Portfolio Volume 1: Major Research Project

The Integration of Personal and Professional Ethical Decision Making Constructs in Trainee Clinical Psychologists

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Submitted to the University of Hertfordshire in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology

June 2018

Word Count: 28 536

Dedication

For Lily and Ellis

Never let barriers stop you from following your dreams.

Acknowledgements

I would like to say a huge thank you to my two supervisors, Dr Helen Ellis-Caird and Professor David Winter. Thank you for your encouragement at every step of the way. I plan to put all the learning I have gained from you about the research process to good future use. A massive thank you too to all the trainees who took the time to participate in this research, and to those who volunteered as trainee consultants. Finally, thank you to my family for supporting me through the ups and downs of this journey. Thank you, Chris, for making it possible to complete the conversion course, and to Mum and Dad for always being there.

Abstract

Ethical decision-making is an important but challenging aspect of the role of a clinical psychologist. Little research has been conducted concerning how clinical psychologists make ethical decisions, with even less known about how trainees manage the process during professional training. The current study aimed to examine how trainees make ethical decisions, and how this process differs between more and less experienced trainees. Thirty-nine trainee clinical psychologists were recruited from a total of 17 doctoral training programmes in the United Kingdom. The sample recruited was demographically similar to the training population. A cross-sectional design was used to examine differences between first year (n = 19) and third year (n = 20) trainees. An online version of The Defining Issues Test questionnaire (DIT-2, Rest et al., 1999) was used to measure level of sophistication of ethical development, and individual face to face or Skype repertory grid interviews examined the integration of trainees' personal and professional ethical decision-making construct subsystems. The vast majority of trainees were found to adopt a sophisticated approach to ethical decision-making, with half of all ethical decisions made from within a postconventional schematic approach. However, a small minority operated from within schemata based on maintenance of societal norms or personal interests. A deterioration in sophistication of thinking was demonstrated for more experienced trainees. Less experienced trainees were found to rely comparatively more heavily on their personal construct subsystems than more experienced trainees and vice versa. Increased integration between the subsystems over the course of training was demonstrated. The study demonstrates support for an acculturation process occurring throughout training. Implications of this and ideas for future research are discussed.

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CHAPTER I

Introduction

One of the most important aspects of the everyday work of a clinical psychologist concerns the need for effective ethical decision-making. This is an integral part of the role, but can also be a challenging part of routine practice. Although substantial research has been undertaken in this area with healthcare professionals more generally, little is known about how clinical psychologists approach ethical decision-making, and the underlying factors informing this process. Even less is known about trainee clinical psychologists' experiences of adapting to a new professional identity where complex ethical decision-making is required. I became interested in ethical decision-making as a research topic because of my own awareness concerning how hard I had personally found grappling with complex ethical scenarios during training, and an ongoing curiosity concerning how other trainees manage this process. The aim of this research is to help shed light on this important but under-researched area. By studying the process of ethical decision-making in trainees, this will help identify the type of support trainees need if they are to develop the requisite skills for managing ethical dilemmas in their future careers.

This introductory chapter will begin by outlining the epistemological position underpinning the study. Key terms are defined and the backdrop provided as to why further research in this area is warranted. The current body of literature is then reviewed, and a rationale provided for the aims and objectives of the research.

1.1 Background

1.1.1 Epistemological position. Epistemology is described as "the study of the nature of knowledge and the methods of obtaining it' (Burr, 2003, p.202). All researchers make assumptions about data, related to broader assumptions concerning the nature of knowledge and reality (Harper, 2011). It is therefore important that researchers consider their

epistemological position, as this will provide a philosophical grounding concerning forms of knowledge considered possible and legitimate in the scope of their research.

The epistemological position maintained throughout the current study is a realist position. This is because there is an existing substantial body of knowledge about ethical decision-making in healthcare professionals which can be taken as a solid basis upon which to build. A realist position is also in keeping with the generally held assumption of quantitative research methods that observable phenomena represent a form of reality. Alongside this, although the research makes no attempt to deconstruct the basis of assumed reality, there is the recognition that there are varying lenses through which knowledge can be perceived. The research therefore adopts a critical realist perspective, whereby data are not viewed as a direct mirroring of reality, contingent as they are on historical and societal contexts (Willig, 2012).

1.1.2 Key terms.

1.1.2.1. Clinical psychology: The current context. The role of a clinical psychologist is to "reduce psychological distress and to enhance and promote psychological well- being" (British Psychological Society; BPS, 2010, p. 3) through the application of knowledge acquired from psychological theory and research. Clinical psychologists in the United Kingdom (UK) work in a wide array of settings, including the National Health Service (NHS) and in private practice. As well as direct clinical work with individuals and groups, their role also includes supervision and research, plus indirect work such as consultation with professionals from statutory and voluntary services, and wider societal and political organisations.

1.1.2.2. Ethics and morals. The Oxford English Dictionary (2017) defines ethics as "moral principles that govern a person's behaviour or the conducting of an activity," and applied ethics are ethics exercised within the scope of professional practice (Beauchamp &

Childress, 2009). Within ethics literature there is considerable overlap between the terms ethics and morals, and for the purposes of clarity the term ethics will be consistently used throughout this account.

1.1.3 The importance of ethical decision-making in healthcare. A high standard of professionalism, which encompasses ethical behaviour, is expected of all healthcare professionals. Relevant standards include those set by institutional bodies such as the Department of Health and Social Care, who hold responsibility for healthcare policy and legislation in the UK. The National Institute for Health and Care Excellence also has a key role in setting evidence-based recommendations regarding standards expected for medical treatments and psychological therapy. Professional bodies too have responsibility, through setting out key ethical principles in their codes of practice. For clinical psychologists, this guidance is outlined in two documents: The Code of Ethics and Conduct produced by the British Psychological Society (2018a) and Standards of Conduct, Performance and Ethics from The Health and Care Professions Council (HCPC; 2017a).

Despite these high expectations of ethical conduct, there have been public examples where standards have fallen well below that expected. An example of this occurred at Winterbourne View, a private hospital for adults with intellectual disabilities. The fact that such extensive and prolonged physical and psychological abuse continued unabated until a television documentary exposé bears testament to the fact that there have been occasions where healthcare professionals have acted extremely unethically. Clinical psychology as a profession is not immune from episodes of malpractice; for example, a clinical psychologist working at the now obsolete charity Kids Company was suspended from practice for one year when it came to light that she shared Class A drugs with young people under her care ("Kids Company Psychologist," 2016).

Examples of extreme ethical malpractice such as these raise fundamental questions concerning how healthcare professionals can act so unethically, and where responsibility for wrongdoing lies. The paper 'Bad apples, bad cases, bad barrels' suggests that finding an answer to this question is more complicated than can be achieved through merely considering an individual's personal characteristics (Kish-Gephart, Harrison & Treviño, 2010). The authors assert that there are a range of influencing factors to consider, including the characteristics of the dilemma itself ('bad case') and the organisational environment ('bad barrel').

1.1.4 The challenge of ethical decision-making in everyday practice. Many questions remain, and much progress is to be made, in the quest to understand what leads healthcare professionals to make unethical decisions. Although undeniably shocking when they occur, examples as extreme as the ones cited here are thankfully rare. However, a challenging but very necessary aspect of daily work for all clinical psychologist concerns the ongoing commitment required to manage the complexity of everyday ethical decision-making. How then do clinical psychologists manage this challenging aspect of their role? In considering this question it is necessary to take into account knowledge attained from both psychological theory and empirical research.

1.2 Psychological ethical decision-making theory

A number of theories have been put forward with regards to the ethical decision-making process. Two more widely known of these include Kitchener's (1984) five ethical principles and Rest's (1979) developmental theory. These will both be outlined here, together with a personal construct account of ethical decision-making, the latter two approaches forming the basis of the methodology used in the current research.

1.2.1 Kitchener's five ethical principles. Kitchener (1984) adapted the work of Beauchamp and Childress (1979) conducted in bioethics and medicine for use in psychology.

The approach outlines five key ethical principles that can guide the ethical decision-making process. The first principle is autonomy, which concerns the promotion of freedom of choice, while also considering how personal autonomy can exert an impact on others. The second principle is non-maleficence, which refers to not causing harm, either intentionally or via the undertaking of actions putting others at risk. Beneficence is the third principle, which entails working towards improving others' welfare. The principle of justice involves acting in a fair manner to all, and attending to individual differences as part of this process. The final principle is fidelity, which involves showing loyalty to commitments and assurances given to others. Kitchener suggests that referring to these overarching principles can help clarify the actions needed when faced with an ethical decision; however, Urofsky, Engels and Engebretson (2009) highlight that there has been limited applicability of Kitchener's theory to the realms of research and practice, and that this could be linked to a lack of evolution of key concepts over time.

1.2.2 Rest's theory of ethical development. Rest's (1979) theory of ethical development was based on the work of Kohlberg (1958, 1963, 1984), who proposed a developmental model, suggesting that the reasoning process is central to ethical decision-making. Kohlberg's theory is based on schema theory which proposes mental representations in the mind known as schemata act as a framework for understanding everyday encounters (Bartlett, 1932; Piaget, 1932; Anderson, 1977). Rest and his colleagues shared this cognitive conceptualisation, taking the view that ethical principles are personally constructed and develop sequentially over time (Rest, 1986; Rest, Narvaez, Bebeau & Thoma, 1999a).

Rest (1979) suggested there are three schemata relevant to the development of ethical thinking. He proposed that during adolescence an awareness develops concerning societal roles, standards and establishments, leading to consideration of what he termed issues of "macro-morality" (Rest et al., 1999a, p.291) such as the distribution of wealth and power.

The three schemata are considered to represent issues of macro-morality at different developmental stages. It is suggested that when a child is utilising the personal interest schema in a moral dilemma, an approach of "micro-morality" (p. 291) is applied, weighing up how each person benefits and stands to lose from the decision made. This schema develops in infancy, and stops being central at around the age of 12. During adolescence, the maintaining norms schema develops alongside awareness of the need for duty led societal co-operation. The developmental model suggests that from late adolescence to adulthood there is a shift from conventional to postconventional thinking (Rest, Narvae, Thoma & Bebeau, 2000; Thoma, Bebeau & Narvaez, 2016). At the level of postconventional thinking, an individual recognises that societal relationships and laws can be negotiated in different ways and conventions are subject to alteration in the quest to establish shared ideals.

Rest suggested that an individual's ethical development can be assessed through a questionnaire named the Defining Issues Test (DIT). An updated version of the measure (DIT-2; Rest, Narvaez, Thoma & Bebeau, 1999b) requires the rating and ranking of 12 statements for each of five ethical dilemmas, shown from the perspective of the three schematic levels of ethical reasoning. The measure has often been used in ethical decision-making research (Bebeau, 2002). Research using the DIT summarised by Rest et al. (1999b) indicates that between 30-50% of variance in DIT scores is associated with level of education, and that sophistication of ethical thinking increases in response to educational intervention.

1.2.3 A personal construct theoretical account of ethical decision-making.

Personal construct psychology (PCP) was developed by George Kelly (1955) and proposes that people act as scientists, attempting to better understand themselves and the world in which they live through developing hypotheses and testing them out. Individuals develop their own unique theoretical frameworks known as personal construct systems and refer to

these when anticipating future events. Constructs are bipolar in nature because meaning is given to experiences through the noticing of similarities and differences. Individuals draw on their idiosyncratic constructs during decision-making (Winter & Procter, 2014). As construing is an active process, an individual's constructs are open to revision (Winter, 1992) depending on the degree of structure in the construct system: a tight system is more structured and a loose system less so.

Stojnov (1996) suggested that although Kelly did not devise a standalone theory of ethics, Kellian principles can be applied to provide a PCP account of ethical decision-making. From this perspective, ethical principles are not accepted as fixed and unchanging but, rather, an individual has an active role in developing their own ethical construct system. Ethical constructs are considered hierarchical in nature, with some being more central to core identity, and others more peripheral (Butt, 2000; Raskin & Debany, 2012). The outcome of this is that some ethical beliefs are more open to change than others. Raskin and Debany suggested that Kelly's circumspection, pre-emption and control (CPC) cycle can explain the ethical decision-making process. Circumspection involves an individual's surveying of available constructs when faced with a dilemma. Pre-emption is the assessment of which construct is most applicable and control relates to the process of alignment with one pole of the pre-empted construct.

PCP methods such as repertory grid technique can be used to measure construing of ethical dilemmas, through the elicitation of an individual's set of bipolar personal constructs. Winter's (1992) review of research related to therapists' construct systems highlights that repertory grid technique has been used in several studies focusing on changes occurring over the course of professional training (e.g. Gottesman, 1962; Lifschitz, 1974; Ryle & Breen, 1974).

1.3 Empirical research conducted with clinical psychologists

Little research to date on ethical decision-making has been conducted with clinical psychologists, most studies having considered psychologists of differing specialties together as one homogenous group. The most common theme within the literature for psychologists concerns the types of dilemmas they experience. Some articles consider individual therapist factors and environmental issues influencing decision-making, while others explore actions psychologists take in the face of a dilemma, or issues making decision-making more difficult.

1.3.1 Type of ethical dilemma. A number of articles highlight dilemmas psychologists find difficult. A study that looked at data collated from an ethics telephone helpline in Norway reported that confidentiality was the most commonly presented issue for psychologists (Dalen, 2006). Colnerud's (1997) survey of 147 Swedish psychologists and Wierzbicki, Siderits & Kuchan's (2012) study of psychologists making contact with a helpline also identified confidentiality as a main concern, along with issues related to dual relationships. Similarly, these were also found to be pressing issues identified in a survey carried out with just under 500 South African psychologists (Slack, Wassenaar & Douglas, 1999).

1.3.2 Individual psychologist factors. Several studies have examined the influence of psychologists' own personal beliefs on ethical decision-making. McGuire, Nieri, Abbott, Sheridan and Fisher's (1995) survey of over 600 psychologists from Florida found a significant relationship between the presence of homophobia and the chances of breaching confidentiality with HIV positive clients; however, in a further study by Keffala and Stone (1999), although the presence of homophobia was again demonstrated, the authors highlighted that psychologists' responses appeared to have followed a careful consideration of legal and ethical issues, and that homophobic tendencies therefore might not necessarily have been an influence.

Religious beliefs may also affect decision-making. A survey of 69 Christian psychologists from California indicated that they found dilemmas related to same-sex relationships and financial issues, e.g. late payment of fees, more difficult than psychologists more generally (Oordt, 1990). It is noteworthy that this study was conducted almost thirty years ago; therefore, findings may no longer be representative of contemporary Christian psychologists' views.

A further area seemingly influenced by personal beliefs is physician assisted suicide. Psychologists and psychiatrists surveyed in New Mexico indicated the action they would take in response to a client desiring assisted suicide tended to be in keeping with their own personal beliefs. A survey of over 200 American psychologists (Schenck, Lyman & Bodin, 2000) highlighted that they also appeared to be influenced by their personal histories: their own experience of corporal punishment was associated with recommendations they went on to make to parents on the issue. A Spanish survey of just over 700 psychologists also indicated that psychologists with personal experience of an identified dilemma judged potential ethical lapses by others in the same domain less harshly (Clemente, Espinosa & Urra, 2011).

Psychologist characteristics such as gender and preferred therapeutic modality have been found to influence perceptions of the appropriateness of non-sexual dual relationships. Authors of an American survey of over 200 psychologists found that female psychologists and psychologists from a psychodynamic orientation were more likely to rate dual relationships as unethical than male psychologists, and those practising from a cognitive or integrative approach (Baer & Murdock, 1995).

1.3.3 Environmental factors. In addition to the content of dilemmas themselves, environmental factors have been found to exert an influence on perceived dilemma severity. Dual relationships, such as multiple business relationships, and working with more than one

client from the same family, were of concern for American psychologists working in rural areas (Schank & Skovholt, 1997). Psychologists reported finding it hard to apply their professional code of practice to dilemmas such as these. Helbok, Marinelli and Walls (2006) also found small town and rural psychologists were more likely to experience multiple relationship dilemmas in their survey of 1000 American psychologists.

Ethical dilemmas related to social media were highlighted as a concern in an American study by Tunick, Mednick and Conroy (2011). They surveyed 246 trainee and qualified psychologists working with children and young people about their clients' social media activity, and found no obvious agreement concerning how matters of internet privacy and safety should be managed.

Differences between American and collectivist Chinese culture were explored in a study exploring responses to 20 ethical scenarios (Zheng, Gray, Zhu & Jiang, 2014). Results indicated that Chinese psychologists appeared less bound by uniform application of rules, and had a greater consideration of the impact of their decision-making on social relationships. The authors stress the importance of considering the potential impact of implicit cultural beliefs on the ethical decision-making process.

1.3.4 Action taken in response to dilemmas. Research indicates that psychologists vary in their responses to ethical dilemmas. A study of just under 300 American psychologists involving 10 vignettes (Haas, Malouf and Mayerson, 1986) found highest response agreement concerning the need to provide warning to potential targets of violence, and in the disapproval of trading therapy services for other professional services. There was less agreement about appropriate advertising of services and working beyond areas of professional expertise. There was also lack of concordance regarding whether a psychologist should report child sexual abuse, or ask someone else to take this action. A follow up article

by the same authors (1988) highlighted that psychologist gender, years of clinical experience and therapeutic orientation were associated with the actions chosen for some dilemmas.

A survey of over 200 Australian psychologists involving hypothetical ethical dilemmas related to funding issues (Politis & Knowles, 2013) indicated that the nature of the dilemma and whether the code of ethics was applicable were influencing factors. If the code could be applied, psychologists appeared more willing to follow through on the course of action they believed they should take.

1.3.5 Issues making ethical decisions more challenging. Duncan, Hall and Knowles (2015) interviewed 20 Australian psychologists about ethical dilemmas concerning breaching confidentiality with adolescent clients. They found that confidentiality dilemmas were perceived as more difficult due to the need to consider multiple issues. These dilemmas were perceived as a non-binary choice, requiring consideration of whether the client should be made aware of any intended disclosure, and the potential impact on the therapeutic relationship. There was also the weighing up of the severity of risk of immediate and more distant harm.

A further issue making decision-making more challenging was highlighted by Holaday and Yost (1995). Their research conducted in the United States with 22 psychologists involved a survey focusing on research related dilemmas, including issues related to authorship and plagiarism. They found that departmental power differentials contributed to distress concerning ethical issues, particularly when individuals in authority suggested unethical actions.

A grounded theory study of 20 Canadian psychologists (Mackay & O'Neill, 1992) indicated that although dilemmas involving conflict arising from differing ethical principles were difficult, those found most challenging were those involving uncontrollable external factors, e.g. legal issues, and employer and contractual commitments.

1.3.6 Summary of qualified psychologist literature. Very little research has been published in relation to the ethical decision-making process of clinical psychologists. Most studies originate from the United States, with none available from the UK, raising a question concerning the generalisability of findings.

The research published indicates that psychologists can find it difficult to make ethical decisions. Particularly difficult dilemmas include those related to confidentiality and dual relationships. There is also some evidence that decision-making may be influenced by psychologists' personal characteristics and biases associated with their own personal life histories and belief systems. There is a small amount of literature related to environmental factors such as geographical location, the online environment, and cultural differences. Overall, very little research is available related to the actual decision-making process itself, and the factors that inform this.

As ethical decision-making is known to be such a complex and difficult task, how do clinical psychologists attempt to engage with and manage this process? One model that has been proposed to explain this is based on the process of acculturation (Berry & Kim, 1988).

1.4 Acculturation and the ethical decision-making process

The ethics acculturation model suggests that how psychologists understand the professional values of their role and integrate these with their own ethical values is important. Handelsman, Gottlieb and Knapp (2005) suggested that psychologists associate to a greater or lesser extent with their personal or professional values, and that this leads to four possible acculturation strategies.

The optimum strategy is an integrated approach whereby the ethics of the psychology profession are adopted while still maintaining a strong sense of personal ethics; however, the person who is low in affiliation with their previous personal values and over-identifies with professional standards may adopt an 'assimilation' strategy. This entails showing an

excessive allegiance to authority and can result in a failure to appreciate imitations in the applicability of professional codes. A 'separation' strategy arises when a psychologist strongly affiliates with a set of personal values but identifies less with the professional values of psychology. This individual may see their own morals as sufficient, with no perceived need for any additional standards offered by the psychology profession; this could lead them to indiscriminately apply previously held principles out of keeping with the values of psychology. Finally, 'marginalisation' is the strategy associated with the most potential harm. This occurs when someone has a poor association with both sets of values, leading to low standards of personal and professional behaviour.

1.5 Ethical decision-making in trainees

The available empirical evidence and psychological theory both highlight that ethical decision-making is not straightforward. Considerable variation exists between individuals regarding how they approach this task; however, despite the associated difficulty, managing ethical dilemmas remains an essential component of the role that all healthcare professionals carry an obligation to manage effectively. How to best support clinical psychologists in developing expertise related to ethical decision-making is therefore an issue of key importance.

One way of helping equip clinical psychologists with the skills they need, is through providing teaching on ethical decision-making over the course of training. Targeting this training at the beginning of their professional careers offers clinical psychologists the opportunity to practise using ethical decision-making tools that can be further developed and refined over time, as they acculturate into their new profession.

For trainees to be provided with support that is tailored to their learning needs, research that helps highlight those needs is necessary. Establishing what is already currently known about how trainees make ethical decisions is the first stage of this process, following

which areas requiring further research can be identified. If the potential applicability of research findings is to be fully understood within the context of clinical psychology training in the UK, however, a brief overview of current ethics training provision and associated trainee professional guidelines is first warranted.

1.5.1 Current ethical guidance and training provision for psychologists. Training as a clinical psychologist in the UK entails a three-year doctoral programme, currently funded by the NHS. There are 31 courses nationwide (Clearing House for Postgraduate Courses in Clinical Psychology, 2018), and the programme involves a range of clinical placements, a taught academic, clinical and research component, plus a major research project. The importance of working ethically throughout the training process is stressed, being one of eight accreditation standards set for clinical psychology doctoral training programmes by the BPS (2017).

The standards of education and training set by the HCPC (2017b) provide guidelines for training courses concerning the teaching of ethics. The standards are set with the aim of ensuring that trainees attain the necessary standards of proficiency (HCPC, 2015) and standards of conduct, performance and ethics (HCPC, 2017a). The HCPC do not stipulate how individual course centres should organise their teaching, e.g. by a dedicated module, but they suggest that "the standards should play a prominent and structured role in the design of a programme" (HCPC, 2017c, p.31). The HCPC standards of education and training (2017a) state that there must be robust procedures in place to guarantee good conduct and character of trainees, and that assessment of this should continue throughout the training process. Course providers should also ensure that students gain an appreciation of the context dependent nature of ethical decision-making.

The BPS (2015) have produced a set of guidelines regarding ethics teaching for psychology students, from undergraduate level through to doctoral level research and

practitioner training courses. The guidelines suggest that teaching students about ethics and ethical action, and assessing their level of understanding "offers a way to counter misconduct and manage changing ethical landscapes" (p.2). The guidelines stress the importance of students learning how to interpret and apply relevant ethical principles, as opposed to merely learning the content of the BPS Code of Ethics and Conduct (2009, revised in 2018). The guidelines map the four ethical principles outlined in the code - respect, competence, responsibility and integrity - onto a model of ethical decision-making for each level of training. The model adopted is Rest's (1982) four component model, which breaks the ethical decision-making process down into four stages. The first stage of the model involves becoming aware of a dilemma, which is known as ethical sensitivity. This is followed by the ethical reasoning stage where options are assessed. The next step is ethical motivation, which concerns the degree of motivation to act in an ethical way. Ethical implementation is the final step, where priorities are determined, and the chosen course of action is carried out.

1.6 Literature Review

In order to establish what is currently known about the ethical decision-making process in trainee clinical psychologists, a systematic review of the literature was undertaken. The review aimed to not only collate the current body of knowledge, but to also highlight gaps, thus ensuring the current study would further extend understanding in this area. The review initially focused on answering the question: What factors inform the ethical decision-making process of trainee clinical psychologists? All factors included were relevant to one or more of the stages of the ethical decision-making process outlined by Rest's four component model (1982).

1.6.1 Search strategy.

The databases PsychInfo, Scopus and PubMed were used for the review over a five- month period from October 2017 to February 2018. The search terms used are shown in Table 1.

Table 1. Literature review search terms

	AND
ethic* OR moral* OR value*	
dilemma* OR decision* OR judgment* OR judgement* OR conduct OR misconduct OR violat*	
trainee* OR training OR intern* OR graduate* OR student*	
psychologist* OR "clinical psycholog*" OR "counselling psycholog*" OR "counseling psycholog*" OR "counsel*" OR "allied health professional*" OR "mental health professional*" OR "mental health practitioner*"	

An initial search of research published in the UK highlighted very few relevant studies involving trainee clinical psychologists; therefore, search parameters were widened to also include trainees from backgrounds including counselling psychology, counselling and psychotherapy. Worldwide studies written in English were included, and no date restrictions were set, to also increase the number of available studies. Inclusion and exclusion criteria for the search are shown in Table 2.

Table 2. Inclusion and exclusion criteria for selection of papers

Inclusion Criteria	**Exclusion Criteria**
Main focus of study concerns ethical decision-making process, as defined by one aspect of Rest's four component model	Primary focus does not concern ethical decision-making process, e.g. focuses on impact of a training intervention
Empirical studies	Studies not written in English
Studies involving trainee participants	Studies focused purely on views of training course staff that involve no trainee participants
Studies involving trainees working in a health related environment	Trainees working in non-health related environments, e.g. educational psychologists; school counsellors
Focus of study relates to trainee talking therapists as follows: clinical and counselling psychologists, psychotherapists, counsellors	Trainees engaged in academic courses involving no client contact
	Studies not distinguishing between training participants and qualified participants

A total of 638 articles were obtained and, following screening of all titles, 143 abstracts were read. This resulted in a total of 12 articles for full-text review (see Appendix

A for a flow chart illustrating the article selection process). Four articles were excluded at this stage: three articles did not separate trainees working in health environments from those in non-health environments and one article did not separate trainees from qualified professionals for purposes of the analysis. One article from the grey literature was included (Ellis-Caird and Wainwright, unpublished 2013) due to its relevance, being conducted in the UK and using the same methodology (DIT-2) as the current study. A review of article references did not find further relevant articles. This left a total of nine studies to be considered in this review.

1.6.2 Quality appraisal. All selected articles were quality appraised using the quality assessment tool by Burns and Kho (2015). This tool was selected as it was recently developed and focuses on appraising surveys, and was therefore applicable to all literature in the review. The criteria briefly cover all main sections of a research report, including research conduct and reporting. A further advantage is the attention paid to questionnaire development and response rate, common areas of difficulty in survey research (Kelley, Clark, Brown & Sitzia, 2003). A limitation acknowledged by Burns and Kho is a lack of consideration of ethical issues; however, completion and return of a questionnaire is usually assumed to convey consent to participate. Although the table of issues to consider does not state sample representativeness, in the full article readers are prompted to consider this as part of the item regarding response rate.

Burns and Kho (2015) did not suggest that reviewers use the checklist as a scoring system, and when used elsewhere (e.g. Anderson, Stephenson & Carter, 2017) scores were not generated for the papers. In keeping with this, the tool was used as a framework to compare the quality of the surveys reviewed, thus ensuring a range of relevant factors were considered. Table 3 shows the quality assessment for all literature included in the review.

Table 3. Quality assessment of survey literature based on Burns and Kho (2015)

Authors	1. Clear research question posed?	2. Target population 2a Target population defined? 2b Sampling frame specified?	3. Systematic approach 3a Item generation and reduction process reported? 3b Questionnaire formatting specified? 3c Pretesting?	4. Questionnaire testing 4a Pilot testing? 4b Clinimetric testing?	5. Response and non-response bias limitation 5a Administration method appropriate? 5b Details of prenotification, cover letter, incentives provided?	6. Optimising response rate 6a Response rate reported? 6b Response rate defined? 6c Response rate enhancement strategies used? 6d Sample size justified?	7. Results reporting 7a Research question addressed? 7b Missing data methods reported? 7c Respondent demographics reported? 7d Analytical methods clear? 7e Results succinctly summarised? 7f Results interpretation aligned with data presented? 7g Results implications stated? 7h Copy of entire questionnaire provided?
Asay & Lal (2014)	Yes	2a Yes 2b Yes	3a No 3b Yes 3c Can't tell	4a Can't tell 4b Can't tell	5a Yes 5b No	6a No 6b No 6c Can't tell 6d No	7a Yes 7b No 7c Partial 7d Yes 7e Yes 7f Yes 7g Yes 7h No
Bernard & Jara (1986)	Yes	2a Yes 2b Yes	3a No 3b Yes 3c Yes	4a No 4b Can't tell	5a Partial 5b No	6a Yes 6b Yes 6c Can't tell 6d No	7a Yes 7b No 7c No 7d Yes 7e Yes 7f Yes 7g Yes 7h No

Authors	1. Clear research question posed?	2. Target population 2a Target population defined? 2b Sampling frame specified?	3. Systematic approach 3a Item generation and reduction process reported? 3b Questionnaire formatting specified? 3c Pretesting?	4. Questionnaire testing 4a Pilot testing? 4b Clinimetric testing?	5. Response and non-response bias limitation 5a Administration method appropriate? 5b Details of prenotification, cover letter, incentives provided?	6. Optimising response rate 6a Response rate reported? 6b Response rate defined? 6c Response rate enhancement strategies used? 6d Sample size justified?	7. Results reporting 7a Research question addressed? 7b Missing data methods reported? 7c Respondent demographics reported? 7d Analytical methods clear? 7e Results succinctly summarised? 7f Results interpretation aligned with data presented? 7g Results implications stated? 7h Copy of entire questionnaire provided?
Betan & Stanton (1999)	Yes	2a Yes 2b Yes	3a No 3b Yes 3c No	4a No 4b Can't tell	5a Partial 5b No	6a Yes 6b Yes 6c Can't tell 6d No	7a Yes 7b Yes 7c Partial 7d No 7e Yes 7f No (*p* value listed as 0.5) 7g Yes 7h No
Bevacqua & Robinson Kurpius (2013)	Yes	2a Yes 2b Yes	3a Yes 3b Yes 3c Yes	4a No 4b Yes	5a Partial 5b Yes	6a No 6b No 6c Yes 6d Yes	7a Yes 7b No 7c Yes 7d Yes 7e Yes 7f Yes 7g Yes 7h No

Authors	1. Clear research question posed?	2. Target population 2a Target population defined? 2b Sampling frame specified?	3. Systematic approach 3a Item generation and reduction process reported? 3b Questionnaire formatting specified? 3c Pretesting?	4. Questionnaire testing 4a Pilot testing? 4b Clinimetric testing?	5. Response and non-response bias limitation 5a Administration method appropriate? 5b Details of prenotification, cover letter, incentives provided?	6. Optimising response rate 6a Response rate reported? 6b Response rate defined? 6c Response rate enhancement strategies used? 6d Sample size justified?	7. Results reporting 7a Research question addressed? 7b Missing data methods reported? 7c Respondent demographics reported? 7d Analytical methods clear? 7e Results succinctly summarised? 7f Results interpretation aligned with data presented? 7g Results implications stated? 7h Copy of entire questionnaire provided?
Cottone, Tarvydas & House (1994)	Yes	2a Yes 2b Yes	3a No 3b No 3c No	4a Yes 4b Partial	5a Partial 5b No	6a No 6b No 6c Can't tell 6d No	7a Yes 7b No 7c No 7d Yes 7e Yes 7f Yes 7g Partial 7h Yes
Ellis-Caird & Wainwright (unpublished 2013)	Yes	2a Yes 2b Yes	3a No 3b No 3c Can't tell	4a Can't tell 4b Partial	5a Partial 5b Partial	6a No 6b No 6c Can't tell 6d No	7a Yes 7b No 7c Yes 7d Yes 7e Yes 7f Yes 7g Yes 7h Yes

Authors	1. Clear research question posed?	2. Target population 2a Target population defined? 2b Sampling frame specified?	3. Systematic approach 3a Item generation and reduction process reported? 3b Questionnaire formatting specified? 3c Pretesting?	4. Questionnaire testing 4a Pilot testing? 4b Clinimetric testing?	5. Response and non-response bias limitation 5a Administration method appropriate? 5b Details of prenotification, cover letter, incentives provided?	6. Optimising response rate 6a Response rate reported? 6b Response rate defined? 6c Response rate enhancement strategies used? 6d Sample size justified?	7. Results reporting 7a Research question addressed? 7b Missing data methods reported? 7c Respondent demographics reported? 7d Analytical methods clear? 7e Results succinctly summarised? 7f Results interpretation aligned with data presented? 7g Results implications stated? 7h Copy of entire questionnaire provided?
Harris & Harriger (2009)	Yes	2a Yes 2b Yes	3a No 3b No 3c No	4a No 4b Can't tell	5a Yes 5b No	6a No 6b No 6c Can't tell 6d No	7a Yes 7b Yes 7c Yes 7d Yes 7e Yes 7f Yes 7g Yes 7h No
Harris & Robinson Kurpius (2014)	Yes	2a Yes 2b Yes	3a No 3b No 3c No	4a No 4b Partial	5a Partial 5b Partial	6a No 6b No 6c Yes 6d Yes	7a Yes 7b Yes 7c Yes 7d Yes 7e Yes 7f Yes 7g Yes 7h No
Mearns & Allen (1991)	Yes	2a Yes 2b Yes	3a Yes 3b No 3c Yes	4a No 4b Partial	5a Partial 5b Partial	6a Yes 6b Yes 6c Can't tell 6d No	7a Yes 7b No 7c Yes 7d Yes 7e Yes 7f Yes 7g Yes 7h No

1.6.3 Summary of paper characteristics. All nine papers employed a cross-sectional questionnaire design. Participants for four of the studies involved trainee clinical psychologists and two studies involved trainee counsellors. One study recruited a mixture of trainee clinical and counselling psychologists; a further study involved a mixture of psychologist and counsellor trainees and the final study involved couple and family therapy trainee participants. Only one study was carried out in the UK, with all others originating from the United States. Sample sizes varied, ranging from 36 to 407 trainees per study. A full summary of each paper is included in Appendix B.

