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The Ethical Decision Making of Clinical Psychology Graduate Students

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THE ETHICAL DECISION MAKING OF CLINICAL PSYCHOLOGY GRADUATE STUDENTS

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INTRODUCTION

In recent years, ethical issues in the professional practice of psychology have received increased attention. Some of the emerging research in this area has focused on the decisions of psychologists as they confront ethical dilemmas. This research provides considerable evidence that psychologists often struggle with decisions about ethical dilemmas that they encounter in clinical practice. Psychologists and psychology graduate students have reported feeling poorly prepared to confront ethical problems (Tyumchuk, Drapkin, Major-Kingsley, Ackerman, Coffman, & Baum, 1982), and when presented with hypothetical problem situations, they do not always agree on the most ethical response (Haas, Malouf & Mayerson, 1988). Furthermore, a relatively recent series of investigations (Bernard & Jara, 1986; Bernard, Murphy & Little, 1987; Wilkins, McGuire, Abbott & Blau, 1990; Smith, McGuire, Abbott & Blau, 1991) has indicated that there is frequently a discrepancy between what psychologists think is the ethically ideal response to a dilemma and what they think they would do if actually confronted with the dilemma.

The present investigation was undertaken in order to replicate and expand upon these latter findings.

Specifically, this study investigated whether situational parameters of a hypothetical ethical dilemma influenced what psychology graduate students thought they should and would do in response to the dilemma.

Research on Should versus Would Discrepancy

The first two studies documenting this should versus would discrepancy were conducted by Bernard and associates (Bernard & Jara, 1986; Bernard, Murphy and Little, 1987). In a discussion of why ethical violations occur, Bernard and Jara (1986) suggest that either there is a lack of understanding that such behaviors are ethical violations or psychologists are simply unwilling to follow what they know to be the ethical course of action. To empirically examine this issue, Bernard and Jara (1986) presented clinical psychology graduate students with two ethical scenarios and a copy of the APA ethical principles that were relevant to these scenarios. The scenarios used in this study depicted colleagues who were engaging in unethical behavior. Bernard and Jara (1986) note that this type of scenario might be particularly problematic for clinicians since they seem to be unwilling to report the unethical behavior of other psychologists.

Indeed, there is empirical evidence to support Bernard and Jara's (1986) suggestion. For example, 40% of a sample of psychologists indicated that they knew of a situation in which action was not taken in response to knowledge of the

"impairment" of a colleague (Wood, Klein, Cross, Lammers & Elliott, 1985). In addition, Haas, Malouf and Mayerson (1986) noted that there was much disagreement among psychologists as to how they should respond to a dilemma which involved a client who is "upset" and reports that her previous therapist made sexual advances toward her. Although a majority of the respondents agreed that they should report the incident to the Ethics Committee (57%), many of the respondents thought that the client should instead be told that she could report the matter to an ethics committee (18%), or that the client's anger should be discussed but that the professional standards regarding this issue should not be discussed (10%). Thus, these findings suggest that psychologists may not perceive or enact a clear, consistent response to dilemmas involving the unethical behavior of colleagues.

For the Bernard and Jara study (1986), the colleague in one scenario was a clinical psychology graduate student depicted as a problem drinker. In another scenario, the sexual involvement of a clinical graduate student with a client was described. For both scenarios participants were asked to assume that they had "discovered" the problem. Participants were asked two questions following each of the dilemmas: "According to the Ethical Principles, what should you do?" and "Speaking pragmatically, and recognizing that he (she) is a friend and fellow graduate student, what do

you think you probably would do?". Following each of these questions, participants were presented with a list of five alternatives, of which they were instructed to chose one course of action which best corresponded to what they thought they should do and one course of action which best corresponded to what they thought they would do. Subjects' responses were scored in terms of their consistency with the APA Ethical Principles. Higher scores reflected greater consistency with the principles. The investigators found that for both of the scenarios at least 50% of the respondents indicated that they would do less than what they said they should do.

In a replication of this study with practicing clinicians, Bernard, Murphy and Little (1987) found similar results. The ethical dilemmas utilized in this study were similar to those used in the Bernard and Jara (1986) study, but were adapted so that they were appropriate for this population. That is, respondents were instructed to assume that they had discovered a colleague's drinking problem or sexual involvement with a client. For the sexual scenario, 37% of the clinicians indicated that they would do less than what they said they should do; for the alcohol scenario, 26% indicated they would do less than what they said they should do. Thus, it seems that for the reporting of the unethical behavior of a colleague, a sizable percentage of graduate students and clinical psychologists may be unwilling to

carry out what they think is the ethically appropriate course of action.

Two studies have expanded on the research of Bernard and associates (1986, 1987) and have attempted to understand why the discrepancy between what respondents say they should and would do occurs. In a study of clinical psychology graduate students, Wilkins et al. (1990) investigated the relationship between the discrepancy between should and would responses to the ethical dilemmas and the degree of closeness of the respondent to the person who committed the violation in each of the scenarios (person-of-reference). Sexual and alcohol dilemmas were depicted, as well as a dilemma involving confidentiality and a dilemma involving need for referral. Participants received all four scenarios, and the scenarios were written in one of four formats, depending on who the person was who committed the violation (you, a close friend, a colleague or an acquaintance). Participants also received a copy of the relevant APA Principles. As in previous research, participants were asked what they thought they should do and what they thought they would do in response to the different dilemmas. Participants responded to each of these questions by choosing one course of action from a presented list of five alternatives. Participants' responses were rated according to a "continuum of restrictiveness" established by the authors. For example, "Do Nothing" was rated as least

restrictive, and "Report the Individual to the Appropriate Ethical Board" was rated as most restrictive.

