more likely to give “supervision advice” responses (58.57%). Moreover, on issues of multiple relationships of nonsexual nature, the results showed that participants were more likely to give “supervision advice” responses (48.21%) followed by more “no action” responses (38.57%), indicating that about issues of multiple relationships with clients, mental health professionals take less serious actions toward the violator. The observed frequencies can be found in detail in Table 4 (p.54). However, the problem with the results of this test was that, as can be seen in the table, marginal frequencies were turned out to be unequal. This stemmed

from the changes in the data analysis phase. When the Ethical Behavior Inventory was conceptualized before collecting data from the participants, 8 case examples were designed to cover 4 different violation categories with two items in each. All violation kinds except sexual misconduct were measured with the responses given to two case examples for each kind. In the beginning, sexual misconduct and economic misconduct were conceived under the violation category of "misconduct". However, during statistical analyses, seeing the differential effects of sexual misconduct became more essential. Thus, total frequency of sexual misconduct category became 140.

Table 4

The Distribution of Frequency of Responses According to Ethical Situations

	Ethical Action Tendencies				Total (N)
Ethical Situations	No action	SV Advice	Warning	Complaint	
Competence					
N	23	168	59	29	279
Percentage	8.24	60.22	21.15	10.39	
Privacy					
N	35	80	108	57	280
Percentage	12.5	28.57	38.57	20.36	
Multiple Relations					
N	108	135	24	13	280
Percentage	38.57	48.21	8.57	4.65	
Sexual Misconduct					
N	1	82	26	31	140
Percentage	0.71	58.57	18.57	22.15	

Chapter 4: Discussion

The purpose of the present study was to investigate the way the mental health professionals think about and make decisions on how to act under different dilemma situations. In addition to some of the factors that may influence the frequency of their own unethical behaviors, we specifically examined the participants' level of knowledge about ethical issues and whether this was related to their ethical decision-making process in dilemma situations and their ethical practice in general. Educational, occupational and professional factors that influence their reactions to violations were also examined. Specifically, the relationship between the frequency of ethical violations reported by the participants and their theoretical orientations as well as supervision and personal psychotherapy backgrounds was addressed. Moreover, professional characteristics such as workplace-related issues and resulting violations were also handled in order to understand contributing factors to reported violations. Finally, the ethical action tendencies of the participants (i.e., no action, supervision advice, warning and complaint) in hypothetical dilemma situations were addressed and the link between these reaction tendencies and ethical knowledge, degree of education, theoretical orientation and violation types (i.e., competence, privacy, multiple relations and sexual misconduct) was investigated.

4. 1. Ethical Violations

We expected to find a relationship between the professionals' ethical knowledge level and a number of characteristics such as years of professional experience and the degree attained. We also expected to find a negative correlation between ethical knowledge level and the frequency of ethical misconduct as measured by the professionals' own report of unethical behavior in the checklist. However, we could not find any association between these variables and the ethical knowledge level. Our findings contradicted with Koocher and Keith-Spiegel (1998) as well as Francis (2009) who found that psychologists' involvement in unethical behavior resulted from lack of knowledge. However, it is reasonable to suspect here that the lack of finding any significance in these comparisons stemmed from the materials that were used to measure these variables. Since the research in the ethics area is limited in our country and there were no standardized measures used to identify the professionals' knowledge levels, the materials were formed by the researcher without any pilot study to evaluate their reliability or validity. The inventory that we used to measure the ethical knowledge of the professionals seemed to be too easy and most of the items could be answered by commonsense. Thus, it could not differentiate between different levels of ethical knowledge. In fact, the range of scores was very limited. Future studies should focus on developing standardized tools aimed at measuring ethical knowledge. Another reason for the failure to find a significant difference might be related to the limited range in terms of unethical behaviors reported. Again, on the 12-item

checklist, the mean report of unethical behavior was 1.03 with minimum and maximum values of 0 and 5, respectively. Most of the participants did not report any violation on this measure. Since we asked the professionals to report their ethical behavior via the checklist, social desirability effect is very likely. Still, it is important to note that this measure yielded significant associations with certain variables (i.e.; supervision and work strains) while the ethical knowledge questionnaire did not yield any significant associations.