All studies were read in full, searching for themes within the topics or findings via which to organise reporting of the studies. Three themes were identified related to factors informing the ethical decision-making of all participants. The first focused on ethical decision-making at an individual level, including the influence of personal values and assumptions, and the development of ethical thinking over time. The second theme concerned decision-making in scenarios with a relational component, including how decisions made as a group differed from those made individually, and the impact of personal relationships on decision-making. The final theme included studies considering how the environment in which ethical decisions were made influenced the process, with a specific focus on dilemmas occurring in a digital environment. In the following review, the papers have been grouped according to the three identified themes and associated sub-themes.

1.6.4 Individual influences. Three articles focused on factors affecting ethical decision-making at an individual level. This included considering the influence of personal values, assumptions and biases, and adopting a developmental approach towards decision-making.

1.6.4.1 The role of values, assumptions and biases. Bevacqua & Robinson Kurpius (2013) explored counselling students' personal values and attitudes toward euthanasia. They

randomised trainees to one of four vignettes, according to age of client (25 or 77) and type of euthanasia (passive or active). They found that support was much greater for a 77-year-old client seeking active euthanasia (assisted suicide) than for a 25-year-old. No differences were found in the case of passive euthanasia (withholding of life support). Higher religiosity was associated with less support for the right to end life. Trainees with less clinical experience were also less likely to support euthanasia than those with more clinical experience, which the authors suggest indicates the latter were more supportive of client autonomy. These results suggest that values biases due to ageism or the presence of religious beliefs can influence how trainees perceive dilemmas. The authors highlight that imposing personal values can lead to discrimination, and advocate a role for clinical supervision and training related to end-of-life decision-making to help minimise the impact of assumptions and biases. It is important to note that the study asked what a person *would* do rather than what they *should* do when facing a dilemma; therefore, no insight was gained concerning the process of how a person moves from weighing up their ethical motivations to implementing their chosen action.

This study was the paper of highest quality according to quality appraisal (Burns & Kho, 2015). It was the only paper to provide full details of how the questionnaire was generated, alongside details of reliability and validity checks. In addition, sufficient power was demonstrated through recruiting more than the number of participants stipulated by a power calculation. The researchers also pretested the questionnaire. A downside of the study was that all trainees were recruited from a single southwestern university in the United States. It is therefore not possible to know how generalisable these findings are to other training institutions, as results could be linked to ethics training provided for these particular trainees. One of the principal researchers of the study was noted to be based at Arizona State University, but it was not stated whether students were also recruited from this site. This

may have been done to preserve anonymity of the training institution; however, it is therefore not possible to determine whether this researcher had a teaching relationship with the trainees, a source of potential bias. It should be stressed, however, that this paper was not alone in this regard; a total of four studies were conducted at either one or two institutions likely to be teaching venues of at least one of the main researchers.

Harris and Harriger (2009) found that individual personal judgements concerning dilemma severity appeared to influence ease of ethical decision-making, leading trainees to feel more uncertain about some courses of actions than others. They explored how trainee couple and family therapists manage ethical dilemmas associated with a client's expression of sexual attraction to a therapist during couple therapy. Just over half the trainees said they would discuss disclosed attraction with the couple, but one third were unsure about doing so. When asked whether they would disclose reciprocated attraction, almost half the trainees were unsure whether being honest would hurt the couple. Half were also unsure whether disclosing that attraction was not reciprocated would hurt them. A substantial number did not know whether disclosure would affect the therapeutic relationship with the partner expressing attraction or the non-attracted partner. More trainees expressed uncertainty concerning whether therapy should continue or be terminated compared with trainees giving either affirmative or negative agreement. Almost all trainees, however, would not refer the couple to a different therapist to pursue the relationship, with one in twenty expressing they would. The authors propose that when trainees judge a situation as clearly unethical, e.g. pursuing a relationship with a client, they appear to find decision-making easier. In less clearly defined situations – such as considering the appropriateness of self-disclosure – they are more uncertain; therefore, individual personal judgements concerning dilemma severity appear to influence ease of ethical decision-making.

A strength of this study is the large sample size of 259 trainees recruited from 27 accredited programmes; however, only 138 of respondents completed questions concerning couple therapy, with no reasons given to account for the high proportion of missing data. There is also no reporting of the questionnaire generation process and no copy of the final version of the questionnaire is provided. It is therefore not possible to examine whether the formatting of the questionnaire contributed to the low completion rate. Although the target population is specified, no calculation of response rate is provided. A further point worth noting is that almost four in five trainees had no prior clinical experience; therefore, the sample is not representative of UK trainee clinical psychologists in this respect.

1.6.4.2 A developmental approach to ethical judgement. The only UK study in the body of literature was carried out by Ellis-Caird and Wainwright (unpublished 2013). They conducted a pilot study examining the ethical decision-making of 36 trainee clinical psychologists from two courses using the DIT-2, a questionnaire measuring an individual's stage of ethical development (Rest et al., 1999b). Quantitative analysis and thematic analysis of trainees' free-text responses related to the ethical decision-making process were undertaken. The majority of trainees were found to be using a highly developed ethical framework in their approach to decision-making, with each participant on average applying thinking at the postconventional level for half the decisions made. There was no correlation between trainees' year of training or age and the degree of sophistication in ethical decision-making; rather, third year trainees had slightly less sophisticated thinking, albeit at a non-significant level. A small minority of trainees across year groups were found to be using a much less refined approach to ethical decision-making, which would not be expected among doctoral level students. This is concerning for the profession if such an approach leads to unethical behaviour, and further research is needed to examine any such association.

A strength of this study is that, in addition to using a questionnaire, thematic analysis was used as a supplementary method. The study was also the only research to take place in the UK and, as participants were trainee clinical psychologists, is most representative of UK trainees' experiences within the context of the NHS. Themes arising from trainees' experiences are therefore particularly noteworthy. Qualitative data highlighted that some trainees experienced tension between their own personal judgements and that of the psychology profession. Ellis-Caird and Wainwright (unpublished 2013) suggest that this lends support to the idea that trainees may adopt the 'separation' strategy proposed in the model of acculturation, whereby they have a stronger affiliation with their own personal values than with those of clinical psychology as a profession (Handelsman et al., 2005). Trainees referred to the influence of pragmatic issues, and the possibility that local procedures and policies could impede action. The authors suggest that the influence of contextual considerations, such as constraints posed via the working environment, are an avenue for future research. They also highlight a possible need for training courses to revisit their ethics teaching to address the lack of advancement in ethical thinking over time. A study limitation highlighted by the authors is that the DIT-2 questionnaire is an assessment of ethical judgement, and there is a need to further investigate the degree of association between this measurement and the ethical behaviour of trainees in their clinical practice. A further limitation is that only two recruitment sites were used; therefore, responses given may not accurately reflect the views of trainees in the UK more generally.

1.6.5 Ethical decisions with a relational component. Of the studies examining ethical decision-making in relational contexts, one study involved exploring differences between making individual and group decisions. A further three studies explored the impact of personal relationships on the ethical decision-making process.

1.6.5.1 Individual vs. group decision-making. Cottone, Tarvydas & House (1994) explored whether ethical decisions were more likely to change following consultation with others rather than when made individually. They did this through measuring change in trainee counsellors' choice of action when they judged a hypothetical non-clinical ethical scenario alone, and then reconsidered following consultation. They found that consulting with others was more likely to result in a different decision, thus indicating that decision-making is not solely related to a person's own individual values and beliefs, but can also be influenced by relational factors. A hindrance to generalising these findings to real world settings relates to the choice of using a highly hypothetical non-clinical scenario. Furthermore, the small magnitude of effect demonstrated calls into question how much confidence can be assumed concerning the potential for reliable replication of results. No details concerning the questionnaire generation process were reported; however, a strength of the study was that details of clinimetric testing were included. The study was one of only two papers to publish a full version of the questionnaire, thus enhancing the opportunity for others to replicate the research.

1.6.5.2 The impact of personal relationships on ethical decision-making. Bernard and Jara (1986) explored how clinical psychology trainees would respond to two written ethical violation scenarios involving fellow trainees who were also friends of the participant. The first ethical violation concerned a fellow trainee having a sexual relationship with a client, and trainees were asked what they *should* do in response, and what they thought they *would* do. Half the trainees said they would do less in response than they thought they should. For the second scenario involving a trainee with an alcohol problem, just over half said that they would do less than they should. No trainees reported that they would go beyond what they thought they should do for either scenario. These findings suggest that when trainees are faced with a dilemma involving someone known to them, a significant

proportion will not follow through on what they ethically think they should do. There were no demographic differences between those who would do less and those who would not in terms of year of training and whether an ethics course had been studied. The authors suggest this could be due to inadequate ethics training provision; however, as participants were recruited from a total of 25 different training institutions, this would represent a somewhat extensive training deficit. Alternatively, the researchers raise the possibility that altering trainees' responses to dilemmas involving friends may not be possible through classroom teaching. Strengths of this research are the large sample size of 170 trainees across a wide range of training institutions. Details of questionnaire formatting and pretesting are provided. The fact that questionnaires were completed anonymously also increases the likelihood that trainees felt able to answer freely. It must be acknowledged, however, that the research was completed over thirty years ago, which may limit the extent to which findings can be generalised to the current training context. Nevertheless, the study is of considerable value in highlighting ambiguity concerning the feasibility of motivating trainees to implement ethical principles that contravene their personal inclinations.

Betan and Stanton (1999) extended Bernard and Jara's (1986) study, focusing on the same ethical dilemma concerning a fellow trainee with an alcohol issue. They presented four versions of the scenario, in which the trainee was either a colleague or a friend, and male or female. A large sample of over 200 trainee clinical psychologists were asked to anonymously report what they should do, and what they actually would do from a choice of five options. They were also asked how confident they were that they would follow through on their intended action, and to indicate strength of emotional response. Just over half of the trainees identified they should report a fellow trainee with a drinking issue to the programme director. This increased to almost all trainees when this option was extended to include informing the programme director or informing the colleague they would take this action if

nothing changed. Half the trainees reported they would take less action than they believed they should. Around one in twenty said they would take more action than they should and the remaining trainees reported no discrepancy between what they should and would do. These results strengthen findings from Bernard and Jara (1986), who found similar results. Betan and Stanton also found three out of five trainees reported high confidence they would carry out what they said they would do. Strengths of the study include the large sample size from a wide spread of training institutions and the inclusion of response rate details; however, the MANOVA results reported for emotional responses to decision-making quote significance levels of $p < .5$ (rather than the conventional $< .05$), most likely a typographical error, and this lack of clarity renders any further results of the study uninterpretable.

Mearns and Allen (1991) conducted a study in which they compared trainee clinical psychologists' and tutors' attitudes concerning their obligation to act when witnessing impaired competence in trainees. The number of peers perceived by trainees to have exhibited impaired behaviours ranged from zero to three in total. Trainees from programmes rated more positively (for example, less competitive or more nurturing) indicated lower knowledge of impairment in peers; however, almost all trainees were aware of impairment in a peer serious enough to impact their professional functioning, and half were aware of unethical behaviour.

Trainees reported they would respond to impairment in a fellow trainee in a more active way than tutors perceived they would. The number of trainees reporting they would directly confront an impaired peer was much higher than predicted by tutors. The most common response to this was to consult with other trainees. The most commonly reported emotional responses of trainees to an impaired peer were feeling angry, conflicted and frustrated. The most common impediments to responding to an impaired peer cited by trainees were being unsure about the appropriateness of the intervention, not thinking it was

their responsibility, or being pessimistic about it making a difference. The same reasons were given for not responding to an ethical infraction, along with concern for unpleasant personal consequences.

Although this study was not carried out in the UK, all 79 participants were doctoral level trainee clinical psychologists; therefore, the sample is similar to UK trainees in this respect. Trainees were also recruited from a wide spread of training courses. Details are provided concerning how questionnaire items were generated, and pretesting was carried out. Response rates are also included; however, a copy of the questionnaire and its formatting details are not provided, thus preventing any personal examination of the measure for formatting issues.

The authors suggest training should not only focus on cognitive problem-solving strategies but also consider the impact of emotions when making ethical decisions. Discussing ethical dilemmas in small groups is suggested as a way of building trust. They also suggest trainees become more involved in the evaluation process, thus increasing their sense of responsibility with regards to prevention of impaired peers entering the profession. One recommendation is for trainees to give constructive feedback through writing peer reports.

1.6.6 Environmental factors. Two research articles focused on how the environment in which ethical decisions were made influenced the process; more specifically, these studies examined dilemmas occurring in a digital environment.

1.6.6.1 Digital dilemmas. The internet has created the opportunity to connect relationally with others through a digital medium. This presents ethical dilemmas for trainees related to gauging whether accessing digital information breaches privacy and/or confidentiality. Asay and Lal (2014) surveyed the online behaviours of over 400 clinical and counselling psychology trainees, the largest sample of all articles reviewed. The vast

majority of trainees had social networking accounts, and had modified their privacy settings since starting training. Around a quarter of trainees had 'Googled' clients and a half had 'Googled' their supervisor. Around three quarters had ethical concerns related to client contact via social networking, with over nine out of ten expressing discomfort about clients contacting them via social media during therapy. Roughly one out of six trainees would see their supervisor's contact via social media as an invasion of privacy, whereas this increased to around one in four for client contact. Just over half said they would feel uncomfortable making an ethical decision in relation to a client contacting them via this route. If this did happen, almost all reported they would discuss the issue with the client, whereas if a supervisor contacted them, just under three quarters would raise the issue with the supervisor. The power imbalance between trainee and supervisor is suggested by the authors as a possible reason for this discrepancy. The authors highlight the interesting observation that most trainees did not view social media contact as an invasion of privacy, yet did feel uncomfortable about online contact. They suggest that trainees' beliefs around privacy may be evolving as use of digital communication has become more widespread. This highlights that societal changes have the potential to influence levels of discomfort in ethical decision-making. They also speculate that being uncomfortable about making an ethical decision could be reflective of a lack of guidance concerning how to manage online decision-making, which is understandable in the context of a continually developing area. It is therefore possible that in newer environmental situations trainees may be more uncertain in their decision-making.

Asay and Lal (2014) stress the importance of training programmes and supervisors discussing online activity from the outset, making clear any policies on internet issues, and modelling openness and transparency. Ethical discussions and role plays during training are offered as a means of addressing discomfort associated with making ethical decisions.

Strengths of the study include the large sample size with participants from a range of course institutions. A noticeable flaw in this study is that participants were not asked to provide their age; therefore, opportunity was missed to distinguish between individuals born before or after the onset of the digital age. This could be an important factor influencing perception of – and discomfort related to – online ethical issues. Further limitations include the lack of detail concerning clinimetric testing and not including a copy of the final version of the questionnaire.

Harris and Robinson Kurpius' (2014) study is noteworthy for its large sample size of 315 psychology and counselling trainees and high statistical power. Participants were recruited from a wide spread of training courses and full demographic details are included. The research examined trainees' social networking habits, perceived knowledge of privacy settings and frequency of online client searches, including whether trainees had sought informed consent. The study also examined online disclosure of client related material. Ethical decision-making was measured using the ethical decision subscale of the Boundaries in Practice measure comprised of ten clinically related ethical scenarios (Kendall et al., 2011). Findings indicated a third of trainees with clinical experience had used the internet to search for a client. More than four out of five trainees who did an online search did not seek informed consent or document the search, and personal curiosity was the most common reason given for conducting a search. For trainees with clinical experience, almost one in five approved of posting an update online with indirect reference to positive expressions concerning a client, and almost one in ten approved of positive expressions online about a client's comments during a therapy session. One in twenty endorsed it was acceptable to post negative comments about a client's comments made during therapy.

Credit hours (indicative of length of time in training) were positively correlated with online client searches, and the amount of social networking experience and online client

searches were also positively correlated. It is therefore possible that trainees with more social networking experience may have less of a dilemma concerning seeking client information online. Overall, these findings reveal a tendency for trainees engaging in client searches to not consider their clients' consent or right to privacy. The authors highlight the importance of establishing therapist intentionality when determining whether their behaviour is ethically questionable. Lower scores on ethical decision-making were positively correlated with higher disclosure of client information, whereas trainees who rated ethical scenarios as unethical were more likely to consider client disclosures to be unethical. The authors suggest it is possible that trainees applying a strict boundary for the real-world scenarios transfer this across to their online activity. They propose that it would be helpful for trainees to consult with supervisors regarding their online behaviour, and suggest training programmes should include discussions related to social networking practices. A study limitation highlighted by the authors relates to the use of an online questionnaire, as this requires a degree of familiarity with online methods; however, this would not hinder generalisability of findings to populations sharing this characteristic, such as doctoral level clinical psychology trainees. A further study limitation is the lack of inclusion of response rate details.

1.6.7 Summary of research literature.

1.6.7.1. Summary of findings. Trainees appear to find some ethical decisions more difficult to make than others. It may be the case that when a situation is perceived as clearly unethical trainees find it easier to decide. Personal biases such as religious beliefs or ageist attitudes also seem to influence decision-making. Most trainees appear to use a highly developed moral framework to make decisions, which is not associated with age or previous clinical experience; however, a small number of trainees appear to use a much less refined approach than expected. Some trainees appear to experience a discrepancy between their

own personal judgements and those of the psychology profession, and are also influenced by pragmatic issues, such as local procedures and policies.

Trainees also appear to be influenced by whether decisions are taken individually or in a group. Findings concerning the influence of personal relationships are mixed. Two studies indicate a significant proportion of trainees would not take the necessary ethical action in a dilemma concerning a fellow trainee. It is therefore questionable as to whether trainees can be motivated to implement ethical principles that go against their personal preferences. A further paper, however, suggests that although trainees can seem unsure about what action they should take - and whether they hold responsibility - they are actually more active and less swayed by loyalty to peers than their tutors assume.

Trainees appear to experience discomfort making ethical decisions related to online activity; it is not clear whether the degree of discomfort is influenced by their age, or if trainees find it harder to make decisions in a less familiar digital environmental. Lower scores on ethical decision-making are associated with higher disclosure of information online and vice versa; therefore, it is possible that trainees applying strict ethical boundaries in scenarios based on real world encounters are also applying these boundaries to their online activity.

With regards to quality of the evidence base, strengths of the literature include the clarity of research questions posed, and well-summarised reporting of results mapping on to these. The interpretation of results also appear, in the main, to be aligned with research findings presented. Clearly defined target populations and sampling frames are usually specified. Deficits in the current body of research include a lack of detail concerning the systematic process involved in questionnaire generation and formatting. A copy of the final version of the questionnaire is provided in just under half of all studies included in the review. This prevents both the possibility of thoroughly reviewing the questionnaire quality,

and any opportunity to replicate the study. Details concerning pilot testing and clinimetric testing are often only partially provided, and information concerning response rates is limited. A further deficit is the lack of diversity in the choice of measures employed, with all but one of the studies employing a design based solely on a survey. Generalisability of findings to the UK training population is a further limiting factor, with only one study having been conducted in a UK setting.

1.6.7.2 Training implications. Several authors refer to a need for training courses to assess the effectiveness of their ethics education. A role for course tutors is outlined in helping trainees to consider their personal biases, and to reflect on the emotional impact associated with ethical dilemmas. Several studies highlight helpful forums for discussing dilemmas. Small group discussions are put forward as a means of building trust. Peer evaluation is suggested as a method for promoting trainee responsibility concerning their actions in response to peer impairment. Discussing ethical issues and reflecting on the influence of personal values and assumptions during clinical supervision is also suggested.

1.7 Study Rationale and Aims

The review of available literature demonstrates a paucity of research concerning how trainee clinical psychologists make ethical decisions. There is a degree of knowledge about specific aspects of ethical decision-making, such as personal factors influencing decisions, and how groups and personal relations may influence the process. A little is also known about how different environments may impact decision-making; however, there appears to be a lack of a broader theoretical understanding of ethical decision-making as a whole.

Methodological limitations in the research conducted to date also cast doubt on the robustness of findings presented. Furthermore, even if findings from the studies are taken as an accurate representation of specific aspects of decision-making, huge gaps remain; therefore, it is very difficult to ascertain the extent to which the training process exerts an

influence on ethical decision-making. A further deficit in the current evidence base is the lack of research conducted in the UK, calling into question the degree to which findings can be generalised to UK trainees. An additional gap concerns the fact that studies to date have focused on ethical decision-making in professional or personal contexts, but none have considered the integration between personal and professional decision-making processes, an important consideration for trainees during the process of acculturation.

The purposes of the current study were therefore twofold. Firstly, the study aimed to develop greater understanding of the personal, relational and environmental factors underlying ethical decision-making. The second aim was to increase understanding concerning how trainees approach decision-making in personal and professional contexts, and their integration of personal and professional ethical decision-making over the course of training.

The research built on Ellis-Caird and Wainwright's (unpublished 2013) pilot study through using the DIT-2 as an assessment of moral judgement, examining again whether findings indicated a lack of ethical development over time. Alongside this, repertory grid technique was used to explore trainees' personal construct systems related to ethical decision-making, using a combination of personal and professional ethical scenarios relevant to their everyday experiences. A combination of questionnaires and repertory grid interviews added robustness to the study design, and provided the scope for thorough examination of any association between complexity of ethical judgement and trainees' management of ethical scenarios.

1.8 Research questions and hypotheses

1.8.1 Research questions.

The research aimed to address the following questions:

1. How developed are trainees' ethical decision-making schemata, and do these become more sophisticated over the course of training?

2. Is sophistication of ethical decision-making related to aspects of trainees' personal construct systems?
3. What differences are there in the construing of personal and professional ethical dilemmas between trainees with more and less experience?
4. How difficult do trainees find making personal and professional ethical decision-making?

1.8.2 Hypotheses. The hypotheses addressed the key areas outlined in the research questions.

1.8.2.1 How developed are trainees' ethical decision-making schemata, and do these become more sophisticated over the course of training? One hypothesis was made concerning the degree of sophistication of ethical development.

1.8.2.1.1 There will be a difference in the level of ethical development between first and third year trainees. This prediction was non-directional due to mixed findings in the evidence base. Research using the DIT summarised by Rest et al. (1999a) indicates that variance in DIT scores is associated with level of education, and that sophistication of ethical thinking increases in response to educational intervention. By way of contrast, Ellis-Caird and Wainwright (unpublished 2013) found no association between trainee clinical psychologists' year of training and their performance on the DIT-2.

1.8.2.2 Is sophistication of ethical decision-making related to aspects of trainees' personal construct systems? One hypothesis was made regarding the correlation between trainees' sophistication of ethical decision-making and their construing.

1.8.2.2.1 More sophisticated ethical development will be associated with more differentiated, looser construing. Higher stages of ethical development are associated with the flexibility to negotiate societal relationships and laws in a variety of ways (Rest et al.,

1999a), which could be expected to reflect a more highly differentiated, looser construct system.

1.8.2.3 What differences are there in the construing of personal and professional ethical dilemmas between trainees at the beginning at end of training? One hypothesis examined differences between trainees' overall configuration of construct systems. A further four hypotheses focused on differences between more and less experienced trainees' personal and professional ethical decision-making subsystems.

1.8.2.3.1 Third year trainees will have less structure in the overall configuration of their construct systems than first year trainees. Previous research has indicated that professional training courses can lead to looser construing (Ryle & Breen, 1974), and hence a directional hypothesis was proposed.

1.8.2.3.2 Third year trainees will have more structure in their professional construct subsystems than first year trainees. Due to teaching and supervision regarding the management of professional ethical decision-making during clinical training, it would be expected that the professional construct subsystem would become more structured over time.

1.8.2.3.3 First year trainees will find their personal constructs more useful than third year trainees when making ethical decisions. Third year trainees will find their professional constructs more useful than first year trainees. As training involves the elaboration of trainees' professional ethical construing, their professional constructs would be expected to discriminate more between elements as training progresses.

1.8.2.3.4 There will be a greater level of integration of personal and professional ethical decision-making subsystems in third year trainees. With the focus of training programmes on reflexivity and reflective practice, it would be expected that the professional construct subsystem will become less isolated and more integrated with the personal construct subsystem over time.

1.8.2.3.5 Third year trainees will find professional scenarios more salient than first year trainees, and first year trainees will find personal scenarios more salient than third year trainees. This was a directional hypothesis. It would be expected that if individuals go through a period of exposure to a new domain, in this case professional ethical dilemmas, this domain will become relatively more salient over time. The personal domain will therefore be expected to become relatively less salient over the course of training.

1.8.2.4 How difficult do trainees find making personal and professional ethical decision-making? One hypothesis examined the difficulty associated with making ethical decisions based on ascribed difficulty ratings for the personal and professional scenarios. A further hypothesis focused on conflict associated with professional decision-making.

1.8.2.4.1 There will be a difference in difficulty ratings for professional decision-making between first and third year trainees. It is possible that as a professional ethical construct subsystem is elaborated, professional ethical decision-making will become less difficult; however, it could be also the case that elaboration of this subsystem involves it becoming more multidimensional. This could lead to professional ethical decision-making being approached less rigidly, and perhaps therefore with more difficulty; therefore, a non-directional hypothesis was stated.

1.8.2.4.2 The degree of conflict associated with professional scenarios will decrease over the course of training. Kelly's 'Fragmentation Corollary' (1955) suggests that when there is inconsistency in construing, this can lead to conflict. If a more coherent, hierarchically organised professional construct subsystem develops during training, conflict associated with professional ethical decision-making would be expected to reduce.

CHAPTER 2

Method

This chapter begins by setting out the rationale for study design. This is followed by details of participant demographics, including power calculations and a comparison with the current UK training population. Steps taken to involve trainees as consultants are highlighted, followed by a full account of study measures and procedural details.

2.1 Design

2.1.1 Design rationale. To consider the most appropriate design for the study, several factors required consideration. These included contextual issues related to psychology research, general strengths and limitations of different methodological approaches, and issues more specific to methodology used in ethics research.

2.1.1.1 Historical context of psychology research. During psychology's development as an academic discipline, priority was given to quantitative methods of analysis, deemed more in keeping with the natural sciences (Brysbaert & Rastle, 2009). An awareness of this places into context the historical tendency for psychology research to view quantitative and qualitative research methods in a polarised fashion. It is now recognised that the most fruitful approach to research design involves a thorough examination of how a study's research questions can best be operationalised (Howitt & Cramer, 2011). Denzin and Lincoln (2000) suggest that this requires a consideration of how amenable the research questions are to full coverage via quantitative or qualitative methods.

2.1.1.2 Methodological strengths and limitations of surveys and interviews. Surveys and interviews both have methodological strengths and limitations. With respect to data collection, a survey offers a time-efficient means of data collection from a large number of respondents. A further advantage is that social desirability bias can be less pronounced for questionnaires when not completed in the presence of an interviewer (Oppenheim, 1992).

One drawback with a design solely based on a survey, however, is that some survey formats require individuals to make a forced choice, which may result in not fully capturing the essence of what is truly meaningful to a participant. An interview offers a more individualised opportunity for a person to express their views in depth. With regards to data analysis, using individual interviews alongside a questionnaire provides the scope for exploration of factors unique to the individual, while also analysing differences between groups using numerical measurement. For the purposes of determining the design of the current research, in addition to these considerations it was also necessary to consider the most appropriate way of operationalising the study's research questions.

2.1.2 Study design. A mixed methods approach involving a correlational and comparative cross-sectional research design was used to explore differences between how more and less experienced trainee clinical psychologists make ethical decisions.

Few questionnaires have been designed for measuring stage of ethical development. Two measures were considered for inclusion in the current study. The first measure was The Ethical Decision-Making Scale (Revised; Dufrene & Glosoff (2004) which was designed for use with counsellors. The second was The Defining Issues Test (DIT-2; Rest et al., 1999b). Although the latter questionnaire does not focus on ethical dilemmas specific to psychotherapy, it was deemed more suitable for several reasons. The Ethical Decision-making Scale (Revised) has limited data available concerning its internal and external validity, and has been used with a limited number of population groups. By way of contrast, the DIT-2 is the most widely used measure for assessing ethical development (Thoma et al., 2016) and has been used in studies of a wide variety of professional groups (Bebeau, 2002). Having a set of established norms for doctoral students (Bebeau, Maeda & Tichy-Reese, 2003) also enabled comparison of these norms with the sample.

One limitation of using the DIT-2 questionnaire concerned the lack of scope to assess differences between decision-making in a personal or professional capacity, a key consideration of the current study. This aspect of the design was fulfilled by using individual interviews in conjunction with the questionnaire.

Repertory grid technique (Kelly, 1955) was chosen as the preferred methodology for the individual interviews for several reasons. This method was viewed as preferable to using a semi-structured format because it provided the scope to separately examine differences between trainees' personal and professional decision-making, and to analyse these by both nomothetic and idiographic means. A further advantage of the grid relates to its capacity to reduce researcher bias. This is because constructs are elicited directly from participants in response to materials provided; therefore, there is much less opportunity for a researcher to steer the course of the interview (Boyle, 2005). Finally, previous research has highlighted an ability of the repertory grid to tap into personal meaning held at an implicit level (Hillier, 1998). This facilitates the illumination and critical examination of previously unexpressed ideas and personal meaning which may not be easy to articulate; these ideas could remain obscured if trainees rely solely on explicit ethical knowledge attained through prior learning.

In summary, using a combination of the DIT-2 questionnaire and individual repertory grid interviews provided a robust approach, which could account for both general methodological considerations and the need for a specific focus on personal and professional decision-making. Using more than one method enabled different perspectives on the ethical decision-making process to be highlighted, in keeping with the critical realist epistemological position of the research (Willig, 2012).

2.2 Participants

All trainee clinical psychologists currently enrolled in a doctoral clinical psychology training course in the UK were eligible to participate. In order to assess study feasibility, it

was first necessary to consider the potential sample size required to observe a significant effect.

2.2.1 A priori power calculations. An a priori power analysis was conducted at varying degrees of effect size, using Cohen's (1988) *d* values as follows: medium (0.5) and large (0.8). The analysis was carried out using G*Power 3 software (Faul, Erdfelder, Lang & Buchner, 2007), and indicated that twenty-one trainees per group would be necessary to detect a mean difference of large magnitude for independent sample *t*-test calculations (power of 70%, alpha = .05, 2-tailed). While this was lower than the usual 80% power convention, it was felt that this would be achievable when considering the limitations of the project's timescale, and the lack of previous published research from which a reliable indication of likely effect size could be determined. Table 4 indicates the sample sizes required to demonstrate a medium and large sized effect at between seventy and ninety percent power.

Table 4. Numbers needed per group for t-tests at varying levels of power

Effect size (*d*)	Power (%)		
	70	80	90
0.8	21	26	34
0.5	51	64	86

An a priori power analysis was also carried out at varying degrees of effect size using Pearson's *r* correlation coefficient. Table 5 indicates the sample sizes required to detect a moderate and strong effect at between 70 and 90 percent power. The analysis indicated that a sample size of 37 would be necessary to detect an effect size of moderate magnitude (power of 0.7, alpha .05, 2-tailed).

Table 5. Numbers needed for correlations at varying levels of power

Effect size (*r*)	Power (%)		
	70	80	90
0.4	37	46	61
0.7	11	13	17

A purposive sampling approach was adopted to recruit a sample representative of the population. Two routes of recruitment were used. Firstly, contact was made with all doctoral level professional clinical psychology courses in the UK, informing them of the study details (see Appendix C for a copy of the study advertisement). The second route was via snowball sampling through colleagues known to the researcher. Almost all participants were recruited through the former route, with one participant recruited via the latter route.

2.2.2 Participant demographics. Trainees from a total of seventeen different training courses participated in the research. As only three trainees recruited were in their second year, their data were excluded from analysis (see Appendix D for second year trainee data), leaving a total of 39 participants. Nineteen trainees were in their first year of training and 20 were in their third year. Fourteen trainees had a face to face interview: eight of these were first year trainees and six were third year trainees. Twenty-five trainees had a Skype interview: eleven of these were first year trainees and 14 were in their third year.

No details of individual trainee course institutions are stated here, in order to protect participant and course centre anonymity. Demographic details are shown in Table 6.

Table 6. Trainee demographics from each year group

Year Group	Age Group						Gender		Ethnicity						
									Black	Asian	White			Other	Mixed
	25-29	30-34	35-39	40-44	45-49	50+	M	F			British	Irish	European		
1	12	4	1	1	-	1	2	17	1*	-	12	1	2	1	1^; 1^^
3	8	12	-	-	-	-	4	16	-	1**	14	-	4	-	1^
Total	20	16	1	1	-	1	6	33	1*	1**	26	1	6	1	2^; 1^^

*African
**Indian;
^Asian/White
^^ Black/White

2.2.2.1 Representativeness of sample. Characteristics of the study sample were compared to the population of trainee clinical psychologists in the UK through reference to data from the Clearing House for Postgraduate Courses in Clinical Psychology (2018) concerning admissions to clinical psychology doctoral training programmes in 2016.

The 39 participants recruited from 17 course centres represented just under 7% of the total number of 585 trainees recruited in 2016; however, as the current study recruited from two year groups, the trainees represented around 3.5% of the target population. Just over 50% of participants were within the 25-29 age range, compared with 61% nationally and none were under the age of 25, unlike in the population where 18% were in this age bracket. Three percent of participants were aged 40 or above, a very similar proportion to the population (2%). The number of participants between the ages of 30 to 40 (44%) was higher than in the population (19%). Eighty five percent of the sample were female and 15% were male, which was almost identical to the population (84% female, 16% male).

The majority of participants were of White British ethnicity (67%), close to the trainee population figure of 71%. Participants from all White ethnicities made up 85% of the sample, almost identical to the population (86%). Just under three percent of participants were of Black ethnicities and three percent were of Asian ethnicities, compared to 2% and

4% in the population generally. A total of 15% of participants were from non-White and mixed ethnicities, just above the population figure of 12%.

In summary, although the number of participants represented only a small proportion of the total population, they were recruited from a wide range of training courses. The sample was representative of the population with regards to gender and ethnicity. The sample was also representative in terms of the low number of trainees above the age of forty, but differed somewhat from the population in having a higher number of trainees in the 30-40 age range, and none below the age of 25.

2.3 Ethical issues

NHS Research Ethics Committee approval was not required (see Appendix E for screening tool); therefore, approval was sought from the University of Hertfordshire Health and Human Sciences Ethics Committee, which was granted on 9th May 2017 (see Appendix F for notification of approval).