For each of the scenarios except the confidentiality dilemma, there were significant differences between what graduate students said they should and would do, with should ratings significantly more restrictive than would ratings. Although the degree of closeness of the person-of-reference did not account for the should versus would discrepancy, Wilkins et al. (1990) found that restrictiveness of choice was related to the closeness of the person-of-reference to the respondent, with psychologists responding more restrictively the closer the "violator" was to the respondent. This finding highlights the possibility that responding to the unethical behavior of a colleague, as opposed to monitoring one's own behavior, may be an area of special ethical concern.

The role of individuals' reasoning as it contributes to the discrepancy between what psychologists said they should and would do in response to ethical dilemmas was investigated by Smith et al. (1991). Rationales used to justify responses to dilemmas were explored and categorized as either codified (upholding the law or a code of ethics) or uncodified (responding based on fear of reprisal by supervisor, financial need, intuition, upholding personal moral values, protection of reputation). Participants were presented with 10 dilemmas. These dilemmas included:

inappropriate transfer/referral, sexual relations with a client, inappropriate media advertising, couple counseling privacy issue, child privacy issue with drugs, limits of competence, adult privacy/Tarasoff-type situation, privacy issue involving child sexual abuse, bartering for services, and inappropriate diagnosis and insurance fraud.

For each of the dilemmas, participants were asked what they thought they should do in the situation and what they thought they probably would do if confronted with the situation. Participants were then presented with a list of alternative courses of action and were asked to indicate which alternative best represented what they thought they should do and then what they thought they would do in response to the dilemma. Response alternatives were assigned scores ranging from one to four, depending upon how consistent the responses were with APA Ethical Principles. Higher scores reflected greater consistency with the Principles. If two alternatives were both congruent with the Principles, the "most direct, proactive stance by the clinician" received the higher value. Thus, participants received an Ethical Choice Score (ECS) which represented the restrictiveness of their responses to the dilemmas. Following each of the responses to the "should" and "would" questions, participants indicated which rationale from the previously presented list best reflected the reason for their response.

Significant differences between what psychologists said they should and would do were found for the following dilemmas: sexual relations with a client, limits of competence, privacy issue involving child sexual abuse and inappropriate diagnosis and insurance fraud. Smith et al. (1991) found that when participants were equally restrictive in their responses as to what they should do and would do in response to an ethical dilemma, codified rationales were used more frequently. When should responses were more restrictive than would responses, uncodified rationales were chosen significantly more frequently.

Because the category "uncodified rationales" is comprised of various elements, however, it remains unclear which uncodified rationales are more frequently chosen when subjects say they would do less than what they think they should do. For example, it is impossible to ascertain whether subjects more often uphold personal ideals and intuitions or consider financial need and fear of legal reprisal when they say that they would do less than what they say they should do (both are "uncodified" rationales). Although it seems clear that when subjects say they would do what they think they should do they more frequently base their decisions on legal or professional codes, it remains unclear what exactly contributes to a discrepancy between what subjects say they should and would do.

In a study conducted prior to the Smith et al. (1991)

study, Haas, Malouf and Mayerson (1988) use a similar procedure to explore rationales used to justify responses to dilemmas. Categories identified by the authors in coding the rationales, however, were slightly more differentiated. Although this study did not directly explore the should versus would discrepancy, it provides further insight into rationales that are used in the ethical decision making process. In this study, subjects were presented with the same ten dilemmas that were utilized in the Smith et al. (1991) study and a list of alternative courses of action for each dilemma. Subjects first chose a course of action which represented their "preferred" response to the dilemma. For example, for a dilemma which described a client who is upset at her previous therapist for making sexual advances toward her, subjects chose from the following alternatives: "Discuss the patient's anger but do not discuss the issue of professional standards"; "Call the previous therapist and tell him that the behavior you have heard about violates professional standards"; "Tell the patient that she has the right to bring her charge to the ethics committee or the state licensing board"; or, "Call the ethics committee or the state licensing board (p. 38)."

After choosing a course of action, subjects were asked to choose a rationale for this response from a list of possible reasons. The authors noted that this list represented reasons based on codified standards (upholding

the law, upholding the code of ethics), noncodified ideals (protecting society's interests, protecting clients' rights, upholding personal standards, safeguarding the therapy process), and one "survival" reason (financial considerations). Most relevant to the present study, Haas, Malouf and Mayerson (1988) found that for the dilemma described above, when respondents indicated that they would discuss the patient's anger or inform her of her rights they more frequently choose noncodified rationales to justify these choices. In other words, they would discuss the client's anger or inform her of her rights and wouldn't report the incident or confront the therapist involved because it protected the client's rights, upheld personal standards, safeguarded the therapy process or protected society's interests.