Problems of limited range in Unethical Behavior Checklist that we developed probably limited the number of significant associations that we found. We expected to find a relationship between theoretical orientation and the frequency of reported violations and personal psychotherapy taken. However, we could not find any significant association between these variables. Our findings did not confirm Cross and Papadopoulos (2001) who indicated that personal therapy enables professional growth ensuring ethical practice. The failure to find a significant relation between therapy and unethical behavior while finding a significant relation between supervision and unethical behavior might be related to several factors. First of all, the nature of these two processes is clearly different. Supervision is more like a directive and educative process whereas therapy ensures the individuals a free space to explore their own feelings, beliefs and behavior trying to reach connections between them. Thus, supervision might be more likely to facilitate understanding of unethical behavior. Moreover, this was consistent with Walker and Clark (1999) who suggested supervision as a risk

management system which enables the reduction of violations. Analyzing the past, present and future of the therapeutic relationship with a supervisor might increase the ethical sensitivity of the professional. Secondly, because the sample was consisted of participants who were in the mental health sector, supervision might have been considered more valuable by this group in order to provide better service to their clients. Lastly, mean age of the sample was 29.67 and this relatively young group of professionals might be more sensitive about pursuing a healthy career by relying on supervision more since supervision enables them to develop personal and professional competence.

We also found a significant inverse relation between the degree of education and reported violations, as expected, indicating that the professionals with only undergraduate degree reported significantly more violations compared to their colleagues with master's or PhD education. This was in line with Koocher and Keith-Spiegel (1998), who indicated that master's and PhD programs dedicate more time to cover ethical issues and include ethics training in the curriculum whereas undergraduate education does not focus as much on ethical issues.

We also hypothesized that professionals who experience more work strain would report more violations in line with Pope and Vasquez's (2007) study. For competence, no significant difference was found, that is, the professionals who were pressured by their institutions to make competence violations did not report significantly more unethical behavior. This might be related to lack of defined boundaries for competence in the professionals'

minds. Since they do not view competence violations as a “violation”, they might tend to underreport violations in this area. This is in line with the second part of the work hypothesis. The relationship between reported violations and the workplace pressure to serve for the best interest of the institution at the expense of client benefit was found to be significant. That is, professionals who had to prioritize the institutional benefits such as conducting unnecessary tests reported more unethical behavior. It is not surprising since if they had to guard the best interest of the institution at any situation, more violations would be likely.

When the reported violations of the participants were examined in detail, the most frequently reported ones were found to be testing without proper training, sharing confidential data outside supervision and engaging in multiple relationships, whereas the least frequently reported violations were confessing emotional and physical attraction to a client and accepting expensive gifts from them. This profile might indicate that the professionals in our country have a solid understanding of basic conspicuous ethical guidelines such as the inappropriateness of accepting gifts from clients and of engaging in self-disclosure for personal purposes. However, they seemed to find no inconvenience in using techniques and materials of which they did not take formal training, sharing of client data in informal colleague chats or in any situations outside supervision. Perhaps most importantly, our participants revealed that they engaged in multiple relationships with clients. Although, we did not know the nature of these relationships- whether they were in the form of an economic exchange or friendship- the

reasons for engaging in multiple relations with clients should be analyzed in depth and any possible contributions of cultural characteristics to these results should be carefully examined in future studies.

4. 2. Ethical Action Patterns

It seemed surprising that the mental health professionals who participated in our study captured the importance of taking supervision for ethical practice. Especially, their heavy reliance on advising supervision to an unethically behaving colleague in hypothetical cases provided a support for this view that supervision is an important component of healthy progression of the practice.

Based on previous research which tapped on ethical actions taken in the face of dilemma situations and the factors that determined to choose one action over the other (Bernard & Jara, 1996; Haas et al., 1998), first of all, we explored the influence of ethical knowledge on the actions taken. It was hypothesized that as the knowledge about ethical issues increases, the likelihood of "no action" answers to unethical cases would decrease. The findings did not confirm this hypothesis. The professionals' being more knowledgeable about ethical guidelines and regulations did not make them more active interferers in violation cases. The failure to find a significant difference might be again related to the inventory that was used to measure ethical knowledge. A different tool might yield significant results.

We also predicted that professionals with higher degree of education would take more serious actions when the kinds of action they prefer to take were asked on ethical violation cases. However, no significant relationship was found between the degree of education and ethical action tendencies to prove this hypothesis. That is, it was found that the professionals with PhD or master's degree did not significantly differ from those with undergraduate degree in terms of the action they took when faced with violation cases. It was interesting that even though the professionals were equipped with necessary training on ethical issues, they might still remain actionless in the face of a colleague's violation. The underlying situational factors for such tendencies should be investigated in future studies.