An important ethical consideration was the need to ensure anonymity of participants. This was achieved through not including details of training course institutions attended. No participant identifiable information was attached to questionnaire or interview data. As a precaution against the unlikely event that a trainee disclosed unethical practice during the course of an interview, the participant information sheet stated that if this were to occur, the principal researcher would be obliged to breach confidentiality. A further protection for trainees was that recruitment was not permitted from within the same year group as the principal researcher at the University of Hertfordshire.

2.4 Trainee consultation

Trainees were consulted during the design of the study to enhance the quality of the research and ensure it was relevant to the target population. During the design phase a focus group was held with five trainee clinical psychologists. Feedback was received regarding the

appearance and content of the study advertisement, and adjustments made. Trainees were asked to comment on the dilemmas deemed most relevant. Based on this feedback, the final scenarios were chosen and a new dilemma related to social media was added. All trainees expressed that they thought the research was relevant and that they considered the design appropriate for the target population.

Further trainee consultation was sought when two trainees were recruited to pilot test the designed repertory grid interview. Feedback from this led to minor procedural alterations and simplifying the language used in one scenario. Full details of trainee consultation are provided in section 2.5.2.1 which outlines the grid design process.

2.5 Measures

2.5.1 The Defining Issues Test (DIT-2). The Defining Issues Test is a questionnaire designed to measure an individual's stage of ethical development (Rest, 1979). More specifically, the measure focuses on the second stage of Rest's four component model of ethical decision-making, which is ethical reasoning (Thoma et al., 2016). Each questionnaire item contains sentence fragments designed to activate ethical reasoning schemata associated with the personal interest, maintaining norms or postconventional schemata to the extent that a person has developed these schemata. It is suggested that when a schema is triggered this will provide the basis for a more in-depth interpretation of the dilemma on the part of the participant, in keeping with the schema in question (Narvaez & Bock, 2002). Completion of the questionnaire requires a reading age of at least 12 years old (Bebeau & Thoma, 2003).

The first version of the DIT contained a series of six ethical dilemmas; this was later revised to include new dilemmas and simplified instructions, and the current version (DIT-2) contains a total of five ethical dilemmas (Rest et al., 1999b). An example of one of the dilemmas concerns a man stealing from a rich man's warehouse to support his family, who are near starvation. A further example relates to a doctor being asked by a 62-year-old

woman in the end stages of colon cancer to administer more pain medication, which would likely shorten her lifespan (see Appendix G for a full copy of the questionnaire).

Following each dilemma participants are asked to choose an action for the main character in each story. For example, in the example related to stealing food the available options include: should take the food; can't decide; should not take the food. A total of twelve issues are then stated which participants rate in terms of importance on a 5-point Likert scale with the following options: great; much; some; little; no. The 'no' option is used if a questionnaire item is perceived as not relevant. Following this, the four most important items are then ranked in order of importance, and it is these ranking data which are used to derive the DIT scores (Thoma et al., 2016). The entire measure extraction procedure is not specified in the DIT-2 scoring guide as, due to purchasing rights, all questionnaire data are exported into an Excel data file, and this is scored in accordance with a scoring manual at The Centre for the Study of Ethical Development at the University of Alabama.

2.5.1.1 DIT-2 indices. The DIT-2 includes various indices, one of which is a 'type indicator.' This indicates an individual's preference for one of the schematic levels. The type indicator also highlights whether an individual approaches ethical decision-making in a consolidated manner, discriminating clearly between schemata, or is in transition and thus less able to discriminate. There are seven type indicators in total (see Table 7); for example, Type 1 and Type 2 indicate a preference for operating within a schema based on personal interests in either a consolidated or transitional manner. An example of a type indicator involving a secondary schema is Type 3, where a preference for the maintaining norms schema is transitional with personal interests as a secondary schema.

Table 7. DIT-2 type indicators showing predominant and secondary schemata

Type indicator	Predominant schema (consolidated/transitional)	Secondary schema
1	Personal interests (consolidated)	-
2	Personal interests (transitional)	-
3	Maintaining norms (transitional)	Personal interests
4	Maintaining norms (consolidated)	-
5	Maintaining norms (transitional)	Postconventional
6	Postconventional (transitional)	-
7	Postconventional (consolidated)	-

Thoma and Dong (2014) highlighted research indicating that people with consolidated thinking take longer to decide about dilemmas and that a deeper level of processing may underpin this (Thoma, Narvaez, Endicott and Derryberry, 2001; Derryberry & Thoma, 2005).

A further measure often extracted from the DIT-2 is the P score, derived from the ranking of postconventional items. In Thoma and Dong's (2014) summary of the historical development of the DIT measure, they highlight that as the postconventional score is a continuous measure, it has been criticised for giving the impression of being a quantitative measure when in fact it is designed to discriminate qualitatively between the three levels of thinking. They also mention that the P score does not consider measurement of the other two levels of schematic thinking. Over the last decade, the N2 score was developed, which adjusts the P score according to both an individual's aptitude in discriminating between postconventional and lower stages of thinking, and their preference for postconventional items. Thoma and Dong recommend that for professional population groups the N2 can help distinguish at levels of more complex thinking. Using the N2 score in addition to the type indicator index is helpful, as an increase in N2 score provides the scope to assess further development of ethical thinking due to education. Use of the measure in educational settings has indicated that between 30-50% of variance in DIT scores relates to level of education (Thoma, 1986) and that sophistication of ethical thinking can increase in response to educational interventions. A ten-year longitudinal research study highlighted that university

attenders had significantly higher levels of ethical development in comparison with non-attenders (Rest & Narvaez, 1994).

2.5.1.2 Reliability and validity. Rest et al. (1999a) reported that the original DIT measure shows adequate reliability, with Cronbach alpha in the upper 0.70s/low 0.80s, with similar values for test-retest reliability. The researchers also report no sacrifice of validity in the updated DIT-2 version of the questionnaire. More recent summaries of research indicate that the DIT-2 has reasonable internal consistency, and is able to discriminate between participant groups expected to have differing scores related to life opportunities and education (Thoma, 2014: Thoma et al., 2016).

2.5.2 Repertory grid technique. To explore the construing of personal and professional ethical dilemmas, individual interviews were conducted using repertory grid technique. Repertory grid technique was developed by George Kelly (1955) as a means of eliciting - and examining the content and structure of - individuals' personal constructs systems. According to Kelly, individuals develop their own unique theoretical frameworks known as personal construct systems, which can help them anticipate and make predictions about future events. Constructs are bipolar in nature because the process of ascribing meaning to a situation necessitates the spotting of both similarities and differences. The pole of a construct which is elicited when a person notices a similarity is known as the emergent pole, and the implicit pole is elicited when a difference is noted. Winter and Procter (2014) give an illustration of a construct through an example of a person who describes themselves as "*reserved*" (p.146). This is the emergent pole of a construct which could be contrasted with possible implicit distinctions such as "*happy, active or sociable*." The constituents of the matter being construed, which could either be situational or involve individuals occupying particular roles, are known as elements, and the repertory grid offers a way to represent relationships between the constructs and elements.

2.5.2.1 Grid design. The grid was designed to include a total of eleven elements and eleven constructs. Although this meant the grid was fairly small, it was anticipated that each interview would require a time commitment of one hour and that a larger grid could limit recruitment. Ten of the elements involved a series of ethical dilemmas, comprised of five personal scenarios and five professional scenarios representative of trainees' experiences. The remaining element asked participants to consider a scenario involving a decision which posed 'no dilemma.'

Ten of the 11 constructs were elicited from participants; this approach was preferred to supplying constructs as it increased the likelihood of obtaining a full picture of each participant's idiosyncratic worldview. The final construct, which was entitled, 'This dilemma is easy – This dilemma is hard', was supplied. This made it possible to examine the correlation between each construct and the individual's construing of the difficulty of the personal and professional dilemmas. A 7-point rating scale was used to rate the elements on the constructs from 1 (implicit pole) to 7 (emergent pole); this had the advantage of giving the option of a midpoint rating if, for example, the construct was not considered applicable to an element.

A total of twenty ethical scenarios were initially devised by the principal researcher: ten of these were personal and ten were professional dilemmas. The professional dilemmas were representative of six common themes of concern previously raised with the BPS via psychologist surveys, queries and complaints, all of which are outlined in the 2009 version of the BPS Code of Ethics and Conduct. These areas include managing multiple relationships; the violation of client trust; unclear standards of practice; confidentiality breaches; issues of competence; research issues. All the devised personal and professional dilemmas were discussed with both members of the research supervisory team, each of whom gave feedback on inclusion/exclusion based on representativeness of the scenarios. Both supervisors also

contributed additional scenarios. In total, this process culminated in a total of 11 personal and 11 professional scenarios to be further considered for inclusion.

2.5.2.2 Pretesting of scenarios. The 22 scenarios were discussed with five trainees as part of a focus group. Each trainee was asked to read the scenarios and highlight those deemed most relevant and meaningful. They were also asked to indicate any important dilemmas that had not been represented. The final five personal and five professional ethical scenarios were selected in accordance with the trainee feedback.

Two trainee clinical psychologist consultants were recruited from the principal researcher's training institution to pilot test the interview. Following this, the language used in the personal ethical scenario, 'You see an older adult shoplifting in a supermarket,' was altered to, 'You see an elderly person shoplifting in a supermarket.' This was based on trainee feedback stating that using the term 'older adult' would make this scenario more fitting for the professional scenario category. Table 8 shows a complete list of all personal and professional scenarios included.

Table 8. Personal and professional ethical scenario grid elements

Personal
You see a parent smacking a child in public
You are friends with a couple, and find out one of them is having an affair without their partner knowing
An expensive item of software you really need is available for free via illegal download online
You are aware a friend of yours regularly drives home from parties when well over the alcohol limit
You see an elderly person shoplifting in a supermarket
Professional
You are in a multidisciplinary meeting and hear a Care Coordinator speak in disparaging terms about a service user
You want to conduct your major research project on self-harm, and there is the possibility of using your sister – who self-harms – as service user consultant
A service user confesses to you that 20 years ago they tried to murder their abusive partner by poisoning the partner's food, but this only resulted in a severe stomach upset. Your service user has not shown any evidence of being a danger to others since that time
You notice a fellow trainee posting a message about fancying a client on the group WhatsApp chat
You are aware that a fellow trainee is setting up a private therapy website, citing their extensive experience

2.5.2.3 Grid analysis. Grids were analysed via two grid software packages. Firstly, a single grid Slater analysis was conducted (Slater, 1977, as cited in Grice, 2002) using the computer software package IDIOGRID, version 2.4 (Grice, 2002) and the relevant measures were extracted from the output (see Appendix H for example outputs for first and third year trainees). Secondly, a conflict analysis was undertaken using GRIDSTAT (Bell, 2004, 2009; see Appendix I for output).

2.5.2.4 Measures extracted from the grid. Several measures were extracted from the IDIOGRID and GRIDSTAT outputs which are grouped here according to whether they measure construct system structure, construct usefulness, or the salience or difficulty of ethical scenarios.

2.5.2.4.1 Measures of construct system structure. The percentage of variance explained by the first principal component (PC-1) of the principal component analysis (PCA) was used as a measure of tightness of the overall construct system. The PCA is a statistical procedure that analyses numerical patterns in data and constructs hypothetical variables summarising this information. Scores are produced indicating the percentage of total variance explained by each principal component. A higher percentage of variance explained by PC-1 is indicative of a tendency towards a construing system that is tighter and more uni-dimensional, whereas a higher value obtained for PC-2 indicates looser, less structured construing (Winter, 1992, 2003).

The degree of structure in the personal and professional construct subsystems was measured by the intensity measure, obtained by squaring the correlation between each pair of constructs in the grid and summing these scores (Bannister, 1960). Values were obtained of the sum of the intensity scores for the interrelationships between constructs within the personal domain and the professional domain, a higher total score indicating a tighter construct subsystem. The level of integration between the personal and professional

construct systems was obtained from the sum of the squared construct correlations between personal and professional constructs. The higher the score obtained, the greater the degree of integration between the personal and professional construct subsystems.

2.5.2.4.2 Construct usefulness. The sum of squares score, presented as a percentage of the total sum of squares, was used as an indication of how useful each construct was to each participant, a higher score indicating the construct is more useful (Winter, 1992) in that it discriminates more highly between the elements. The sum of the personal construct scores and the sum of the professional construct scores were used as a measure of the usefulness of each construct subsystem; a higher score indicates constructs are found more useful.

2.5.2.4.3 Salience of the ethical scenarios. The sums of the percent total sum of squares of the elements scores for the personal and professional scenarios were used as a measure of how salient participants found the personal and professional scenarios, a higher score indicating a higher degree of salience.

2.5.2.4.4 Difficulty ratings of scenarios. The degree of difficulty associated with the scenarios was obtained through obtaining the mean difficulty ratings of the personal and professional scenarios, a score of 7 indicating an easy dilemma and 1 indicating a hard dilemma.

2.5.2.4.5 Conflict associated with dilemmas. The presence of conflict in a grid refers to inconsistencies and contradictions present in a person's construing (Bell, 2004). Conflict can occur when an element is similar to two construct poles which are different. It can also occur if an element is similar to one construct pole, but different from another construct pole, when both construct poles are similar. The amount of conflict associated with ethical decision-making was measured by the percent total conflict score. The degree of conflict associated with the construct subsystems was obtained via the sum of the conflict values for the personal dilemmas and the sum of the conflict for professional dilemmas.

2.5.2.4.6 Distances between elements. The standard Euclidean distance between elements score indicates the degree of perceived similarity or difference between elements. Scores obtained on this measure range from zero to two; scores of less than 0.8 indicate similarity between dilemmas, while scores above 1.2 indicate dilemmas are perceived as different (Makhlouf-Norris & Norris, 1973).

2.5.2.5 Reliability and validity. The grid has been reported to have test-retest reliability and internal consistency in the acceptable to good range (Smith, 2000). The grid has also been used in previous research measuring change over time associated with professional training in therapists, social workers and nurses (e.g. Gottesman, 1962; Lifschitz, 1974; Ryle & Breen, 1974; Ellis, 2006).

2.6 Procedure

An incentive of a fifty pounds gift voucher prize draw was offered to trainees in return for taking part. Trainees who had received details of the study and were interested in participating were contacted and provided with an information sheet (see Appendix J). Participants were advised that the study involved two aspects. Firstly, they would complete an online questionnaire in which they would be asked to consider a series of ethical dilemmas. This would be followed by either a face-to-face or Skype interview lasting for approximately one hour in which they would consider a number of personal and professional ethical dilemmas. They were informed that they were able to withdraw from the study at any time, and that all information collected would be confidential.

Trainees wishing to proceed were sent e-mail links to the SurveyMonkey website and a participant identification code. They were asked to complete an online informed consent form (see Appendix K), and a questionnaire including both demographic details and an electronic version of the DIT-2 (see Appendix G). This was completed anonymously, each trainee inserting the supplied unique participant identification code when prompted.

Individual face to face or Skype repertory grid interviews were conducted during which trainees were presented with a series of five triads of personal ethical dilemmas and five triads of professional dilemmas. The order in which triads were presented was counterbalanced, whereby half the trainees were first presented with a triad of personal dilemmas, and half with the professional. Constructs were elicited using the triadic method: participants were asked to identify a way in which two elements were alike and so were different from a third element (Fransella, Bell & Bannister, 2004). This identified the emergent pole of the construct, and asking participants to describe the opposite of this similarity established the implicit pole. This procedure was repeated for all elements by successively adding one new element and removing one already used for comparison. This was repeated until ten constructs were elicited (see Appendix L for a list of all elicited constructs). Participants were then asked to rate each element, including the 'no dilemma' element, with regards to each of the ten elicited constructs. This was followed by rating all elements on the supplied construct, 'This dilemma is easy – This dilemma is hard.' Any construct viewed as not relevant to a given element following discussion was allocated a midpoint rating. Debriefing then occurred: opportunity was given for further questions and interviewer contact details were provided (see Appendix M for copy of Debrief Sheet). Trainees were asked if they would like to receive a summary of the study findings, and contact details were checked with trainees expressing an interest in dissemination.

CHAPTER 3

Results

This chapter commences with an outline of the rationale for the chosen analyses and describes the results obtained. Each hypothesis is addressed in turn. This is followed by idiographic analysis of one trainee per year group. Results are presented in full as no missing data were present.

3.1 Rationale for chosen analyses. Statistical analyses were chosen to address each hypothesis, taking account of the four assumptions of parametric tests, as outlined by Field (2013). The first assumption is that data have a normal distribution. Data should also be at an interval or continuous level and have a linear relationship. The third assumption concerns homogeneity of variance, and the final assumption is that data are independent.

The properties of the data in the current study were deemed appropriate for parametric testing, as data are of at least interval level. To address the assumption of homogeneity of variance, reference was made to Levene's test during the interpretation of test results (see Appendix N for a table summarising statistical analyses and Appendix O for all SPSS output). To assess for normality, skewness and kurtosis values, along with visual examination of P-P plots, indicated all data were normally distributed.

Two extreme scores were noted in the data, related to the N2 score from the DIT-2. Both trainees with extreme scores were in their third year of training. Both scores were within the parameters of three standard deviations away from the mean, and were not reflective of any errors in procedure. They were therefore considered relevant to understanding the research questions, and the decision was made to include them in the analysis.

3.2 Results of statistical analyses.

Results are presented grouped according to each research question and its corresponding hypotheses.

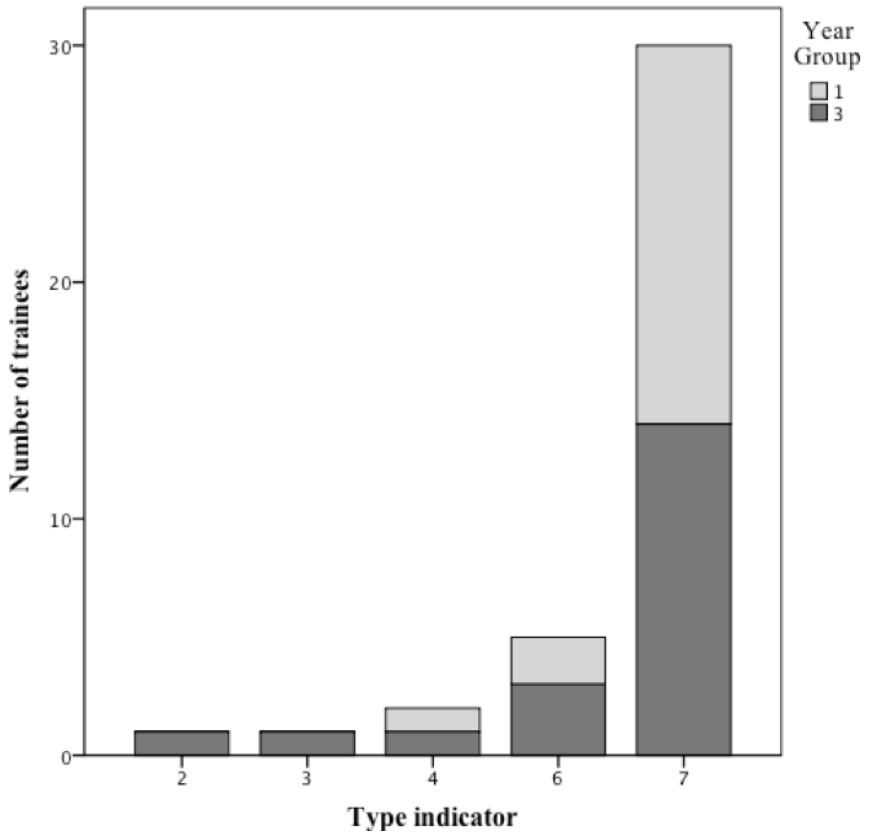
3.2.1 Level of ethical development. One hypothesis focused on trainees' level of ethical development by examining the difference in type indicator and DIT-2 schema scores between the year groups.

3.2.1.1 There will be a difference in the level of ethical development between first and third year trainees. It was predicted that there would be a difference in the sophistication of moral reasoning between first and third year trainees. This was analysed by two measures extracted from the DIT-2 questionnaire. The first of these was a categorisation type describing the stage of ethical development, and the second consisted of schema scores.

3.2.1.1.1 Type indicator. The DIT-2 includes various indices, including a 'type indicator' which indicates an individual's preference for personal interests, maintaining norms and postconventional schemata. The type indicator also ascribes individuals to either a consolidated or transitional phase according to whether they discriminate clearly (consolidated) or fail to discriminate between types of schemata, the latter being indicative of a developmental, transitional phase. There are seven type indicators in total.

Figure 1 indicates the type indicator allocated to first and third year trainees. One third year trainee was allocated to Type 2 (personal interests but transitional) and one to Type 3 (maintaining norms schema but transitional). No first-year trainees were allocated to either of these categories. One trainee from each year group was allocated to Type 4 (maintaining norms schema and consolidated) and none were allocated to Type 5. Two trainees from the first year and three from the third year were Type 6 (postconventional but transitional) and the remaining 30 trainees – 16 from Year 1 and 14 from Year 2 - were Type 7 (postconventional and consolidated). Only four trainees in total, one from Year 1 and three

from Year 3, were allocated to stage four and below, which consists of a predominance in either maintaining norms or personal interest schemata.



Key
Type 2 (personal interests, transitional); Type 3 (maintaining norms, transitional); Type 4 (maintaining norms, consolidated); Type 6 (postconventional, transitional); Type 7 (postconventional, consolidated)

Figure 1. Trainees from each year group allocated to each type indicator

There was found to be no significant relationship between trainees from each year group and their allocation to the postconventional thinking type indicators (Type 6 and Type 7) or type indicators five and below (p = .605, Fisher's exact test).

3.2.1.1.2 DIT-2 schema scores. The personal interest schema score shows how many responses are in keeping with stage two and three thinking, in which personal advantages and disadvantages associated with a decision are weighed up. A personal interests approach means that an individual will consider the interests of the self and other close relationships, but broader societal systems are neglected (Rest et al., 1999a). The maintaining norms

schema score highlights the proportion of responses in line with stage 4 considerations, which are associated with societal cooperation such as the maintenance of legal structures and societal roles. The N2 score assesses an individual's preference for postconventional items, as well as aptitude for discriminating between postconventional and less developed stages of thinking.

Figure 2 shows the mean scores for personal interest, maintaining norms and postconventional thinking for trainees from each year group.

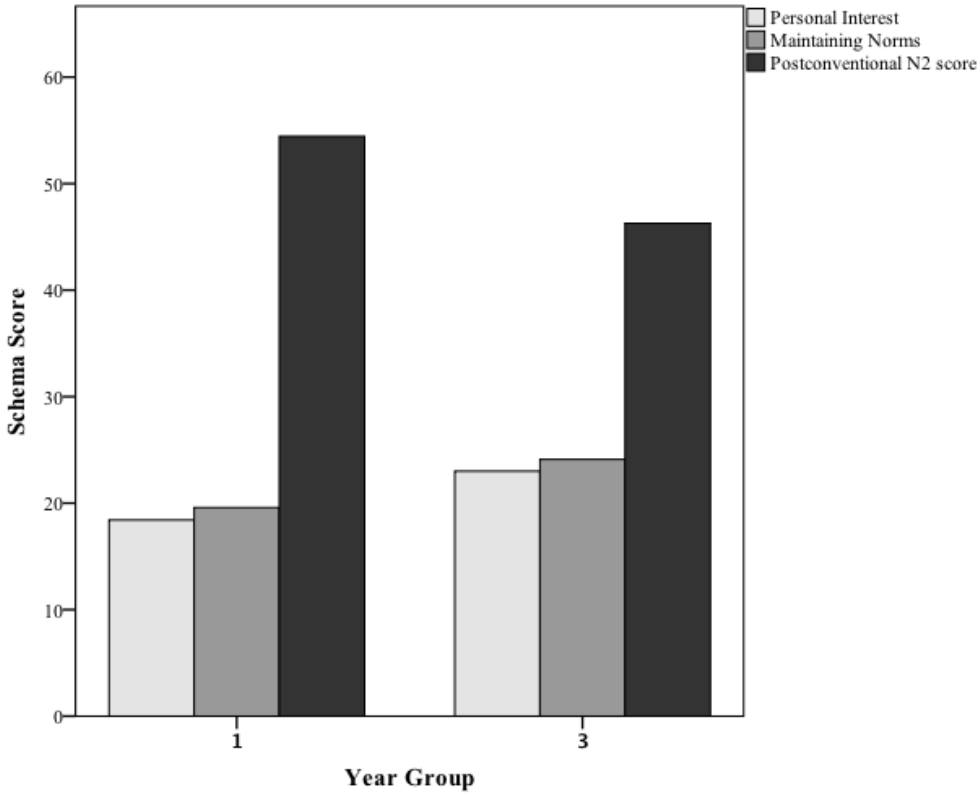


Figure 2. Schema scores obtained for first and third year trainees

First year trainees had a mean personal interest score of 18.42 (*SD* = 11.21) and third year trainees scored 23.00 (*SD* = 9.57). An independent samples t-test indicated that this difference (– 4.58, 95% CI: – 11.33 to 2.17) was not significant, *t* (37) = – 1.38, *p* = .178, 2-tailed. The first years had a mean maintaining norms score of 19.58 (*SD* = 13.67), and third years scored 24.10 (*SD* = 11.23). An independent samples t-test again indicated that this

difference (– 4.52, 95% CI: – 12.62 to 3.58) was not significant, t (37) = – 1.13, p = .265, 2-tailed.

The mean postconventional N2 score of all trainees indicated that, on average, trainees appeared to use a postconventional approach for around half of their decision-making. First year trainees scored 54.45 (SD = 9.58), which was higher than the third year trainee score of 46.28 (SD = 12.31). This difference (8.18, 95% CI: 1.00 to 15.36) was significant, t (37) = 2.31, p = .027, 2-tailed, equal variances assumed, representing a medium-sized effect according to Cohen's (1988) conventions (d = 0.74).

In summary, findings from the DIT-2 type indicator and schema score data indicated that around 90% of trainees were situated within the most postconventional ethical thinking categories (Type 6 and Type 7) but around 10% of trainees (one first year and three third year trainees) were operating at a less sophisticated level; most of these were operating from an approach based on the maintaining norms schema and one was operating from within the personal interest schema. There was no association established between the degree of sophistication in ethical decision-making schemata of more and less experienced trainees according to the type indicator measure; however, less experienced trainees appeared to more often use highly developed ethical reasoning abilities than more experienced trainees when referring to the difference in N2 score. Age and gender did not appear to exert a confounding influence on schema score (see Appendix P for age and gender analyses).

3.2.2 Relationship between sophistication of decision-making and construing. One hypothesis examined the correlation between sophistication in ethical thinking and the degree of structure in the construct systems of trainees.

3.2.2.1 More sophisticated ethical development will be associated with more differentiated, looser construing. It was predicted that the degree of structure in trainees' ethical construct systems would correlate with their sophistication of ethical reasoning. This

was analysed by measuring the association between the N2 score from the DIT-2 and the PC-1 score from the grid, which measures tightness of construing. A weak negative relationship was found between N2 and PC-1 scores for trainees as a whole ($r = –.33$, $p = .021$, 1-tailed); this relationship was more apparent in first years, where there was a medium strength association ($r = –.49$, $p = .017$, 1-tailed) and was not present in third year trainees ($r = –.15$, $p = .267$, 1-tailed). These results indicated that less experienced trainees with more highly developed ethical reasoning abilities tended to have looser, less structured, construct systems.

3.2.3 Differences in construing between year groups. A series of five hypotheses addressed differences between year groups with regards to their construing of dilemmas. The first of these concerned the overall degree of structure present in the construct system as a whole. A further four examined differences in personal and professional ethical decision-making subsystems between groups. This included the degree of structure in the personal and professional subsystems and how useful trainees found the respective subsystems. The level of integration between the subsystems was also examined, and the salience of the personal compared to the professional scenarios.

3.2.3.1 Third year trainees will have less structure in the overall configuration of their construct systems. The PC-1 value gives an indication of the degree of tightness in structure, a higher value indicating a more structured system. An independent samples *t*-test indicated that the difference in PC-1 score between year groups (– 4.93, 95% CI: – 11.45 to 1.58) was not significant, $t\ (37) = – 1.54$, $p = .067$, 1-tailed, equal variances assumed; therefore, there appeared to be no difference in the degree of structure in the ethical construct systems of more and less experienced trainees.

3.2.3.2 Third year trainees will have more structure in their professional construct subsystems than first year trainees. The sums of the intensity scores for the professional constructs was used as a measure of tightness in the professional subsystem. The difference

between groups (– 0.36, 95% CI: – 0.84 to 0.13) was not significant, t (37) = – 1.50, p = .071, 1-tailed, equal variances assumed. These results indicated no difference between first and third year trainees in the overall structure of their personal and professional construct subsystems.

3.2.3.3 First year trainees will find their personal constructs more useful than third years when making ethical decisions. Third year trainees will find their professional constructs more useful than first years. This was examined by comparing the percent total sum of squares scores for the personal constructs and the professional constructs between first and third years, as an indication of the usefulness of the construct system. First year trainees had a higher mean score for their personal constructs than third year trainees. An independent samples t-test indicated that this difference (3.44, 95% CI: .37 to 6.50) was significant, t (37) = 2.27, p = .015, 1-tailed, equal variances assumed, representing a medium-sized effect (d = .62).

With regards to the usefulness of their professional construct system, first year trainees had a lower mean percent total sum of squares score than third year trainees. This difference (– 3.44, 95% CI: – 6.26 to – .62) was significant, t (37) = 2.47, p = .009, 1-tailed, equal variances assumed, representing close to a large-sized effect (d = .79). These results indicated that first year trainees found their personal construct subsystems comparatively more useful than third years, whereas third year trainees found their professional construct system more useful than first years.

3.2.3.4 There will be a greater level of integration of personal and professional ethical decision-making subsystems in third year trainees. An independent samples t-test examined the level of integration of personal and professional subsystems between trainees from each year group, measured by the intensity of relationships between personal and professional constructs. First year trainees had a lower mean intensity score than third years,

and this difference (– 1.12, 95% CI: – 2.40 to .15) was significant, t (37) = – 1.79, p = .041, 1-tailed, equal variances assumed, representing a medium-sized effect (d = .57). Third year trainees were therefore found to have more integration between their personal and professional construct systems.

3.2.3.5 Third year trainees will find professional scenarios more salient than first year trainees, and first year trainees will find personal scenarios more salient than third year trainees. The difference in salience was examined by a between groups comparison of the sums of the percent total sum of squares of the elements scores for both the personal and the professional scenarios. An independent samples t-test indicated that the difference in salience for personal scenarios between year groups (1.31, 95% CI: – 3.28 to 5.90) was not significant, t (37) = 0.58, p = .283, 1-tailed, equal variances assumed. The difference (0.51, 95% CI: – 3.29 to 4.32) between groups with respect to professional dilemmas was also not significant, t (37) = 0.27, p = .393, 1-tailed, equal variances assumed. These findings indicated there was no difference between more and less experienced trainees in the degree of salience associated with personal or professional scenarios.

3.2.4 Difficulty making ethical decisions. The degree of difficulty associated with making decisions was examined by two hypotheses. The first of these involved difficulty ratings ascribed to personal and professional scenarios between groups. The second hypothesis focused on levels of conflict associated with professional ethical decision-making over the course of training.

3.2.4.1 There will be a difference in difficulty ratings for professional ethical decision-making between first and third year trainees. This hypothesis was analysed through assessing the difference in difficulty ratings ascribed to the dilemmas. The mean rating of dilemma difficulty on the grid for personal scenarios (where 7 is easy and 1 is difficult) was very similar in both groups, and the difference (0.04, 95% CI: – 0.59 to 0.68)

was not significant, t (37) = .143, p = .887, 2-tailed, equal variances assumed. For professional scenarios, again the difference (0.17, 95% CI: – 0.33 to 0.68) was not significant, t (33.18) = 0.704, p = .487, 2-tailed, equal variances not assumed. These findings indicated there was no overall difference between first and third year trainees in terms of the difficulty they ascribed to personal and professional ethical dilemmas.

3.2.4.2 The degree of conflict associated with professional scenarios will decrease over the course of training. An independent samples t-test was conducted to examine the difference in conflict between year groups concerning professional dilemmas using the sum of the professional conflict scores. This indicated that the difference in conflict experienced regarding the professional scenarios between year groups was not significant, t (37) = 0.17, p = .433, 1-tailed, equal variances assumed. These results indicated there was no discernible difference between more and less experienced trainees concerning the overall level of conflict experienced in relation to personal or professional scenarios.

3.2.5 Additional findings of interest. Additional findings of interest were obtained in relation to the salience of personal dilemmas for all trainees, and the level of conflict associated with dilemmas from the personal domain.

3.2.5.1 Salience of personal scenarios. The difference in salience between personal and professional dilemmas was examined for trainees as a whole, by comparing the sums of the percent total sum of squares of the elements scores for the personal and the professional scenarios. Both first and third year trainees appeared to find the personal scenarios more salient than the professional scenarios. A paired samples t-test indicated that the difference in salience (8.73, 95% CI: 4.83 to 12.63) was significant, t (38) = 4.54, p = < .001, 2-tailed, representing a medium magnitude of effect (d = 0.73). For first years as a group, the difference (9.14, 95% CI: 3.29 to 14.98) was significant, t (18) = 3.29, p = .004, 2-tailed, again representing a medium magnitude of effect (d = 0.75). For third years, the difference

(8.33, 95% CI: 2.62 to 14.06) was again significant, t (19) = 3.05, p = .007, 2-tailed, representing an effect of medium magnitude (d = 0.68). These findings indicated that all trainees found the personal ethical scenarios more salient than the professional scenarios.

3.2.5.2 Level of conflict associated with personal and professional scenarios. The level of conflict for personal scenarios appeared to be considerably higher than professional scenarios for trainees as a whole. A paired samples t-test indicated that the difference for all trainees (8.72, 95% CI: 5.30 to 12.14) was significant, t (38) = 5.16, p = < .001, 2-tailed, representing a large sized effect (d = 0.83). The difference (9.05, 95% CI: 3.47 to 14.63) was also significant for first years, t (18) = 3.41, p = .003, 2-tailed, representing close to a large sized effect (d = 0.78) and again (8.40, 95% CI: 3.84 to 12.96) for third year trainees, t (19) = 3.85, p = .001, 2-tailed, representing a large sized effect (d = 0.86). Results from the conflict analyses demonstrated that for all trainees, independent of their stage of training, the personal dilemmas caused more conflict than the professional dilemmas.