Summary and Critique of Previous Research

The studies reviewed so far suggest several things about the ethical decision making of psychologists and psychology graduate students. First, it seems that psychologists are inconsistent in how they respond to dilemmas which involve the unethical behavior of a colleague. For example, for a dilemma involving a colleague who makes sexual advances toward a client, psychologists seem to disagree about whether a psychologist should confront the violating clinician, report the incident, or simply discuss the client's anger or her rights regarding

the incident. In addition, it seems that psychologists respond less restrictively to ethical violations involving a colleague than they do to their own or a close friend's unethical behavior. Clarification of what contributes to inconsistent and less direct, active responding to the unethical behavior of another psychologist seems necessary.

Findings from the study by Haas, Malouf and Mayerson (1988) help clarify this issue to a certain extent. Their results suggest that when psychologists respond in a less direct manner (discussing the clients feelings or rights regarding the incident as opposed to confronting the violator or reporting the incident), they frequently claim to do so because this course of action protected society's interests, protected the client's rights, upheld personal standards, or safeguarded the therapy process.

The studies so far reviewed also suggest that psychologists frequently indicate that for certain ethical dilemmas, they would do less than what they think is ethically ideal. This was demonstrated for dilemmas involving sexual relations with a client, inappropriate use of alcohol, need for referral, limits of competence, privacy issue involving child sexual abuse and inappropriate diagnosis and insurance fraud. Studies which have investigated why psychologists frequently report that they would do less than what they think they should do have shed some light on this issue. It seems that when psychologists

follow through in their actions with what they think they should do, it is primarily because that behavior is consistent with legal or ethical codes. Conversely, rationales other than those based on legal or professional codes seem to be used to justify doing less than what they think they should do. In other words, when psychologists do not rely on ethical or legal codes and instead base their decisions about ethical dilemmas on factors such as the protection of their reputation, personal moral values, intuitions, or fear of reprisal they may be less likely to behave according to what they think is ethically appropriate.

As Welfel and Lipsitz (1984) noted, however, ethical codes serve only as guidelines as they cannot address every conceivable ethical dilemma. Psychologists must be able to translate the general codes into specific situations and must be able to make sophisticated judgments about dilemmas for which the APA Ethical Principles do not provide a clear solution. Different situations may call for different interpretations of ethical codes and applications of principles. Responding to ethical dilemmas, therefore, involves a complex decision making process in which many factors are balanced. These factors include, but are not limited to, formal codes and guidelines, situational variables and personal values. Any one of these factors might contribute to psychologists' responses to dilemmas,

both in terms of what they think is the ethically ideal response to the dilemma and what they would do if actually confronted with the dilemma.

The research to date has not addressed the complexity of the ethical decision making process. More specifically, there are several ways in which this research has been limited. First, the dilemma scenarios utilized in these studies are very brief. There are several factors which may be involved in a potential ethical dilemma that are not included in these dilemmas. As a result of a review of research regarding the reporting of suspected child abuse, Brosig and Kalichman (1992), for example, identify three primary influences on clinician's willingness to report child abuse: 1) knowledge, understanding and interpretation of statutory requirements and legal definitions regarding child abuse; 2) clinician characteristics such as years of experience, training, attitudes and previous experience; and 3) situational factors such as attributes of the victim, type and severity of abuse, and the evidence that is available. It seems, then, that psychologists may be influenced by several factors in making their ethical decisions.

Although the influence of ethical and legal codes on decision making has been explored in previous research, research regarding the ethical decisions of psychologists has yet to sufficiently examine the influence of factors

related to the specific circumstances of the dilemma and those involved in the dilemma. For example, in previous research utilizing dilemmas involving the unethical behavior of a colleague, subjects were instructed that they simply "discovered" this information. The specific way in which this information is "discovered", however, may impact upon the course of action that an individual decides to take. If a psychologist discovers that another psychologist has behaved unethically by the report of a client, then the attitude of the client in reporting the behavior may influence how that psychologist chooses to respond to the dilemma. This study attempts to address this issue by examining the effects of the attitude of a client on psychology graduate students' responses to a dilemma involving a client reporting the unethical behavior of her previous therapist.

Second, studies which have investigated the ethical decision making process of psychologists have typically utilized questionnaires structured in a closed-ended format. This format has limited the response options of participants both in terms of how participants respond to presented dilemmas, and in terms of rationales used by participants to justify these responses. Thus, previous research has focused on the final decisions of psychologists regarding ethical dilemmas, and not on the complexity of the reasoning and decision making process of psychologists. Ethical decision

making can be seen as a multi-staged process, with different contributing factors at each stage of the process. A model proposed by Rest (1984) characterizes the ethical decision making process of psychologists in this way, and may be helpful in organizing research in this area.

Ethical Decision Making Process Model

In order to account for the multi-faceted nature of the ethical decision making process, Rest (1984) constructed a model specifying four components which contribute to moral behavior. Each of these components has a major function, and Rest (1984) suggests that the psychological functions associated with these four components must be carried out whenever a person behaves morally. Specifically, the person must: (1) interpret the situation in terms of who is involved and what actions are possible; (2) formulate the morally ideal course of action; (3) decide what s/he intends to do; (4) implement this course of action.

Rest's model may be used to organize the research investigating psychologists' ethical decision making. Psychologists' articulation of what they think they should do and what they think they would do in particular ethical situations may be seen as representative of different components of the ethical decision making process. What psychologists think they "should" do may correspond to Rest's second component; that is, formulation of the ethical ideal. What psychologists think they actually would do seems

to represent Rest's third component, deciding what one intends to do.