The relationship between theoretical orientation and "no action" responses was also investigated based on previous findings in the literature. Borys and Pope (1989) argued that professionals with psychodynamic orientation are more sensitive about and reactive to ethical issues compared to their colleagues with other orientations. Therefore, we expected that psychodynamically-oriented professionals would give less "no action" responses in violation cases. The findings confirmed this hypothesis indicating that professionals with analytic orientation preferred not to remain passive and inactive when faced with violation situations compared to their counterparts with cognitive-behavioral or other orientation.

Finally, the relationship between the professionals' action patterns and violation categories were investigated. In line with the Korkut et al.'s (2006) findings, we compared the action patterns of the participants across

four main categories of violation: competence, privacy, multiple relations and sexual misconduct. We expected less serious action like “no action” or “supervision” advice on competence issues, since the boundaries of competence were not clearly defined in our country. Findings were consistent with our expectations that the professionals would be more likely to prefer supervision advice in these cases. Moreover, on privacy issues, participants were more likely to choose complaint and warning responses which might be related to the fact that the guidelines about this area are much known by the professionals. Since sexual involvement with a client is viewed as unacceptable even with commonsensical knowledge, we expected more serious actions. This hypothesis was partly confirmed, participants were less likely to prefer no action responses. However, they were more likely to prefer supervision advice than complaining to the Ethics Committee. The reason that professionals do not react on it much by taking active stance might be related to social pressure. When the general trend of action patterns was examined, it was seen that only 12.6 % of the total responses was “complaint”. Thus, professionals might refrain from complaining their colleagues even in serious cases like sexual misconduct. Situational factors and social pressures might be investigated in future studies. And finally, professionals were more likely to prefer no action and supervision responses on issues of multiple relations. Displaying less serious actions in this violation category might imply that multiple relations might be viewed as natural parts of one-to-one interaction. In line with prior findings (Sonne, 2006), any culture-specific characteristics which might

impose difficulties in drawing professional boundaries should be investigated in further studies. Taken together, these results indicated that the professionals' responses were determined on the basis of violation categories, they tend to remain less active in some violation areas whereas more active in others.

4. 3. Summary and Conclusion

Lower levels of education, lack of supervision and working in a pressured environment have been found to be significant determinants of unethical behavior. Therefore, mental health professionals –if they are dedicated to provide service to people- should undertake further education since undergraduate curriculum does not adequately focus on ethical issues. However, in our country, available M.A. and PhD programs are very limited compared to the high demand. Thus, at a personal level, professionals should take advantage of every chance to invest in their professional career in order to pursue reliable practice. At a collective level, professional ethics seminars should be regularly implemented and become widespread in order to disseminate awareness about ethical issues psychologists in training. They should also be encouraged to take supervision when they begin to work actively in the field of psychotherapy. In addition, working in stressful and demanding work environments might promote unethical behavior as the results have shown. Moreover, the professionals' reactions concerning multiple relationship and sexual involvement violations showed that these areas seemed to be the least understood part of the ethical codes. They were

not sensitive enough to take more serious actions especially about sexual misconduct issues. In these cases, the fact that the professionals very well digest the ethical guidelines and regulations to follow as well as that they can get help and support from the Turkish Psychological Association contribute much to diminish unethical conduct.

Finally, future studies should focus on developing sound ways to evaluate the ethical knowledge of the professionals in the field and how it is related to unethical behavior and action tendencies of the professionals in violation cases. Still, any attempt to study ethical issues will be invaluable to the field since they are very limited in our country. More research in this area will contribute to the development of our profession.

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APPENDICES

Appendix A: Informed Consent

Ruh Sağlığı Uygulamalarında Etik

Sayın katılımcı,

İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi olan Müjde Hardal'ın yürütmekte olduğu yüksek lisans tezi için bazı anket ve envanterleri doldurmanız beklenmektedir. Mesleki farkındalık ve sorumluluğa yönelik çalışmalar ülkemizde son yıllarda önem kazanmaktadır. Bu çalışma kapsamında dolduracağınız formlarda kendiniz ve genel olarak mesleğiniz ile ilgili konularda bazı değerlendirmeler yapmanız istenecektir. Bu işlemin ortalama 20-25 dakikanızı alacağı tahmin edilmektedir. Minimum 50 profesyonelin katılmasını beklediğimiz bu çalışmada katılımcı olarak kimliğiniz gizli kalacaktır. Anket formlarına birer kimlik numarası verilecektir ve anketlerin herhangi bir yerinde isim, adres bilgileriniz sorulmayacaktır. Bu çalışmaya katılmak gönüllülük esasına dayanmaktadır ve katılımınızın sizin üzerinizde herhangi bir olumsuz etkiye neden olması beklenmemektedir.