3.2.6 Post hoc power calculation. Post hoc power calculations were carried out using G*Power 3 software (Faul, Erdfelder, Lang & Buchner, 2007) to determine the power of the study based on composite effect sizes. This indicated power of around 65% had been achieved for t-test analyses and power of around 60% had been achieved for correlational analyses.

3.3 Individual case studies

In addition to adopting a nomothetic approach involving the examination of differences between trainees of differing levels of experience and varying schematic profiles, idiographic analysis of grid and DIT-2 measures offers a further route for exploring individual trainee approaches to ethical decision-making. The two case examples provided concern trainees with differing levels of experience and contrasting DIT-2 and grid profiles (see Appendix H for IDIOGRID and Appendix I for GRIDSTAT output for both trainees).

Pseudonyms have been used, demographic details kept to a minimum and the wording of some constructs altered slightly to preserve trainee anonymity.

3.3.1 Case study 1: First year trainee. Gabby's grid was selected for in-depth analysis as her DIT-2 profile indicated she was situated within a postconventional approach to ethical reasoning, being allocated to the Type 7 category. A very high N2 score in relation to trainees as a whole and doctoral level students more generally (see Appendix Q for population norms) indicated a high level of postconventional reasoning. Gabby's DIT-2 and grid scores are shown in Table 9.

Table 9. First year trainee DIT-2 and grid measures

Variable	Score	Variable	Score
Personal interest	2.00	PC-1	30.19
Maintaining norms	10.00	Easy (per) dilemma	2.80
N2 score	71.88	Easy (pro) dilemma	4.40
Total SS (per) cons	42.72	% total conflict	47.30
Total SS (pro) cons	47.05	% conflict (per)	51.40
Int (per)	1.81	% conflict (pro)	45.10
Int (pro)	1.33	Total SS (per el)	42.97
Int corr	1.49	Total SS (pro el)	46.12

Total SS(per) cons: Percent total sum of squares of the personal constructs
Total SS(pro) cons: Percent total sum of squares of the professional constructs
Int (per): Sum of intensity scores for personal constructs
Int (pro): Sum of intensity scores for professional constructs
Int corr: Correlations between personal and professional intensity scores
PC-1: Size of the first component on the principal component analysis
Easy (per) dilemma: Difficulty rating for personal dilemma (7=easy, 1=difficult)
Easy (pro) dilemma: Difficulty rating for professional dilemma
% total conflict: Percent total conflict
% conflict (per): Conflict associated with personal elements
% conflict (pro): Conflict associated with professional elements
Total SS (per) el: Percent total sum of squares of the personal elements
Total SS (pro) el: Percent total sum of squares of the professional elements

Table 10 shows Gabby's elicited constructs in response to the personal and professional ethical dilemmas.

Table 10. First year trainee personal and professional constructs

Elicited constructs	
Personal	Professional
Relational – Individual	Actions of professional – Actions of service user
Illegal – Morally dubious	Current - Historical
Tangible goods - Behaviour	Web based – Real world based
Having victims – Victimless crime	Trainees – Another member of multidisciplinary team
Adults - Child	Conduct at work – Conduct outside of work

Gabby's constructs appear to cover a wide array of themes, including a consideration of who is acting unethically, and the severity of any consequences. Contextual factors such as whether the dilemma occurred in the past or present, and environmental issues including where the scenario took place, and whether it was virtual vs. real-world are highlighted.

A PCA plot was obtained through conducting a Slater (1977) analysis via Idiogrid (Grice, 2002). The plot gives a visual representation of the construct system by illustrating the way in which elements and constructs are loaded on the first two principal components. The horizontal axis represents the first principal component and the vertical axis represents the second component.

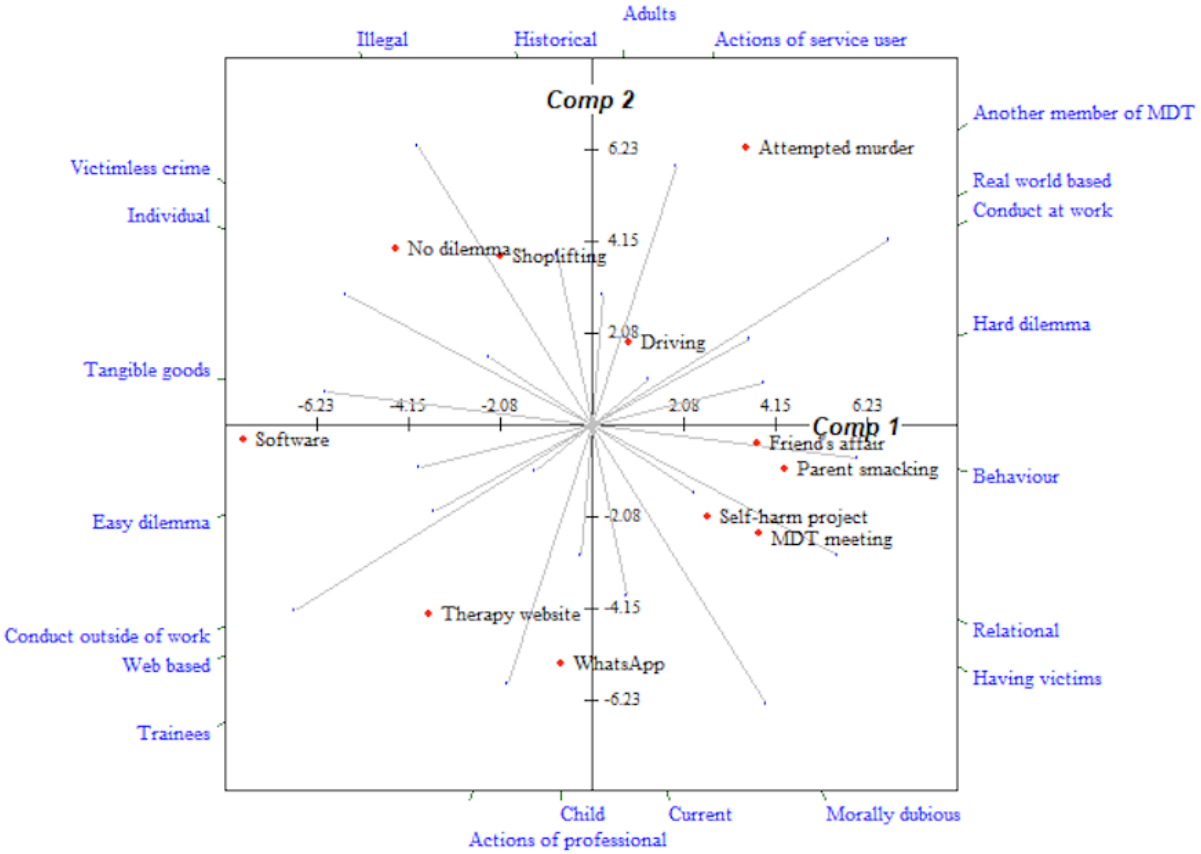


Figure 3. Principal component analysis plot for first year trainee

Visual inspection of a plot can provide insight into an individual's construing. Elements in opposing quadrants, for example, can be considered the most dissimilar and

those situated furthest away from the origin are most salient (Winter, 1992). Gabby's constructs are distributed across the four quadrants of the plot, as opposed to being configured around the axes. This is indicative of a loose, less structured construct system. Gabby's intensity scores for personal and professional construing are also somewhat lower than the mean for all trainees, indicative of loose construing in both subsystems.

The PC-1 value measures the percentage variance that is accounted for by the first principal component, thus indicating the overall degree of tightness or looseness in an individual's construct system. A higher PC-1 value is found in a more highly structured, unidimensional system. The mean PC-1 value for all trainee participants was particularly low, especially as smaller grids generally tend to produce higher PC-1 scores (Winter, 1992). Gabby's PC-1 value was one of the lowest scores of all trainees.

Table 11 shows loadings of constructs on the first and second principal components and percent total sum of squares of the constructs from Idiogrid analysis of Gabby's grid.

Table 11. Construct loadings and percent total sum of squares of the constructs for a first year trainee

Constructs	Components		% total sum of squares
	1	2	
Actions of professional – Actions of service user	-1.90	-5.84	10.57
Relational - Individual	5.58	-2.93	9.39
Current - Historical	0.77	-3.86	5.79
Illegal – Morally dubious	-3.94	6.31	12.89
Web based – Real world based	-6.74	-4.19	13.84
Tangible goods - Behaviour	-6.02	0.74	7.65
Trainees – Another member of multidisciplinary team	-1.29	-1.05	3.01
Having victims – Victimless crime	2.34	-1.52	6.93
Conduct at work – Conduct outside of work	3.56	1.96	13.84
Adults - Child	0.25	2.94	5.86
Easy dilemma - Hard dilemma	-3.91	-0.97	10.24

The constructs most highly loaded on Gabby's main dimension of construing concern whether the dilemma occurs at an individual level, is web based, and involves tangible goods. These factors are contrasted with relational, real world, behaviour based scenarios. Gabby's second major dimension of construing concerns whether a dilemma is illegal or involves the actions of a service user. This is contrasted with scenarios that are morally dubious or involve the actions of a professional.

The constructs with the highest percent total sum of squares values involve contextual considerations related to the environment, including whether the dilemma involves conduct at work or outside of work, and takes place online or in the 'real world.' This highlights that Gabby finds it helpful to consider contextual factors during the ethical decision-making process. The value obtained for the percent total sum of squares of the professional constructs was higher than the mean score for all trainees, and the value for personal constructs was lower than the average. This indicates that Gabby finds her professional construing more useful to her in comparison with others, which might help explain why she rated the professional dilemmas as slightly easier than average. Gabby rated the personal dilemmas as considerably harder than average, but experienced more conflict in relation to professional dilemmas.

The PCA plot and standardised Euclidean distance score of 0.4 highlight that Gabby construes two professional scenarios very similarly (scores of less than 0.8 indicate similarity; Winter, 1992). These scenarios include a trainee using her sister as a service user consultant, and hearing a colleague speak disparagingly about a client in a multidisciplinary meeting. The friend's affair and a parent smacking a child are two personal scenarios that are similar for Gabby (standardised element Euclidean distance: 0.64). The percent total sum of squares of the elements score (13.05) highlights that the professional scenario concerning a client confessing to attempted murder is the most salient. The software scenario also carries

meaning for Gabby (percent total sum of squares score: 12.34). The salience of these two scenarios is also indicated by their distance from the origin on the PCA plot.

3.3.2 Case study 2: Third year trainee. Tessa was selected for analysis as scores obtained on the DIT-2 indicated a schema preference based on personal interest, i.e. the allocated type indicator was type 2, predominant in personal interest schema but transitional. Tessa's level of postconventional thinking was much lower than that of the sample of trainees as a whole and doctoral students more generally (see Appendix Q for comparison of norms). Tessa's scores for all DIT-2 and grid measures are shown in Table 12.

Table 12. Third year trainee DIT-2 and grid measures

Variable	Score	Variable	Score
Personal interest	38.00	PC-1	61.18
Maintaining norms	30.00	Easy (per) dilemma	4.00
N2 score	22.90	Easy (pro) dilemma	3.20
Total SS (per) cons	44.50	% total conflict	42.30
Total SS (pro) cons	45.43	% conflict (per)	51.20
Int (per)	4.25	% conflict (pro)	34.80
Int (pro)	2.75	Total SS (per el)	51.08
Int corr	1.50	Total SS (pro el)	31.19

Total SS(per) cons: Percent total sum of squares of the personal constructs
Total SS(pro) cons: Percent total sum of squares of the professional constructs
Int (per): Sum of intensity scores for personal constructs
Int (pro): Sum of intensity scores for professional constructs
Int corr: Correlations between personal and professional intensity scores
PC-1: Size of the first component on the principal component analysis
Easy (per) dilemma: Difficulty rating for personal dilemma (7=easy, 1=difficult)
Easy (pro) dilemma: Difficulty rating for professional dilemma
% total conflict: Percent total conflict
% conflict (per): Conflict associated with personal elements
% conflict (pro): Conflict associated with professional elements
Total SS (per) el: Percent total sum of squares of the personal elements
Total SS (pro) el: Percent total sum of squares of the professional elements

The personal and professional constructs elicited during the interview with Tessa are shown in Table 13.

Table 13. Third year trainee elicited personal and professional constructs

Elicited constructs	
Personal	Professional
Impact on relationships - Wouldn't affect anyone	Professional guidelines - Personal responsibility
Impact on people - Doesn't directly impact people	Clearer process with guidelines - Context unclear
Ethics about finances – Ethics about people	Emotions affecting process - Clearer to know what to do
Wouldn't intervene – Intervene	Acting against someone important to me - Acting against other people
Wouldn't know process - Process for reporting	Less likely to cause harm - More likely to cause harm

Two themes are apparent from Tessa's elicited constructs, and these themes both appear in three constructs. The first theme occurs in three constructs highly loaded on the first principal component, and involves considering oneself from within a relational frame. These constructs include 'Impact on relationships – Wouldn't affect anyone' and 'Impact on people – Doesn't directly impact people' from the personal domain and 'Acting against someone important to me - Acting against other people' from the professional construct system. The latter of these had the highest percent total sum of squares value, and a wide range of ratings on the elements were used during its application, indicating that Tessa finds this construct particularly helpful in decision-making. This appears to fit with a preconventional approach, where personal needs and sometimes the needs of close others are prioritised or, alternatively, a conventional level of ethical thinking where loyalty to close others is valued, independent of potential consequences. These constructs indicate that the extent to which Tessa knows the people concerned, and how the scenario may impact her personal relationships, are important factors for her.

Winter (1992) highlights Landfield and Epting's suggestion (1987) that attending to the phrasing of the constructs is important, for example, considering whether content seems more concrete and descriptive in nature or is more nuanced in its consideration of factors underlying relational behaviour. In Tessa's case, her relational constructs seem similar, in that they appear to refer to impact on others, but with no elaboration concerning the nature of the impact and how this might be experienced.

The second most common theme concerns professional guidelines and procedures. The first two constructs, 'Professional guidelines – Personal responsibility' and 'Clearer process with guidelines' were elicited in response to professional scenarios, while 'Wouldn't know process – Process for reporting' occurred in response to personal ethical dilemmas. As constructs related to adherence to professional standards were elicited a total of three times,

this appears to indicate that ethical thinking is in keeping with a maintaining norms perspective, whereby importance is placed on having respect for authority and the preservation of social rules.

Figure 4 shows the PCA plot of Tessa's construct system.

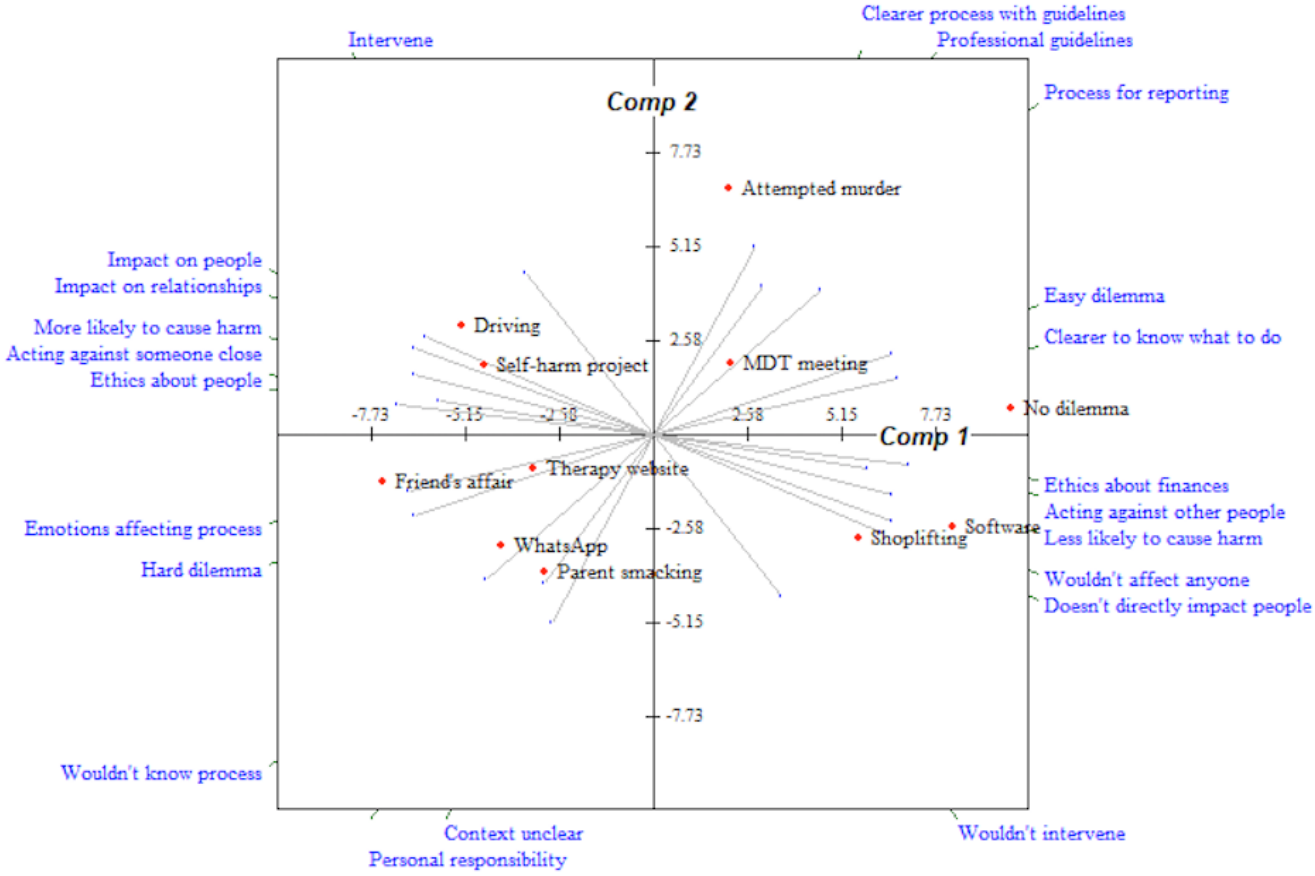


Figure 4. Principal component analysis plot for third year trainee

Visual inspection of the plot highlights that a good number of Tessa's constructs are grouped around the first principal component. Tessa's PC-1 value was at the top end of the range in relation to other trainees, indicating a more tightly organised and unidimensional system. The intensity scores, indicative of the degree of structure in Tessa's personal and professional construct subsystems, are again considerably higher than average, as is the sum of the intensity scores for the correlation between personal and professional construct systems. Overall, this indicates that Tessa adopts a structured approach to personal and

professional ethical decision-making and her personal and professional ethical constructs are well integrated.

Table 14 shows loadings of constructs on the first and second principal components and percent total sum of squares of the constructs from Idiogrid analysis of Tessa's grid.

Table 14. Construct loadings and percent total sum of squares of the constructs for a third year trainee

Constructs	Components		% total sum of squares
	1	2	
Impact on relationships - Wouldn't affect anyone	-6.54	2.38	8.94
Professional guidelines - Personal responsibility	3	4.07	8.3
Impact on people - Doesn't directly impact people	-6.22	2.68	8.97
Clearer process with guidelines - Context unclear	2.77	5.17	8.07
Ethics about finances – Ethics about people	6.99	-0.84	10.29
Emotions affecting process - Clearer to know what to do	-6.72	-1.56	9.29
Wouldn't intervene – Intervene	3.49	-4.42	7.46
Acting against someone important to me - Acting against other people	-5.89	0.93	10.9
Wouldn't know process - Process for reporting	-4.58	-3.96	8.84
Less likely to cause harm - More likely to cause harm	6.56	-1.63	8.87
Easy dilemma - Hard dilemma	6.55	2.22	10.06

Constructs most highly loaded on the first principal component concern ethics related to people and the impact of emotions on making an ethical decision, in contrast with ethics related to finance and being clearer about what action to take. Tessa's second major dimension of construing concerns having a clear process with guidelines and intervening, which is contrasted with the context being unclear and not intervening.

Tessa appears to find both her personal and professional construct subsystems equally useful, indicated by the similar values obtained for the total sum of squares scores for the personal compared with professional constructs. The values obtained for these figures are roughly in line with the average scores for trainees as a whole.

The PCA plot and Euclidean element distance score highlight that Tessa views the ethical scenarios concerning a friend driving home after drinking alcohol and involving a

sister as a service user consultant similarly (standardised Euclidean element distance: 0.39); the service user consultant scenario is also construed similarly to the scenario where a trainee sets up a therapy website. These are construed as difficult dilemmas, which might be influenced by emotional responses. Scenarios viewed as more clear cut and easier include illegally downloading software and an elderly person shoplifting.

The percent total sum of squares of the personal elements score is considerably higher than that of the professional elements, indicating that Tessa finds the personal ethical dilemmas more salient. This is also illustrated by the position of the personal dilemmas on the PCA plot which are generally situated further away from the origin of the plot than the professional dilemmas. Tessa also appears to have experienced more conflict in relation to the personal dilemmas, which might be expected if these are more salient.

CHAPTER 4

Discussion

This chapter summarises the results obtained in relation to the four research questions, relating these findings to theoretical and empirical literature. This is followed by a consideration of clinical implications of the research, and an examination of the study's strengths and limitations. Finally, suggestions for future research are outlined.

4.1 Research findings.

Four research questions were posed. The first of these focused on the level of sophistication of trainees' ethical decision-making schemata and how this develops over training. The second examined the association between sophistication of ethical thinking and construing. The third question focused on differences in construing between more and less experienced trainees, and the final question explored how difficult trainees find the decision-making process.

4.1.1 Sophistication of ethical decision-making schemata. Trainees appear to draw on sophisticated schemata during their ethical decision-making, with the vast majority of trainees operating from within the most advanced schema, a consolidated, postconventional approach. Having said that, a small minority of trainees appear to adopt a less sophisticated approach to decision-making, predominating in approaches based on maintaining norms or personal interests. When viewed in the context of results for doctoral level students more generally, trainee clinical psychologist schema scores are very similar (Bebeau Maeda & Tichy-Reese, 2003; see Appendix Q for details of statistical comparison with normed data). However, the presence of a less sophisticated approach in a minority is a matter of some concern for the profession of clinical psychology which requires frequent and complex ethical decision-making as a key competency. This is not the first time this phenomenon has been observed in healthcare professionals. Interviews conducted with

doctors applying to train as orthopaedic surgeons showed that ranking of candidate performance highlighted a wide variation in postconventional schema scores obtained (Bohm et al., 2014). This was despite the fact that an ethical dilemma was discussed as part of the interview process.

An interesting finding was demonstrated with regards to the sophistication of ethical decision-making between trainees at the beginning and end of training. Although there was no significant relationship between trainees from each year group and their allocation to the postconventional thinking type indicators, more experienced trainees were found to have a lower N2 score. This is a measurement of discrimination between postconventional and lower stages of thinking, as well as a preference for postconventional items. These findings differ somewhat from Ellis-Caird and Wainwright (unpublished 2013), who found no difference between year groups for schema scores; however, neither did they find evidence of more sophisticated ethical reasoning over time. It is noteworthy that the authors collapsed second and third year trainees into one group for the purposes of analysis, so there is the possibility this could have diluted any effect.

The difference in N2 score is an interesting outcome, as previous research using the DIT summarised by Rest et al. (1999a) indicates that between 30-50% of variance in DIT scores is related to level of education and that sophistication of moral thinking increases in response to educational interventions. The N2 value should pick up changes occurring throughout training as it is designed to not only measure discrimination between postconventional items on the DIT-2, but also to highlight choices related to personal interests, which would be expected to decrease. This same effect was also demonstrated in Hren, Marušić and Marušić's (2011) study of medical students in Croatia: postconventional reasoning scores regressed following commencement of clinical placements. The authors offer several interesting suggestions to explain this phenomenon. Firstly, they refer to the

presence of an organisational hierarchy. It could be the case that medical students commencing practical placements will be aware of a power imbalance and consequently attempt to seek approval from those in authority by complying with potentially less ethical social norms. They also highlight that if trainees feel unsupported and lack the personal resources to manage dilemmas independently, they may be more likely to attempt to cope by following perceived expected standards of conduct. Finally, the authors suggest the possibility of an 'unseen' curriculum related to implicit values associated with the culture of the training environment. These may run contradictory to explicitly stated values of the institution, leading to student cynicism. There is some research to suggest that a tendency to conform to the 'status quo' is a strategy also adopted by trainee clinical psychologists. Qualitative data from Ellis-Caird and Wainwright (unpublished 2013) highlighted several limiting factors influencing trainees' willingness to implement ethical decisions. These included a pressure to conform due to awareness of the competency evaluation process, together with perceived lack of personal autonomy associated with lack of status. Employment obligations and service practice restraints were also cited.

It is important to also consider other factors specific to clinical psychology training which may have influenced a lack of development in ethical reasoning. One possibility relates to most clinical psychology trainees having had a degree of clinical experience prior to training, some having undertaken over six years' experience (BPS, 2018b). Perhaps this is an indication that first year trainees already have highly developed ethical decision-making schemata at the point of entry to training; however, even if this were the case, the apparent deterioration is somewhat puzzling.

A further possibility for the decrease in N2 score is that perhaps the study sample is not representative of the current trainee population. It must be acknowledged that only a small percentage of the total population of trainees eligible took part in the study.

Nevertheless, the sample is demographically similar to the current UK training population, the only exception being that a greater proportion of study trainees are in their thirties, while comparatively more trainees in the population as a whole are in their twenties. As schema score was not found to be age related, it can be concluded that the sample is highly representative.

An alternative explanation is that the DIT-2 is not sensitive to changes that occur throughout training; therefore, changes could be occurring but remain hidden. A clear deficit of the DIT-2 is that it lacks capacity to differentiate between personal and professional decision-making, and therefore will not pick up on changes at this level. Also relevant is that while the DIT-2 is able to measure the highly abstract markers of stages occurring over the course of lifespan development, there is considerable doubt concerning its aptitude to measure what Bebeau and Thoma (1999) refer to as 'intermediate concepts'. These are less abstract than the three basic schema stages and include, for example, the ideas of autonomy, informed consent and confidentiality. The authors highlight that these concepts may not fit with a model of sequential development; therefore, the DIT-2 may not be sensitive to increased sophistication occurring over time in these areas.

A final possibility explaining deterioration over time could be that the ethics teaching provided by clinical psychology training courses is not proficient in helping trainees develop the requisite skills they need to make ethical decisions. If this is the case, it is likely that this is a global training deficit, rather than related to specific course centres, as the current study recruited trainees from over half of all courses situated throughout the UK.

4.1.2 Association between sophistication of ethical thinking and construing.

Results from the current study indicate that more sophisticated ethical decision-making schemata are associated with looser construing in first year trainees, a relationship not present in third year trainees. Ellis' (2006) PCP account of professional identity development helps

explain this phenomenon. She suggests that changes in construct system structure can occur alongside the training process. When an individual first chooses a career, they build up an anticipatory view concerning their new role. Once they begin their career a series of validations and invalidations of constructs then occurs, leading a person to revise their constructs. A degree of flexibility is required to navigate this period of adaptation successfully. In the case of clinical psychology trainees in the current study, it could be argued that those first year trainees possessing advanced ethical decision-making skills also appear to have the flexibility to revise and develop their ethical decision-making constructs. This does not, however, account for the lack of an observed relationship between greater sophistication of ethical thinking and looser construct system structure in third year trainees. One potential explanation for this change over the course of training is that trainees starting the course will be relying on their personal ethical decision-making construct systems. As they become more familiar with the expected standards of professionalism required, perhaps there is a tendency for trainees to adopt a more uni-dimensional, structured, rules based approach to ethical decision-making as a way of fulfilling perceived expectations.

The loosening process in first year trainees also fits with the theory of acculturation. Successful integration of personal and professional ethical decision-making necessitates losing a degree of identification with one's personal value system, in order to develop a new integrated system of personal and professional values (Handelsman et al., 2005; Knapp, VandeCreek & Fingerhut, 2017). It is possible that this process of holding less tightly to a previous set of values is being captured in the grids of less experienced trainees possessing more sophisticated ethical thinking.

4.1.3 Differences in construing between year groups. No significant difference was demonstrated between more and less experienced trainees with regards to the overall degree of structure present in their construct systems, or the degree of structure found in their

respective personal and professional subsystems. This indicates that trainees of differing experience levels do not appear to vary in the degree of differentiation in their construct systems. It is worth highlighting, however, that third years were found to be close to significance with regards to having more structure both in their overall construct systems and in their professional subsystems. It could be the case that if a larger sample size had been recruited this difference would have reached significance.

The current study adds to the body of literature by providing support for an acculturation process, thus contributing to a broader theoretical understanding of the ethical decision-making process in trainee psychologists. A clear difference was demonstrated concerning how useful trainees from each year group find their personal and professional subsystems. Trainees initially rely comparatively more on their personal ethical decision-making constructs when they commence training and, as they gain experience, begin to find their professional ethical decision-making constructs more useful. This then appears to lead to greater integration between personal and professional decision-making over time.

4.1.4 Difficulty associated with personal and professional ethical decision-making. No difference was demonstrated between year groups regarding difficulty ratings ascribed to personal or professional dilemmas. There was also no difference demonstrated in the level of conflict associated with making personal and professional ethical decisions. However, additional findings indicated that all trainees appear to find personal ethical scenarios more salient than professional scenarios.

The BPS guidelines on teaching ethics to students (2015) highlight the influence of cognitive biases in the ethical decision-making process, referring to Kahneman's cognitive research on decision-making (Kahneman, 1963; Tversky and Kahneman, 1974: Kahneman & Frederick, 2002). Kahneman proposes that people unconsciously take mental shortcuts called heuristics when faced with problems. These have the advantage of being fast and requiring

little mental effort but are prone to error. The recently revised BPS Code of Ethics and Conduct (2018a) highlights that one source of bias concerns the salience of a situation which can influence how readily a situation comes to mind, thus contributing to biased recall. So, for example, if an ethical situation is highly salient, it is more likely to be noticed and attended to than one that holds less meaning. In the case of the current research, if trainees find professional scenarios less salient then it is possible that they are less likely to notice and attend to these issues. Drawing on Rest's four component model, this could indicate reduced ethical sensitivity for professional versus personal ethical dilemmas. This could result in professional ethical problems being missed, which is a concern.

Also important is the clear discrepancy for all trainees between the amount of conflict associated with personal dilemmas compared to professional dilemmas: all trainees have much more conflict associated with personal ethical decision-making, demonstrated by a large effect size. From a PCP perspective, the presence of conflict in a grid relates to the presence of inconsistencies and contradictions in a person's construing (Bell, 2004). Results from the current study suggest that all trainees experience more inconsistency in their construing for personal dilemmas. It is possible that professional dilemmas are associated with less conflict because trainees are managing them by simply following professional guidelines and regulations, whereas dilemmas in the personal ethical domain may be viewed as more complex and ambiguous. It is important to note that a degree of inconsistency is not necessarily unhelpful. A very high level of inconsistency could mean that a person is rendered unable to act in the face of a dilemma; however, a total lack of inconsistency may reflect an inability to tolerate conflict, perhaps because superordinate constructs, which are higher in a person's hierarchical construct system, are not sufficiently permeable.

4.1.5 Case study findings. The case studies add an important dimension to the study. Individual analysis of the PCA plot and grid measures for trainees at the beginning

and end of training serve to highlight a great deal about trainees' idiosyncratic worldviews, which could go unnoticed using a solely nomothetic approach.

An association between more sophisticated ethical decision-making as measured by the DIT-2 and looser construing is apparent for the first year trainee, in keeping with findings from the correlational analysis. This case study also highlights a range of themes in the content of constructs. These relate to the context in which ethical decisions are made, e.g. 'online' vs. 'real world' and whether decisions involve a relational component. The third-year trainee case study highlights the association between operating within a less sophisticated schematic approach and having a more uni-dimensional, tighter construct system. This tightness is also evident in the presence of a number of constructs grouped around two themes. These themes relate to the impact on decision-making of personal relationships and the importance of professional guidelines; these themes might be expected for an individual operating from a position of personal interest or maintaining norms.

4.2 Clinical implications

Important implications can be drawn from the research related to selection of candidates for clinical training, and supporting current trainees in their development of ethical decision-making skills.

4.2.1 Selection of candidates for clinical training. Working as a clinical psychologist involves managing difficult ethical dilemmas on a routine basis. It is therefore a matter of real concern for the profession if a small minority of trainees do not possess the sophistication of ethical decision-making required to effectively manage this aspect of the professional role. While it could be argued that these skills can be developed over the course of training, findings from the DIT-2 in the current study indicate that this does not appear to be the case. One possible way of ensuring trainees have the requisite skills needed could involve screening for ethical decision-making ability prior to selection. By asking candidates

to complete the DIT-2 as part of the interview procedure, this could facilitate greater insight concerning which applicants predominate in a postconventional approach. Drawbacks associated with this approach include the measure's lack of specific focus on professional ethical decision-making; therefore, it does not assess aptitude in this domain. Also, limited data are available more generally concerning the usefulness of selection tests in predicting the future professional aptitude of clinical psychology trainees (Woolf et al., 2015).

4.2.2 Supporting development of trainees' ethical decision-making skills. The recently revised standards of education and training set by the Health and Care Professions Council (2017a/b) stress the need for an increased emphasis on teaching and assessment of professional standards of conduct, performance and ethics during training. The current study highlights a number of areas for course providers to consider in supporting trainees.

4.2.2.1 Supporting trainees with the ethics acculturation process. Findings from the repertory grid analyses support the presence of ethics acculturation occurring over the course of training. This leads to increased integration between personal and professional decision-making subsystems over time. In light of this novel finding, it is helpful for training courses to give consideration as to how they best support trainees during the transition associated with the development of their professional identity. Providing specific ethics teaching in which trainees are encouraged to identify their personal values and the values of the profession would be helpful at the commencement of training. In addition to this, having a periodical individual 'ethics review' with a course tutor could help promote the development of greater ethical sensitivity with respect to professional dilemmas. The mapping of the BPS ethical principles against the standards outlined for practitioner psychologist trainees (BPS, 2015) could provide a helpful framework to guide the content of discussions as part of this review process. The current research, however, serves to highlight that the development of ethical decision-making skills can be a fragile process, vulnerable to

other influences and swayed and tested during the course of training. Having an awareness of these influences and pressures is essential if course teams are to successfully help trainees develop the resilience to manage ethical scenarios during their professional careers.