As noted by Rest (1984), different components may be influenced by different factors. For example, when formulating an ethically ideal response to a situation, a person may be primarily influenced by ethical codes. Deciding what one intends to do in this situation, however, may be more influenced by other, more personal values, religious ideologies or emotional relationships. When a person is asked how s/he might respond to a particular dilemma, then, these different considerations might evoke different responses to the same dilemma, depending upon whether a person is asked a question which corresponds to the second (the ethically ideal course of action) or the third component (the plan of action that the person intends to carry out) of Rest's model.

Research reviewed thus far suggests that when psychologists are consistently influenced by a consideration of legal and ethical codes as they formulate the ethically ideal course of action and decide what course of action to implement, they are more likely to implement what they believe to be the ethically ideal course of action. Furthermore, the research of Smith, et al (1991) begins to explore ethical decision making at different stages of this process. They found, for example, that when participants formulated the ethically ideal response to the dilemma

(Rest's second component), formal laws or codes of ethics seemed to play a central role in their thinking. The findings in this area are sparse, however, and it is necessary to gather more in depth information about the processes that occur at each of these different stages.

The Present Study and Hypotheses

With this consideration of the different components and factors involved in the ethical decision making process, this study attempted to replicate and expand upon previous research examining psychologists' responses to ethical dilemmas. The two dilemmas that were utilized in the present investigation depict a colleague who is sexually involved with a client and a colleague who is "impaired" by use of alcohol. This is in response to previous research which suggests that responding to the unethical behavior of a colleague may be particularly problematic for psychologists.

The dilemmas, although based on previous research (Bernard & Jara, 1987; Wilkins et al. 1990), were modified to include more information about how the respondent came to know of the ethical violation. In previous research, subjects were simply asked to assume that they "discovered" the violation. For some dilemmas, however, the way in which the violation is discovered may have some impact on the course of action that the psychologist chooses to implement. This might be especially true for dilemmas involving the unethical behavior of a colleague, since it is likely that

this information could be revealed to the respondent by a former client of the violator. In such cases, the psychologist's response to the dilemma may be influenced by the interests of the client.

For example, a psychologist may choose to respond differently to the situation depending upon whether the client wants to take action against her previous therapist or is embarrassed and hesitant about discussing the situation. When a client is angry about the incident and demanding that something be done, a psychologist may be more likely to confront a colleague or report the unethical behavior because the attitude of the client seems congruent with this more restrictive, direct response. In contrast, when a client is hesitant or embarrassed about reporting information, revealing this information to anyone may be seen as compromising the interests and the confidentiality rights of the client. The APA Principles clearly state that "psychologists have a primary obligation and take reasonable precautions to respect the confidentiality rights of those with whom they work...(p. 1611)." They further state that when a psychologist believes that a colleague has behaved unethically, that psychologist attempts to resolve the situation informally. If informal resolution is not appropriate, then the psychologist is to take further action "unless such action conflicts with confidentiality rights in a way that cannot be resolved (p. 1611)." Thus, it seems

clear that in a situation in which the client is embarrassed and does not want anyone to know about the unethical behavior of her previous therapist, the APA Principles indicate that the confidentiality rights of the client take precedence over addressing or reporting the unethical behavior in the interest of justice, the profession or future clients of the violator if the client's identity cannot be protected. In sum, it seems that there may be different ethical responses to a dilemma in which a colleague has behaved inappropriately. If a psychologist comes to know of the unethical behavior of another psychologist through the report of a client, the client's attitude in reporting may contribute to different responses to this situation.

In previous research examining psychologists' responses to ethical dilemmas, however, participants (psychologists or psychology graduate students) are not given specific information about the way in which the participant comes to know that another psychologist has behaved unethically. Participants are instead are only told that they have "discovered" the violation or that the client is "upset" as she reports the violation. In neither case is the specific attitude of the client made explicit. Thus, respondents are left to assume or construct a specific context for the presented dilemma. Depending upon the context that is assumed, participants may respond differently and still

ethically. As such, lack of agreement in responding may not be seen as problematic for the profession, but instead may reflect psychologists' effectiveness in balancing principles and sensitivity to specific situational parameters as they interpret general ethical principles.

For the current study, graduate students in clinical psychology were asked to respond to one of two ethical dilemmas which depicted a client explaining the unethical behavior of her previous therapist. The client was either not described, described as angry and demanding that the situation be addressed, or described as embarrassed and not wanting anyone to find out about the incident. Students indicated both what they thought they should do in response to the presented dilemma and what they thought they would do if actually confronted with the situation, and responded to a series of open-ended and closed-ended questions designed to explore the reasons for their decisions. Three sets of analyses were conducted on the data in order to test a series of hypotheses about the ethical decision making process and to explore this process.

First, the relationship between students' formulation of the ethically ideal response to a dilemma and their estimation of what they thought they actually would do in that dilemma was investigated. It was hypothesized that, consistent with previous research, there would be a significant difference between what respondents said they

should and would do. It was expected that respondents would indicate that they would do less than what they said they should do.