Soruları dikkatlice okuyup boş bırakmadan bütün soruları yanıtlamanızı ve anketin sonundaki GÖNDER tuşuna basarak sonlandırmanızı rica ediyoruz. Bütün soruları olabildiğince eksiksiz ve açık bir şekilde cevaplamanız sonuçların sağlıklılığı açısından çok önemli olacaktır. Çalışma ve sonucu ile ilgili ayrıntılı bilgi almak isterseniz, araştırmacı Müjde Hardal'ın mujdehardal@student.bilgi.edu.tr eposta adresine ya da araştırmanın danışmanı Zeynep Çatay'ın zcatay@bilgi.edu.tr adresine e-posta yoluyla sorularınızı ulaştırabilirsiniz. Çalışmamıza yapmış olduğunuz katkı için teşekkür ederiz.

1. Bu bilgiler ışığında belirtilen çalışmaya katılmayı

□ Kabul ediyorum.

□ Kabul etmiyorum.

Appendix B: Demographic Information Questionnaire

Demografik Bilgiler

1. Cinsiyet:

□ Kadın □ Erkek

2. Yaş: _____

3. Medeni Hal:

□ Bekar □ Evli □ Boşanmış □ Ayrı yaşıyor □ Dul

4. Eğitim durumu (işaretleyiniz, bölümünüzü belirtiniz):

Lisans/Bölüm: _____ Yüksek Lisans/Bölüm: _____ Doktora/Bölüm: _____

5. Çalıştığı kurum/kuruluşun türü (işaretleyiniz):

□ Psikolojik Danışmanlık Merkezi

□ Devlet Hastanesi

□ Özel Hastane/ Klinik

□ Özel Okul

□ Özel Eğitim/ Rehabilitasyon Merkezi

□ Anaokulu/ Kreş

□ Huzurevi

□ Diğer (belirtiniz) _____

6. Kaç yıldır aktif psikolog olarak çalışıyor, danışan görüyorsunuz? _____

7. Teorik yöneliminiz nedir? Size uyanları işaretleyiniz.

□ Psikanalitik/ Psikodinamik

□ Bilişsel Davranışçı

□ Hümanistik

□ Diğer (belirtiniz) _____

8. Bireysel psikoterapi alıyor musunuz?

□ Evet □ Hayır

9. Geçmişte bireysel psikoterapi aldınız mı? Ne kadar süre ile? _____

10. Süpervizyon alıyor musunuz?

□ Evet □ Hayır

11. Geçmişte süpervizyon aldınız mı? Ne kadar süre ile? _____

12. Çalıştığınız kurumun beklentileri ile mesleki sorumluluklarınızın çatıştığı durumlar oluyor mu? Örneğin, yetkinliğinizin sınırlarını aşan bir işi yapmanızı bekliyorlar mı?

□ Evet □ Hayır

13. Ya da kurumun çıkarlarını danışana yararlı olamamak pahasına gözetmenizi bekliyorlar mı? (ör: Kuruma maddi kazanç sağlamak için gereksiz testler yapılmasını istemek gibi)

□ Evet □ Hayır

14. Bu gibi durumlarda ne yaparsınız?

□ Karşı çıkarım, yetkinliğimin sınırlarını aştığını belirtirim.

□ İşimi kaybetmemek için bazı konularda taviz vermeyi göze alabilirim.

□ Diğer (açıklayınız) _____

Appendix C: Ethical Behavior Inventory

Lütfen aşağıdaki örnekleri dikkatlice okuyunuz ve etik ilkeler doğrultusunda ne yapacağınızı belirtiniz. Doğru veya yanlış cevap yoktur, sizin için doğru olan, anlatılan durumda öncelikli olarak tercih edeceğiniz şıkkı işaretlemeniz yeterlidir.

1. Bir erkek terapist, evliliğinde karmaşa yaşadığını söylediği bir dönemde kadın danışanının sevgi dolu yaklaşımlarından etkilenerek onunla birkaç kez cinsel yakınlaşma içine girmiştir. Terapist, danışanıyla arasındaki bu yakınlaşmaların danışanının özgüvenini desteklediğini ve yalnızlık hissini giderdiğini düşünmektedir. Meslektaşınız laf arasında bu durumu sizinle paylaşmıştır.

Bu durumda ne yaparsınız? (işaretleyiniz)

□ Hiçbir şey yapmam, ortada bir sorun görmüyorum.