It would also be helpful to encourage trainees to draw on psychological models that can be meaningfully applied to the sphere of ethical decision-making. One model trainees may find helpful is Mason's model of 'safe uncertainty' (Mason, 1993). Central to the model is the acknowledgement of a human tendency to adopt a position of certainty, because of an associated sense of assumed safety. Privileging certainty can sometimes however lead to lack of creativity and immobilisation. Mason suggests that moving towards safe uncertainty involves moving to a position of "authoritative doubt" (p.192) which, while recognising expertise and knowledge already attained, also recognises the value in retaining a sense of 'not knowing.' Accepting that professional life as a clinical psychologist will involve regularly facing dilemmas and that these will be associated with uncertainty and doubt can help trainees feel more comfortable with the process of decision-making. Recognising too that solutions to dilemmas may not necessarily be finite – but can be viewed instead as representing less of a dilemma than the alternative – is important. These ideas may help trainees be open to new perspectives concerning ethical dilemmas, more accepting of feeling unsure, and thus enable them to not shy away from making difficult decisions.

PCP theory may also help trainees reflect on the process of ethical decision-making. The creativity cycle suggests that as a person creates new constructions this will involve a loosening of construing (Kelly, 1955). During this process, an individual will be re-assigning elements to various positions in relation to the construct poles. This allows the generation of new ideas to occur but there must be a subsequent process of tightening if a degree of predictability is to be obtained which can assist a person in their anticipation of events. This provides the opportunity for new constructs to be tested out and revised accordingly. An

awareness of this process can help normalise the experience of 'not knowing' and uncertainty for trainees which may occur as part of the loosening process when ideas seem more changeable.

4.2.2.1.1 The influence of training course culture. As well as considering ethical decision-making at an individual level, the 'Bad apples, bad cases, bad barrels' paper (Kish-Gephart, Harrison & Treviño, 2010) highlights the importance of considering the influence of the culture of the organisational environment. It has also been suggested that endeavouring to enrich the 'ethical culture' of the training community can help foster the ethical development of trainees (Cornish 2014).

One suggestion for training programme communities could be to ask course tutors to outline some of the types of ethical dilemmas they themselves have encountered, and reflect on how their own set of personal and professional values have influenced them at various points during training and beyond. This could be placed within the context of working within the NHS, discussing the impact of employment obligations and service practice restraints highlighted in previous research (Ellis-Caird & Wainwright, unpublished 2013). Preparing trainees for the potential challenges associated with managing ethical decision-making post training would help foster an awareness of the need to continue to adopt a sophisticated approach rather than default to a more basic way of functioning.

4.2.2.2 Enhancing trainee self-awareness. The current research highlights that trainees as a whole find personal dilemmas more salient than professional dilemmas. Lack of ethical sensitivity to the presence of a dilemma is the first component of Rest's ethical decision-making model. The BPS guidelines for student psychologists (2015) highlight the importance of ethical sensitivity, noting that when a dilemma goes unnoticed this is "an obvious threat to ethical practice" (p.3); therefore, the current research has important

implications for clinical practice, because if trainees find professional scenarios less salient, there is a danger that important professional ethical dilemmas remain undetected.

The Johari window (Luft & Ingham, 1955) is a model that may help trainees further develop ethical sensitivity, through enhancing understanding concerning knowledge currently held outside of conscious awareness. The model suggests that for every individual there will be a degree of knowledge that they hold about themselves, and also knowledge that others will hold about them. This knowledge can be allocated to one of four quadrants, one of which is the 'unknown' area concerning areas unknown to the self or to others. Findings from the current research highlight that the grid appears to have a particular aptitude for illuminating 'unknown' knowledge, and as such is a helpful means of gaining self-awareness regarding the ethical decision-making process.

A useful exercise for trainees would be to complete their own grid at the beginning of clinical training. This could help trainees to identify the types of scenarios that they find most salient, and those dilemmas which they construe similarly or differently. By doing so, this will help trainees identify the types of dilemmas they do not find as meaningful, but nonetheless are important dilemmas to consider. A further extension to completing an individual grid would be to then hold a classroom discussion. During this process trainees could use the ethical scenarios as a starting point for group discussion concerning pertinent issues raised by each dilemma, and reflect on alternative ways of managing the scenario, thus contributing to an environment of shared learning. Completing a second grid at the end of training and examining differences would also be a potential route for tracking change over time.

4.3 Strengths and limitations of the study

The study's quality will be first assessed against Burns and Kho's (2015) quality criteria followed by a more general consideration of strengths and limitations.

4.3.1 Study quality assessment rationale. In order to assess the quality of the current research, consideration was given as to which quality assessment tool would be most suitable. No specific tool is routinely used for repertory grid technique research (D.A. Winter, personal communication, April 30, 2018) and therefore the chosen tool needed to be broad enough to encompass main quality indicators of both survey and quantitative methodologies. The Burns and Kho (2015) criteria were deemed most fitting for this task because of their relevance to survey methodology, and their scope to cover the main quality indicators of quantitative research. Details of the study quality assessment are shown in Table 15.

Table 15. Study quality assessment, based on Burns & Kho (2015) criteria

Quality Indicator	Overall	DIT-2	Grid
1. Clear research question posed?	Yes		
2. Target population			
2a Target population defined?	Yes		
2b Sampling frame specified	Yes		
3. Systematic approach			
3a Item generation and reduction process reported?	Partial	No	Yes
3b Formatting specified?	Yes	Yes	Yes
3c Pretesting?	Partial	No	Yes
4. Questionnaire testing reported			
4a Pilot testing?	Partial	No	Yes
4b Clinimetric testing?	Partial	Partial	No
5. Response and non-response bias limitation			
5a Administration method appropriate?	Partial		
5b Details of pre-notification, cover letter, incentives provided?	Yes		
6. Optimising response rate			
6a Response rate reported?	Yes		
6b Response rate defined?	Yes		
6c Response rate enhancement strategies used?	Yes		
6d Sample size justified?	Yes		
7. Results reporting			
7a Research question addressed?	Yes		
7b Missing data methods reported?	Yes		
7c Respondent demographics reported?	Yes		
7d Analytical methods clear?	Yes		
7e Results succinctly summarised?	Yes		
7f Results interpretation aligned with data presented?	Yes		

4.3.2 Study quality assessment. In recognition of the need to provide a detailed analysis of both methods, methodology specific quality criteria (items 3 and 4) related to the development and testing of measures are addressed separately for each method. Methodology specific critique is first provided, followed by a synthesis of strengths and limitations of the research as a whole.

4.3.2.1 Methodology specific quality assessment. The current study partially addressed reporting of the item generation and reduction process. The DIT-2 is a

predesigned, longstanding and well-established measure and, as such, pilot testing was not deemed necessary. It was also considered more appropriate to cite reliability and validity obtained in subsequent research rather than provide a detailed account of the initial design process; details of questionnaire items have however been provided in the Method section and a copy of the entire questionnaire is included in Appendix G. As the repertory grid was designed specifically for the current research, steps taken in the design process were reported in full. This included a full description of the scenarios used and subsequent adjustments made in response to pretesting and pilot testing (see Method section).

4.3.2.2 Statement of research aims, objectives and target population. These criteria were met. Clear objectives of the research were stated, along with research questions and their associated hypotheses. The target population was also defined and recruitment targeted to include all UK training courses.

4.3.2.3 Response bias and response rate. These criteria were partially met. Details of the recruitment process were provided, including steps taken to contact course centres which had not responded, and the use of a prize draw incentive. Response rates were reported and sample size justification provided through inclusion of a priori and post hoc power calculations. A potential source of bias relates to the principal researcher's position as a current clinical psychology trainee, and the primary supervisor's role as a tutor on a UK Clinical Psychology Doctorate course. This may have deterred some potential trainees from participating and influenced responses given.

A further consideration with respect to bias concerns whether participants consciously gave responses they considered to be correct or socially acceptable. Both the DIT-2 and the grids limit the possibility of this occurring. The DIT-2 involves internal reliability checks and any questionnaires with low reliability are excluded from analysis (Rest et al., 1999b). Furthermore, completing the questionnaire involves a series of ratings followed by rankings

across five dilemmas, and the scoring process uses a weighted algorithm, contributing to low face validity. Grids similarly have relatively low face validity, as although participants will be aware of the content they share during the interview, they will be less aware of relational patterns in the data, which are the primary feature of grid analysis (Fransella, Bell & Bannister, 2004).

4.3.2.4 Results reporting. These criteria were met. Results reporting was organised according to each research question. There were no missing data and full demographic details of participants were provided and compared to those of candidates admitted to training in 2016. Full details of analyses were given and interpretation of results was in keeping with data presented.

4.3.3 Summary of research strengths. The quality appraisal highlights a number of strengths of the research. Two methods were used, adding robustness to the study design. The DIT-2 focuses on ethical reasoning, and highlights an apparent deterioration in ethical sophistication over the course of training. By way of contrast, the repertory grids provide clear evidence of a process of transition taking place in trainees as they begin to find their professional ethical decision-making constructs more useful to them over time. Using these two methods in conjunction created a design capable of tapping into different aspects of the ethical decision-making process.

Further methodological strengths of the research relate to its novelty and generalisability. The current study is the first to use repertory grid interviews to study ethical decision-making and, as such, improves the methodological diversity of research in the field. It is the also the second of two UK studies to focus on trainee clinical psychologists' ethical decision-making, and the first of its kind to differentiate between personal and professional ethical decision-making in this population. The current evidence base was also taken into account at the design stage of the project. The literature review had highlighted that ethical

decision can be influenced by individual, relational and environmental factors, and these factors were all included in the content of ethical scenarios.

The current research enhances the generalisability of findings demonstrated by Ellis-Caird and Wainwright (unpublished 2013) due to the wide breadth of recruitment sites. Findings from the repertory grid interviews also have high generalisability to the UK trainee population, interviews having been completed with trainees representing a wide variety of training courses in the UK. It is also noteworthy that the numbers recruited allowed sufficient study power to demonstrate effect sizes of considerable magnitude.

Finally, the study is notable for including trainee clinical psychologists as consultants. This helped devise scenarios representative of the ethical issues trainees face in their everyday work and ensure that the research was as relevant as possible.

4.3.4 Summary of study limitations. There are a number of research limitations that must be acknowledged. The first of these relates to the format in which the research measures were administered. Using a web based platform to collect DIT-2 responses meant that there was no control of environmental confounders which could have adversely impacted response accuracy, e.g. poor internet connectivity or a noisy environment leading to distraction. Consideration must also be given to the environment in which repertory grid technique interviews were conducted. In order to maximise recruitment from a broad geographical range, an option of either a face to face or Skype interview was offered. During Skype interviews, while participants were studying the ethical scenarios they had no visual contact with the interviewer. Although no discernible differences in either rapport or the quality of data collected were noted by the interviewer, this may have influenced participant responses. For example, it is possible that participants felt less connected to the interviewer than in a face-to-face interview and were therefore less likely to speak freely. Alternatively, a lack of eye contact may have conversely led trainees to feel less scrutinised and perhaps

more able to talk openly. None of these effects were observed by the principal researcher in practice. Aside from the format employed, it is also necessary to consider the status of the interviewer as a fellow trainee. Again, this may have influenced the degree to which trainees felt they could be transparent in their responses. Having a shared professional identity may have led trainees to be more open; however, there may also have been a concern about having one's responses judged and even perhaps a worry about the researcher revealing information perceived as unethical to the authorities.

There are also methodological limitations to consider related to the DIT-2 and the grids. As the DIT-2 does not specifically focus on professional scenarios, the extent to which findings map onto this aspect of their decision-making is not clear. Neither is it known whether trainees would do in practice what they state in theory.

The DIT-2 is a measure of ethical reasoning which Bebeau (2002) highlights represents only one facet of ethical decision-making according to Rest's (1982) four component model. The first step of the ethical decision-making process is ethical sensitivity, which requires an individual to be aware of others' emotional experiences, and to be aware of the available choices. Following the ethical reasoning stage is ethical motivation; Bebeau highlights this may be influenced by factors including the working environment and interpersonal relationships. Such influences may lead a person to act unethically even though they are aware of the correct ethical course of action. Finally, ethical implementation concerns the implementation of action, which Bebeau highlights can be influenced by lack of competence or a response to external pressures or distractions. Bebeau points out that these other components of the four-component model may exert an impact on the decision-making process throughout the process of professional training and could be masked if relying solely on the DIT-2 as a measure.

It is also worth considering any potential advantages that would have been gained if in-depth interviews had been used instead of repertory grid technique. In-depth interviews may have provided more in-depth data on reported ethical decision-making strategies and reported restrictions and limitations concerning ethical decision-making in practice. This might have led to further learning with respect to other aspects of Rest's (1982) four component model and how these aspects interact in practice. Adding a qualitative feedback component to the study could have provided increased understanding concerning the way trainees completed the DIT-2 questionnaire; however, as trainees had already made a substantial time commitment by participating in both a questionnaire and an interview, it was felt that extending this further could have had a negative impact on recruitment.

A further potential methodological limitation relates to the use of supplied elements in the grid. Although the use of trainee consultation helped ensure the dilemmas were relevant, including scenarios directly elicited from trainees could have provided the means to make these more bespoke. Further research would benefit from including some elicited elements, for example, "The most difficult ethical dilemma that I have faced in my personal or professional life."

Little is known about the characteristics of trainees who chose not to participate in the research. If these trainees have less interest in ethical issues, this could mean that they approach ethical decision-making differently. Alternatively, it is possible that trainees were drawn to participate because they find ethical decision-making difficult and that this is reflected in the data.

4.4 Suggestions for further research

There are clear avenues for further research emerging from the study. A simple extension to the current project would involve completing a content analysis of elicited constructs. There are coding systems currently in use for the analysis of repertory grid data

(Feixas, Geldschläger and Neimeyer, 2002; Green, 2004); however, as these focus on constructs applied to people it would be necessary to devise a system which could be applied to ethical situations. Devising a bottom-up coding system for the personal and professional constructs would help determine the main themes present, aiding the examination of differences and similarities between subsystems. Due to a limited timescale, this was beyond the scope of the current study.

A further key area of research relates to the observed decrease in the level of sophistication in ethical reasoning highlighted in third year trainees. Administering the DIT-2 to a larger sample size of trainees from a range of UK training institutions would help determine the robustness of this effect. Research which focuses on the development of measures able to assess the influence of intermediate concepts is also warranted. It may be the case that fine grained change is exerting a considerable influence on the decision-making process, but this may not be measureable on the DIT-2, which has a broader focus on stages of schematic development.

A further research area relates to the need for a study based on a longitudinal design. For the purposes of the current study, inferences were made between trainees at the beginning and end of training; however, it is not possible to say with certainty whether the differences observed between year groups were associated with idiosyncratic sample characteristics. An extension of the current study would be to conduct a follow-up study with trainees to track their ethical decision-making development over time. Alternatively, undertaking a repeated measures design with a new group of trainees, measuring decision-making at both the beginning and end of training would also allow change over time to be measured. It would also be helpful if training course centres evaluate the effectiveness of specific ethics training interventions they provide with a view to sharing expertise.

In addition to considering immediate avenues of research prompted by the current study it is also important to place these findings into a broader context. The study findings are the first to highlight evidence of a process of ethics acculturation in trainee clinical psychologists, and further research is warranted to develop understanding concerning the different strategies trainees adopt to manage this process. Studies focusing on the impact of ethics training interventions aimed to facilitate the acculturation process would help training course providers consider how they best support trainees in adjusting to a new professional identity. More research is needed overall to expand the small body of knowledge examining individual, relational and environmental factors influencing the decision-making process. This will help ensure that an individual, "bad apples" approach to research (Kish-Gephart, Harrison & Treviño, 2010, p.1) is not privileged over research related to "bad cases and bad barrels" aiming to explore the influence of broader relational and organisational contexts.

4.5 Personal reflections

This Discussion chapter would feel incomplete without the inclusion of some brief personal reflections. Prior to starting this research, I had heard stories from colleagues about how engrossed they had become by their research topic; however, it still came as something of a surprise to learn just how much of my leisure time I would begin to spend considering ethical issues. During the summer of my second training year I began to have a heightened awareness of – and fascination with - ethical dilemmas, spending many an hour pondering alternative solutions! Noticing my own ethical sensitivity, and an associated growing appreciation of the complexity related to decision-making, has fostered a growing conviction that training interventions focused on increasing ethical sensitivity could have a key role to play in helping trainees engage with what can be a challenging area of professional practice.

My own interest in ethically challenging areas of clinical practice has continued to grow as I have continued with this research, perhaps contributing in part to my choosing a

final year placement involving complex ethical decision-making. I will find the words of Mason helpful to remember as I continue along my own ethical decision-making journey, "Solutions are only dilemmas that are less of a dilemma than the dilemma one had" (1989, as cited in Mason, 1993, p.193).

4.6 Conclusions

The current study makes a substantial contribution to the under-researched area of ethical decision-making in trainee clinical psychologists in the UK. The research enhances the knowledge base by using a robust study design including two methodologies: the well-established DIT-2 questionnaire in conjunction with repertory grid technique, the latter method representing a novel aspect of research design in the field.

The research adds credence to previous findings highlighting that most trainees adopt a sophisticated approach to ethical decision-making, but that a small minority have a less sophisticated approach. A matter of concern arising from findings in the current study is that the DIT-2 index most commonly used as a marker for ethical development in educational programmes was found to be lower in more experienced trainees. The research also adds further evidence to the body of current knowledge concerning the potential influence of implicit values and assumptions on trainees' ethical decision-making.

As well as adding to pre-established knowledge, the current research addresses a gap in the current knowledge base concerning differences between personal and professional decision-making processes. Findings indicate that new trainees find their personal ethical decision-making constructs comparatively more useful to them than more experienced trainees, and that more experienced trainees find their professional constructs comparatively more useful. The integration of personal and professional ethical decision-making subsystems also increases over the course of training. These results provide evidence of an acculturation process, thus helping establish a broader theoretical framework for

understanding the ethical decision-making process as a whole in trainee clinical psychologists. Further research is needed to expand the current small body of knowledge related to the influence of individual factors on ethical decision-making, and to explore the impact of broader relational and environmental contexts on the process.

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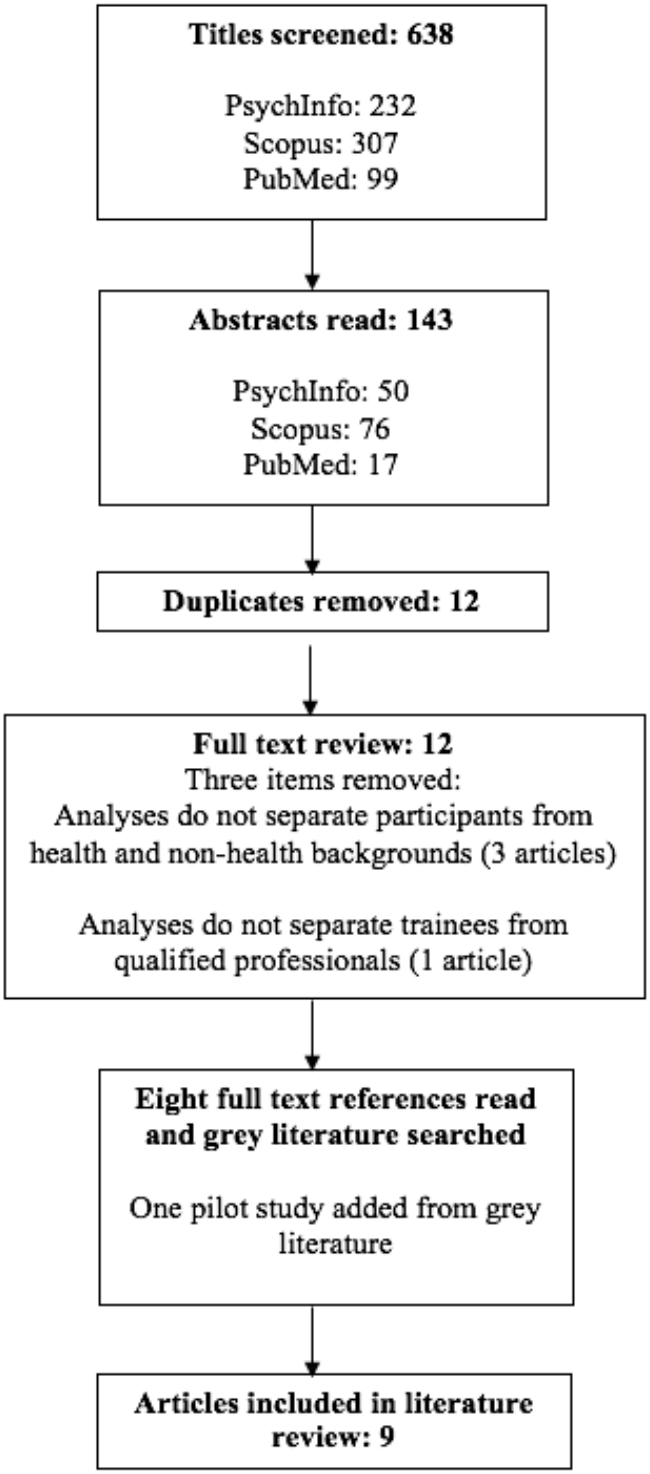
Appendices

Appendix A. Literature review selection process



Appendix B. Summary of systematic literature review papers

Author, title and location of study	Sample details	Study design	Findings	Key implications
Asay & Lal (2014) *Who's googled whom? Trainees internet and online social networking behaviours and attitudes with clients and supervisors* **USA**	407 trainees attending a master's or doctoral level clinical psychology (86.6%) or counselling psychology (12%) course (1.4 indicated 'other' course.) 84.4% female,15.3% male and 1.4% indicated other. No age range stipulated.	Survey containing some yes/no responses, plus Likert scale and free text responses.	-The vast majority of trainees had social networking accounts, and had modified privacy settings since starting training. - Around a quarter had 'Googled' clients and a half had 'Googled' their supervisor. - Around three quarters were concerned about the ethics of contacting clients via social network accounts, and just over 90% expressed concern regarding clients making contact with them via social media during therapy. - Just over half of trainees said they would feel uncomfortable making an ethical decision in the event of client contact via social media. If this happened, almost all reported they would discuss with the client and their supervisor, whereas if a supervisor contacted them, just under three quarters would raise the issue with their supervisor. - Roughly one out of six trainees would see their supervisor's contact as an invasion of privacy, whereas this increased to around one in four for client contact.	- Stresses importance of course teams and supervisors discussing online activity from the outset, making clear any policies on internet issues, and including training on issues before trainees start clinical work. - Suggestion that modelling openness and transparency in supervision highlights importance of issue, much as this would when endeavouring to demonstrate multicultural competence. - Continued ethical discussions and role plays during training offered as a means of addressing discomfort of trainees with making ethical decisions. - Suggests need for future research focusing on how trainees *do* act, rather than on how they feel they *should*. Also suggests research investigating impact of age and level of experience on making ethical decisions about online activity, as well as the need to learn more about the views of supervisors.
Bernard & Jara (1986) *The failure of clinical psychology graduate students to apply understood ethical principles* **USA**	170 graduate students from 25 APA approved clinical psychology training programmes. Five schools in each of 5 geographical areas randomly selected. Demographic details of sample are not listed.	Two written ethical violation scenarios and questionnaire measuring trainee reactions to scenarios (what they *should* do in response and what they think they *would* do). Two relevant APA Code of Conduct principles were stated following the scenarios.	-No trainees reported they would go beyond what they thought they should in each scenario - Both ethical scenarios involved fellow trainees who were also a friend. The first ethical violation concerned a fellow trainee having a sexual relationship with a client. Half of participants said they would do less in response than they thought they should. For the scenario involving a trainee with an alcohol issue, 55% said that they would do less than they should. -There were no demographic differences between those who would do less and those who would not in terms of year of training and whether an ethics course had been studied.	- Ethical scenarios involving someone known to the trainee may influence response to the dilemma. - As variables such as experience level of trainee and previous ethics training were no different between those who would or wouldn't do less than they should, this suggests ethics training could be inadequate or that managing a dilemma involving a friend is not something than can be taught. -It is suggested that motivating trainees to implement principles they understand may prove difficult.

Author, title and location of study	Sample details	Study design	Findings	Key implications
Betan & Stanton (1999) *Fostering ethical willingness: Integrating emotional and contextual awareness with rational analysis* **USA**	258 clinical psychology trainees from 59 training APA accredited training programmes. 180 women and 78 men; age range not listed.	Extension of Bernard and Jara's (1986) study. Participants asked to consider responses when a fellow with a drinking problem was either a colleague or a friend. Rating of emotional responses on a 5-point Likert scale.	-Just over half of the trainees identified they should report colleague with a drinking issue to the programme director. -Almost all (95%) expressed they would either inform programme director or tell colleague they would inform if colleague did not stop drinking. -Half the trainees reported they would take less action than they believed they should (*ethical willingness*), 4% said they would take more action than they should and the remaining reported no discrepancy between what they should and would do. -Of those who said they should inform programme director/supervisor (n=140), only 37% said they would. -Majority of trainees (60%) reported high confidence they would carry out what they said they would do (*ethical resoluteness*). -No statistical support for hypotheses that those making inappropriate ethical decision would report more anxiety and less compassion, but qualitative responses indicated emotions influenced how they would intervene. -Trainees willing to follow through on ethical decision-making had less anxiety and greater compassion (significance level listed as $p < 0.5$, not 0.05). -Qualitative responses suggest anxiety impedes action taken.	-Findings suggest ethical knowledge does not determine ethical behaviour. -Authors suggest trainees may not be fully aware of influence of emotions, values and contextual factors when making ethical decisions. -They also suggest training models should focus on increasing trainee knowledge of interpersonal nature of ethics.
Bevacqua & Robinson Kurpius (2013) *Counselling students' personal values and attitudes toward euthanasia* **USA**	83 counselling students at one university in a southwestern university. 65 enrolled in a master's programme, 17 in a doctoral programme and one did not specify. 17 men and 64 women and mean age 28.	Randomised design to one of four vignettes with 2 conditions; age of client (25 or 77) and type of euthanasia (passive or active). Six statements assessments assessing support for client autonomy rated on a 5-point scale.	-Support was much greater for the 77-year-old client seeking active euthanasia than for the 25-year-old. -No differences were found in supporting clients of different ages in the case of passive euthanasia. -More religiosity was associated with less support for the right to end life. -Trainees with less clinical experience were less likely to support euthanasia than those with more clinical experience.	-Suggests ageism, whereby a values bias can influence perception of situation. -Authors suggest that more experienced trainees are more supportive of client autonomy and that this fits with previous research findings in this area. -Authors suggest that the negative relationship between increased religiosity and respect for client autonomy indicates evidence of potential for own personal values to be imposed on a client, and could lead to discrimination. -Highlights importance of clinical supervision and training related to both end-of-life decision-making and biases towards older adults.

Author, title and location of study	Sample details	Study design	Findings	Key implications
Cottone, Tarvydas & House (1994) *The effect of number and type of consulted relationships on the ethical decision-making of graduate students in counselling* **USA**	234 counselling trainees from one graduate counsellor educator programme of over 300 masters or doctoral trainees in a Midwestern state of US. 39 trainees allocated to each version of survey presented.	Survey comprised of a 7-point Likert scale, each involving an individual response to a hypothetical scenario and then one of six conditions, according to number of consulted relationships (1,2 or 3) and type of consultation (individual or conjoint). Results analysed by ANOVA.	-The mean change in decision-making for individually consulted relationships was significantly greater than with individual reassessment when there were 1 or 3 individually consulted relationships, but not when there were 2 individually consulted relationships. -There was greater change in ethical decision-making when there were two conjoint consultations or three individual consultations than when there were two separate or 3 conjoint consultations (effect size of interaction was small).	-The number and type of consulted relationships influence ethical decision-making, inferring that there is a relational component to ethical decision-making. -Authors conclude there is no simple explanation for the interaction between number and type of consulted relationships. -Authors highlight that using a highly hypothetical scenario limits generalisability to real world settings.
Ellis-Caird & Wainwright (unpublished 2013) *A pilot study to consider the ethical decision-making of trainee clinical psychologists* **UK**	36 trainee clinical psychologists from 2 UK courses (76% female, age range 24-54).	Defining Issues test (DIT-2) 5 part questionnaire. Quantitative analysis and thematic analysis of trainees' free-text responses regarding decision-making.	-The majority of trainees are using a highly developed moral framework to make ethical decisions (50% using thinking at the postconventional level (measured by *p* value). -No correlation was found between trainees' year of training and age and their degree of sophistication in ethical decision-making. Trainees in their third year had a lower *p* score (at a non-significant level). -Some trainees highlighted a difference between their own personal judgements and that of the psychology profession. Some referred to pragmatic issues which could influence action taken, and the influence of local procedures/policies as an impeding factor.	-Suggestion that ethics teaching may need addressing due to lack of advancement in moral thinking over time. -Suggests that a tension between personal views and professional requirements could fit with the 'separation' strategy outlined in the acculturation model (Berry). -Authors suggest environmental factors within the context of NHS constraints could be influencing moral behaviour and recommend further research in this area. -Limitation highlighted of questionnaire focus on non-intimate relationships and does not explore how personal friendships may alter decision-making process.
Harris & Harriger (2009) *Sexual attraction in conjoint therapy* **USA**	259 trainee marriage and family therapists recruited from 27 accredited master's training programmes across the US. Of these, 138 completed section of questionnaire concerning treating couples together in therapy and these results are reported in study. 79% of participants had no prior clinical experience. (Mean age: 31; 72% female: 83% White, 6% Hispanic, 4% Asian, 3% Black).	41 item questionnaire related to questions specific to a client expressing attraction to therapist during a conjoint couple therapy session. Responses rated on a 5 point Likert agreement scale.	-Just over half of trainees (53%) said they would discuss the disclosed attraction with the couple together. One third were unsure whether to discuss this way. -Almost half the trainees (47%) were unsure whether being honest about reciprocated attraction would hurt the couple, with half (51%) also unsure whether disclosing attraction was not reciprocated would hurt them. -A substantial number did not know whether disclosure would affect the therapeutic relationship with the partner expressing attraction(42%) or the non-attracted partner (67%). More trainees expressed uncertainty concerning whether therapy should continue or be terminated compared with trainees giving either affirmative or negative agreement. Most trainees (92%) would not refer the couple to a different therapist to pursue the relationship, but 5% expressed they would.	-The vast majority of trainees would not pursue the relationship, which the authors suggest infers trainees find it easier to make decisions concerning behaviour which is clearly unethical than when this is less clearly defined. -The authors suggest normalising sexual attraction during training, and highlighting how this differs from sexual contact will help facilitate open conversation around ethical dilemmas related to sexual attraction.

Author, title and location of study	Sample details	Study design	Findings	Key implications
Harris & Robinson Kurpius (2014) *Social networking and professional ethics: Client searches, informed consent and disclosure* **USA**	315 psychology and counselling trainees recruited from accredited training programmes from 35 US states (264 female, 49 male, 2 not identified). 226 trainees had clinical experience. Mean age 28.4. Ethnicity – white 78.5%, Asian 6.3%, Black 5.4%. 0.6% Hispanic, 3.4% other. Counselling (n=95), counselling psychology (n=76), clinical psychology (n=11), school counselling (n=28), school psychology (n=59), clinical psychology doctoral programme (n=46).	Online survey measuring: -Frequency of online client searches (2 items; 6 point Likert scale) -Seeking informed consent (5 items; 6 point Likert scale) -Online disclosure frequency (8 items; 6 point Likert scale) -Ethical decision-making using subscale of Boundaries in Practice measure (Kendall et al., 2011) -Perceived knowledge of privacy settings (4 items on 6 point Likert scale)	-A third of trainees with clinical experience had used the internet to search for a client. Of these, most said they did not discuss with the client how they would discuss a breach of confidentiality with the client and did not obtain informed consent before searching (84%). Most also did not document search in the client's file. -For trainees with clinical experience, 18% approved of posting an update online with indirect reference to positive expressions concerning a client; 9% approved of positive expression online about a client's comments in a therapy session; 5% approved of negative comments about a client's comments in a session. -Credit hours (indicative of length of time in training) was positively correlated with online client searches. Amount of direct clinical contact was not correlated (however, the overall sample had limited clinical contact). -Amount of social networking experience and online client searches were also positively correlated. -More than 4 out of 5 trainees that did an online search did not seek informed consent or document the search. -Personal curiosity was the most common reason given for conducting a search. -Trainees from clinical and counselling programmes endorsed lower levels of disclosure than those from school programmes. -Lower scores on ethical decision-making were positively correlated with higher disclosure of client information.	-A high proportion of trainees that engaged in client searches did not appear to consider client consent and the client's right to privacy. The study suggests that trainees with more social networking experience may have less of a dilemma concerning seeking client information online. -The authors highlight the importance of therapist intentionality, e.g. conducting a search because of personal curiosity, in establishing whether behaviour is ethically questionable. -Trainees that rated ethical scenarios as unethical were more likely to consider client disclosures unethical. Authors suggest that trainees that apply a strict boundary for the hypothetical scenarios appear to transfer this across to their real-world online activity. -Authors highlight the need for trainees to consult with supervisors regarding online behaviour and to document it. -Authors suggest training programmes should discuss social networking practices with trainees. -Authors highlight limitation of using an online questionnaire which requires a degree of familiarity with online methods on the part of participants.
Mearns & Allen (1999) Graduate students' experiences in dealing with impaired peers, compared with faculty predictions: An exploratory study. **USA**	73 trainees (37 female, 36 male; mean age 29.3) from 65% of 40 doctoral clinical psychology training programmes randomly selected via the APA 29 tutors (12 female, 17 male; mean age 42.5) from 43% of programmes. All trainees had completed at least one year of training.	Survey assessing: -Training programme climate (competitive, nurturing, staff and student involvement and satisfaction) -Attitudes concerning student and staff obligations to take action when students have perceived impaired competence -38 behaviours and characteristics listed that could be an indication of impaired functioning, such as drug/alcohol use and poor social judgement. -Reactions to impairments – trainees reported how they	- Trainees and tutors both viewed tutors as holding more responsibility with regards to taking action. -Trainees rated the tutors as less active in screening trainees than tutors did. -Trainees and tutors both maintained tutors should ensure impaired trainees do not qualify; however, trainees saw tutors as significantly less active than tutors viewed themselves. -Perceived number of trainees with impaired behaviours was low for both trainees and tutors, ranging from 0 to 3. -Trainees from programmes rated more positively indicated lower knowledge of impairment in peers. -Almost all trainees (95%) were aware of impairment in a peer serious enough to impact professional functioning, and half (49%) were aware of unethical behaviour. Most commonly reported were: interpersonal aversiveness (11%), narcissism (9%), sexist style (7%), passive aggressiveness (5%) and lack of empathy (5%). The most	-Results from emotional responses suggest trainees' sense of ethical obligation overrides concerns regarding protecting peers. Authors suggest a need for training to not only focus on cognitive problem-solving strategies but also consider the impact of emotions when making ethical decisions. They suggest discussing ethical dilemmas in small groups to do this as a way of building trust. -Authors highlight a high degree of trainee pessimism about whether an intervention could make a difference. They suggest trainees being more involved in the evaluation process could help increase their sense of responsibility with regards to prevention of impaired peers entering the profession, e.g. through writing peer reports as a means of constructive feedback.

		responded to impairments witnessed and tutors were asked how a typical trainee would react. -Trainees and tutors asked to consider the worst impaired functioning they had seen and had heard of. -Asked to tick how they responded from list of behaviours; state the 3 most predominant emotions experienced; tick what impeded their responding.	common behaviours reported were: confidentiality breach (12%), exam cheating (5%), dual relationship involvement (4%). -Tutors overestimated the number of trainees that would do nothing in the case of peer impairment (39% prediction from staff, 26% from trainees) and trainee behaviour (32% from staff, 25% from trainees). -43% trainees reported they would directly confront an impaired peer, which was much higher than predicted by tutors (12%). The most common response to an impaired peer was to consult with other trainees (71%), a response which tutors underestimated (36%). -The most commonly reported emotional responses of trainees to an impaired peer were feeling angry (42%), conflicted (33%) and frustrated (20%0. Tutors overestimated the number of trainees who would feel worried or disloyal to the impaired peer and those who would feel uninvolved. -The most common impediments to responding to an impaired peer cited by trainees were: being unsure about appropriateness of intervention (57%), not thinking it is their responsibility (43%), and being pessimistic about it making a difference (43%). The same reasons were given for not responding to an ethical infraction, along with concern for unpleasant personal consequences.	