In addition, the client's attitude was examined as it impacted upon these responses. In this way, the extent to which different factors influenced respondents' reasoning at different stages of the ethical decision making process was examined. Based on the rationale previously discussed, a second hypothesis was that subjects would respond overall more restrictively and directly to dilemmas which depict an angry and open client as compared to dilemmas which depict an embarrassed and hesitant client. Thus, it was expected that graduate students would respond less restrictively (less directly or actively) to dilemmas in which the client is described as hesitant and embarrassed.

These less restrictive responses also seem to be less apt to be challenged by or to conflict with personal interests or consequences. As such, less restrictive ethically ideal courses of action may be more likely to be carried out in comparison to a more restrictive ethically ideal course of action such as reporting or confronting a colleague. Reporting or confronting may seem difficult courses of action to implement, since they involve consideration of such factors as legal, verbal or social reprisal by the therapist involved in the dilemma. A third hypothesis of this study, then, was that there would be a

greater discrepancy between what psychologists say they should do and what they say they would do when the client in the dilemma was depicted as angry, open and suggesting that the therapist should not get away with treating clients in this manner.

A second set of analyses examined responses to closed-ended questions which asked about factors influencing both the should and the would responses. Responses to these questions were summarized and the extent to which codified and noncodified rationales were used at different stages of the reasoning process was explored. Hypotheses regarding codified and noncodified rationales were formulated to be consistent with the findings of Smith et al. (1991). As a fourth hypothesis of this study, then, it was expected that codified rationales would be used significantly more frequently than expected by chance in response to the "should" question. The fifth and sixth hypotheses of this study pertained to the relationship between what participants said they should and would do. It was expected that when there was a consistency between what participants said they should and would do participants would more frequently utilize codified rationales to justify responses. Conversely, it was expected that when there was a discrepancy between what participants thought they should and would do, participants would more frequently utilize noncodified rationales to justify responses.

A third set of analyses was conducted in order to characterize participants responses to open-ended questions which asked about factors influencing both what subjects said they should and would do in response to presented dilemmas. Responses were again summarized and the extent to which client centered and non-client centered rationales were utilized at different stages of the reasoning process was explored. There were no specific hypotheses guiding the analyses regarding client centered rationales. Instead, these analyses were exploratory.

CHAPTER II

METHOD

Participants

The sample consisted of 71 clinical psychology graduate students from six Ph.D. programs and two Psy.D. programs in the Chicago area. Demographic information describing the sample is presented in Table 1. The majority of the sample was female (74.6%) and enrolled in a Ph.D. program (76.1%).

Participants were fairly evenly distributed across four main theoretical orientations: eclectic (29.5%), psychodynamic (23.9%), cognitive (15.5%), and cognitive-behavioral (14.1%). A majority of the participants indicated that they had received training in ethics in a formal ethics class (78.9%), during discussions in other general clinical courses (85.9%), in discussion with colleagues (67.6%), and/or in informal discussion with a supervisor or other trainees at a clinical placement (67.6%). The ages of respondents ranged from 22 to 46 years (M = 27), the year in graduate training ranged from 1 to 7 years (M = 2.5), and the number of months of clinical training/experience ranged from 2 to 104 months (M = 24.7).

TABLE 1

SAMPLE DEMOGRAPHICS

Characteristic	n	%
Gender		
Female	53	74.6
Male	18	25.4
Race		
Caucasian	61	85.9
Latino/Latina	4	5.6
African-American	3	4.2
Asian	2	2.8
Other (Caucasian/Latina)	1	1.4
Program		
Ph.D.	54	76.1
Psy.D.	17	23.9
Theoretical Orientation		
Eclectic	21	29.5
Psychodynamic	17	23.9
Cognitive	11	15.5
Cognitive-Behavioral	10	14.1
Behavioral	4	5.6
Other		
Systemic	3	4.2
Integ. Prob. Solv.	2	2.8
Unsure/Unspecified	2	2.8
Humanistic	1	1.4
Ethics Training		
In other courses	61	85.9
Formal coursework	56	78.9
Clinical discussion	48	67.6
Discuss with colleagues	48	67.6
Readings	22	31.0
Other	6	8.5
Seminar (1-2)	4	5.6
Seminar (3 or more)	0	0.0
Mean age		27.0
Mean months of training		24.7
Mean year in graduate school		2.5

Materials

Each participant was given a packet of materials which contained a consent form, relevant excerpts from APA Ethical Principles of Psychologists and Code of Conduct (1992) and the decision making questionnaire. The questionnaire consisted of a demographic data sheet, a vignette depicting an ethical dilemma, and a series of questions and items related to the vignette.

Demographic Data Sheet

Participants were asked to provide demographic information regarding their age, gender, ethnicity, year in graduate school, program type (Ph.D. or Psy.D.), amount and type of clinical training, theoretical orientation and type of ethical training that they have received.

Vignette

The two ethical dilemma vignettes utilized in this study were adapted from those developed by Bernard and Jara (1986). One vignette involved the sexual misconduct of a colleague, and the other involved a colleague's inappropriate use of alcohol. Both vignettes included a client's report as the source of information about the colleague's behavior. In each dilemma the clinician was male, as Bernard and Jara (1986) found no effect for sex of clinician with either a sexual or an alcohol scenario.

