Ethics as a Located Story: A Comparison of North American and Cuban Clinical Ethics

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Theory Psychology 2002 12: 533
DOI: 10.1177/0959354302012004298

Ethics as a Located Story

A Comparison of North American and Cuban Clinical Ethics

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Abstract. This paper provides a comparative perspective on applied professional ethics. As part of a multi-site research project, findings from a qualitative interview study of Cuban psychologists were compared to findings from a similar study of psychologists and social workers in three Canadian human service settings. The comparison generates insights into the contingent nature of conceptions and applications of ethics: that is, the authors found that different 'stories' about the meaning of professional ethics derived from the different historical, political and economic relations of Cuba and North America. Such differences were manifested in the relation of the professional to the political, in collectivist versus individualist orientations to ethics, and in relationships between the personal and the professional. The authors contend that the importance of a comparative approach is that it encourages a reflexive attitude to ethics by unsettling the notion that there are universal prescriptions for ethics. In addition, the comparison opens space for including the dynamics of privilege, marginalization, power and resistance as crucial elements of the social construction of professional ethics.

Key Words: comparative ethics, culture, ethics, postmodern ethics, postmodern mental health

The purpose of this article is to report on the comparative meaning of ethics derived from a multi-site project on applied ethics. The importance of a comparative approach to ethics is that it enables the development of a reflexive position in relation to one's own location. Our comparison of Canadian and Cuban perspectives on ethics opens this space immediately when one is confronted with the contingency of professional ethics on

Theory & Psychology Copyright © 2002 Sage Publications. Vol. 12(4): 533–556
[0959-3543(200208)12:4;533–556;026298]

historical contexts. The hegemonic tendency of North American professional ethics is to position itself as the only story; we in North America have a difficult time entertaining the idea that professional ethics may not be universal, and that our version grows from our particularity. As an interruption to this imperialistic gesture, the Cuban data teach us that history gives rise to different versions of ethics—versions that may help us become more reflexive about our own.

Contrary to our own professional socialization, in which we tacitly consented to a kind of universal ethics, we learned that different stories of ethics emerge from time and place, from culture and history. In North America, against the background of the 'first world', our participants' perspectives on ethics were most immediately shaped by the current context of the neo-conservative agenda, with its disastrous consequences for funding of human services. Here, time, resources and safety organized the local parameters of ethics. Ethics is constructed within the relations of power of the particular location. In Cuba, the effects of the American embargo and the collapse of the Soviet Union ground the particular social relations of ethics in terms of isolation and extreme deprivation. But behind these local and particular renditions of ethics, the history, economics and politics of both Cuba and Canada profoundly shape the meanings of professional ethics. Cuban professional ethics are tied to its history as a colonized nation that underwent a socialist revolution and that daily opposes, while trying to survive, the crushing economic and ideological power of the United States. Canada, on the other hand, depends heavily on American conceptions of professional ethics, and such ethics have been constructed implicitly in relation to a national history of capitalist expansion within a persistent and shifting imperialist framework.

To set the stage for comparison, we clarify the historical perspective that grounds our understanding of contemporary North American professional ethics. Professional ethics in the US and Canada emerged in the context of the ascendance of professional power in society (Kultgen, 1988). The bureaucratic organization of rapid industrialization according to presumed scientific principles during the 20th century strengthened professionals' social status (Lenrow & Cowden, 1980). As professional groups expanded their domains of social influence, they succeeded in convincing industry and government that their knowledge was scientifically legitimate. Consequently, hegemonic processes created the belief that professionals are better equipped to solve personal and social problems than laypeople are, resulting in an asymmetrical relationship between professional and client. Even during the community mental health movement in the 1960s and 1970s, founded on the espoused principle of accountability to local citizens, mental health professionals engaged instead in paternalistic decision-making for the protection of the public (Walsh, 1988).

Like other professional groups claiming scientific foundations, clinical

psychologists inherited considerable social power over the human objects of their treatments. Although the overarching values of their profession encompass respecting human dignity and protecting human welfare, clinical psychologists have been trained to relate to the persons whom they serve and study from a supposedly value-free position of scientific detachment and neutrality (Hobbs, 1965). In striving for objectivity in professional relationships, psychologists have internalized what is in essence a paternalistic notion of detachment from the inherently value-laden and emotionally involving nature of clinical work. This epistemological position, endowed with societal prestige, has enabled professional psychologists to compartmentalize the professional from the personal (Brown, 1997).

The purpose of the development of professional codes of ethics was to protect the recipients of professionals' services, but the codes also had the effect of ensuring the legitimacy of professional groups (Kultgen, 1988). Psychologists' ethical guidelines, for example, were created initially to reassure the public regarding professional psychologists' competence (Pettifor, 1996). In 1953 the American Psychological Association (APA) published the first set of ethical standards for psychologists, based on a survey of actual professional activities and critical ethical incidents (Pope & Vetter, 1992); the latest revision appeared in 1992. However, the APA codes have been fundamentally problematic in several respects. First, the criterion for judgements about what was ethical lay in professional consensus derived from professional mores, that is, from what psychologists customarily did, not from explicit notions of morality and virtue (Hobbs, 1965). Second, implicit in the code was a steadfast faith in the ethical neutrality and objective vision of scientifically trained psychologists who are unaffected by human interests, values, ideologies and social locations (Brown, 1997). Third, the codes have been reactive in nature, directed at transgressors, rather than anticipatory, directed at improvement and prevention (Prilleltensky, Rossiter, & Walsh-Bowers, 1996). Finally, the codes focus on ethical norms for *practitioners* not on the ethical rights of *clients* receiving clinical services, such as the right to the least intrusive, least restrictive intervention and the right to refuse treatment (Tutty, 1990).