Appendix C. Study advertisement

How do you make decisions about ethical dilemmas?

Do you ever find yourself wrestling with complex ethical dilemmas as a trainee? Every week as a DClinPsy trainee we are faced with difficult decisions, which so often have an ethical core. It's such an important area, but little research has been conducted into how we as trainees make ethical decisions and what teaching during our training would help our ethical development.

I would therefore like to invite you to participate in my research exploring how trainees approach ethical dilemmas in their personal and professional lives. The research involves completing an online questionnaire which asks you to consider a series of ethical dilemmas, and a one hour individual interview involving the completion of a repertory grid. During the interview, you will be asked to consider similarities and differences between a series of ethical dilemmas. Interviews can either take place in a face to face format at a location convenient for you, or can be conducted via Skype.

I know how busy life as a trainee can be, and it's hard to fit in research participation, but this research has the potential to be of real benefit to trainees that come after us, helping us to understand the learning needs of trainee clinical psychologists, and contribute to future training programmes. If you are interested in participating, please do take a moment to read through the information provided. If you decide to take part, you will automatically be entered for a £50 Amazon gift voucher prize draw.

I would very much appreciate you participating in this important study. **If you have any questions about the research, or would like to take part, please do get in touch.**

Many thanks,

Angie Jenkin
Trainee Clinical Psychologist
University of Hertfordshire, College Lane
Hatfield, Hertfordshire AL10 9AB
Email: a.jenkin@herts.ac.uk
Tel: 07570 465396

Supervisor:
Dr Helen Ellis-Caird
Email: h.ellis-caird@herts.ac.uk

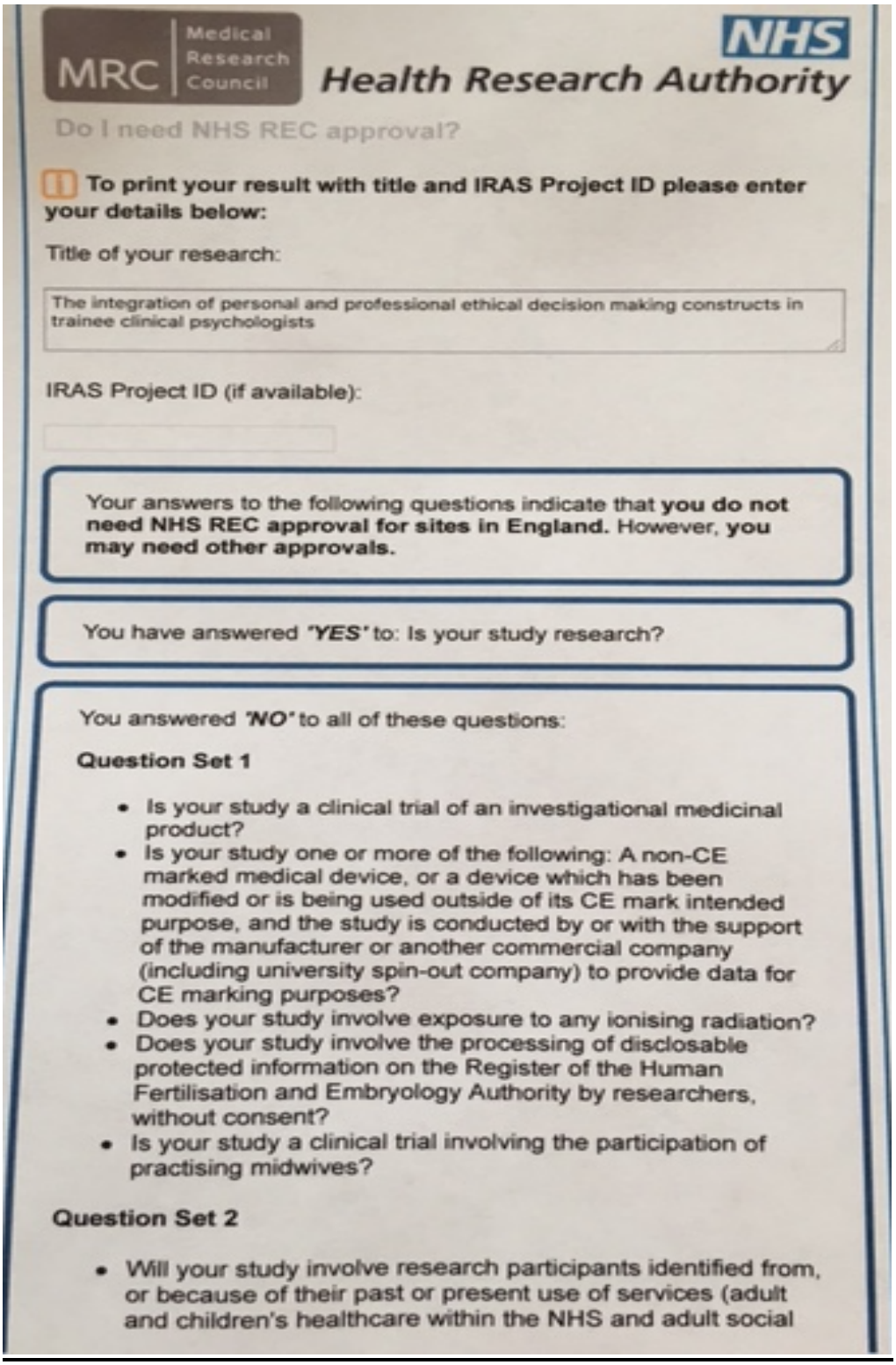
This study has been approved by the University of Hertfordshire Health and Human Sciences Ethics Committee. Protocol Number: LMS/PGR/UH/02820

Appendix D. Second year trainee data

Table D1. Second year trainee demographics.

Age Group						Gender		Ethnicity						
								Black	Asian	White			Other	Mixed
25-29	30-34	35-39	40-44	45-49	50+	M	F			British	Irish	European		
1	2	-	-	-	-	1	2	-	-	2	-	1	-	-

Appendix E. NHS screening tool



MRC Medical Research Council

NHS Health Research Authority

Do I need NHS REC approval?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

The integration of personal and professional ethical decision making constructs in trainee clinical psychologists

IRAS Project ID (if available):

Your answers to the following questions indicate that **you do not need NHS REC approval for sites in England.** However, **you may need other approvals.**

You have answered ***'YES'*** to: Is your study research?

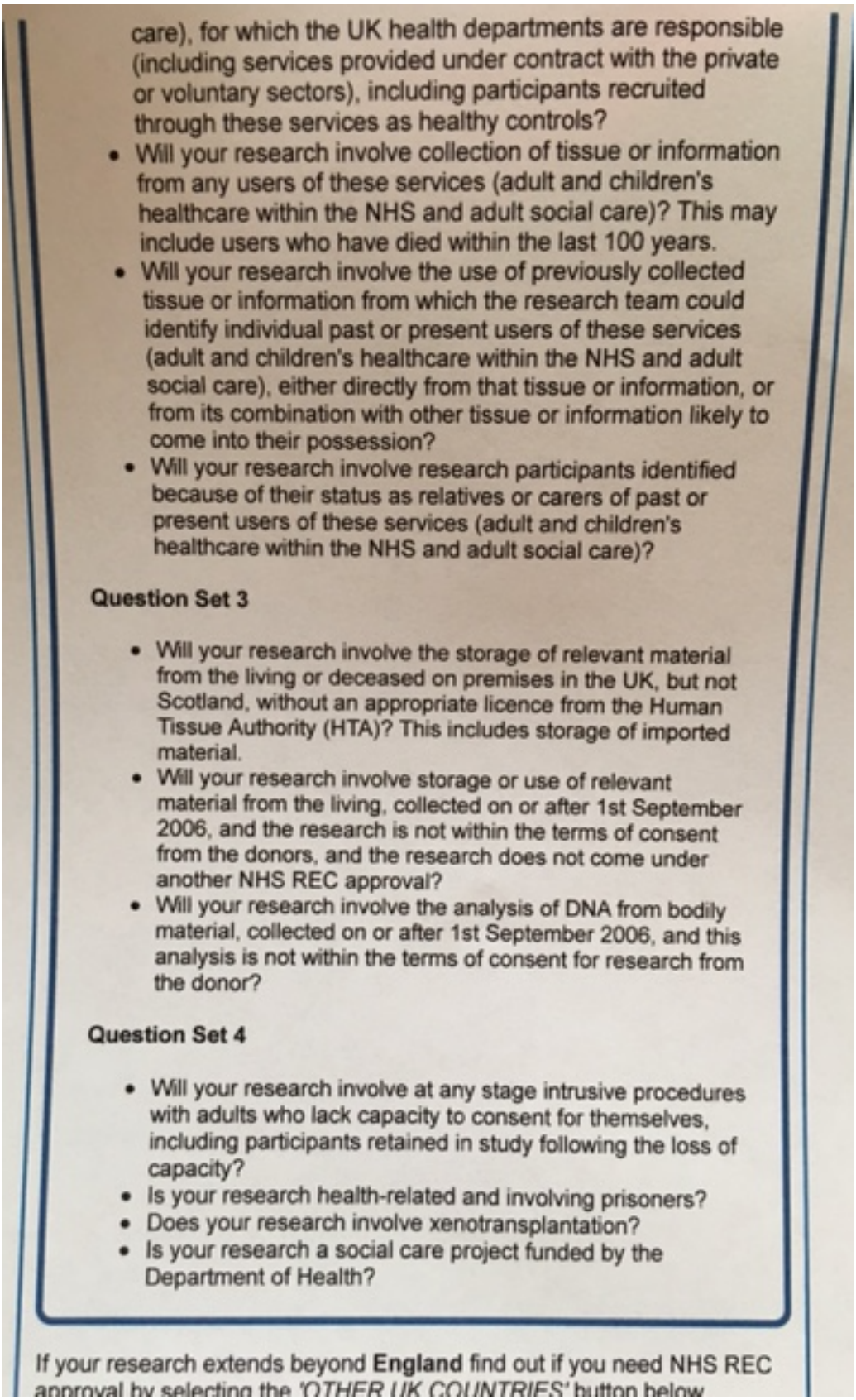
You answered ***'NO'*** to all of these questions:

Question Set 1

- Is your study a clinical trial of an investigational medicinal product?
- Is your study one or more of the following: A non-CE marked medical device, or a device which has been modified or is being used outside of its CE mark intended purpose, and the study is conducted by or with the support of the manufacturer or another commercial company (including university spin-out company) to provide data for CE marking purposes?
- Does your study involve exposure to any ionising radiation?
- Does your study involve the processing of disclosable protected information on the Register of the Human Fertilisation and Embryology Authority by researchers, without consent?
- Is your study a clinical trial involving the participation of practising midwives?

Question Set 2

- Will your study involve research participants identified from, or because of their past or present use of services (adult and children's healthcare within the NHS and adult social



care), for which the UK health departments are responsible (including services provided under contract with the private or voluntary sectors), including participants recruited through these services as healthy controls?

- Will your research involve collection of tissue or information from any users of these services (adult and children's healthcare within the NHS and adult social care)? This may include users who have died within the last 100 years.
- Will your research involve the use of previously collected tissue or information from which the research team could identify individual past or present users of these services (adult and children's healthcare within the NHS and adult social care), either directly from that tissue or information, or from its combination with other tissue or information likely to come into their possession?
- Will your research involve research participants identified because of their status as relatives or carers of past or present users of these services (adult and children's healthcare within the NHS and adult social care)?

Question Set 3

- Will your research involve the storage of relevant material from the living or deceased on premises in the UK, but not Scotland, without an appropriate licence from the Human Tissue Authority (HTA)? This includes storage of imported material.
- Will your research involve storage or use of relevant material from the living, collected on or after 1st September 2006, and the research is not within the terms of consent from the donors, and the research does not come under another NHS REC approval?
- Will your research involve the analysis of DNA from bodily material, collected on or after 1st September 2006, and this analysis is not within the terms of consent for research from the donor?

Question Set 4

- Will your research involve at any stage intrusive procedures with adults who lack capacity to consent for themselves, including participants retained in study following the loss of capacity?
- Is your research health-related and involving prisoners?
- Does your research involve xenotransplantation?
- Is your research a social care project funded by the Department of Health?

If your research extends beyond **England** find out if you need NHS REC approval by selecting the *'OTHER UK COUNTRIES'* button below

Appendix F. Ethics approval notification

University of Hertfordshire UH

HEALTH SCIENCES ENGINEERING & TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO: Angie Jenkin

CC: Dr Helen Ellis-Caird

FROM: Dr Amanda Ludlow, Health,Sciences,Engineering & Technology ECDA Vice Chair

DATE: 09/05/2017

Protocol number: LMS/PGR/UH/02820

Title of study: The integration of personal and professional ethical decision making constructs in trainee clinical psychologists.

Your application for ethics approval has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

This approval is valid:

From: **09/05/2017**

To: **01/06/2018**

Additional workers: no additional workers named
Please note:

If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and your completed consent paperwork to this ECDA once your study is complete.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

Appendix G. Copy of DIT-2 questionnaire

DIT-2

Defining Issues Test

Version 3.0

University of Minnesota
Center for the Study of Ethical Development

Instructions

This questionnaire is concerned with how you define the issues in a social problem. Several stories about social problems will be described. After each story, there will be a list of questions. The questions that follow each story represent different issues that might be raised by the problem. In other words, the questions / issues raise different ways of judging what is important in making a decision about the social problem. You will be asked to rate and rank the questions in terms of how important each one seems to you.

This questionnaire is in two parts: one part contains the **INSTRUCTIONS** (this part) and the stories presenting the social problems; the other part contains the questions (issues) and the **ANSWER SHEET** on which to write your responses.

Here is an example of the task:

Presidential Election

Imagine that you are about to vote for a candidate for the Presidency of the United States. Imagine that before you vote, you are given several questions, and asked which issue is the most important to you in making up your mind about which candidate to vote for. In this example, 5 items are given. On a rating scale of 1 to 5 (1=Great, 2=Much, 3=Some, 4=Little, 5=No) please rate the importance of the item (issue) by filling in with a pencil one of the bubbles on the answer sheet by each item.

Assume that you thought that item #1 (below) was of great importance, item #2 had some importance, item #3 had no importance, item #4 had much importance, and item #5 had much importance. Then you would fill in the bubbles on the answer sheet as shown below.

GREAT	MUCH	SOME	LITTLE	NO	Rate the following 12 issues in terms of importance (1-5)
●	②	③	④	⑤	1. Financially are you personally better off now than you were four years ago?
①	②	●	④	⑤	2. Does one candidate have a superior moral character?
①	②	③	④	●	3. Which candidate stands the tallest?
①	●	③	④	⑤	4. Which candidate would make the best world leader?
①	●	③	④	⑤	5. Which candidate has the best ideas for our country's internal problems, like crime and health care?

Further, the questionnaire will ask you to rank the questions in terms of importance. In the space below, the numbers 1 through 12, represent the item number. From top to bottom, you are asked to fill in the bubble that represents the item in first importance (of those given you to choose from), then second most important, third most important, and fourth most important. Please indicate your top four choices. You might fill out this part, as follows:

Rank which issue is the most important (item number).

Most important item ●②③④⑤⑥⑦⑧⑨⑩⑪⑫ Third most important ①②③●⑤⑥⑦⑧⑨⑩⑪⑫

Second most important ①②③④●⑥⑦⑧⑨⑩⑪⑫ Fourth most important ①●③④⑤⑥⑦⑧⑨⑩⑪⑫

Note that some of the items may seem irrelevant to you (as in item #3) or not make sense to you—in that case, **rate** the item as "No" importance and do not **rank** the item. Note that in the stories that follow, there will be 12 items for each story, not five. Please make sure to consider all 12 items (questions) that are printed after each story.

In addition you will be asked to state your preference for what action to take in the story. After the story, you will be asked to indicate the action you favor on a three-point scale (1 = strongly favor some action, 2 = can't decide, 3 = strongly oppose that action).

In short, read the story from this booklet, then fill out your answers on the answer sheet. Please use a #2 pencil. If you change your mind about a response, erase the pencil mark cleanly and enter your new response.

[Notice the second part of this questionnaire, the Answer Sheet. The Identification Number at the top of the answer sheet may already be filled in when you receive your materials. If not, you will receive instructions about how to fill in the number. If you have questions about the procedure, please ask now.

Please turn now to the Answer Sheet.]

Famine— (Story #1)

The small village in northern India has experienced shortages of food before, but this year's famine is worse than ever. Some families are even trying to feed themselves by making soup from tree bark. Mustaq Singh's family is near starvation. He has heard that a rich man in his village has supplies of food stored away and is hoarding food while its price goes higher so that he can sell the food later at a huge profit. Mustaq is desperate and thinks about stealing some food from the rich man's warehouse. The small amount of food that he needs for his family probably wouldn't even be missed.

[If at any time you would like to reread a story or the instructions, feel free to do so. Now turn to the Answer Sheet, go to the 12 issues and rate and rank them in terms of how important each issue seems to you.]

Reporter— (Story #2)

Molly Dayton has been a news reporter for the *Gazette* newspaper for over a decade. Almost by accident, she learned that one of the candidates for Lieutenant Governor for her state, Grover Thompson, had been arrested for shop-lifting 20 years earlier. Reporter Dayton found out that early in his life, Candidate Thompson had undergone a confused period and done things he later regretted, actions which would be very out-of-character now. His shop-lifting had been a minor offense and charges had been dropped by the department store. Thompson has not only straightened himself out since then, but built a distinguished record in helping many people and in leading constructive community projects. Now, Reporter Dayton regards Thompson as the best candidate in the field and likely to go on to important leadership positions in the state. Reporter Dayton wonders whether or not she should write the story about Thompson's earlier troubles because in the upcoming close and heated election, she fears that such a news story could wreck Thompson's chance to win.

[Now turn to the Answer Sheet, go to the 12 issues for this story, rate and rank them in terms of how important each issue seems to you.]

School Board— (Story #3)

Mr. Grant has been elected to the School Board District 190 and was chosen to be Chairman. The district is bitterly divided over the closing of one of the high schools. One of the high schools has to be closed for financial reasons, but there is no agreement over which school to close. During his election to the school board, Mr. Grant had proposed a series of "Open Meetings" in which members of the community could voice their opinions. He hoped that dialogue would make the community realize the necessity of closing one high school. Also he hoped that through open discussion, the difficulty of the decision would be appreciated, and that the community would ultimately support the school board decision. The first Open Meeting was a disaster. Passionate speeches dominated the microphones and threatened violence. The meeting barely closed without fist-fights. Later in the week, school board members received threatening phone calls. Mr. Grant wonders if he ought to call off the next Open Meeting.

[Now turn to the Answer Sheet, go to the 12 issues for this story, rate and rank them in terms of how important each issue seems to you.]

Cancer— (Story #4)

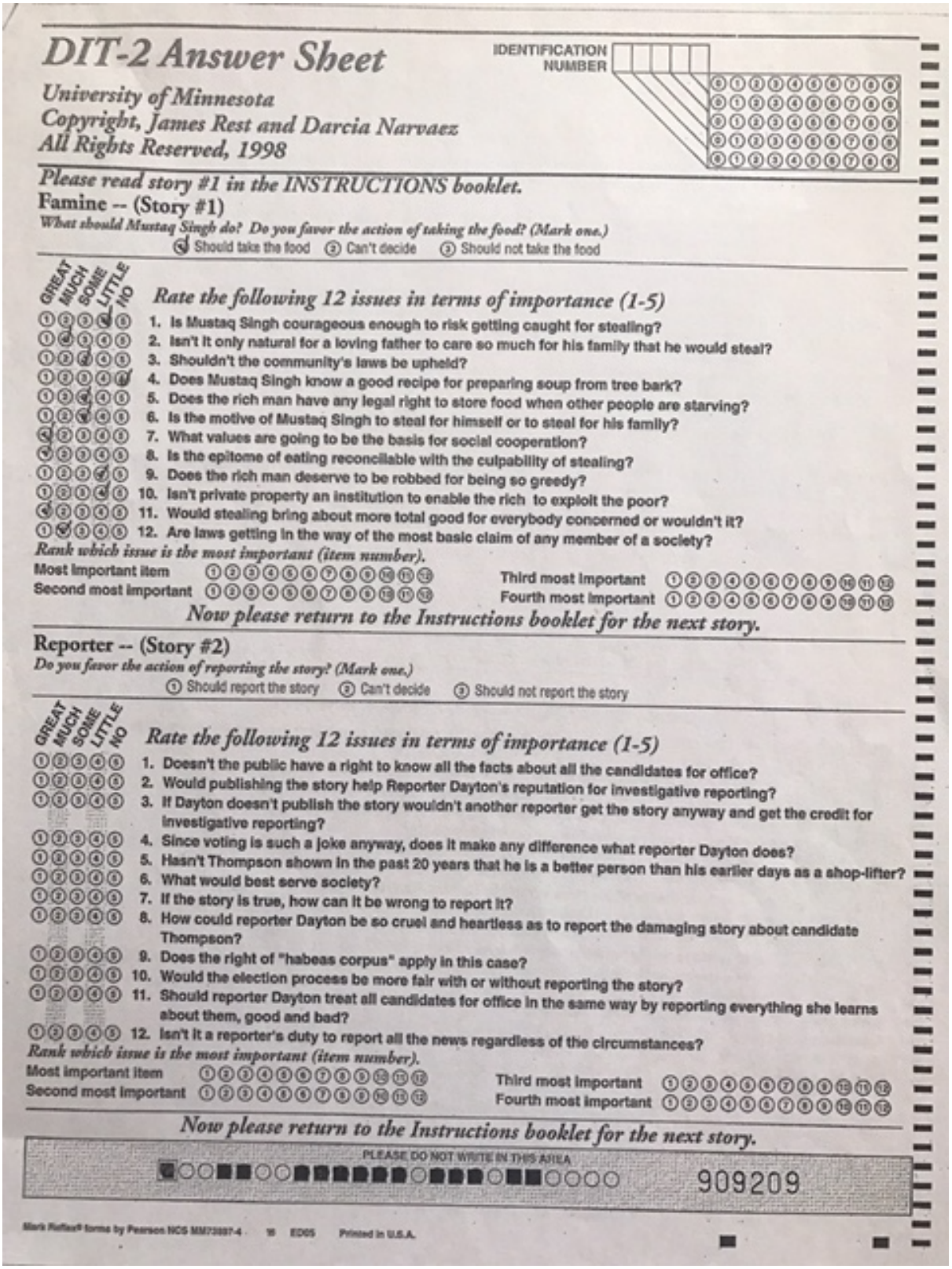
Mrs. Bennett is 62 years old, and in the last phases of colon cancer. She is in terrible pain and asks the doctor to give her more pain-killer medicine. The doctor has given her the maximum safe dose already and is reluctant to increase the dosage because it would probably hasten her death. In a clear and rational mental state, Mrs. Bennett says that she realizes this; but she wants to end her suffering even if it means ending her life. Should the doctor give her an increased dosage?

[Now turn to the Answer Sheet, go to the 12 issues for this story, rate and rank them in terms of how important each issue seems to you.]

Demonstration — (Story #5)

Political and economic instability in a South American country prompted the President of the United States to send troops to "police" the area. Students at many campuses in the U.S.A. have protested that the United States is using its military might for economic advantage. There is widespread suspicion that big oil multinational companies are pressuring the President to safeguard a cheap oil supply even if it means loss of life. Students at one campus took to the streets, in demonstrations, tying up traffic and stopping regular business in the town. The president of the university demanded that the students stop their illegal demonstrations. Students then took over the college's administration building, completely paralyzing the college. Are the students right to demonstrate in these ways?

[Now turn to the Answer Sheet, go to the 12 issues for this story, rate and rank them in terms of how important each issue seems to you.]



DIT-2 Answer Sheet

IDENTIFICATION NUMBER

University of Minnesota

Please read story #1 in the INSTRUCTIONS booklet.

Famine -- (Story #1)

What should Mustaq Singh do? Do you favor the action of taking the food? (Mark one.)

① Should take the food ② Can't decide ③ Should not take the food

Rate the following 12 issues in terms of importance (1-5)

GREAT MUCH SOME LITTLE NO

1. Is Mustaq Singh courageous enough to risk getting caught for stealing?
2. Isn't it only natural for a loving father to care so much for his family that he would steal?
3. Shouldn't the community's laws be upheld?
4. Does Mustaq Singh know a good recipe for preparing soup from tree bark?
5. Does the rich man have any legal right to store food when other people are starving?
6. Is the motive of Mustaq Singh to steal for himself or to steal for his family?
7. What values are going to be the basis for social cooperation?
8. Is the epitome of eating reconcilable with the culpability of stealing?
9. Does the rich man deserve to be robbed for being so greedy?
10. Isn't private property an institution to enable the rich to exploit the poor?
11. Would stealing bring about more total good for everybody concerned or wouldn't it?
12. Are laws getting in the way of the most basic claim of any member of a society?

Rank which issue is the most important (item number).

Most important item
Second most important
Third most important
Fourth most important

Now please return to the Instructions booklet for the next story.

Reporter -- (Story #2)

Do you favor the action of reporting the story? (Mark one.)

① Should report the story ② Can't decide ③ Should not report the story

Rate the following 12 issues in terms of importance (1-5)

GREAT MUCH SOME LITTLE NO

1. Doesn't the public have a right to know all the facts about all the candidates for office?
2. Would publishing the story help Reporter Dayton's reputation for investigative reporting?
3. If Dayton doesn't publish the story wouldn't another reporter get the story anyway and get the credit for investigative reporting?
4. Since voting is such a joke anyway, does it make any difference what reporter Dayton does?
5. Hasn't Thompson shown in the past 20 years that he is a better person than his earlier days as a shop-lifter?
6. What would best serve society?
7. If the story is true, how can it be wrong to report it?
8. How could reporter Dayton be so cruel and heartless as to report the damaging story about candidate Thompson?
9. Does the right of "habeas corpus" apply in this case?
10. Would the election process be more fair with or without reporting the story?
11. Should reporter Dayton treat all candidates for office in the same way by reporting everything she learns about them, good and bad?
12. Isn't it a reporter's duty to report all the news regardless of the circumstances?

Rank which issue is the most important (item number).

Most important item
Second most important
Third most important
Fourth most important

Now please return to the Instructions booklet for the next story.

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909209

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School Board -- (Story #3)

Do you favor calling off the next Open Meeting?

① Should call off the next open meeting ② Can't decide ③ Should have the next open meeting

GREAT MUCH SOME LITTLE NO

Rate the following 12 issues in terms of importance (1-5)

1. Is Mr. Grant required by law to have Open Meetings on major school board decisions?
2. Would Mr. Grant be breaking his election campaign promises to the community by discontinuing the Open Meetings?
3. Would the community be even angrier with Mr. Grant if he stopped the Open Meetings?
4. Would the change in plans prevent scientific assessment?
5. If the school board is threatened, does the chairman have the legal authority to protect the Board by making decisions in closed meetings?
6. Would the community regard Mr. Grant as a coward if he stopped the open meetings?
7. Does Mr. Grant have another procedure in mind for ensuring that divergent views are heard?
8. Does Mr. Grant have the authority to expel troublemakers from the meetings or prevent them from making long speeches?
9. Are some people deliberately undermining the school board process by playing some sort of power game?
10. What effect would stopping the discussion have on the community's ability to handle controversial issues in the future?
11. Is the trouble coming from only a few hotheads, and is the community in general really fair-minded and democratic?
12. What is the likelihood that a good decision could be made without open discussion from the community?

Rank which issue is the most important (item number).

Most important item ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫
Second most important ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫
Third most important ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫
Fourth most important ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫

Now please return to the Instructions booklet for the next story.

Cancer -- (Story #4)

Do you favor the action of giving more medicine?

① Should give Mrs. Bennett an increased dosage to make her die ② Can't decide ③ Should not give her an increased dosage

GREAT MUCH SOME LITTLE NO

Rate the following 12 issues in terms of importance (1-5)

1. Isn't the doctor obligated by the same laws as everybody else if giving an overdose would be the same as killing her?
2. Wouldn't society be better off without so many laws about what doctors can and cannot do?
3. If Mrs. Bennett dies, would the doctor be legally responsible for malpractice?
4. Does the family of Mrs. Bennett agree that she should get more painkiller medicine?
5. Is the painkiller medicine an active heliotropic drug?
6. Does the state have the right to force continued existence on those who don't want to live?
7. Is helping to end another's life ever a responsible act of cooperation?
8. Would the doctor show more sympathy for Mrs. Bennett by giving the medicine or not?
9. Wouldn't the doctor feel guilty from giving Mrs. Bennett so much drug that she died?
10. Should only God decide when a person's life should end?
11. Shouldn't society protect everyone against being killed?
12. Where should society draw the line between protecting life and allowing someone to die if the person wants to?

Rank which issue is the most important (item number).

Most important item ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫
Second most important ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫
Third most important ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫
Fourth most important ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫

Now please return to the Instructions booklet for the next story.

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Demonstration -- (Story #5)

Do you favor the action of demonstrating in this way?

① Should continue demonstrating in these ways ② Can't decide ③ Should not continue demonstrating in these ways

GREAT MUCH SOME LITTLE NO

Rate the following 12 issues in terms of importance (1-5)

1. Do the students have any right to take over property that doesn't belong to them?
2. Do the students realize that they might be arrested and fined, and even expelled from school?
3. Are the students serious about their cause or are they doing it just for fun?
4. If the university president is soft on students this time, will it lead to more disorder?
5. Will the public blame all students for the actions of a few student demonstrators?
6. Are the authorities to blame by giving in to the greed of the multinational oil companies?
7. Why should a few people like Presidents and business leaders have more power than ordinary people?
8. Does this student demonstration bring about more or less good in the long run to all people?
9. Can the students justify their civil disobedience?
10. Shouldn't the authorities be respected by students?
11. Is taking over a building consistent with principles of justice?
12. Isn't it everyone's duty to obey the law, whether one likes it or not?

Rank which issue is the most important (item number).

Most important item ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫
Second most important ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫
Third most important ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫
Fourth most important ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫

Please provide the following information about yourself:

1. Age in years:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

2. Sex (mark one): ○ Male ○ Female

3. Level of Education (mark highest level of formal education attained, if you are currently working at that level [e.g., Freshman in college] or if you have completed that level [e.g., if you finished your Freshman year but have gone on no further].)
   - ○ Grade 1 to 6
   - ○ Grade 7, 8, 9
   - ○ Grade 10, 11, 12
   - ○ Vocational/technical school (without a bachelor's degree) (e.g., Auto mechanic, beauty school, real estate, secretary, 2-year nursing program).
   - ○ Junior college (e.g., 2-year college, community college, Associate Arts degree)
   - ○ Freshman in college in bachelor degree program.
   - ○ Sophomore in college in bachelor degree program.
   - ○ Junior in college in bachelor degree program.
   - ○ Senior in college in bachelor degree program.
   - ○ Professional degree (Practitioner degree beyond bachelor's degree) (e.g., M.D., M.B.A., Bachelor of Divinity, D.D.S. in Dentistry, J.D. in law, Masters of Arts in teaching, Masters of Education [in teaching], Doctor of Psychology, Nursing degree along with 4-year Bachelor's degree)
   - ○ Masters degree (in academic graduate school)
   - ○ Doctoral degree (in academic graduate school; e.g., Ph.D. or Ed.D.)
   - ○ Other Formal Education. (Please describe: _____)

4. In terms of your political views, how would you characterize yourself (mark one)?
   - ○ Very Liberal
   - ○ Somewhat Liberal
   - ○ Neither Liberal nor Conservative
   - ○ Somewhat Conservative
   - ○ Very Conservative

5. Are you a citizen of the U.S.A.?
   ○ Yes ○ No

6. Is English your primary language?
   ○ Yes ○ No

Thank You.