There were three forms of each vignette; one in which the client was described as embarrassed and hesitant about

the information that she is reporting, one in which the client was described as angry and demanding that the information that she is reporting be addressed, and one in which the attitude or feelings of the client about the information was not described. Each participant received either the sexual or the alcohol dilemma, written in one of the three forms of the dilemma (embarrassed client, angry client, or undescribed client). A copy of the two types of dilemmas, written in the three attitude forms, is presented in Appendix A. The manipulation of the client's attitude is demonstrated in the following dilemma, which was used in this study to depict a colleague's use of alcohol (underlining is added to indicate the parts of the dilemma that were manipulated):

> Ms. R, a 32-year-old woman, has recently been referred to you. You have had about five sessions with her, in which time you have established good rapport. During the course of a therapy session one day, Ms. S angrily/tearfully tells you about sessions with her previous therapist, in which she could tell that he had been drinking. She recounts times when she felt uncomfortable because his speech was slurred and she could smell alcohol on his breath. She says that at these times, he would come to sessions late or end sessions early. As she describes these sessions, she seems very open/embarrassed. She says that she feels like he shouldn't be able to get away with treating clients like that/she really doesn't want anyone to know about this. Ms. R indicates that you are the only person that she has told this to. You feel confident that your client is giving an honest account of her experience.

The following dilemma was used as the control dilemma for the alcohol scenario, and is an example of a client whose attitude was not described:

> Ms. R, a 32-year-old woman, has been recently referred to you. You have had about five sessions with her in which time you have established good rapport. During the course of a therapy session one day, Ms. S tells you about sessions with her previous therapist in which she could tell that he had been drinking. She recounts times when she felt uncomfortable because his speech was slurred and she could smell alcohol on his breath. She says that at these times, he would come to sessions late or end sessions early. Ms. R indicates that you are the only person that she has told this to. You feel confident that your client is giving an honest account of her experience.

The following scenario demonstrates the manipulation of the client's attitude for the sexual dilemma (underlining is added to signify the parts of the dilemma that were manipulated):

> Ms. R, a 32-year-old woman, has recently been referred to you. You have had about five sessions with her, in which time you have established good rapport. During the course of a therapy session one day, Ms. S <u>angrily/tearfully</u> tells you that her previous therapist made repeated sexual advances toward her. She recounts sessions during which he said that he was attracted to her and was interested in having a personal relationship with her. She says that it made her feel uncomfortable when he touched her in erotic ways and suggested that they end sessions early to go out for a drink. As she describes these sessions, she seems very <u>open/embarrassed</u>. She says that <u>she feels like he shouldn't be able to get away with treating clients like that/she really doesn't want anyone to know about this</u>. Ms. R indicates that you are the only person that

she has told this to. You feel confident that your client is giving an honest account of her experience.

The control dilemma for the sexual dilemma was presented as follows:

> Ms. R, a 32-year-old woman, has recently been referred to you. You have had about five sessions with her, in which time you have established good rapport. During the course of a therapy session one day, Ms. S tells you that her previous therapist made repeated sexual advances toward her. She recounts sessions during which he said that he was attracted to her and was interested in having a personal relationship with her. She says that it made her feel uncomfortable when he touched her in erotic ways and suggested that they end sessions early to go out for a drink. Ms. R indicates that you are the only person that she has told this to. You feel confident that your client is giving an honest account of her experience.

Vignette Questions

Following the vignette, participants were asked to respond to a series of questions related to what they thought they should do and what they thought they would do in response to this situation. They were first asked what they thought they should do in response to this situation and were presented with a list of five alternative courses of action from which to choose a response. The five response choices that were listed were adapted from Bernard and Jara (1986). The response choices were assigned scores ranging from 1 to 5 according to the level of restrictiveness represented

by the response. Restrictiveness was established in terms of directness of the action (e.g., reporting is more direct than encouraging someone else to report). A score of "1" reflected the least restrictive response choice and a score of "5" the most restrictive response.

Following the question about what participants thought they should do in response to the situation, they were asked to rank their level of confidence that this was the most ethical course of action. There were five levels of confidence, ranging from "not at all confident" to "completely confident". Following the confidence rating, participants responded to an open-ended question which asked them to identify the most important factor which influenced their decision and to describe their decision making process.

Next, participants were asked what they thought they actually would do in response to this dilemma, and were presented with the same five alternative courses of action from which to choose a response. As with the "should" question, this question was followed by a question about participants' confidence; this time, participants were asked to rank their confidence that the choice that they indicated was what they actually would do if confronted with the dilemma. Following this confidence rating, participants again responded to an

open-ended question which asked them to identify the most important factor which influenced their decision about what they would do and to describe their decision making process. Following this was a question which requested respondents to explain, if they indicated that they would do something different from what they earlier said was the ethically ideal response, why this difference occurred. These open-ended questions provided information about what factors influenced what psychology graduate students thought they should do in response to ethical dilemmas and what they indicated they actually would do.