□ Hiçbir şey yapmam, beni ilgilendirmez.

□ Bu davranışın yanlış olduğunu anlatır gerekirse süpervizyon almasını öğütlerim.

□ Bu davranışına devam ederse Etik Kurul'a şikayet etmek zorunda kalacağımı söylerim.

□ Etik Kurul'a şikayette bulunurum.

2. Psikolog D.'nin çalıştığı merkeze test uygulanması için 10 yaşında bir çocuk yönlendiriliyor. Psikolog, söz konusu testin eğitimini almadığı halde el kitabına bakarak uygulayabileceğini görüyor ve uygulamayı yapıp raporunu yazıyor.

Bu durumu öğrenen siz ne yaparsınız? (işaretleyiniz)

□ Hiçbir şey yapmam, ortada bir sorun görmüyorum.

□ Hiçbir şey yapmam, beni ilgilendirmez.

□ Bu davranışın yanlış olduğunu anlatır gerekirse süpervizyon almasını öğütlerim.

□ Bu davranışına devam ederse Etik Kurul'a şikayet etmek zorunda kalacağımı söylerim.

□ Etik Kurul'a şikayette bulunurum.

3. Psikolog A., bir süredir bireysel psikoterapiye devam ettiği danışanın varlıklı biri olduğunu anlayıp yeterince ödeyebileceğini düşünerek yüksek miktarda seans ücreti talep ettiğini sizinle paylaşmıştır.

Bu durumda ne yaparsınız? (işaretleyiniz)

□ Hiçbir şey yapmam, ortada bir sorun görmüyorum.

□ Hiçbir şey yapmam, beni ilgilendirmez.

□ Bu davranışın yanlış olduğunu anlatır gerekirse süpervizyon almasını öğütlerim.

□ Bu davranışına devam ederse Etik Kurul'a şikayet etmek zorunda kalacağımı söylerim.

□ Etik Kurul'a şikayette bulunurum.

4. Akıl hastanesinden yeni taburcu olan ve iş deneyimi olmayan danışanı Bayan B.'ye yardımda bulunmak isteyen psikolog, eleman arayan bir

arkadaşının mağazasında ona tezgahtar olarak iş bulduğunu sizinle paylaşmıştır.

Bu durumda ne yaparsınız? (işaretleyiniz)

□ Hiçbir şey yapmam, ortada bir sorun görmüyorum.

□ Hiçbir şey yapmam, beni ilgilendirmez.

□ Bu davranışın yanlış olduğunu anlatır gerekirse süpervizyon almasını öğütlerim.

□ Bu davranışına devam ederse Etik Kurul'a şikayet etmek zorunda kalacağımı söylerim.

□ Etik Kurul'a şikayette bulunurum.

5. Bir klinik psikoloji programından mezun olan, tüm uygulamaları, alan çalışmaları ve stajyerlik deneyimini yetişkin hastalarla gerçekleştiren Psikolog B., çocuk gelişimi ve psikopatolojisine ilişkin dersler almamasına rağmen şimdi çocuklarla da bireysel görüşmeler yapmak istemiştir. Sizin çalışmaya başladığınız merkezce işe alınarak çocuk danışanlar kabul etmeye başlamıştır.

Bu durumda ne yaparsınız? (işaretleyiniz)

□ Hiçbir şey yapmam, ortada bir sorun görmüyorum.

□ Hiçbir şey yapmam, beni ilgilendirmez.

□ Bu davranışın yanlış olduğunu anlatır gerekirse süpervizyon almasını öğütlerim.

□ Bu davranışına devam ederse Etik Kurul'a şikayet etmek zorunda kalacağımı söylerim.

□ Etik Kurul'a şikayette bulunurum.

6. Öğretim üyesi bir psikolog, engelli bir çocuğun zihinsel değerlendirmesinden arşivlediği test malzemelerini yüksek lisans sınıfında kullanıyor. Çizim kopyaları ve test protokollerinin üstünde açık isim yazılı bir şekilde öğrenciler tarafından incelendiğine şahit oluyorsunuz.

Bu durumda ne yaparsınız? (işaretleyiniz)

□ Hiçbir şey yapmam, ortada bir sorun görmüyorum.

□ Hiçbir şey yapmam, beni ilgilendirmez.

□ Bu davranışın yanlış olduğunu anlatır gerekirse süpervizyon almasını öğütlerim.

□ Bu davranışına devam ederse Etik Kurul'a şikayet etmek zorunda kalacağımı söylerim.

□ Etik Kurul'a şikayette bulunurum.