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Appendix H. Idiogrid output

First year trainee

Original Grid

	MDT meeting	Self-harm project	Attempted murder	Parent smacking	Friend's affair	Software	WhatsApp	Driving	Therapy website	Shoplifting	No dilemma	
Actions of professional	7.00	7.00	1.00	1.00	4.00	6.00	7.00	4.00	7.00	4.00	2.00	Actions of service user
Relational	7.00	7.00	7.00	7.00	2.00	7.00	7.00	7.00	7.00	4.00	1.00	Individual
Current	7.00	5.00	2.00	7.00	7.00	5.00	7.00	6.00	7.00	7.00	3.00	Historical
Illegal	1.00	1.00	7.00	1.00	2.00	6.00	1.00	7.00	4.00	7.00	5.00	Morally dubious
Web based	1.00	1.00	1.00	1.00	1.00	7.00	7.00	1.00	7.00	1.00	4.00	Real world based
Tangible goods	1.00	1.00	1.00	1.00	1.00	7.00	1.00	1.00	4.00	4.00	4.00	Behaviour
Trainees	4.00	7.00	6.00	4.00	4.00	6.00	7.00	6.00	7.00	6.00	4.00	Another member of MDT
Having victims	6.00	5.00	7.00	7.00	7.00	6.00	4.00	6.00	7.00	1.00	3.00	Victimless crime
Conduct at work	7.00	7.00	7.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	4.00	Conduct outside of work
Adults	4.00	4.00	7.00	1.00	7.00	4.00	4.00	5.00	4.00	7.00	4.00	Child
Easy dilemma	5.00	7.00	2.00	1.00	1.00	6.00	2.00	4.00	6.00	2.00	7.00	Hard dilemma

Descriptive Statistics for Elements

	Means	Sum of Squares	Percent Total Sum of Squares
MDT meeting	0.23	43.83	7.89
Self-harm project	0.41	50.56	9.10
Attempted murder	0.05	72.56	13.05
Parent smacking	-1.40	59.65	10.73
Friend's affair	-0.50	35.11	6.32
Software	0.78	68.56	12.34
WhatsApp	0.05	47.47	8.54
Driving	0.05	22.02	3.96
Therapy website	1.23	41.93	7.54
Shoplifting	-0.31	53.47	9.62
No dilemma	-0.59	60.65	10.91

Note. Values are based upon deviation matrix in which construct means were removed from the original grid scores.
Total SS: 555.82

Element Direction Cosines (correlations)

	MDT meeting	Self-harm project	Attempted murder	Parent smacking	Friend's affair	Software	WhatsApp	Driving	Therapy website	Shoplifting	No dilemma
MDT meeting	1.00										
Self-harm project	0.81	1.00									
Attempted murder	-0.03	0.03	1.00								
Parent smacking	0.05	-0.22	-0.04	1.00							
Friend's affair	0.09	-0.27	0.08	0.53	1.00						
Software	-0.51	-0.36	-0.37	-0.48	-0.57	1.00					
WhatsApp	-0.03	-0.04	-0.58	0.07	0.11	0.04	1.00				
Driving	-0.36	-0.32	0.31	0.08	0.24	-0.22	-0.35	1.00			
Therapy website	-0.18	-0.07	-0.57	-0.31	-0.31	0.61	0.52	-0.12	1.00		
Shoplifting	-0.50	-0.48	0.02	-0.24	0.05	0.12	-0.17	0.34	-0.31	1.00	
No dilemma	-0.28	-0.09	0.08	-0.31	-0.62	0.51	-0.44	-0.28	-0.19	0.19	1.00

Note. Values reflect angle cosines (correlations) between elements in the full component space.

Element Euclidean Distances

	MDT meeting	Self-harm project	Attempted murder	Parent smacking	Friend's affair	Software	WhatsApp	Driving	Therapy website	Shoplifting	No dilemma
MDT meeting	0.00										
Self-harm project	4.24	0.00									
Attempted murder	10.95	10.95	0.00								
Parent smacking	9.90	11.58	11.75	0.00							
Friend's affair	8.49	10.39	10.00	6.78	0.00						
Software	12.96	12.73	13.93	13.78	12.65	0.00					
WhatsApp	9.70	10.10	13.71	10.00	8.60	10.58	0.00				
Driving	9.38	9.70	8.37	8.72	6.63	10.39	9.59	0.00			
Therapy website	10.05	9.95	13.30	11.53	10.05	6.71	6.56	8.43	0.00		
Shoplifting	12.08	12.41	11.14	11.83	9.17	10.39	10.86	7.21	11.18	0.00	
No dilemma	11.53	11.00	11.09	12.53	12.37	7.94	12.45	10.15	11.05	9.64	0.00

Element Euclidean Distances (standardised)

	MDT meeting	Self-harm project	Attempted murder	Parent smacking	Friend's affair	Software	WhatsApp	Driving	Therapy website	Shoplifting	No dilemma
MDT meeting	0.00										
Self-harm project	0.40	0.00									
Attempted murder	1.04	1.04	0.00								
Parent smacking	0.94	1.10	1.11	0.00							
Friend's affair	0.80	0.99	0.95	0.64	0.00						
Software	1.23	1.21	1.32	1.31	1.20	0.00					
WhatsApp	0.92	0.96	1.30	0.95	0.82	1.00	0.00				
Driving	0.89	0.92	0.79	0.83	0.63	0.99	0.91	0.00			
Therapy website	0.95	0.94	1.26	1.09	0.95	0.64	0.62	0.80	0.00		
Shoplifting	1.15	1.18	1.06	1.12	0.87	0.99	1.03	0.68	1.06	0.00	
No dilemma	1.09	1.04	1.05	1.19	1.17	0.75	1.18	0.96	1.05	0.91	0.00

Note. Values are standardised around the expected distance between random pairings of elements. For this grid: 10.54.

Descriptive Statistics for Constructs

	Means	Sum of Squares	Percent Total Sum of Squares
Actions of professional	4.55	58.73	10.57
Relational	5.73	52.18	9.39
Current	5.73	32.18	5.79
Illegal	3.82	71.64	12.89
Web based	2.91	76.91	13.84
Tangible goods	2.36	42.55	7.65
Trainees	5.55	16.73	3.01
Having victims	5.36	38.55	6.93
Conduct at work	2.91	76.91	13.84
Adults	4.64	32.55	5.86
Easy dilemma	3.91	56.91	10.24

Total SS: 555.82
Bias: 0.40
Variability: 0.75

Construct Correlations

	Actions of professional	Relational	Current	Illegal	Web based	Tangible goods	Trainees	Having victims	Conduct at work	Adults	Easy dilemma
Actions of professional	1.00										
Relational	0.17	1.00									
Current	0.47	0.39	1.00								
Illegal	-0.37	-0.45	-0.47	1.00							
Web based	0.45	-0.34	0.05	0.01	1.00						
Tangible goods	0.14	-0.80	-0.13	0.48	0.60	1.00					
Trainees	0.50	0.19	-0.02	0.20	0.43	0.14	1.00				
Having victims	-0.05	0.54	0.00	-0.23	-0.03	-0.28	-0.13	1.00			
Conduct at work	0.01	0.14	-0.55	-0.15	-0.40	-0.34	-0.07	0.08	1.00		
Adults	-0.09	0.00	-0.22	0.52	-0.27	-0.01	0.14	-0.21	0.09	1.00	
Easy dilemma	0.44	-0.43	-0.31	0.06	0.35	0.45	0.21	-0.10	0.35	-0.26	1.00

Direction cosines between Constructs and Elements

	MDT meeting	Self-harm project	Attempted murder	Parent smacking	Friend's affair	Software	WhatsApp	Driving	Therapy website	Shoplifting	No dilemma
Actions of professional	0.40	0.46	-0.62	-0.49	-0.21	0.24	0.55	-0.31	0.66	-0.22	-0.34
Relational	0.44	0.32	0.16	0.37	0.52	-0.73	0.29	0.27	0.03	-0.41	-0.89
Current	0.18	-0.11	-0.72	0.33	0.46	-0.15	0.56	0.05	0.33	0.09	-0.65
Illegal	-0.66	-0.50	0.44	-0.46	-0.31	0.41	-0.52	0.57	-0.05	0.60	0.38
Web based	-0.38	-0.25	-0.50	-0.35	-0.45	0.77	0.60	-0.40	0.82	-0.19	0.18
Tangible goods	-0.51	-0.39	-0.33	-0.47	-0.53	0.95	-0.11	-0.21	0.45	0.33	0.56
Trainees	-0.24	0.19	-0.06	-0.52	-0.42	0.23	0.41	0.12	0.55	0.05	-0.25
Having victims	0.21	0.04	0.22	0.36	0.34	-0.14	-0.09	0.13	0.25	-0.74	-0.45
Conduct at work	0.69	0.77	0.55	-0.25	-0.27	-0.37	-0.41	-0.29	-0.41	-0.36	0.17
Adults	-0.19	-0.17	0.49	-0.52	0.31	-0.12	-0.25	0.32	-0.28	0.55	-0.08
Easy dilemma	0.22	0.51	-0.25	-0.59	-0.77	0.52	-0.21	-0.27	0.40	-0.29	0.53

Note. Values reflect construct/element cosines (correlations) in the full component space.

Construct Loadings

	PC_1	PC_2
Actions of professional	-1.90	-5.84
Relational	5.58	-2.93
Current	0.77	-3.86
Illegal	-3.94	6.31
Web based	-6.74	-4.19
Tangible goods	-6.02	0.74
Trainees	-1.29	-1.05
Having victims	2.34	-1.52
Conduct at work	3.56	1.96
Adults	0.25	2.94
Easy dilemma	-3.91	-0.97

Construct Eigenvectors

	PC_1	PC_2
Actions of professional	-0.15	-0.51
Relational	0.43	-0.25
Current	0.06	-0.34
Illegal	-0.30	0.55
Web based	-0.52	-0.36
Tangible goods	-0.47	0.06
Trainees	-0.10	-0.09
Having victims	0.18	-0.13
Conduct at work	0.27	0.17
Adults	0.02	0.26
Easy dilemma	-0.30	-0.08

Note. Values for orienting (drawing) constructs in component space.

Eigenvalue Decomposition

	Eigenvalue	% Variance	Cumulative %	Scree
PC_ 1	167.80	30.19	30.19	|*******
PC_ 2	132.36	23.81	54.00	|******
PC_ 3	106.79	19.21	73.22	|*****
PC_ 4	52.05	9.36	82.58	|***
PC_ 5	44.31	7.97	90.55	|***
PC_ 6	23.93	4.30	94.86	|**
PC_ 7	16.07	2.89	97.75	|**
PC_ 8	6.86	1.23	98.98	|*
PC_ 9	3.86	0.69	99.68	|*
PC_10	1.79	0.32	100.00	|*

Element Loadings

	PC_1	PC_2
MDT meeting	3.80	-2.44
Self-harm project	2.60	-2.07
Attempted murder	3.50	6.28
Parent smacking	4.36	-0.98
Friend's affair	3.73	-0.42
Software	-7.91	-0.33
WhatsApp	-0.73	-5.40
Driving	0.83	1.85
Therapy website	-3.70	-4.29
Shoplifting	-2.06	3.81
No dilemma	-4.43	3.98

Note. Values for plotting elements in the component space.

Element Eigenvectors

	PC_1	PC_2
MDT meeting	0.29	-0.21
Self-harm project	0.20	-0.18
Attempted murder	0.27	0.55
Parent smacking	0.34	-0.08
Friend's affair	0.29	-0.04
Software	-0.61	-0.03
WhatsApp	-0.06	-0.47
Driving	0.06	0.16
Therapy website	-0.29	-0.37
Shoplifting	-0.16	0.33
No dilemma	-0.34	0.35

Original Grid

	Parent smacking	Friend's affair	Software	MDT meeting	Self-harm project	Attempted murder	Driving	WhatsApp	Shoplifting	Therapy website	No dilemma	
Impact on relationships	5.00	7.00	1.00	4.00	7.00	5.00	7.00	4.00	2.00	5.00	1.00	Wouldn't affect anyone
Professional guidelines	3.00	1.00	4.00	7.00	4.00	7.00	3.00	4.00	1.00	4.00	7.00	Personal responsibility
Impact on people	6.00	7.00	1.00	5.00	6.00	6.00	7.00	4.00	2.00	5.00	1.00	Doesn't directly impact people
Clearer process with guidelines	2.00	4.00	6.00	7.00	6.00	7.00	6.00	1.00	3.00	4.00	7.00	Context unclear
Ethics about finances	1.00	1.00	7.00	3.00	2.00	3.00	1.00	1.00	6.00	4.00	7.00	Ethics about people
Emotions affecting process	4.00	7.00	1.00	2.00	5.00	1.00	6.00	6.00	2.00	5.00	1.00	Clearer to know what to do
Wouldn't intervene	7.00	4.00	7.00	6.00	4.00	1.00	2.00	4.00	6.00	4.00	7.00	Intervene
Acting against someone close	1.00	5.00	1.00	3.00	7.00	3.00	5.00	7.00	2.00	7.00	1.00	Acting against other people
Wouldn't know process	7.00	6.00	5.00	3.00	4.00	1.00	4.00	6.00	1.00	6.00	1.00	Process for reporting
Less likely to cause harm	2.00	1.00	7.00	5.00	2.00	3.00	1.00	4.00	6.00	3.00	7.00	More likely to cause hard
Easy dilemma	2.00	1.00	7.00	3.00	2.00	7.00	4.00	2.00	6.00	2.00	7.00	Hard dilemma

Descriptive Statistics for Elements

	Means	Sum of Squares	Percent Total Sum of Squares
Parent smacking	-0.45	45.69	8.08
Friend's affair	-0.08	61.50	10.88
Software	0.19	80.50	14.24
MDT meeting	0.28	22.05	3.90
Self-harm project	0.37	31.23	5.52
Attempted murder	-0.08	56.41	9.98
Driving	0.10	42.60	7.53
WhatsApp	-0.17	44.14	7.81
Shoplifting	-0.72	58.50	10.35
Therapy website	0.37	22.50	3.98
No dilemma	0.19	100.32	17.74

Note. Values are based upon deviation matrix in which construct means were removed from the original grid scores.

Total SS: 565.45

Element Direction Cosines (correlations)

	Parent smacking	Friend's affair	Software	MDT meeting	Self-harm project	Attempted murder	Driving	WhatsApp	Shoplifting	Therapy website	No dilemma
Parent smacking	1.00										
Friend's affair	0.54	1.00									
Software	-0.25	-0.80	1.00								
MDT meeting	-0.22	-0.55	0.26	1.00							
Self-harm project	0.00	0.73	-0.86	-0.15	1.00						
Attempted murder	-0.53	-0.43	-0.02	0.38	-0.04	1.00					
Driving	0.09	0.76	-0.84	-0.38	0.78	0.21	1.00				
WhatsApp	0.32	0.52	-0.50	-0.49	0.37	-0.55	0.20	1.00			
Shoplifting	-0.24	-0.58	0.71	-0.12	-0.75	-0.07	-0.66	-0.33	1.00		
Therapy website	0.08	0.60	-0.53	-0.41	0.67	-0.45	0.36	0.71	-0.54	1.00	
No dilemma	-0.49	-0.95	0.86	0.55	-0.75	0.29	-0.78	-0.63	0.64	-0.66	1.00

Note. Values reflect angle cosines (correlations) between elements in the full component space.

Element Euclidean Distances

	Parent smacking	Friend's affair	Software	MDT meeting	Self-harm project	Attempted murder	Driving	WhatsApp	Shoplifting	Therapy website	No dilemma
Parent smacking	0.00										
Friend's affair	7.07	0.00									
Software	12.53	15.97	0.00								
MDT meeting	9.06	11.14	9.00	0.00							
Self-harm project	8.77	5.39	14.07	7.81	0.00						
Attempted murder	12.49	12.96	11.79	7.21	9.54	0.00					
Driving	8.94	5.10	14.87	9.38	4.12	8.83	0.00				
WhatsApp	7.81	7.14	13.56	9.85	6.93	12.45	8.31	0.00			
Shoplifting	11.36	13.75	6.48	9.43	12.41	11.09	12.92	11.66	0.00		
Therapy website	7.94	6.24	12.17	7.94	4.24	10.54	6.56	4.69	10.95	0.00	
No dilemma	14.59	17.64	5.10	8.43	14.70	10.63	15.65	15.10	7.75	13.64	0.00

Element Euclidean Distances (standardized)

	Parent smacking	Friend's affair	Software	MDT meeting	Self-harm project	Attempted murder	Driving	WhatsApp	Shoplifting	Therapy website	No dilemma
Parent smacking	0.00										
Friend's affair	0.66	0.00									
Software	1.18	1.50	0.00								
MDT meeting	0.85	1.05	0.85	0.00							
Self-harm project	0.83	0.51	1.32	0.73	0.00						
Attempted murder	1.17	1.22	1.11	0.68	0.90	0.00					
Driving	0.84	0.48	1.40	0.88	0.39	0.83	0.00				
WhatsApp	0.73	0.67	1.28	0.93	0.65	1.17	0.78	0.00			
Shoplifting	1.07	1.29	0.61	0.89	1.17	1.04	1.22	1.10	0.00		
Therapy website	0.75	0.59	1.14	0.75	0.40	0.99	0.62	0.44	1.03	0.00	
No dilemma	1.37	1.66	0.48	0.79	1.38	1.00	1.47	1.42	0.73	1.28	0.00

Note. Values are standardized around the expected distance between random pairings of elements. For this grid: 10.63.

Descriptive Statistics for Constructs

	Means	Sum of Squares	Percent Total Sum of Squares
Impact on relationships	4.36	50.55	8.94
Professional guidelines	4.09	46.91	8.30
Impact on people	4.55	50.73	8.97
Clearer process with guidelines	4.82	45.64	8.07
Ethics about finances	3.27	58.18	10.29
Emotions affecting process	3.64	52.55	9.29
Wouldn't intervene	4.73	42.18	7.46
Acting against someone close	3.82	61.64	10.90
Wouldn't know process	4.00	50.00	8.84
Less likely to cause harm	3.73	50.18	8.87
Easy dilemma	3.91	56.91	10.06

Total SS: 565.45
Bias: 0.16
Variability: 0.76

Construct Correlations

	Impact on relationships	Professional guidelines	Impact on people	Clearer process with guidelines	Ethics about people	Emotions affecting process	Wouldn't intervene	Acting against other people	Wouldn't know process	Less likely to cause harm	Easy dilemma
Impact on relationships	1.00										
Professional guidelines	-0.27	1.00									
Impact on people	0.96	-0.18	1.00								
Clearer process with guidelines	-0.07	0.63	-0.06	1.00							
Ethics about finances	-0.87	0.24	-0.90	0.36	1.00						
Emotional attachment affecting decision making	0.77	-0.58	0.66	-0.50	-0.78	1.00					
Wouldn't intervene	-0.67	-0.04	-0.66	-0.15	0.52	-0.38	1.00				
Acting against someone close	0.66	-0.18	0.52	-0.23	-0.56	0.76	-0.60	1.00			
Wouldn't know process	0.40	-0.43	0.38	-0.59	-0.54	0.68	0.09	0.38	1.00		
Less likely to cause harm	-0.97	0.36	-0.96	0.20	0.88	-0.78	0.63	-0.57	-0.48	1.00	
Easy dilemma	-0.70	0.39	-0.66	0.51	0.77	-0.85	0.12	-0.66	-0.75	0.69	1.00

Direction cosines between Constructs and Elements

	Parent smacking	Friend's affair	Software	MDT meeting	Self-harm project	Attempted murder	Driving	WhatsApp	Shoplifting	Therapy website	No dilemma
Impact on relationships	0.28	0.86	-0.93	-0.27	0.90	0.03	0.92	0.31	-0.78	0.51	-0.88
Professional guidelines	-0.43	-0.65	0.22	0.82	-0.14	0.62	-0.28	-0.34	-0.22	-0.28	0.54
Impact on people	0.37	0.80	-0.91	-0.16	0.79	0.13	0.88	0.25	-0.79	0.40	-0.85
Clearer process with guidelines	-0.62	-0.44	0.24	0.65	0.03	0.67	0.04	-0.79	-0.10	-0.39	0.49
Ethics about finances	-0.53	-0.83	0.91	0.25	-0.71	0.10	-0.78	-0.56	0.76	-0.42	0.89
Emotions affecting process	0.39	0.93	-0.78	-0.59	0.74	-0.50	0.70	0.72	-0.57	0.74	-0.89
Wouldn't intervene	0.31	-0.37	0.67	0.29	-0.60	-0.56	-0.81	-0.18	0.50	-0.32	0.53
Acting against someone close	-0.15	0.60	-0.72	-0.36	0.85	-0.18	0.58	0.69	-0.58	0.87	-0.69
Wouldn't know process	0.71	0.67	-0.32	-0.41	0.31	-0.69	0.23	0.64	-0.52	0.66	-0.67
Less likely to cause harm	-0.42	-0.89	0.90	0.39	-0.79	0.01	-0.91	-0.34	0.74	-0.48	0.91
Easy dilemma	-0.57	-0.85	0.74	0.23	-0.71	0.59	-0.45	-0.68	0.64	-0.73	0.83

Note. Values reflect construct/element cosines (correlations) in the full component space.

Element Eigenvectors

	PC_1	PC_2
Parent smacking	-0.16	-0.37
Friend's affair	-0.40	-0.13
Software	0.44	-0.25
MDT meeting	0.11	0.19
Self-harm project	-0.25	0.19
Attempted murder	0.11	0.67
Driving	-0.28	0.30
WhatsApp	-0.23	-0.30
Shoplifting	0.30	-0.28
Therapy website	-0.18	-0.09
No dilemma	0.53	0.07

Construct Loadings

	PC_1	PC_2
Impact on relationships	-6.54	2.38
Professional guidelines	3.00	4.07
Impact on people	-6.22	2.68
Clearer process of professional guidelines	2.77	5.17
Ethics of economics	6.99	-0.84
Emotional attachment affecting decision making	-6.72	-1.56
Wouldn't intervene	3.49	-4.42
Going against my own	-5.89	0.93
Wouldn't know process	-4.58	-3.96
Less likely to cause harm	6.56	-1.63
Easy dilemma	6.55	2.22

Eigenvalue Decomposition

	Eigenvalue	% Variance	Cumulative %	Scree
PC_ 1	345.95	61.18	61.18	|**********
PC_ 2	102.99	18.21	79.39	|*****
PC_ 3	40.30	7.13	86.52	|**
PC_ 4	36.08	6.38	92.90	|**
PC_ 5	19.32	3.42	96.32	|**
PC_ 6	12.67	2.24	98.56	|*
PC_ 7	4.78	0.85	99.41	|*
PC_ 8	2.12	0.38	99.78	|*
PC_ 9	1.17	0.21	99.99	|*
PC_10	0.07	0.01	100.00	|*

Element Loadings

	PC_1	PC_2
Parent smacking	-2.99	-3.76
Friend's affair	-7.43	-1.27
Software	8.20	-2.55
MDT meeting	2.13	1.95
Self-harm project	-4.65	1.93
Attempted murder	2.06	6.75
Driving	-5.27	3.01
WhatsApp	-4.20	-3.02
Shoplifting	5.62	-2.83
Therapy website	-3.30	-0.93
No dilemma	9.82	0.72

Note. Values for plotting elements in the component space.

Construct Eigenvectors

	PC_1	PC_2
Impact on relationships	-0.35	0.24
Professional guidelines	0.16	0.40
Impact on people	-0.33	0.26
Clearer process of professional guidelines	0.15	0.51
Ethics of economics	0.38	-0.08
Emotional attachment affecting decision making	-0.36	-0.15
Wouldn't intervene	0.19	-0.44
Going against my own	-0.32	0.09
Wouldn't know process	-0.25	-0.39
Less likely to cause harm	0.35	-0.16
Easy dilemma	0.35	0.22

Note. Values for orienting (drawing) constructs in component space.

Appendix I. GRIDSTAT output

First year trainee

Personal			Professional	
Parent smacking	16.8		MDT meeting	9.4
Friend's affair	12.6		Self-harm project	7.7
Software	4.5		Attempted murder	12.6
Driving	7.7		WhatsApp	11.2
Shoplifting	9.8		Therapy website	4.2
Total:	51.4		Total:	45.1
Total Conflict:	47.3			

```
    Option :
2
      Overall Percentage Conflict in Grid :  47.3%

       % Conflict attributable to Element
    ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
       9.4  MDT meeting
       7.7  Self-harm project
      12.6  Attempted murder
      16.8  Parent smacking
      12.6  Friend's affair
       4.5  Software
      11.2  WhatsApp
       7.7  Driving
       4.2  Therapy website
       9.8  Shoplifting
       3.5  No dilemma
```

Third year trainee

Personal			Professional	
Parent smacking	9.4		MDT meeting	7.4
Friend's affair	12.1		Self-harm project	5.9
Software	12.5		Attempted murder	12.9
Driving	8.6		WhatsApp	6.6
Shoplifting	8.6		Therapy website	2
Total:	51.2		Total:	34.8
Total Conflict:	42.3			

```
    Option :
2
      Overall Percentage Conflict in Grid :  42.3%

       % Conflict attributable to Element
    ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
       9.4  Parent smacking
      12.1  Friend's affair
      12.5  Software
       7.4  MDT meeting
       5.9  Self-harm project
      12.9  Attempted murder
       8.6  Driving
       6.6  WhatsApp
       8.6  Shoplifting
       2.0  Therapy website
      14.1  No dilemma
```

Appendix J. Participant information sheet

How do you make ethical decisions?

Introduction
You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulations governing the conduct of studies involving human participants can be accessed via this link: http://sitem.herts.ac.uk/secreg/upr/RE01.htm

Who is carrying out the study?
The study is being carried out by Angie Jenkin, Trainee Clinical Psychologist, as part of a Doctoral qualification in Clinical Psychology. The study is supervised by Dr Helen Ellis-Caird (Research Tutor at the University of Hertfordshire) and Professor David Winter (Professor Emeritus, Centre for Personal Construct Psychology at the University of Hertfordshire).

The study has received full ethical approval by The University of Hertfordshire Health and Human Sciences Ethics Committee with Delegated Authority.

What is the purpose of this study?
Little research has been conducted exploring how clinical psychology trainees approach ethical decision making. There has, however, been increasing interest in this area, culminating in guidelines produced by the British Psychological Society in 2015. The guidelines highlight the importance of teaching ethics and ethical action to trainees, and assessing their level of understanding concerning ethics. The current research study will explore trainee clinical psychologists' constructs underlying decision making, which will help build the current body of evidence in an area where there is currently a gap in knowledge.

Do I have to take part?
It is completely up to you whether you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. If you change your mind at any time during the study you can withdraw, without giving a reason. If you decide to withdraw from the study at a later time, your data will be destroyed. Your decision to participate or withdraw from the study will not be communicated to your university.

Are there any restrictions that may prevent me from participating?
You are eligible to take part in the research if you are a trainee clinical psychologist enrolled on a doctoral level clinical psychology training course in the UK.

How long will my part in the study take?
If you decide to take part you will complete an online questionnaire at home which should take less than 30 minutes to complete. This will later be followed by a 1 hour face to face or Skype interview. It is possible that you may be contacted again at a future date, as a further study may explore how trainees' construing changes over time.

What happens if I am interested in taking part?
If you are interested in taking part you can contact me by email or by phone and we can discuss any questions you may have. If you decide to participate, the first thing to happen is you will be sent an email link to a questionnaire which will first ask you for some demographic details, followed by some questions asking you how you would approach several ethical dilemmas. At a later date, you will take part in either a face to face or Skype interview, during which you will be asked to consider some professional and personal ethical dilemmas.

What are the possible disadvantages, risks or side effects of taking part?
The possible disadvantages, risks or side effects to all participants have been considered. It is unlikely, but it may be possible, that you find the interview process distressing, for example, you may remember particular ethical dilemmas you have faced prior to or during training. Also, if you were to reveal an ethical dilemma involving risk to you or to others of serious concern, it would be necessary for the principal investigator to make contact with the course team from your training institution. This step would only be taken following discussion with you in the first instance.

What are the possible benefits of taking part?
The study provides an opportunity to explore the way in which you approach ethical dilemmas, and to contribute to the currently small knowledge base in this area for clinical psychology trainees. It is hoped that this research may play a role in highlighting training needs for trainees, which can help shape future training provision. If you decide to take part, you will automatically be entered into a £50 Amazon gift voucher prize draw.

How will my taking part in this study be kept confidential?
You will be assigned an anonymous code which will be attached to your questionnaire and interview data, and your identity will be known only to members of the research team. Details of your training institution will not be stated in any reports related to the research, and any feedback provided to training courses will be of a general nature, and will not identify you. The project may be published in a research paper and to protect your identity, all data will be anonymised by changing your name and other details that would identify you.

What will happen to the data collected within this study?
All data collected will be anonymised and stored electronically, in a password-protected environment, for a period of 10 years, after which time it will be destroyed under secure conditions. Data will also be stored in hard copy format, and destroyed under secure conditions after 10 years. It is possible that data may be re-used or further analysed in future ethically-approved studies.

The study findings will be written in a thesis for doctoral-level research. An article will then be written and submitted to a relevant academic psychology journal for publication. There will be no identifying features or names written in the thesis or academic journal.

Who has reviewed this study?
This study has been reviewed by The University of Hertfordshire Health and Human Sciences Ethics Committee with Delegated Authority. The protocol number is LMS/PGR/UH/02820.

Who can I contact if I have any questions?
If you would like further information or would like to discuss any details, please get in touch with me, in writing, by phone or by email.

Angie Jenkin
Address: Clinical Psychology Doctoral Training College. College Lane Campus, University of Hertfordshire, Hatfield, Hertfordshire, AL10 9AB.
Email: a.jenkin@herts.ac.uk
Tel: 07570 465396

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar.

Thank you very much for reading this information.

Appendix K. Consent form

Participant Consent Form (EC3)

UNIVERSITY OF HERTFORDSHIRE
ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC3
CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

I, the undersigned *[please give your name here, in BLOCK CAPITALS]*

.....

of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

.....

hereby freely agree to take part in the study entitled:

The integration of personal and professional ethical decision making constructs in trainee clinical psychologists

(UH Protocol number LMS/PGR/UH/02820)

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

4 I understand that if there is any revelation of unlawful activity or any indication of circumstances that would or has put others at risk, the University may refer the matter to the participant's training institution.

5 I have been told that I may at some time in the future be contacted again in connection with this or another study. It is also possible that anonymous data from this study and related future studies may be amalgamated. Data may be included in peer reviewed publications, and may be used for secondary analysis in further studies.

Signature of participant.....Date.....

Signature of (principal) investigator.....Date.....