After responding to these initial questions regarding what they thought they should and would do, participants responded to a series of closed-ended questions designed to further explore factors which may have influenced their decision making process. Participants were first presented with a list of people whose interests they may have considered as they responded to the dilemma: the client, the respondent, the client's previous therapist, other clients, the profession, and the agency in which the respondent worked. They were asked to indicate whose interests they considered as they thought about what they should do, then rank the indicated interests in order of importance (1=most important, 6=least important, 7=not

considered). Next, participants were asked to rank, from a list of possible factors which influenced their decision, the three factors which most influenced their decision regarding what they should do. The following items comprised the presented list of rationales: upholding the law; upholding a code of ethics; unable to identify a specific reason/it just feels right (intuition); upholding personal moral values/standards; fear of legal reprisal, malpractice action filed by the client; fear of legal reprisal, being sued by the therapist involved; fear of verbal/social reprisal by supervisor; fear of verbal/social reprisal by the therapist involved; fear of verbal/social reprisal by the client; protection of personal/professional reputation; protecting society's interests; protecting clients' rights; safeguarding the therapy process; other. This list represents a replication and expansion of the list of rationales utilized by Smith et al. (1991).

Following these two closed-ended questions regarding whose interests and which factors participants considered as they thought about what they <u>should</u> do, participants were then asked these same two questions regarding what they actually <u>would</u> do in response to the dilemma. That is, subjects were asked whose interests they considered and what factors they

considered as they thought about what they would do. Finally, in order to ascertain subjects' familiarity with APA's Ethical Principles (1992), participants were asked whether they were familiar with these principles prior to the study and whether they referred to the provided excerpts from the Ethical Principles as they responded to the items in the questionnaire.

Procedure

To obtain the sample, the researcher contacted the directors of clinical training at various Ph.D. and Psy.D. programs in the Chicago area, described the general nature of the study, and invited the directors to volunteer their programs for the study. A total of seven programs participated in the study. Students from these programs were contacted in groups (e.g., classrooms, program meetings), or individually by phone or by mail and invited by the researcher to participate in the study. A copy of the letter sent to program directors is presented in Appendix B.

Testing times were scheduled with those students who agreed to take part in the study. Participants were tested in small groups or individually at their graduate institutions. Testing involved completing the previously described questionnaire. Participants were given consent forms and informed that their participation was voluntary and that their responses

would be anonymous. At the scheduled testing times, anonymity of responses was maintained by collecting consent forms separate from questionnaire packets. Participants first read over and signed the consent form and returned it to the researcher. Then, participants completed the questionnaire and returned this to the researcher independent of the consent form. Finally a debriefing form was given to subjects, and they were given the opportunity to receive a copy of the results of the study when completed. A copy of the consent form is presented in Appendix C, a copy of the questionnaire is presented in Appendix D and a copy of the debriefing form is presented in Appendix E.

CHAPTER III

RESULTS

Three sets of analyses were conducted on the data. The first set examined forced choice responses to the "should" versus "would" questions following the vignette and the impact of situational factors depicted in the vignette on these responses. The second set of analyses examined participants' responses to the closed-ended questions asking about factors influencing both the should and the would responses. The third set examined participants responses to open-ended questions regarding the reasons behind the should and would decisions.

Should versus Would Discrepancy

The first set of analyses examined whether there was a significant difference between what participants said they should and would do in response to the presented ethical dilemma. In addition, the effect of the described attitude of the client on the overall restrictiveness of responses and on the discrepancy between should and would responses was examined. A 2 X 3 X 2 repeated measures ANOVA was conducted, with dilemma type (sex or alcohol) and attitude of client

(angry, embarrassed, or control) as between subjects independent variables and question asked (should or would) as the within subjects independent variable. Response score was the dependent variable. As previously indicated, for both the should and the would questions, participants selected one course of action from a list of five alternatives. The five response choices were assigned scores ranging from 1 to 5 according to the level of restrictiveness represented by the response. Restrictiveness was established in terms of directness of the action (e.g., reporting is more direct than encouraging someone else to report). A score of "1" reflected the least restrictive response choice and a score of "5" the most restrictive response.

Only the within subjects effect of question asked reached statistical significance, F (1, 65) = 6.37, p = .014, indicating that there was a significant difference between what subjects said they should do and what they said they would do in response to the presented dilemma. As hypothesized, the mean of the response scores for the should question (M = 3.62) was significantly higher than the mean of the response scores to the would question (M = 3.43), indicating that participants tended to report that they would do less than they actually believed they should do. Of the

71 respondents in this study, ten (14%) indicated that they would do less than what they indicated they should do. Thus, 86% of the participants in this study indicated that they would do what they indicated they should do in response to the situation.

This pattern of responding occurred for both dilemma types and across all client attitudes; there were no significant main effects or interactions involving dilemma type or client attitude (all *p*'s > .15). Thus, there was no support for the second and third hypotheses of this study. Participants did not respond overall more restrictively to dilemmas which depicted an angry and open client as compared to dilemmas which depicted an embarrassed and hesitant client. Furthermore, there was not a greater discrepancy between what respondents said they should do and what they say they would do when the client in the dilemma was depicted as angry, open and suggesting that the therapist should not get away with treating clients in this manner. There was a fairly equal distribution of discrepancies across the attitude conditions; four of the discrepancies occurred in the condition in which the client was described as angry, four in the condition in which the client was described as embarrassed and two in the control condition. A breakdown of the means and standard deviations for the

response scores across the dilemma types and described attitude of the client is presented in Table 2.