For decades, Canadian psychologists relied on the APA codes until they developed their own in 1986, later revised in 1991 (Canadian Psychological Association, 1992). Although in some ways similar, the Canadian code is distinct from the American in its four foundational principles derived from Kantian ethics (Pettifor, 1996). The intention of the CPA code is for professional psychologists to rely upon an understanding of the relevant principles and their respective values, which then in turn are used as the basis for ethical decision-making in relation to specific standards. Thus, each principle subsumes common ethical values that clinicians ought to consider, from which particular guidelines flow. Nevertheless, like its APA predecessors, the CPA code is focused on professionals' perspectives and privileges

rather than acknowledging clients' rights, it positions psychologists' ethical responsibilities to their community and society as least important, and fails to address the social and societal contexts in which ethical issues and dilemmas actually are played out. As our account of professional ethics as a located story makes clear, psychologists' workaday, ethical decision-making is fraught with complex economic, political, institutional, organizational and interpersonal realities rather than a detached exercise of cognitive problem-solving.

Method

Our interpretations are based on a series of studies that took place in Canada and Cuba. We conducted five separate studies in as many locations, with four sites in Canada and one in Cuba. In Canada, we explored the lived experience of ethics in a family counselling agency in a major city, in a social work department of a hospital in a small city, in a child guidance clinic in a mid-size city, and in a feminist collective in Ontario. In Cuba, we interviewed participants who were gathered in a major city for a psychology conference. The findings from these studies have either been published or submitted for publication. We refer to them below.

In the present article we concentrate on the comparative meaning of ethics across two cultures. Based on the entire corpus of our work we strive to understand applied ethics in cultural context. The starting-point for this article is the end-point of our reflections based on previous research and our theoretical orientation. To contextualize our theorizing in the current essay, we review the philosophical foundations of our work and the lessons we derived from immersing ourselves in the lived experience of ethics of close to 80 participants. But first, a few words about the origins of the entire project.

As former clinicians and current educators in the mental health professions, the three of us, one social worker and two psychologists, shared the feeling that the resources available to deal with ethical dilemmas were inadequate. Conceptual models of applied ethics failed to reflect on the role of power in professional relationships, and codes of ethics and prescriptive frameworks defined the subject matter in narrow terms, excluding the social and political context in which ethics are lived. To our mind, several of the shortcomings in the ethics literature derived from an over-reliance on cognitive models of decision-making that neglected the lived experience of ethics. We were uncomfortable both with the explanatory models put forth for ethical dilemmas and with their implications for action. Such was our point of departure. With these thoughts in mind we set out to explore the lived experience of ethics to obtain a rich picture of what ethics was all about for mental health workers. We hoped that a phenomenological and

grounded approach would throw light on the strengths and weaknesses of the existing literature. The investigations were based on two primary needs: first, the need to understand applied ethics from the perspective of the lived experience of workers; and, second, the need to understand how conceptions of ethics are related to culture and society.

Much of our discomfort at the outset of this project could be explained by our theoretical orientation. In the next section we make clear our thinking on applied ethics, our dissatisfaction with the resources available, and the lessons we gathered along the way. Following that brief review, we present a series of postulates concerning the comparative meaning of ethics.

Conceptual Orientation

Current models of applied ethics tend to define the subject in narrow terms and do not take sufficiently into account the contexts in which ethical dilemmas occur (Attig, 1995; Bowden, 1997; Brown, 1997; Bursztajn, Gutheil, & Cummins, 1987; Chambliss, 1996; Dokecki, 1996; Kitchener, 1996; Prilleltensky et al., 1996; Trevino, 1987; Wegener, 1996). In order to develop more useful models of applied ethics, we investigated the lived experience of ethics with several groups of service providers in the human service and mental health fields in North America and Cuba. We used the data from Cuba to understand ethics in a vastly different culture and to re-evaluate our own models of ethics in light of cross-cultural perspectives.

Our conceptual orientation is informed by grounded, contextual, critical and feminist approaches. While statements of values and principles abound, descriptions of lived experiences of ethics are scarce. Some exceptions include research by Chambliss (1996), Holland and Kilpatrick (1991), and Reiser, Bursztajn, Appelbaum and Gutheil (1987). Research identifying ethical concerns faced by psychologists comes closer to our goal of obtaining grounded input (Pope, Tabachnick, & Keith-Spiegel, 1987; Pope & Vetter, 1992), but that line of inquiry does not delve into the subjective experience of the clinicians or into the organizational contexts of the dilemmas.

Accounts documenting the daily ethical struggles of professionals are missing. Professionals do not see themselves readily reflected in the literature because it is based on either aspirational statements (e.g. Clark & Abeles, 1994; Garfat & Ricks, 1995) or simplified research vignettes (e.g. Seitz & O'Neill, 1996). A grounded methodology suggests that theory-building requires the input of lived experiences. Our research confirms that lived experience must be taken into account when analyzing ethical dilemmas. Issues of power, safety, control, dialogue and communication permeated our data. In the absence of safety and trust, clinicians do not feel comfortable to reveal doubts and weaknesses. As a result, all the cognitive models of ethical decision-making are of limited value.

The second source of our thinking is contextual theory, according to which ethics are constructed by culture and social location. We could not automatically transfer principles from North America to Cuba, or vice versa. We seek knowledge that is culturally specific. We try to answer Toulmin's (1996a) call for an approach to applied ethics that is particular not universal, local not general, timely not eternal and—above all—concrete not abstract. The analysis that follows shows that indeed Cuban conceptions of ethics differ markedly from those of North Americans.