7. Öğretim görevlisi olan psikologun öğrencilerinden biri kendisinin yaklaşımını çok beğendiğini ve ancak ona güvenip açılabileceğini hissettiğini söyleyerek bireysel terapi için ona başvurmak istediğini söylemiştir. Bu durumdan etkilenen psikolog da öğrencisini terapiye almaya ikna olmuştur.

Bu durumda ne yaparsınız? (işaretleyiniz)

□ Hiçbir şey yapmam, ortada bir sorun görmüyorum.

□ Hiçbir şey yapmam, beni ilgilendirmez.

□ Bu davranışın yanlış olduğunu anlatır gerekirse süpervizyon almasını öğütlerim.

□ Bu davranışına devam ederse Etik Kurul'a şikayet etmek zorunda kalacağımı söylerim.

□ Etik Kurul'a şikayette bulunurum.

8. Bir ders esnasında terapist olan öğretim görevlisi anlattığı konuyla bağlantılı olarak bir danışanından örnek vermiş, daha anlaşılır olması açısından danışanla yaptığı seansın ses kaydının belli bir bölümünü öğrencilerine dinletmiştir. Bu derse konuk konuşmacı olarak katılan siz kaydı dinlerken o danışanı tanıdığınızı fark ettiniz ve terapistin kayıtları danışanın iznini almadan tuttuğunu öğrendiniz.

Bu durumda ne yaparsınız? (işaretleyiniz)

□ Hiçbir şey yapmam, ortada bir sorun görmüyorum.

□ Hiçbir şey yapmam, beni ilgilendirmez.

□ Bu davranışın yanlış olduğunu anlatır gerekirse süpervizyon almasını öğütlerim.

□ Bu davranışına devam ederse Etik Kurul'a şikayet etmek zorunda kalacağımı söylerim.

□ Etik Kurul'a şikayette bulunurum.

Appendix D: Ethical Violations Inventory

Lütfen aşağıda belirtilen her bir vakayı dikkatlice okuyun ve soruları yanıtlayın.

1. Eşiniz/sevgiliniz tarafından aldatıldığınızı öğrendiniz ve bir süredir bu durumla başa çıkabilmek için alkole başvurmaktasınız. Son zamanlarda içme sıklığını arttırdınız ve seanslarınıza geç gelmeye ve ön hazırlıksız girmeye başladınız.

a. Bu vakada sizce etik ihlal söz konusu mudur?

□ Evet □ Hayır

b. İhlal olduğunu düşünüyorsanız, neden? (belirtiniz)

_____

c. Eğer bu vakada bir etik ihlal olduğunu düşünüyorsanız bu sizce hangi alanda? (işaretleyiniz)

□ Ayrımcılık

□ Dürüstlük

□ Çoklu ilişkiler

□ Yetkinlik/ Yeterlilik

2. Bir buçuk yıl önce çalışmaya başladığınız engelli ergenin zekasını yeniden ölçüp çıkan sonucu bireyin ailesiyle paylaşıyorsunuz. Sonuçları dinleyen aile, test protokolü ve ham puanlamanın bulunduğu dökümanları ısrarla talep ediyor, siz de bu talebi geri çeviremiyorsunuz.

a. Bu vakada sizce etik ihlal söz konusu mudur?

□ Evet □ Hayır

b. İhlal olduğunu düşünüyorsanız, neden? (belirtiniz)

_____

c. Eğer bu vakada bir etik ihlal olduğunu düşünüyorsanız bu sizce hangi alanda? (işaretleyiniz)

□ Yetkinlik/ Yeterlilik

□ Kötüye kullanım

□ Çoklu ilişkiler

□ Gizlilik

3. Sevgilinizle ilişinizde problemler yaşadığınız bir dönemde danışanınızın sevgi dolu yaklaşımlarından etkilenerek onunla duygusal olarak yakınlaşma içine girdiniz. Kendinizi danışana sürekli iltifatlarda bulunurken ve seans günlerinde görünümünüze fazlaca özen gösterirken buluyorsunuz.

a. Bu vakada sizce etik ihlal söz konusu mudur?