Name of (principal) investigator

ANGIE JENKIN

Appendix L. Elicited constructs

Key:
Professional constructs
Personal constructs

Year 1 trainees
Unsure whether to intervene – Wouldn't think about it twice
There's a way to address it – No way to address it
Impact on other people – No impact on others
Taking action while maintaining personal relationships – Taking action while maintaining professional relationships
Political beliefs lead me to think no harm done – Very dangerous
Breaking boundaries (more complicated) – Clear about boundaries
No excuse – Depends on circumstances
Protecting interests – Less of a need to protect interests
Not right – More compassion
Helping people understand their impact on others – Reflecting on the impact I have

Risk of physical harm - Abstract (not necessarily resulting in harm)
Harm to individual – Corporate/indirect harm
Acting in an unethical way – Action of other
If don't disclose you're implicated – Acceptance and acknowledgement of best course of action
Potentially serious – Potentially inconsequential
Could be symptomatic of problem which could be helped – An individual's ethical dilemma or choice
Indirect disrespect – Direct disrespect
Witnessing and certainty of harm – Not witnessing and uncertainty of harm
Misinformed but good intention – Ulterior motive
Illegal – Civil matter

Sharing sensitive information – Not disclosing something important
Intervene – Not intervene
Personal connection – Professional connection
Legality – Morally wrong
Professional boundaries – Working within professional guidelines
Personal harm – Financial harm
Service user mistreatment – False professional claims
Personal involvement – No personal involvement
Less ambiguous – More ambiguous
Direct intervention – Indirect intervention

Other people's intimate life – No involvement with intimate life
Direct involvement – Not directly involved
Related to breaking the law – Not related to the law
Obvious ethical issue – More exploration needed
Outcome affects corporation – Outcome affects person
Peer issue – Clinical issue
Relating to people you don't know – Relating you people you do know
Lack of respect for individual service users – Impacts on service users more generally
Emotional difficulty – Economic difficulty
More unusual breaches – Everyday breaches

Affects someone directly – Victimless
No immediate risk – Risk issue
Illegal – Not illegal
Guidelines on what to do – Less clear on whether it's right or wrong
Less acceptable – Morally acceptable
Clearly wrong – Need more information
Harmful – Harmless
Inappropriate – Have good intentions
Targeted – Less obvious consequences
Knowledge and choice (of person harmed) – Lack of knowledge and choice (for the person harmed)

People in relationships – Material
Patient care – Personal relationship
Relationship dilemma – Interpersonal dilemma
Seek supervision – No need for supervision
Somebody else's responsibility – My responsibility
Current risk – Historical risk
Potentially involves person lacking capacity – Capacity is assumed
More responsible – Less responsible
Negative impact on another person – Negative impact on an institution
Professional dilemma – Personal dilemma

Illegal – Not illegal
Less risk – More definite risk
Finding wrongdoing out – Knowing about own wrongdoing
Individual responsibility – Shared responsibility
Indirect impact on people – Possible direct impact on individuals
Shows concern about fitness to practice – No concerns about fitness to practice
Wrongdoing with strangers – Wrongdoing with friend
Easier to speak out – Difficult to speak out
More upset – Not upset
Needing advice with regards to course of action – Would not need advice

Breaking confidentiality to keep people safe – Keeping information that might be harmful to self
My place to intervene – Doing what suits me best
Service user in vulnerable position – Service user in danger
Someone else getting harmed – Repercussions to myself
Flag up straight away – Keep an eye on
Who is it harming? – Real possibility of harm
Transparency about opinions of others – Transparency about myself
Trying to protect from harm – No obvious harm
Larger power imbalance – Power imbalance has less of an impact
Anonymous – Personal implications

Confronting the person – Looking within myself
Managing risk – Managing dynamics
Illegal activities – Not nice, but not illegal
Following professional guidelines – Not following professional guidelines
Involves others – Just involves me
What trainees should be doing – Responding to a service user
Reporting stranger – Reporting a friend
Language use about people – Language use about oneself
More than one person affected – Only one person affected
Professional relationship – Personal relationship

Consulting with clinical team – Consulting with university
Consider when to confront, protect, inform – Own personal dilemma
Aware of the dilemma – A hidden unknown
Personal impact – Less personal impact
More ambiguity about responsibility – Clear situation with no concerns around further actions
Public not in danger – Public in danger
More empathy and thinking of wider perspective – Less empathy
Others may bear brunt of actions – Doesn't really affect other people
Ensuring guidelines/regulations followed – More complexity
No imminent risk for vulnerable person – Vulnerable person

Other people's actions – Own actions
Moral judgements – Legal judgement
Impact on individuals – More general risk
Clear cut – More difficult to make a decision
Somebody I know – Somebody I don't know
Things – Human safety
Relationships – Information
Public behaviour – Private behaviour
Other people's professionalism – My own professionalism
No background knowledge – Some background knowledge

Blurred boundaries – Fairly easy to address
More of an impact on people – I don't care
Here and now: taking action – In the past
Personal connection – Disconnected
Breaking codes of conduct – More messy
Less serious consequences – More risky consequences
Lack of respect for individuals – Broader lack of respect
Choice taken away – No choice taken away
Objectively unacceptable – Generates loads of discussions
Less weighing up of actions – Weighing up consequences of my action

Actions of professional – Actions of service user
Relational – Individual
Current – Historical
Illegal – Morally dubious
Web based – Real world based
Tangible goods – Behaviour
Trainees – Another member of MDT
Having victims – Victimless crime
Conduct at work – Conduct outside of work
Adults – Child

Direct impact on people – Indirect potential harm
Direct risk to others – Professional conduct
Illegal activities – Moral dilemma
Outside the therapy room – Inside the therapy room
Meeting essential needs – Leisure
Already carried out – Waiting for a response
Vulnerable population – Not a vulnerable population
Information about service users – Information about trainees
Family relationships – Individual
Meeting own goal – Seeking support

Physical harm – Emotional harm
Illegal – Not illegal
Ethical conflict with service users – Ethical conflict with a colleague
Dilemma in relation to friends – Dilemma in relation to self
Online use – Face to face
Stealing – Not related to theft
Unprofessionalism – Ethical concerns but not unprofessional
Seen it happen – Just aware (not necessarily seen)
Directly affects work – Out of circle of concern
In public – In private

Responsibility lies with me – Less my responsibility
Intervention is required – Not doing it
Risk of harm to others – Less of a risk
Breaking the law – Breaking moral code
Trainee behaviour – My practice
Other people doing something wrong – Potentially me doing something wrong
Talking behind someone's back – Not talking behind someone's back
Strangers (less responsible) – Someone I know (more responsible)
A problem – Not a problem
Risk of harm to a person – Risk of harm to faceless corporation

Lawbreaking – Morally wrong
Tug between personal and professional values – Within realm of professional values
Hurting others emotionally – Financial loss
Not having choice – Having a choice
Doing something wrong to meet a need – Choosing a path that isn't safe
Exploiting position – Open and transparent
More serious harm – Less serious harm
Lack of respect and dignity to others – Misrepresentation of professional self
Seeking out something different – Implementing an established rule
Accessing resources in a way that's beneficial – Not beneficial

Balancing duty to different parties – Duties not polarised
Breach of boundaries – Dilemma does not involve boundary breach
Compromising a personal relationship – Not compromising a personal relationship
Overlap between both personal and professional dilemma – Just a professional dilemma
Harmful impact difficult to calculate – Clear potential for unambiguous serious harm
Fellow trainee breaching boundaries – Does not involve trainee boundaries
Member of public breaking the law – Personal friend breaking the law
Dilemma involving colleague at the same level – Dilemma involving colleague at different level
Dilemma involving legal breach – Dilemma involving moral but not legal breach
Inappropriate behaviour inside healthcare – Inappropriate behaviour outside healthcare

Direct contact – Indirect contact
More morally wrong – Less morally wrong
Blurred boundaries – Professional lines clear
A pull to intervene – No pull to intervene
Service users' best interests at heart – Service users and public's best interest
Not very serious – Life threatening
Clearly disrespectful – Ambiguous
Action in public – Personal action
More information needed – Less information needed
Less serious event – Serious event

Year 3 trainees

Other people's choices – A matter of law
Emotional hurt – Serious harm
Personal responsibility – Reckless
Can be managed sensitively – Insensitive
Consequences for self – Could involve others
Unashamed – Conscientious
Requires some more understanding – Requires proactivity
Thoughtless – Purposeful
Harmful – Harmless
Relational – Self-benefiting

Betrayal of trust – No wellbeing at stake
Potential to be unspoken – Spoken
Disgust – Run of the mill
Can conceptualise – Shock
Indirectly witnessed – Directly witnessed
Personal – Professional
Enabled – Disabled (from intervening)
Blurry – Clearer
Disconnected – Entangled
Reconceptualised – Static

Open to interpretation – Objectively right or wrong
Context is justifying – Never justified
Harmful to other people – Not dangerous to other people
Relate personally to dilemma – Professional stance (what you should do)
Costs of breaking law – Benefits of breaking law
Lying as a bad thing - Lying as a good thing
No immediate judgement – Can make immediate judgement
Misusing professional power – Aware we are all equal
Personal responsibility – Letting things take their own course
Full professional responsibility – Personal experience coming in too much

Doing something about it – Figuring it out
Illegal – Morally wrong
Failure to act – Acting
Socially sanctioned – Personally moral
Collective responsibility – Personal responsibility
Laws you don't always need to follow by the book – Laws that you always follow
Clear harm – Ambiguous harm
Individual victim – Corporate victim
Directly connected to victim – Indirectly connected to victim
Stranger – Someone you know

Tackling behaviour you disapprove of – Not making judgement on behaviour
Making judgement on another's behaviour in personal life – One's own behaviour
Navigating boundaries between personal and professional – No personal aspects
Sense of knowing – Fact
Knowing protocols of action – Fuzzier
Indefensible – Defensible
Managing relationships with other trainees – Managing professional interactions
Intervening in the moment – Vaguer in time
Actions have already happened – A choice to come
No sense of context – Knowing the context

Illegal – Immoral
Professional dilemma – Service user dilemma
More socially acceptable – Less socially acceptable
Potential for harm to others – Less of a risk to others
Need (survival) – No need
Professional misconduct – Member of public's conduct
Public arena – Private arena
Virtual – Real life
Relational – Independent
Somebody else's behaviour – Your behaviour

Passive professional issue – Created professional issue
Less need for advocacy – More need for advocacy
Personal professional issues – Professional professional issues
Moral grey areas – Categorically wrong
Honest – Dishonest
Don't care – Do care
Compelled to act – Not compelled to act
Harmful to others – Victimless
Misguided – Intentional
Less emotional response to inaction – More emotional response to inaction

Duty to report – My choice
Defined by society – Personal ethics
Trainee ethical dilemma – Service user ethical dilemma
Not life threatening – Life threatening
Current risk – Historic risk
Personal importance – Feeling detached
Inappropriate language – Inappropriate action
Highly distressing – Not distressing
Impact on one person – Impact on community
Witnessed act – Personal involvement

Requires action – Requires no action
Personal directly affected hurt – Possibility of indirect hurt
Professionals crossing boundaries – Not crossing boundaries
No immediate obligation – Much more worried
Managed through workplace – Managed through the course
Not much risk – Risk of bad things happening
Subjective misconduct – Clear breach of contract
Risk to others – No risk to others
Managing someone else's conduct – Managing one's own conduct
Acting ignorant – Not acting ignorant

Direct involvement – No direct involvement
Professional role – Personal role
Personal connection – No personal connection
More blurred – Less blurred
More seriously illegal – less seriously illegal
More information needed – More concrete
Injury – Limited injury
Already happened – Not happened yet
Public – Private
Knowing the rules – Not knowing the rules

Putting values on someone else – My action affects me
Contemplate options – Immediate decision
Being moral – Everyday
Maintaining a therapeutic boundary – Mistrust
Life isn't at risk – Life is at risk
Competent – Not feeling good enough
Duty – I could walk away
Misuse of power – Power used in an ethical way
In public – Affects me privately
Unprofessional – Professional

Speak in supervision – Don't take to supervision
Legal implications – No legal decision to make
Problem with boundaries – No problem with boundaries
Getting involved – Not getting involved
Unprofessional behaviour – Professional behaviour
Justifiable – Not justifiable
Not reflecting on actions – Reflecting on actions
Stigma – No stigma
Needs not being taken into consideration – Needs being taken into consideration
Being judged – Not being judged

Crossing the boundary – Professional responsibility
What to do with others – Self-morals
Grey area – Clear cut
Knowledge – Action
Dependent on more information – More concrete
Others' illegal action – Your illegal action
Impact on service user – Professional liability
External – Personal
Professional misconduct – Professional development
Public responsibility – Personal responsibility

Thinking rationally and clearly – Led by emotions
Morally wrong – It's okay
If guidelines not adhered to, could lead to dismissal – Guidelines to be followed but doesn't lead to dismissal
Provokes a strong feeling of anger – Doesn't seem a big deal
Taking advantage of position – Using your position for the best outcome
Depends on circumstances – Never depends on circumstances
Harm can be minimised – Harm already done
Disregard of boundaries in society – Regards for boundaries in society
Not patient centred – Patient centred
Hurting someone dear – Not hurting anyone

Digging for more information – More black and white
My place to say something – Not a dilemma
Inappropriate – Very appropriate
Feel angry – Feel calm
Fair enough (may not agree but can see how got to that decision) – Harder to empathise with
Negative judgements – Positive judgements
Out of character – Within character
Speak up – Wouldn't speak up
Talking to colleagues for advice – Wouldn't need to talk to anybody
Clear there is a victim – No obvious victim

Negative consequences of risk – Positive consequences
Intervening – Not knowing whether to intervene
Good ethical practice – Poor ethical practice
Taking the moral position – Not taking the moral position
Added complications – No added complications
More acceptable – Less acceptable
Sole responsibility – Shared responsibility
Being involved – Not involved
Muddier – Clear cut
Less secretive – Hidden

Individual being hurt – Industrial crime
Managing repercussions – Not happened yet
Crimes – Moral deception
Link between personal/professional position – Code of conduct
Level of innocence – Selfish for personal ease
Being confident to question morals as a trainee – Have more power
Using a snapshot and making assumptions – Making judgement with more information
Diffusion of responsibility – Individual responsibility
Vulnerable persons potentially needing protection – Somebody making a bad choice
Helping them to see ethical dilemma – Can I see ethical dilemma

Humiliation – No humiliation
Requires action – Can still be thought through
More judgement – Less judgement
Need more information – Information is there
Not that bothered – Risky
Deal with at university – Deal with at placement
I have some responsibility – Not feeling responsibility
Don't know what I would do – Clear idea
Another person involved – Own person's risk
Creates ethical dilemma – Not sure if a dilemma

Impact on relationships – Wouldn't affect anyone
Professional guidelines – Personal responsibility
Impact on people – Doesn't directly impact people
Clear process of professional guidelines – Contextual ambiguity
Ethics of economics – Ethics of humanity
Emotional attachment affecting decision-making – Clearer to know what to do
Wouldn't intervene – Intervene
Going against my own – Go against the other
Wouldn't know process – Process for reporting
Less likely to cause psychological harm – More likely to cause psychological harm

Less urgency – In the moment response
Have the opportunity – Time to consider
Duty – Personal morals
My own responsibility – Diffusion of responsibility
More important – Less important
Professional duty – Personal duty
Strangers – Friend
Consult with peers – Me in the moment
Public – Personal
How I conduct myself – How others conduct themselves

Appendix M. Debrief sheet

DEBRIEFING INFORMATION

The integration of personal and professional ethical decision-making constructs in trainee clinical psychologists

Thank you for your participation in this study. Your participation is greatly appreciated.

This debrief sheet provides you with more information about the study.

Why was this study conducted?
There is growing recognition of the need to teach ethics and ethical action to clinical psychology trainees (British Psychological Society, 2015). The current research study explores trainees' constructs underlying ethical decision-making, which will help build the current body of evidence in this under-researched area.
It would be appreciated if you do not discuss details of the study with others until the end date of the study (30th June '18).

What will happen next?
If you have found that discussing ethical dilemmas raised any issues causing personal distress, and you would like further support, you may wish to have a discussion with your allocated personal tutor from your training institution. You can also access support from student counselling services based at your university.

It is possible that a member of the investigating team may contact you in the future, to ask if you would like to participate in a follow-up study. The principal investigator will be in contact with you to let you know the outcome of the study following its completion. If you would like any further information regarding the study or have any further questions, please do not hesitate to contact the principal researcher using the contact details below:

Angie Jenkin
Trainee Clinical Psychologist
E-mail: a.jenkin@herts.ac.uk

This study has been approved by the University of Hertfordshire Health and Human Sciences Ethics Committee.
Protocol Number: LMS/PGR/UH/02820

Appendix N. Statistical analyses

Table N1. *Differences between groups (independent samples t-tests)*

	Total		Year 1		Year 3			
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*t*	*p*
Total SS (per) cons	48.09	4.97	49.86	5.26	46.42	4.15	2.27	.015^
Total SS (pro) cons	43.33	4.63	41.57	4.59	45.00	4.10	-2.47	.009^
Int (per)	2.70	1.90	2.21	1.45	3.17	2.17	-1.62	.114
Int (pro)	1.61	0.76	1.43	0.67	1.78	0.81	-1.50	.071
Int corr	4.33	2.02	3.76	1.75	4.88	2.15	-1.79	.041^
PC-1	42.47	10.21	39.94	8.35	44.88	11.40	-1.54	.067
Easy (per) dilemma	4.47	0.97	4.49	0.97	4.45	0.99	0.14	.887
Easy (pro) dilemma	4.17	0.77	4.26	0.60	4.09	0.91	0.70	.487
% total conflict	40.98	3.76	41.33	4.58	40.65	2.86	0.56	.578
% conflict (per)	48.91	5.46	49.41	5.92	48.44	5.10	0.55	.588
% conflict (pro)	40.19	5.66	40.35	6.17	40.04	5.30	0.17	.433
Total SS (per) el	48.33	7.00	49.00	7.13	47.69	7.00	0.58	.283
Total SS (pro) el	39.60	5.79	39.87	5.38	39.35	6.29	0.27	.393

Note: ^ $p < .05$ one-tailed.

Key
Total SS (per) cons: Percent total sum of squares of the personal constructs
Total SS (pro) cons: Percent total sum of squares of the professional constructs
Int (per): Sum of intensity scores for personal constructs
Int (pro): Sum of intensity scores for professional constructs
Int corr: Sum of the correlations between personal and professional intensity scores
PC-1: Size of the first component on the principal component analysis
Easy (per) dilemma: Difficulty rating for personal dilemma (7=easy, 1=difficult)
Easy (pro) dilemma: Difficulty rating for professional dilemma (7=easy, 1=difficult)
% total conflict: Percent total conflict
% conflict (per): Conflict associated with personal elements
% conflict (pro): Conflict associated with professional elements
Total SS(per) el: Percent total sum of squares of the personal elements
Total SS(pro) el: Percent total sum of squares of the professional elements

Appendix O. SPSS output

Fisher's exact test for type indictor between first and third year trainees

Year Group * less_6 Crosstabulation

			less_6		Total
			yes	no	
Year Group	1	Count	1	18	19
		% within Year Group	5.3%	94.7%	100.0%
		% within less_6	25.0%	51.4%	48.7%
	3	Count	3	17	20
		% within Year Group	15.0%	85.0%	100.0%
		% within less_6	75.0%	48.6%	51.3%
Total		Count	4	35	39
		% within Year Group	10.3%	89.7%	100.0%
		% within less_6	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.004[a]	1	.316		
Continuity Correction[b]	.225	1	.636		
Likelihood Ratio	1.049	1	.306		
Fisher's Exact Test				.605	.322
Linear-by-Linear Association	.978	1	.323		
N of Valid Cases	39				

a. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.95.

b. Computed only for a 2x2 table

Descriptive statistics indicating data distribution

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
N2 score (N2 score)	39	15.23	75.20	50.2609	11.68131	-.594	.378	1.753	.741
Number of cannot decide choices	39	.00	3.00	1.2821	.99865	.224	.378	-.972	.741
PC-1	39	25.21	65.21	42.4721	10.21136	.610	.378	-.505	.741
RI Personal	39	.80	8.79	2.7044	1.89558	1.354	.378	1.777	.741
RI Professional	39	.34	4.44	1.6103	.75612	1.523	.378	4.312	.741
RI Pers and Prof corr	39	1.43	8.80	4.3333	2.02177	.716	.378	-.299	.741
TSSquare El (Per)	39	36.45	66.03	48.3308	7.00485	.720	.378	.029	.741
TSSquare El (Pro)	39	26.61	48.75	39.6023	5.79111	-.386	.378	-.652	.741
Total midpoint	39	3.00	27.00	16.1282	5.56861	-.477	.378	-.213	.741
Easy dil (Per)	39	2.60	6.40	4.4718	.96626	-.174	.378	-.437	.741
Easy dil (Pro)	39	2.60	5.80	4.1744	.77075	.080	.378	-.547	.741
TSSquare Con (Pers)	39	39.75	64.50	48.0936	4.97383	.825	.378	1.794	.741
TSSqaure Con (Prof)	39	27.71	51.96	43.3313	4.63149	-.723	.378	2.305	.741
TSSquare Con (Diff)	39	-11.91	36.79	4.7613	9.35509	.863	.378	2.405	.741
% Total Conflict	39	34.70	52.10	40.9821	3.76010	.648	.378	.772	.741
Valid N (listwise)	39								

Independent sample *t*-tests comparing first year and third year trainees

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
N2 score (N2 score)	Equal variances assumed	.653	.424	2.306	37	.027	8.17714	3.54622	.99181	15.36247
	Equal variances not assumed			2.321	35.652	.026	8.17714	3.52336	1.02901	15.32527
TSSquare Con (Pers)	Equal variances assumed	.068	.795	2.272	37	.029	3.43732	1.51271	.37227	6.50236
	Equal variances not assumed			2.258	34.248	.030	3.43732	1.52199	.34508	6.52956
TSSqaure Con (Prof)	Equal variances assumed	.041	.841	-2.469	37	.018	-3.43963	1.39329	-6.26271	-.61655
	Equal variances not assumed			-2.461	36.023	.019	-3.43963	1.39742	-6.27367	-.60559
TSSquare Con (Diff)	Equal variances assumed	.001	.978	2.440	37	.020	6.87792	2.81892	1.16625	12.58959
	Equal variances not assumed			2.427	34.740	.021	6.87792	2.83407	1.12292	12.63293
RI Personal	Equal variances assumed	1.512	.227	-1.619	37	.114	-.96297	.59471	-2.16798	.24203
	Equal variances not assumed			-1.636	33.315	.111	-.96297	.58877	-2.16040	.23445
RI Professional	Equal variances assumed	.282	.599	-1.501	37	.142	-.35766	.23834	-.84058	.12526
	Equal variances not assumed			-1.508	36.303	.140	-.35766	.23715	-.83847	.12316
RI Pers and Prof corr	Equal variances assumed	2.229	.144	-1.785	37	.082	-1.12416	.62984	-2.40033	.15202
	Equal variances not assumed			-1.795	36.123	.081	-1.12416	.62641	-2.39442	.14610

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Easy dil (Per)	Equal variances assumed	.007	.935	.143	37	.887	.04474	.31362	-.59072	.68019
	Equal variances not assumed			.143	36.959	.887	.04474	.31346	-.59042	.67990
Easy dil (Pro)	Equal variances assumed	6.153	.018	.697	37	.490	.17316	.24861	-.33057	.67689
	Equal variances not assumed			.704	33.182	.487	.17316	.24608	-.32740	.67371
% Total Conflict	Equal variances assumed	4.452	.042	.561	37	.578	.68158	1.21561	-1.78148	3.14464
	Equal variances not assumed			.554	29.930	.584	.68158	1.22973	-1.83011	3.19326
Number of cannot decide choices	Equal variances assumed	.307	.583	-.431	37	.669	-.13947	.32341	-.79477	.51582
	Equal variances not assumed			-.432	36.996	.668	-.13947	.32287	-.79368	.51474
TSSquare El (Per)	Equal variances assumed	.020	.889	.580	37	.566	1.31218	2.26395	-3.27502	5.89939
	Equal variances not assumed			.579	36.814	.566	1.31218	2.26505	-3.27802	5.90239
TSSquare El (Pro)	Equal variances assumed	.148	.703	.273	37	.786	.51276	1.87826	-3.29296	4.31849
	Equal variances not assumed			.274	36.616	.786	.51276	1.87063	-3.27884	4.30437
PC-1	Equal variances assumed	2.635	.113	-1.535	37	.133	-4.93339	3.21450	-11.44660	1.57981
	Equal variances not assumed			-1.547	34.803	.131	-4.93339	3.18907	-11.40886	1.54207

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
% Conflict (Pers)	Equal variances assumed	1.238	.273	.547	37	.588	.96526	1.76580	-2.61259	4.54311
	Equal variances not assumed			.545	35.568	.589	.96526	1.77272	-2.63151	4.56203
% Conflict (Prof)	Equal variances assumed	.711	.404	.170	37	.866	.31263	1.83797	-3.41144	4.03670
	Equal variances not assumed			.169	35.535	.866	.31263	1.84529	-3.43149	4.05675

Independent sample *t*-tests for DIT-2 scores according to age

Group Statistics

	2age	N	Mean	Std. Deviation	Std. Error Mean
Personal Interest (Stage 2/3)	1.00	20	21.6000	11.76256	2.63019
	2.00	19	19.8947	9.27299	2.12737
Maintain Norms (Stage 4)	1.00	20	20.8000	13.00040	2.90698
	2.00	19	23.0526	12.24506	2.80921
N2 score (N2 score)	1.00	20	50.2877	11.30178	2.52716
	2.00	19	50.2326	12.37899	2.83993

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference Lower	Upper
Personal Interest (Stage 2/3)	Equal variances assumed	2.498	.123	.501	37	.619	1.70526	3.40369	-5.19128	8.60180
	Equal variances not assumed			.504	35.813	.617	1.70526	3.38284	-5.15670	8.56722
Maintain Norms (Stage 4)	Equal variances assumed	.187	.668	-.556	37	.581	-2.25263	4.04892	-10.45652	5.95125
	Equal variances not assumed			-.557	36.998	.581	-2.25263	4.04255	-10.44362	5.93836
N2 score (N2 score)	Equal variances assumed	.033	.857	.015	37	.988	.05508	3.79247	-7.62918	7.73935
	Equal variances not assumed			.014	36.256	.989	.05508	3.80154	-7.65292	7.76308

*Group 1(age under 30); Group 2 (age 30 and above)

Independent sample *t*-tests for DIT-2 scores according to gender

Group Statistics

	Gender	N	Mean	Std. Deviation	Std. Error Mean
Personal Interest (Stage 2/3)	Male	6	19.3333	8.35863	3.41240
	Female	33	21.0303	10.95583	1.90717
Maintain Norms (Stage 4)	Male	6	26.3333	15.35795	6.26986
	Female	33	21.0909	12.04254	2.09634
N2 score (N2 score)	Male	6	49.1431	9.44580	3.85623
	Female	33	50.4641	12.15812	2.11646

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference Lower	Upper
Personal Interest (Stage 2/3)	Equal variances assumed	1.309	.260	-.359	37	.721	-1.69697	4.72304	-11.26676	7.87282
	Equal variances not assumed			-.434	8.482	.675	-1.69697	3.90918	-10.62315	7.22921
Maintain Norms (Stage 4)	Equal variances assumed	.764	.388	.942	37	.352	5.24242	5.56625	-6.03587	16.52072
	Equal variances not assumed			.793	6.168	.457	5.24242	6.61103	-10.82777	21.31261
N2 score (N2 score)	Equal variances assumed	.341	.563	-.252	37	.803	-1.32098	5.24941	-11.95730	9.31535
	Equal variances not assumed			-.300	8.348	.771	-1.32098	4.39885	-11.39170	8.74975

Paired samples *t*-tests for salience of personal and professional elements

Table A: *All trainees*

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	TSSquare EI (Per) - TSSquare EI (Pro)	8.72846	12.02061	1.92484	4.83183	12.62509	4.535	38	.000

Table B. *Year 1 trainees*

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	TSSquare EI (Per) - TSSquare EI (Pro)	9.13842	12.12746	2.78223	3.29317	14.98367	3.285	18	.004

Table C. *Year 3 trainees*

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	TSSquare EI (Per) - TSSquare EI (Pro)	8.33900	12.21998	2.73247	2.61988	14.05812	3.052	19	.007

Paired samples *t*-tests for personal and professional conflict levels

Table A. All trainees

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	% Conflict (Pers) - % Conflict (Prof)	8.71795	10.54419	1.68842	5.29992	12.13598	5.163	38	.000

Table B. Year 1 trainees

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	% Conflict (Pers) - % Conflict (Prof)	9.05263	11.58013	2.65666	3.47119	14.63407	3.408	18	.003

Table C. Year 3 trainees

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	% Conflict (Pers) - % Conflict (Prof)	8.40000	9.75192	2.18060	3.83596	12.96404	3.852	19	.001

Pearson correlations (*r*) for all trainees

Correlations

		Number of cannot decide choices	Easy dil (Per)	Easy dil (Pro)	% Total Conflict	Total midpoint
Number of cannot decide choices	Pearson Correlation	1	.464**	-.066	-.303	.249
	Sig. (2-tailed)		.003	.692	.060	.127
	N	39	39	39	39	39
Easy dil (Per)	Pearson Correlation	.464**	1	-.031	-.255	.063
	Sig. (2-tailed)	.003		.850	.117	.704
	N	39	39	39	39	39
Easy dil (Pro)	Pearson Correlation	-.066	-.031	1	.066	-.057
	Sig. (2-tailed)	.692	.850		.691	.731
	N	39	39	39	39	39
% Total Conflict	Pearson Correlation	-.303	-.255	.066	1	-.385*
	Sig. (2-tailed)	.060	.117	.691		.016
	N	39	39	39	39	39
Total midpoint	Pearson Correlation	.249	.063	-.057	-.385*	1
	Sig. (2-tailed)	.127	.704	.731	.016	
	N	39	39	39	39	39

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Pearson correlations (*r*) for all trainees

Correlations

		N2 score (N2 score)	PC-1	RI Pers and Prof corr	TSSquare EI (Per)	TSSquare EI (Pro)
N2 score (N2 score)	Pearson Correlation	1	-.328*	-.288	.094	.007
	Sig. (2-tailed)		.042	.075	.571	.968
	N	39	39	39	39	39
PC-1	Pearson Correlation	-.328*	1	.820**	.154	-.366*
	Sig. (2-tailed)	.042		.000	.349	.022
	N	39	39	39	39	39
RI Pers and Prof corr	Pearson Correlation	-.288	.820**	1	.171	-.470**
	Sig. (2-tailed)	.075	.000		.299	.003
	N	39	39	39	39	39
TSSquare EI (Per)	Pearson Correlation	.094	.154	.171	1	-.763**
	Sig. (2-tailed)	.571	.349	.299		.000
	N	39	39	39	39	39
TSSquare EI (Pro)	Pearson Correlation	.007	-.366*	-.470**	-.763**	1
	Sig. (2-tailed)	.968	.022	.003	.000	
	N	39	39	39	39	39

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Pearson correlations (*r*) for Year 1 trainees

Correlations

		Number of cannot decide choices	Easy dil (Per)	Easy dil (Pro)	% Total Conflict	Total midpoint
Number of cannot decide choices	Pearson Correlation	1	.412	-.438	-.205	.522*
	Sig. (2-tailed)		.079	.060	.399	.022
	N	19	19	19	19	19
Easy dil (Per)	Pearson Correlation	.412	1	-.485*	-.042	-.088
	Sig. (2-tailed)	.079		.035	.865	.720
	N	19	19	19	19	19
Easy dil (Pro)	Pearson Correlation	-.438	-.485*	1	.059	-.243
	Sig. (2-tailed)	.060	.035		.811	.315
	N	19	19	19	19	19
% Total Conflict	Pearson Correlation	-.205	-.042	.059	1	-.539*
	Sig. (2-tailed)	.399	.865	.811		.017
	N	19	19	19	19	19
Total midpoint	Pearson Correlation	.522*	-.088	-.243	-.539*	1
	Sig. (2-tailed)	.022	.720	.315	.017	
	N	19	19	19	19	19

*. Correlation is significant at the 0.05 level (2-tailed).

Pearson correlations (*r*) for Year 1 trainees

Correlations

		N2 score (N2 score)	PC-1	RI Pers and Prof corr	TSSquare EI (Per)	TSSquare EI (Pro)
N2 score (N2 score)	Pearson Correlation	1	-.486*	-.390	.133	-.143
	Sig. (2-tailed)		.035	.099	.587	.560
	N	19	19	19	19	19
PC-1	Pearson Correlation	-.486*	1	.735**	.213	-.213
	Sig. (2-tailed)	.035		.000	.382	.382
	N	19	19	19	19	19
RI Pers and Prof corr	Pearson Correlation	-.390	.735**	1	.167	-.296
	Sig. (2-tailed)	.099	.000		.494	.219
	N	19	19	19	19	19
TSSquare EI (Per)	Pearson Correlation	.133	.213	.167	1	-.876**
	Sig. (2-tailed)	.587	.382	.494		.000
	N	19	19	19	19	19
TSSquare EI (Pro)	Pearson Correlation	-.143	-.213	-.296	-.876**	1
	Sig. (2-tailed)	.560	.382	.219	.000	
	N	19	19	19	19	19

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Pearson correlations (*r*) for Year 3 trainees

Correlations

		Number of cannot decide choices	Easy dil (Per)	Easy dil (Pro)	% Total Conflict	Total midpoint
Number of cannot decide choices	Pearson Correlation	1	.515*	.165	-.457*	-.010
	Sig. (2-tailed)		.020	.486	.043	.966
	N	20	20	20	20	20
Easy dil (Per)	Pearson Correlation	.515*	1	.243	-.600**	.213
	Sig. (2-tailed)	.020		.302	.005	.368
	N	20	20	20	20	20
Easy dil (Pro)	Pearson Correlation	.165	.243	1	.064	.070
	Sig. (2-tailed)	.486	.302		.788	.769
	N	20	20	20	20	20
% Total Conflict	Pearson Correlation	-.457*	-.600**	.064	1	-.155
	Sig. (2-tailed)	.043	.005	.788		.515
	N	20	20	20	20	20
Total midpoint	Pearson Correlation	-.010	.213	.070	-.155	1
	Sig. (2-tailed)	.966	.368	.769	.515	
	N	20	20	20	20	20

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Pearson correlations (*r*) for Year 3 trainees

Correlations

		N2 score (N2 score)	PC-1	RI Pers and Prof corr	TSSquare EI (Per)	TSSquare EI (Pro)
N2 score (N2 score)	Pearson Correlation	1	-.148	-.103	.014	.074
	Sig. (2-tailed)		.534	.666	.954	.757
	N	20	20	20	20	20
PC-1	Pearson Correlation	-.148	1	.850**	.167	-.460*
	Sig. (2-tailed)	.534		.000	.480	.041
	N	20	20	20	20	20
RI Pers and Prof corr	Pearson Correlation	-.103	.850**	1	.240	-.596**
	Sig. (2-tailed)	.666	.000		.308	.006
	N	20	20	20	20	20
TSSquare EI (Per)	Pearson Correlation	.014	.167	.240	1	-.690**
	Sig. (2-tailed)	.954	.480	.308		.001
	N	20	20	20	20	20
TSSquare EI (Pro)	Pearson Correlation	.074	-.460*	-.596**	-.690**	1
	Sig. (2-tailed)	.757	.041	.006	.001	
	N	20	20	20	20	20

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Appendix P. DIT-2 schema scores according to age and gender

Table P1. DIT-2 scores according to age

	Age bracket (n)						
	25-29	30-34	35-39	40-44	50-54		
Schema score	20	16	1	1	1		
	Under 30	Age 30 and above				*t*	*p*
	M (SD)	*M (SD)*					
Personal interest	21.60 (11.76)	19.89 (9.27)				0.50	.619
Maintaining norms	20.80 (13.00)	23.05 (12.25)				-0.56	.581
Postconventional (N2)	50.29 (11.30)	50.23 (12.38)				0.02	.988

Table P2. DIT-2 schema scores according to gender

Schema score	Female (n=33) *M (SD)*	Male (n=6) *M (SD)*	*t*	*p*
Personal interest	19.33 (8.36)	21.03 (10.96)	-3.59	0.721
Maintaining norms	26.33 (15.36)	21.09 (12.09)	0.94	0.352
N2 score	49.14 (9.45)	50.46 (12.16)	-0.25	0.803

Appendix Q. Comparison of sample with DIT-2 norms

The level of sophistication of trainees' ethical decision-making schemata was compared with normative data available for 10 553 individuals at various levels of education, 169 of whom were doctoral level students (Bebeau, Maeda & Tichy-Reese, 2003). A comparison of means was carried out via the software package MedCalc for Windows, version 18.2.1 (MedCalc Software, 2018).

Table Q1. Comparison of trainee schema scores with norms for doctoral level students

Schema	Trainee sample (n = 39)		Doctoral students (N = 169)		Mean difference	*df*	*t*	*p*
	M	*SD*	*M*	*SD*				
Personal interest	20.77	10.52	18.71	11.63	-2.06	206	-1.01	0.312
Maintaining norms	21.90	12.52	27.24	14.05	5.34	206	2.18	0.030
Postconventional (N2)	50.26	11.68	48.99	15.60	1.27	206	0.48	0.633

There was no significant difference between the personal interest and postconventional schema scores of trainee clinical psychologists and the norms for doctoral students; however, clinical psychology trainees appeared to have lower maintaining norms schema scores than doctoral students more generally, and this difference (5.34, 95% CI: 0.51 to 10.17) was found to be significant t (206) = 2.18, p = .030, 2-tailed. This indicated that trainee clinical psychologist schema scores were in keeping with doctoral students more generally, with the exception that trainees were found to operate from within a maintaining norms schematic approach to a lesser extent.