The third influence that shapes our thinking is critical theory. Critical theory advances a concrete epistemology as well as a moral philosophy. From an explanatory point of view, it postulates that human interaction can be rendered intelligible only when power differentials are taken into account. From a moral point of view, it claims that the Good Life and the Good Society are predicated on equality, fairness and justice (Geuss, 1981; Gustavsen, 1996; Habermas, 1990; Richardson & Fowers, 1997). Our findings revealed that most clinicians in North America do not incorporate a justice framework in their work.

Feminists (e.g. Hare-Mustin & Marecek, 1997; Wilkinson, 1997) and gay and lesbian psychologists (e.g. Kitzinger, 1997) have documented the abuse sustained by women and gays and lesbians in the hands of caring professionals. The history of the helping professions is replete with examples of abuses of power. These abuses provide ample argumentation against the romantic notion that professionals can overcome personal interests for the sake of the public. In a culture that glorifies individual success and personal gratification above all else, professionals are at definite risk for engaging in abusive behavior (DeVaris, 1994; Dineen, 1996; Dokecki, 1996; Mack, 1994; Pilgrim, 1992; Spinelli, 1994). Critical of institutional arrangements that perpetuate patriarchy and inequality, feminists strive to deconstruct the machinery of oppression and to turn it into tools for mutual respect and dignity (Bowden, 1997; Haraway, 1988; Lather, 1991; Maynard & Purvis, 1994). Thus, like critical theory, the project of feminism also has the dual objectives of explanation and transformation. In our research, we use feminist resources to sensitize us to gender and racial discrimination inherent in professional helping relationships. In most of our sites we noticed a lack of explicit policies or theories regarding gender and racial discrimination in the workplace.

In essence, we are involved in the process of formulating a framework of applied ethics that is informed by grounded, critical and feminist theory, and that emphasizes the need for context-sensitive knowledge (Bowden, 1997; Chambliss, 1996; Fox & Prilleltensky, 1997; Gustavsen, 1996; Kincheloe & McLaren, 1994; Morrow, 1994; Toulmin, 1996a, 1996b). In order to enliven and refine our emerging conceptualizations, we need grounded input from people involved in the helping encounter.

Research Objectives, Methodology and Analysis

Our research in Canada and Cuba had a theoretical as well as an applied objective. As a theoretical project, the research was intended to contribute to the development of theory and to the creation of relevant and useful ethical frameworks. As an applied research project, the research inquired about clinicians' (a) general concepts of applied ethics, (b) values, (c) ethical challenges, (d) ethical resources and impediments, and (e) recommendations for maintaining or improving ethical decision-making processes.

Individual Interviews and Focus Groups

We used a qualitative methodology to elicit from participants their perspectives on applied ethics. We organized semi-structured interviews and focus groups to parallel the research objectives. In Canada we conducted primarily individual interviews, whereas in Cuba we also used focus groups. In all cases we asked questions about concepts of ethics, values, dilemmas, resources, barriers and recommendations. The main questions were: *What does ethics mean to you in your work? What values guide your practice? What type of ethical dilemmas do you encounter in your job? What barriers do you encounter in attempts to resolve ethical dilemmas? What resources help you resolve ethical dilemmas?* And *What recommendations can you make at the personal, professional and organizational levels for improving ethical thinking and action?* Workers were encouraged to provide concrete examples of their struggles and not to remain at a conceptual level. This facilitated a phenomenological understanding of their dilemmas. With participants' permission, each interview was tape-recorded and later transcribed. In Cuba, all interviews and focus groups were conducted in Spanish.

Participants

A total of 28 people were interviewed in Cuba; 15 on an individual basis, and 13 in four different focus groups. In Canada, we interviewed workers in four different settings. In total, we interviewed over 50 mental health workers in Canada, most of them psychologists and social workers. The individual interviews had a duration of 40 to 60 minutes and the focus groups in Cuba met for an average of one and a half hours. Participants in Cuba were from four different regions. In Canada, participants were from two provinces. Most participants were in clinical, health and educational settings, with a few working in community settings.

Data Analysis

Transcripts of the interviews and focus groups were read line by line, and themes related to the six questions and objectives of the research (concepts, values, dilemmas, resources, limitations, recommendations) were identified. Potential quotes were selected during the third reading of the transcribed interviews. A second level of categorization was grouping the themes under a particular category. In all cases the researchers read the transcripts separately and then came together for discussion and analysis. The conclusions reflect the collaboration among the researchers. For different projects we included the respective research assistants in the discussions. In the case of the Cuban project we invited two of our participants to come to Canada to discuss with us our findings. They helped in corroborating our emerging impressions of the material. We held several meetings where our ideas about comparative ethics took shape. One of us, Isaac, helped in the process of translating between English and Spanish. The meaning of the data was discussed during intensive and extensive consultations between the authors and the two Cuban key informants.

Our analysis was not limited to the identification of themes as represented in the interviews and focus groups, but rather included a critical analysis of what was reported in the research. In other words, we examined participants' narratives in light of the conceptual framework of critical and feminist theory described above. Although we did our best to represent accurately what participants said and felt, we went a step beyond that level of analysis and critiqued their renditions of ethics. Thus, in this paper we report not only what people perceived, but also our own interpretations of their renditions. Our voice is not meant to undermine the voice of participants, but rather to place the narratives in a critical context. After reflecting on all of our material, we thought that it would be important to develop a theoretical integration on ethics on the basis of a cross-cultural perspective. This essay relies on our data from two countries to understand the limits of our own beliefs.