□ Evet □ Hayır

b. İhlal olduğunu düşünüyorsanız, neden? (belirtiniz)

_____

c. Eğer bu vakada bir etik ihlal olduğunu düşünüyorsanız bu sizce hangi alanda? (işaretleyiniz)

□ Dürüstlük

□ Çoklu ilişkiler

□ Kötüye kullanım

□ Yetkinlik/ Yeterlilik

4. Bir danışanınız, sizden 5 yıldır her hafta düzenli olarak psikoterapi almaktadır. Danışanınız terapiye ilk başladığında söz ettiği şikayetleriyle uzun bir süredir başarılı bir biçimde baş edebilmektedir ama sizinle terapi seansları yapmaya da çok bağımlı hale gelmiştir. Danışanın terapiye artan bağımlılığı dışında duygu durumunda önemli bir değişiklik gözlememenize rağmen kendinizi onun annesi/babası olarak gördüğünüzü ve koruyucu öğütler verdiğinizi fark ediyorsunuz.

a. Bu vakada sizce etik ihlal söz konusu mudur?

□ Evet □ Hayır

b. İhlal olduğunu düşünüyorsanız, neden? (belirtiniz)

_____

c. Eğer bu vakada bir etik ihlal olduğunu düşünüyorsanız bu sizce hangi alanda? (işaretleyiniz)

□ Kötüye kullanım

□ Dürüstlük

□ Yetkinlik/ Yeterlilik

□ Çoklu ilişkiler

5. 14 yaşında bir ergen, yaşadığı semtteki ruh sağlığı merkezine başvurmuştur. Orada görevli psikolog olan siz, başvuruyu değerlendirip kendisini ilk görüşmeye alıyorsunuz. Bu görüşme sırasında size yaşadığı

sorunları açıkça anlatmış, evde ailesi tarafından şiddete maruz kaldığını söylemiştir. Ancak, sizden bu durumunu kimseyle, özellikle de ailesiyle konuşmamanızı istemiştir. Görüşlerinizi çocukla paylaşıyor ve reşit olmayan kimseye, velayet sahibinin izni olmadan müdahale edemeyeceğinizi bildiriyor, ayrıca fiziksel şiddet gibi durumlarda sorumluluğunuz gereği sosyal hizmetleri bilgilendirmeniz gerektiğini söylüyorsunuz. Çocuk bu açıklamalar karşısında kendisini ihanete uğramış gibi hissettiğini söylüyor. Siz de onu küstürmemek adına, nasılsa sonra ikna ederim diye düşünerek, ailesine bildirmeden çalışmayı kabul ediyorsunuz.

a. Bu vakada sizce etik ihlal söz konusu mudur?

□ Evet □ Hayır

b. İhlal olduğunu düşünüyorsanız, neden? (belirtiniz)

_____

c. Eğer bu vakada bir etik ihlal olduğunu düşünüyorsanız bu sizce hangi alanda? (işaretleyiniz)

□ Bilgilendirilmiş Onam

□ Çoklu ilişkiler

□ Yetkinlik/ Yeterlilik

□ Dürüstlük

6. Bir devlet hastanesinde psikolojik değerlendirmeden sorumlu olarak çalışan bir psikologsunuz, silah ruhsatı almak için başvuran bir kişiye ön görüşme yaptıktan sonra kişilik değerlendirme envanteri uyguladınız. Özel

güvenlik olarak çalışmak için bu ruhsata başvurduğunu anlatan kişinin test sonuçları ruhsat almasının doğru olmayacağına dair bulgular içerse de ön görüşmedeki sempatik tavırları sizin ruhsatı verme yönünde karar almanızı sağlıyor.

a. Bu vakada sizce etik ihlal söz konusu mudur?

□ Evet □ Hayır

b. İhlal olduğunu düşünüyorsanız, neden? (belirtiniz)

_____

c. Eğer bu vakada bir etik ihlal olduğunu düşünüyorsanız bu sizce hangi alanda? (işaretleyiniz)

□ Sorumluluk

□ Dürüstlük

□ Gizlilik

□ Yetkinlik/ Yeterlilik

7. Bayram tatiline başlamak üzere ofisinizden çıkmaya hazırlanırken bir danışanınızdan telefon gelir. Bu danışan kendine zarar verme riski olan biridir ve telefondan böyle bir risk olduğu anlaşılmaktadır. Danışanınıza doktoru ile temasa geçmesini ve pazartesi sabah da sizi görmeye gelmesini söylüyorsunuz. Başka da bir müdahale girişiminde bulunmuyorsunuz.

a. Bu vakada sizce etik ihlal söz konusu mudur?