Comparative Meanings of Ethics

In this section, we examine three overarching themes that emerged in our interpretation of our data: the relationship of ethics to practice; individual vs collective orientations to ethics; and the nature of ethics with respect to personal and professional domains. We trace some of the different meanings of ethics in the hopes of unsettling any universal prescription for ethics, and of opening space for reflecting on how dimensions of privilege and marginalization, of power and resistance can enrich our understanding of ethics. In other words, the goal of our comparison is to extend our consciousness about our own location in questions of professional ethics.

Ethics in Relation to Practice

We begin with a basic difference in orientation to ethics. When asked to explain what ethics means to one typical Canadian participant in her daily work, she replied:

> In my daily work I . . . I guess I er . . . I don't know that I give it conscious thought, but I try to maintain a certain level of standard in my practice. Sort of across the board. So when I'm working with children or working with parents, I'm aware that I need to adhere to certain principles, I guess, and make sure that I'm delivering quality service.

We notice in this quote two aspects that were thematic in our Canadian data. First, ethics is perceived as an entity that is split from practice. It is an add-on: something one applies to practice. Second, it consists of principles to which one adheres; it is a rule. In this sense, ethics is associated with technique. Most of our Canadian participants formally described ethics as a set of technical procedures, involving the code of ethics and rules on its administration that are designed to resolve an ethical dilemma. In this way, ethics is present when a conflict about ethical principles arises, and there are technical solutions that can be applied in order to produce an ethical outcome.

Indeed, in the Canadian sites we investigated, the organization's expectation of the outcome of the study was a better technical, pragmatic approach to ethics. Managers were interested in this outcome as a way to avoid ethics problems that might affect the reputation or the security of the organization. In fact, we could characterize this orientation to ethics as ways of getting rid of problems. This approach was particularly evident in the ways that managerialism organizes ethics as damage control in the agencies we studied. Ife (1997) describes managerialism as a belief that good management is able to solve the problems of human service organizations, and will make them more effective and efficient. Ethics within managerialism becomes a way of avoiding wrong-doing.

However, Canadian practitioners also described personal frustration with technical approaches, advocating instead for dialogue and reflection rather than a rule orientation. Reflection and dialogue, however, were difficult to achieve in the political climates of hierarchical organizations where the job and professional security of workers could be put at risk by challenging the orientation of ethics as organizational protection. Yet even with workers who advocated for reflection and dialogue as opposed to a rule orientation, the outcome of ethics was still oriented to resolution of dilemmas, that is, ethics consisted of solving a problem.

Our Canadian participants rarely mentioned a national, historical or economic context to their practices. Their understanding of ethics seemed to be derived from the context of professions that are severed from their social and political roots, where ethics is compartmentalized as a source of codes

and techniques for solutions. The Canadians frequently reported that the possibility of implementing this approach to ethics was often confounded by the immediate politics of their particular situation, but societal politics and ethics evidently were viewed as separate domains.

In Cuba, the response to questions concerning the meaning of ethics was: 'ethics is the foundation of psychology' and 'human beings are defined by ethics; there is no behavior, there is nothing in our thinking where morals are not involved'. In this response, psychology is viewed as a practice of ethics rendered through a psychological orientation. That is, at a *personal* level, ethics are a unity of affective and cognitive activities of reflection that ideally guide the mental health worker's actions in all areas of his or her life. The Cubans' 'psychology of ethics' seems to reflect a holistic, dialectical framework. By contrast, when any of our Canadian participants referred to the psychological processes at work in contemplating ethics, he or she described them strictly in terms of cognitive problem-solving language, as in the *de rigeur* North American term 'ethical decision-making'. The reader should note, however, that our Cuban and Canadian data do not tell us how these mental health workers concretely make ethical decisions.

The Cuban notion that ethics is the foundation of practice is in turn consequent on the sense in which there is a shared national morality. One Cuban participant explained as follows:

> We are a society that is rooted in a Marxist-Leninist ideology. So the concepts of democracy and equality help us shape our thinking, our point of view on any subject. Also, the political conviction of our people, the political/ideological preparation given to us from birth, I think this also helps us to promote these values.

One of our informants summed up the Cuban perspective on ethics with the word 'solidarity'. She cited a study on values she conducted in which the only value that all participants mentioned was solidarity. This shared value extends from a shared history. She stated:

> Dignity in the Cuban people is very much linked to national pride: that is, there is a strong root to his/her nationality, the pride to know their history. . . . Cubans feel themselves very attached to their social project, very much a part of their social project, and this gives their life meaning, gives them dignity, and it gives them this national pride.

We want to emphasize the difference between an ethics premised on solidarity and an ethics that focuses on ethical outcomes of dilemmas. This difference underscores different manifestations of ethics in Cuba and Canada. In the Cuban orientation, an ethics of solidarity creates practice as a social contribution towards national values. In Canada, outcome-based ethics constructs practice as a neutral professional endeavor where ethical conflicts are solved through the application of methods for resolving such conflicts.

An example of the problem orientation of professional ethics in North America can be seen in a recent book for social workers. The book provides guidance on how to define the ethical problem; gather information; mobilize theories, the code of ethics and values; and produce options from which one decides on resolution. Problem definition is the first step: because in social work ethical issues are usually embedded in complex personal or social issues, one of the most difficult tasks in ethical decision-making is focusing on the problem that must be addressed (Rothman, 1998, p. 168). An ethical dilemma and its technical resolution are the field of ethics. In comparison, González Serra (1997) characterizes Cuban ethics as follows:

> We consider that psychological science cannot be reduced to simple knowledge or a technique, rather it has to have moral goals and make efforts to form people and a society that is spiritually superior in creativity, independence, humanism, compassion with the humble, and patriotism, at the same time promoting national and regional identity. (p. 168)

In this quote, the broad conception of professional ethics as rooted in national, spiritual and social justice dimensions is evident, and contrasts sharply with the prescriptive notion of professional ethics found in North America.

Collectivist vs Individualist Orientations

The historical context of professional practice gives rise to different conceptions of the goals of practice. The Cubans define practice against the background of socialist values, which entails a collectivist perspective that connects individual welfare to community and nation, which is the ground of practice ethics. In contrast, Canadian practitioners formulate goals in terms of the betterment of individuals through respectful treatment by the individual practitioner. This approach involves respect for autonomy, dignity and empowerment of the individual. Although the Cubans subscribe to the same values concerning the individual, the operationalization of them is tied to larger society, not just the client/professional relationship. That is, respect and empathy in the helping relationship are intended to evoke and produce justice.

As would be expected from a socialist orientation, the Cubans lean toward a structural view of personal troubles as a manifestation of public issues. This difference led informants to define their job as attempting to implement the values of the revolution in everyday life. In this definition, democratic values and individual well-being are interconnected. What is striking here is the way that Cubans' practice is value-based, with particular reference to social justice as a precondition for individual well-being. The spiritual health of the community is the concern of the mental health worker.

Canadians, on the other hand, were more focused on individual diagnosis and on pathology as arising from individual dysfunction among their

clientele. In the Canadian context, although our data on this point are indirect, democratic values are associated strictly with voting rights, rather than quotidian ethics. When discussions of government, nation or community took place, it was primarily a discussion of government policies with respect to cutbacks and to the current neo-conservative climate in Canada. We had no sense that community or national ideals guided our participants' practice. Clinical work involved individual clients' problems where individual solutions were applied as if the economic, social and community context in which the problem was embedded was neutral or invisible.

These different understandings of practice inform a different sensibility about methods. The Cubans regarded a dialectical process of self-criticism as the primary method of practicing ethics. For example, one participant described her work in a factory where workers were dissatisfied with management practices. She encouraged the factory personnel to create a theatrical representation of a meeting, where participants took the roles of workers and managers. Discussions of the drama ensued, where actors became aware of dynamics that led to worker dissatisfaction. In this situation we see practice as embedded in ethics, and ethics carried out though critical reflective processes.

On the other hand, the Cubans tended to see themselves as less sophisticated in the area of professional ethics. Some of the Cubans psychologists, for instance, expressed the need to formalize ethics within Cuban psychology by creating ethics courses, establishing ethics committees in work sites and developing a Cuban code of ethics. It is tempting to interpret these desires as adopting the dominant North American professional ethics discourses, thus failing to resist hegemonic influences of North American psychology. However, one psychologist told us that, 'I don't think it is helpful to extrapolate an ethics code from another country to ours. The psychology needs to be particular in terms of how to practice it where you live, according to what surrounds you professionally.' This quote illustrates the fundamental tension for Cuban practitioners in the pull between the attraction to professional discourses of North American orientations and the need to retain a uniquely Cuban perspective.

Canadian practitioners, after socialization in the relevant, professional code of ethics, have internalized the professional discourses of ethics, which locate clinical ethics in a monadically deliberating subject/practitioner. Cognizant of the potential for their supervisors to use the code to evaluate their professional behavior, individual practitioners consult the code and ideally implement methods for prioritizing the ethical imperatives found therein. Yet despite being organized at a formal level by this dominant professional ethics discourse, Canadians talked about the need to engage in critical reflection about clinical ethics, and they reported that such talk in the current practice context is marginal. Canadian practitioners described the open dialogue they required as having no 'official' space in their agencies.

Indeed, there was a gap between the image of the professional who consults the code and makes a decision, and the reality that practitioners needed reflective dialogue in order to deal with ethical dilemmas.

It is interesting that reflective dialogue, as the method valued by both Canadian and Cuban practitioners, was seen in both contexts as carrying risk. In Canada, the need to talk about ethical dilemmas could signal professional incompetence to managers. Disclosing the need required exposing the uncertainty or doubt in a context of job insecurity due to funding cutbacks and bureaucratic pressures on clinical supervisors and their staff to do more with less. The Canadian practitioner ideally '*should*' manage clients with little fuss by applying ethics rules where doubt exists. Canadian practitioners were caught between a silencing pressure to avoid getting their agency in trouble and the need to speak openly about ethical dilemmas.

In Cuba, however, risk exists in two ways. First, open dialogue is truncated by pressure to conform. One must be seen to be a proponent of the values of the revolution, where those values can be judged and found wanting by others in the bureaucracy who are in a position to further their own interests by making negative judgements. There was some indication that judgements about adherence to the values of the revolution interact with hierarchies in employment contexts (i.e. bosses or supervisors) in ways that heighten the perception of risk involved in speaking openly. Thus, the need to placate power interests by silencing complexity curtails open dialogue for Cuban practitioners. Second, Cubans are always aware of the need to maintain solidarity in the face of the massive power of the United States. In this kind of climate, it is difficult to negotiate open dialogue and democratic speech when solidarity and dissidence are in question. Indeed, we were constantly aware in our interviews of the possibility of putting our respondents at risk by encouraging them to be open.