□ Evet □ Hayır

b. İhlal olduğunu düşünüyorsanız, neden? (belirtiniz)

_____

c. Eğer bu vakada bir etik ihlal olduğunu düşünüyorsanız bu sizce hangi alanda? (işaretleyiniz)

□ Zarar vermemek/ Yararlı olmak

□ Dürüstlük

□ Gizlilik

□ Yetkinlik/ Yeterlilik

8. Maddi olarak biraz sıkıntı içerisindesiniz ve evinizi dekore ettirmek için iyi bir usta bulamamaktan yakınıyorsunuz. Mobilyacı olan bir danışanınız bekleme odasındayken sizin telefon konuşmanızı duyuyor ve size bu işlemi daha uygun fiyata kendisinin yapabileceğini ama bunun karşılığında da seans ücretlerinde indirime gitmenizi teklif ediyor. Ve siz de içinde bulunduğunuz şartlarda makul görünen bu teklifi kabul ediyorsunuz.

a. Bu vakada sizce etik ihlal söz konusu mudur?

□ Evet □ Hayır

b. İhlal olduğunu düşünüyorsanız, neden? (belirtiniz)

_____

c. Eğer bu vakada bir etik ihlal olduğunu düşünüyorsanız bu sizce hangi alanda? (işaretleyiniz)

□ Sorumluluk

□ Çoklu ilişkiler

□ Gizlilik

□ Yetkinlik/ Yeterlilik

9. Uzun dönemli bireysel psikoterapiye devam ettiğiniz danışanınızın bir sosyal paylaşım sitesinden size yolladığı arkadaşlık teklifini kabul ederek arkadaş listenize ekliyorsunuz.

a. Bu vakada sizce etik ihlal söz konusu mudur?

□ Evet □ Hayır

b. İhlal olduğunu düşünüyorsanız, neden? (belirtiniz)

_____

c. Eğer bu vakada bir etik ihlal olduğunu düşünüyorsanız bu sizce hangi alanda? (işaretleyiniz)

□ Zarar vermekten kaçınma

□ Dürüstlük

□ Çoklu ilişkiler

□ Yetkinlik/ Yeterlilik

10. Erkek kardeşinizin çocuğuna okuduğu okul tarafından psikolojik değerlendirme yaptırılması mecburiyeti getirilir. Kardeşiniz de 10 yaşındaki yeğeninize bu değerlendirmeyi sizin yapmanızı rica ediyor ve siz de bunu standart bir testle ölçerek çocuğun zeka bölümünü tespit ediyorsunuz.

a. Bu vakada sizce etik ihlal söz konusu mudur?

□ Evet □ Hayır

b. İhlal olduğunu düşünüyorsanız, neden? (belirtiniz)

_____

c. Eğer bu vakada bir etik ihlal olduğunu düşünüyorsanız bu sizce hangi alanda? (işaretleyiniz)

□ Yakınlara müdahale

□ Gizlilik

□ Dürüstlük

□ Yetkinlik/ Yeterlilik

* Yukarıdaki maddelerde anlatılan durumlardan herhangi biri başınıza geldi mi?

□ Evet □ Hayır

*Evet ise hangisi/hangileri? Belirtiniz.

_____

*O durumda neler yaptınız, kısaca açıklayınız.

_____

Appendix E: Unethical Behavior Checklist

Aşağıda bazı durumlar listelenmiştir. Meslek yaşantınız boyunca bu durumlardan kendi başınıza gelmiş olanları işaretleyiniz.

	Evet	Hayır
Danışanlarınızdan maddi değeri yüksek olan hediyeler kabul etmek		
Bir danışanınıza gereksiz olduğunu düşündüğünüz test uygulamalarında bulunmak		
Bir danışanınızla terapist-danışan ilişkisinin dışında bir tür ilişki içinde olmak (öğrenci, öğretmen, işveren-çalışan, arkadaşlık gibi)		
Bir danışanınızdan kişisel bir sorununuz için yardım istemek		
Bir danışanınıza ondan duygusal ve fiziksel olarak etkilendiğinizi itiraf etmek		
Formel eğitimini almadığınız bir psikolojik testi veya terapi tekniğini uygulama yönergelerini okuyup uygulamak		
Danışanınıza ait özel bilgileri süpervizyon dışındaki bir ortamda paylaşmak		
Bir danışanınızla internetteki sosyal ağlar üzerinden iletişim kurmak		
Bir danışanınızın seansı sırasında onun önünde ağlamak		
Danışanınızın izni olmaksızın seansın ses kaydını tutmak		
Test uyguladığınız bir danışanınızın (ya da ailesinin) talebi üzerine testin ham datasını danışanınıza (ya da ailesine) vermek		
Maddi durumu iyi olan bir danışanınızdan karşılayabileceğini düşündüğünüz için daha yüksek seans ücreti talep etmek		