The Personal and Professional Relation

An important comparison in Cuban and North American perspectives is evident in how both groups talked about the place of their profession in their lives. Cubans tended to make less distinction between personal (private) and professional (public) values. Indeed, they stressed the importance of practice as a holistic phenomenon that explicitly combines personal, political, spiritual and professional dimensions. For example: 'The profession is a system of knowledge; it's also a method, and a way of life as well. I don't stop being a psychologist when I leave my office or leave the hospital; rather, I am actually a psychologist in life.' Here, our informant speaks of psychology as part of his personal values—values that have been shaped by the political context of Cuba. His personal values are enacted through his work as a psychologist. Indeed, he goes on to say, 'I am immensely proud of my life's trajectory, and I am very poor.' His profession is more than his

occupation. It is the way he acts on his social, political, spiritual and moral commitments, and he values the gifts these commitments make to himself and others, despite the fact that there is little financial gain in the practice of psychology in Cuba. In short, the work of the psychologist is explicitly for the public good, where public and private are seen as inextricable.

In Canada, practitioners spoke very differently about their profession. We heard very little that suggested that Canadians view their professional work as an extension of social/political values. Canadian practitioners value ethical practice and aspired to be both competent and ethical practitioners. Yet the role of practitioner was limited to one's occupation and much of its meaning is associated with high-caliber performance of the occupation; work is guided by the particular profession's ethics code and by the professional responsibility to do a good job. Here, doing a good job is associated with helping individual client or client groups. In our interviews with Canadian practitioners, we heard very little discussion of how the occupation contributes to the larger context. Personal, political and social values were rarely talked about in the context of the interviews; they did not seem to belong within the discourse of helping individuals. We believe that many of our participants held deep convictions about the larger political and social contexts—but there seemed to be no forms of talk that imbricated social with individual goals. Thus, practitioners' social convictions were relegated to the domain of the private citizen, kept separate from the public, professional role.

For Canadians, whose goal of practice is helping individuals, the purpose of ethics remains individualistic. Professional ethics becomes a way of avoiding doing harm rather than shaping how one actively contributes to the world. One participant, who, when asked how she thought about ethics, made reference to the code of ethics and talked about how the code acts as a form of self-regulation:

> Well, because I feel that if I violate one of them, then I'm in big trouble and I won't be able to have a job and I won't be able to work. Like they're very important as far as the punitive aspects that could happen to you.

Yet with the code of ethics as her sole reference for ethics, she goes on to say, when asked how she uses the code as a resource:

> I guess only at the beginning when you start out and you do a year of provisional license with somebody supervising you, these things are laid out. To tell you the truth I might have looked at them once since then, but I couldn't even tell you what they are off the top of my head, but I do know that I believe in them.

The kinds of ethical principles alluded to by this worker and others in our study involve issues of confidentiality, self-determination, respect for the client, and so on. These are generated from codes of ethics that primarily

regulate individual professionals' conduct with respect to individual clients. Thus, Canadian professionals in our study used ethics as a kind of technology to avoid wrong-doing between individuals engaged in a private interaction. This contrasts with Cuban ethics as principles directly related to the achievement of social ideals.

The differences in boundaries between personal (private) and professional (public) are also evident in how Cubans and North Americans understand the meaning of professional relationships with clients. As noted above, both Cubans and North Americans believe that the therapeutic relationship must be based on empathy and respect. However, for Cubans, the value within which these virtues take place is solidarity. This distinction means that Cuban mental health workers might be more likely, at least ideally, to see themselves as working alongside their clients rather than on behalf of them. Such a tendency is buttressed materially, because the income disparities between Cuban mental health workers—such as the psychologists in our study—and their clients are minimal. However, at the level of practice, we do not have enough data to enable us to understand specifically how power plays out in therapeutic relationships in Cuba, and we do not wish to make the naïve claim that such relationships are fundamentally egalitarian.

Canadian practitioners enact the values of empathy and respect from a different perspective. Here, the professional orchestrates the rectification of problems, but does not see himself/herself necessarily in a relationship of political solidarity with the client. We heard little to suggest that Canadian practitioners saw their work as ultimately a route to creating a better society for clients and themselves as citizens affected by the same social order. Indeed, Canadian practitioners were more likely to view their work altruistically as 'helping others in need', of performing work with the sole goal of alleviating individual distress. Empathy and respect are seen as part of the technology of helping, rather than a necessity for relations of solidarity. An exception to this tendency would be North American feminist psychology, critical psychology and postmodernist positions in social work, but these critical perspectives have been developed as reactions against dominant discourses in psychology and social work, respectively. In general, our data point to the tendency of Cubans to construct professional ethics as connected to public good, and for Canadians to frame ethics as helping individuals.

Finally, the Cuban value of solidarity has implications for the therapeutic relationship. With their professional intention extending to building a better society, Cuban practitioners have a personal stake in the outcome of their work. They live in the society they support and enhance through their profession. In North America there is less of a sense that contributions to individual welfare affect the social fabric of which one is part. Individual welfare is the goal in itself, and its contribution to the common good is abstract.

Theoretical Integration

With comparisons of professional ethics in Cuba and North America in mind, we now gather together the threads of our discussion. We have made the point that our comparisons allow us to focus on our own location with a reflexive vision that can enable exploration of our own limitations and potentials from a different perspective. The point of our comparison is not to claim that we *know* the Cuban orientation to ethics, nor to claim that we *know* North American reality because we are insiders. We are aware that we have interpreted our Cuban data through the lens of our own critical view of North American practices. Our interpretation is undoubtedly romanticized by the fact that our data consist of espoused ethics rather than practiced ethics and that the espoused ethics of Cubans dovetails neatly with our critique of North American professional ethics. In addition, we cannot address from these data the nature of the helping relationship in Cuba vis-à-vis North America. Our interview content in all settings focused on the ideological, organizational and interpersonal context of ethical practice, not on what takes place in the clinical relationship. However, we certainly can discuss the social role of the clinician in the two cultures. More specifically, we attempt to make a contribution to the issue of the identity of professional ethics in relation to political culture. Highlighting the social role of clinicians allows us to reflect on our conflicted position within our own location. In our interpretation, we reflect from our position as professionals who work from a critical perspective in the hopes of aligning clinical work with social justice.

Social Justice in Comparative Contexts

A reprise from one interview illustrates how feelings were triggered in us that promoted reflection. The participant said, 'I am immensely proud of my life's trajectory and I am very poor.' The feeling we had in response to this statement was envy. We would like to be able to look at our careers in practice, scholarship and teaching with such immense pride, but find ourselves confronted with our own ambivalence about our relationship to the mental health professions. It is here that privilege and power become indeed complicated. We authors are not at all poor. We have access to resources, money, assistance, facilities and technology that is impossible in Cuba. North American professionals might regard themselves as quite privileged in relation to their Cuban colleagues, who struggle with meager resources, state controls and institutional constraints. Yet we *felt* poor at personal and spiritual levels. The Cubans manifested a creative energy about their work that sprang from a sense of harmony between national, community, professional and personal ideals. In other words, while we had the privilege of resources and wealth from our location in the first world, Cubans had the

resources of a greater integration between self and profession (notwithstanding the tensions with respect to dissent and the attraction to the power and privilege of North American psychology). In articulating this difference, however, we do not mean to characterize Cubans as poor but happy. We are not so arrogant as to deny the tensions and threats that arise from Cuba's current economic crisis, and we will discuss some of the implications of this state of affairs later. But we were interested in exploring the personal commitment to creating a better society that our colleagues believed they were making through their profession, because we were confronted by comparison with our own ambivalence about the nature of our professions' social contribution.

An incident that occurred during our key informants' visit to Toronto illustrates this issue. We took our colleagues to a local, community service for immigrant and refugee women. The agency provides settlement assistance, language training, employment assistance, abuse counseling and other related services. One colleague asked about the role of psychology in the agency and was shocked by the Executive Director's response of 'Oh, no, that's like calling the police.' We, as North American professionals, understood the Director's response and were sympathetic to it, given our own experience with the disciplinary functions embedded in professional roles. We understood her fear that psychologists would emphasize pathology, attempt to rectify individual flaws, and assume the universality of Western culture. This would contradict the agency's stress on reducing isolation, promoting economic empowerment, identifying choices and valuing difference. Our colleague's shock woke us to the extent to which we understand professional disciplining of individuals as natural and normal. The incident triggered reflection on the development of conventional professional work within discourses of discipline and regulation rather than liberation and solidarity, and forced us to acknowledge the ways in which the normal practice of ethics in North American settings is oppressive for ordinary professionals because of the ways that discipline and care interpenetrate.

Michel Foucault (1979, 1997) documented the development of modern power as a means of producing consent—of creating a citizenry that is obedient to power while simultaneously understanding itself as free. By examining how professional knowledge grew in relation to the development of such forms as prisons, asylums and clinics, Foucault claimed that professional knowledge created categories of normal and abnormal, thus installing particular forms of obedience in the individual. Professional knowledge is part of a history where self-government came to replace external force, and human service professionals, while helping, worked to create citizens who were fit for and consented to the prevailing social order.

The legacy for North American professionals is our location in the apparatus of modern power. We in North America live out this place in

power at great cost: we know that the history of our professions raises troubling questions about our relationship to power, yet the discourses and forms of our professions leave very little room for consideration of how our professional actions are both shaped by power and give shape to power. When the response of the immigrant women's center to our informant's question about the role of the psychologist was to identify the control and discipline functions of professionals with respect to marginalized groups, we are confronted with the control functions we inherit with modern power. Thus, we have to acknowledge that we are operating with forms, discourses and historical agendas that may not be consistent with our values and aspirations. Modern power works in part by disguising obedience as individual will. It is in this space that the Cubans help us understand our depletion. Our self-understanding in global capitalism is that we act as individuals, yet the alternative glimpse afforded by our discussions with the Cubans is that the program for our professional actions is made in a history we are asked not to know. We are mystified by the way we find ourselves acting against our own beliefs and values by participating in professional activities that we also believe to be helpful.

Wittingly or not, in mental health service we wield professional power and control over our clientele, mediated by scientifically legitimated knowledge. It is within this sophisticated technology of surveillance of society's Others that we have constructed systems of ethical principles and permissible ethical discourse. When we take a critical position in relation to these systems, our values and beliefs are split from the forms and discourse of the professions. We wonder if this split takes a toll on creative energy.

We were struck with how our key informants presented the values of their nation, their personal values and their professional ethics as congruent (even as we acknowledge state pressure to present an ideal version). It was evident in our discussions that they were able to draw from a creative energy that seems possible only when one's personal aspirations find expression in public life. This creative energy comes from spiritual values concerning the worth of human beings and the worthiness of working towards values of dignity, equality and respect. We sensed a vibrancy about professional life that comes from an active engagement as a citizen, where the roles of professional and citizen are not split. The Cuban data serve to highlight the remarkable differences between the two cultures regarding the role of politics, in terms both of ideology, and of institutional structures and dynamics. The Cubans' understanding of political issues goes far beyond what North Americans refer to as 'office politics'. Indeed, what is striking for us is the Cubans' overt discussion of a collectivist vision for society as the crucible for their professional ethics (at least ideally). This consciousness stands in sharp contrast to the North American ignorance of macro factors impinging upon their clientele and upon ethical practice. It also contrasts with the tacit allegiance of North Americans to individualism.

The Problem of Speaking

Yet this ideal portrayal of integrated national, personal and professional values is troubled by issues related to speech and dissidence, and the way that censorship of speech in Cuba arises from its history and its current global position. Our Cuban participants were clear about the threatening effects of Cuba's economic position. It creates a double morality that troubles solidarity, and it stimulates envy of North American wealth, thus jeopardizing the values of the revolution. Cubans are in the untenable position of opposing the values of capitalism, while being exposed to its benefits. Cuba's burgeoning tourist industry makes first world lifestyles constantly visible, but more importantly, the overwhelming force of capitalist ideologies generated by the first world surrounds and threatens revolutionary goals. These threats lay the groundwork for the inhibition of democratic speech, because protection of the agenda of the revolution competes with dissent.

We were aware that the issue of censorship of speech pervaded our discussions and made certain topics unsafe. In this sense, the value of solidarity that seems liberating to us as a professional value has a dark side. Solidarity could exist as an ethic, but could also form the basis for censorship and for discipline and regulation through condemnation. Our Cuban colleagues described to us ways in which judgements on one's loyalty to the values of the revolution could be made by colleagues and superiors as ways of carrying out immediate and local political agendas. Thus, for example, a bureaucrat can block a promotion in an organization by calling the employee's values into question. This possibility contributes to a climate of repression and self-protection.

Yet again, comparison can lead to uncomplicated binaries such as 'repressed vs free'. Our encounters with the Cubans caused us to question the meaning of our own freedom of dissent and freedom to speak. What is the meaning of such freedom in a system where critical discourses are managed rather than repressed by power? In modern power, our claim that we can say anything is contaminated by the ways in which we regulate our own speech. For example, we easily rationalize standards of practice that reproduce containment and regulation of marginalized people by adhering to individualized standards of ethics, abstracted from interpersonal, institutional and corporate realities. These standards are the available discourses. The rationalization process works, in brief, as follows: North American mental health professionals learn to administer an ethics of surveillance within a complex system in which they themselves are administered. This type of professional identity-formation militates against transforming the conventional discourse of professional ethics to that of cultivating an active democracy that incorporates all citizens as full participants in socio-economic well-being, that is, like the Cubans' ideal. Thus, surveillance

works in different ways in both Cuban and North American professional contexts. Cubans are not free moral agents in intentional communicative processes because of the nature of confinement in solidarity. North Americans are free within highly regulated and mystified contexts.

The Pull of Professionalism

Our comparison of the differences with respect to democratic communication is put at risk when we consider the ways North Americans and Cubans take up professionalism in their respective contexts. It seems evident from our data that North American professionals take up the notion of professionalism unproblematically. The idea of expert knowledge, scientifically legitimated and rendered through specific skilled practices, is taken-for-granted common sense. However, we are aware through our own work that a substantial critique of the nature of professionalism is an easily available discourse, and one with which many North American professionals would have at least some acquaintance. Such critiques are regulated through their encapsulation as critical psychology or radical social work. Nevertheless, they are named and available, although we might argue that they may be seen by most professionals as beside the point or not relevant to their immediate concerns regarding practice.

In Cuba, however, we heard very little critique of professionalism. It may be that the rooting of professions in the radical values of the revolution makes such a critique redundant. However, in our view, the absence of conscious critique leaves Cubans without internal mechanisms for critically reflecting on mainstream mental health work. Thus, despite the holistic nature of the Cubans' orientations to ethics, practitioners advocated such resources as standard ethics committees, testing materials, access to North American research materials, and so on. We heard no evidence concerning how mainstream North American psychology or other helping professions might contradict the values of the revolution, nor did we hear much that suggested that professions in a formerly colonized, 'third world' country unconsciously may carry hegemonic tendencies.

For us, the most challenging insight derived from our experiences with our Cuban colleagues concerns our position with respect to North American conventions for mental health professionals. The two cultural groups take up progressive or critical professional work from fundamentally different positions. The Cubans see their work as exposing and remedying the gaps between social ideals and daily life experiences. They are insiders who defend their ideals from external threat. Those practicing from a critical perspective in North America, however, work in opposition to the reigning political culture, positioned as outsiders to the conventional professional culture, trying to exercise influence on the mainstream. Our work is always threatened by its proximity to the norms of the mainstream, which have

organizing effects, both internally and externally. Our imagination is structured by our political culture; thus, critical work demands that we work against ourselves in order to act from our political values. This constant necessity to work against the dominant structures of conventional professional approaches, and against the internalization of these structures, informs the subjectivity of those of us who work from critical perspectives.

The major question that we authors are left with concerns what sorts of support we might imagine can sustain work against dominant structures when one is also part of that dominant structure. It is sobering to contrast the creative energy of the Cubans with our own sense of chipping away at a Sisyphean task. Is our location in human service professions ultimately too disempowering to be politically viable? What is the most politically useful role for critical psychologists and social workers? Such questions are beyond the scope of this paper. Nevertheless, the dialogue with our Cuban colleagues has helped us gain a deeper understanding of the effects of our own location in North America on our version of professional ethics.

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ACKNOWLEDGEMENTS. This research was supported by a research grant from the Social Sciences and Humanities Research Council, awarded to Richard Walsh-Bowers, Amy Rossiter and Isaac Prilleltensky.

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