TABLE 2

MEANS AND STANDARD DEVIATIONS FOR RESPONSES TO SHOULD AND WOULD QUESTIONS BY DILEMMA AND ATTITUDE

	Question			
	Should		Would	
Dilemma/Attitude	M	SD	M	SD
Sex Dilemma				
Angry	3.67	.99	3.42	.79
Embarrassed	3.42	.79	3.25	.87
Control	4.00	.89	3.91	.83
Alcohol Dilemma				
Angry	3.62	.87	3.46	.78
Embarrassed	3.60	.97	3.20	.92
Control	3.39	.51	3.31	.48

Overall, the majority of participants chose responses that involved either 1) counseling the client about actions that she could take in the form of an ethical complaint (60.6%); 2) approaching the colleague and discussing their knowledge of his behavior (19.0%); or, 3) reporting the colleague to the appropriate ethics committee (14.5%). The should versus would discrepancy seemed to reflect a tendency for some participants to shift toward responses that required less direct action on their part when responding to the

would question. The shift usually represented a one to two point shift (e.g., from "report the therapist" to "counsel the client regarding actions that she could take").

After participants indicated a response choice for the should and would questions, they were asked to indicate for the should question their level of confidence that this was the most ethical course of action, and for the would question their confidence that the choice that they indicated was what they actually would do if confronted with the dilemma. There were five levels of confidence, ranging from "not at all confident" ("1") to "completely confident" ("5"). In order to determine whether there were significant differences between confidence ratings across the questions asked or attitude or dilemma types, a 2 X 3 X 2 repeated measures ANOVA was conducted with confidence rating as the dependent variable, with dilemma type (sex or alcohol) and attitude of client (angry, embarrassed, or control) as between subjects independent variables and with question asked (should or would) as the within subjects independent variable. There were no significant main effects or interactions for confidence ratings (all p's > .15). Thus, participants' rated confidence in their response choices regarding the ethically ideal course of action

did not differ significantly from their rated confidence in their response choices regarding what they actually thought they would do. Moreover, these confidence ratings seemed not to systematically vary according to dilemma type or client attitude.

Decision-Making Rationales: Closed-Ended Responses Whose Interests Considered

As indicated in the "Method" section, participants were presented with a series of closed-ended questions following their responses to the should and would questions. First, they were presented with a list of people whose interests they may have considered as they responded to the dilemma: the client, the respondent, the client's previous therapist, other clients, the profession, and the agency in which the respondent worked. Participants were asked to indicate whose interests they considered as they thought about what they should do and then as they thought about what they would do, then rank the indicated interests in order of importance (1=most important, 6=least important, 7=not considered). The mean and modal rankings for each interest category are presented in Table 3.

TABLE 3

MEAN RANKINGS OF INTERESTS CONSIDERED IN RESPONDING TO SHOULD AND WOULD QUESTIONS

	Described Attitude of Client	
Interests	Should	Would
Client	1.27 (1)	1.29 (1)
Your Own	3.91 (3)	3.39 (2)
Therapist	4.27 (3)	4.44 (3)
Other Clients	3.04 (2)	3.58 (2)
Profession	4.32 (3)	4.78 (4)
Agency	5.97 (7)	5.96 (7)

Note: The numbers in parentheses indicate the modal response for each category of interest.

The mean ranking gives a sense of the relative indicated importance of each person's/institution's interests, with lower mean scores reflecting a higher overall ranking of importance. As is apparent from Table 3, the interests of the client seem to be considered of primary importance to this sample of graduate students in considering both what they should and would do.

There seems to be a slight difference, however, between participants' responses to the should and would questions in terms of whose interests subjects ranked as next in terms of importance. The interests of other clients received the next highest ranking score ($\underline{M}$ = 3.04, mode = 2) from subjects as they thought about

what they should do, followed by a consideration of their own interests ($\underline{M}$ = 3.91, mode = 3). Interestingly, this ranking is reversed when subjects thought about what they actually would do in response to the dilemma. Participants gave their own interests ($\underline{M}$ = 3.39, mode = 2) a slightly higher mean ranking than and an equal modal ranking to that for the interests of other clients ($\underline{M}$ = 3.58, mode = 2). In addition, the consideration of the interests of the profession fell from a mode of 3 and a mean of 4.32 for the should question to a mode of 4 and a mean of 4.78 for the would question.

Rationales Used to Justify Responses

Participants were also asked to indicate, from a list of 14 alternative factors, which factors were most important to them as they considered what they should do in response to the presented dilemma and what they would do. They were to rank the top three factors (1 = most important, 2 = second most important, 3 = third most important, 4 = not ranked). The following items comprised the presented list of rationales: upholding the law; upholding a code of ethics; unable to identify a specific reason/it just feels right (intuition); upholding personal moral values/standards; fear of legal reprisal, malpractice action filed by the client; fear of legal reprisal, being sued by the therapist

involved; fear of verbal/social reprisal by supervisor; fear of verbal/social reprisal by the therapist involved; fear of verbal/social reprisal by the client; protection of personal/professional reputation; protecting society's interests; protecting clients' rights; safeguarding the therapy process; other. This list represents a replication and expansion of the list of rationales utilized by Smith et al. (1991). Rankings for each rationale are described in Tables 4 and 5.

TABLE 4

PERCENTAGE OF PARTICIPANTS WHO RANKED RATIONALES FIRST OR IN TOP 3 IN RESPONSE TO SHOULD QUESTION

	Rank	
Rationale	1st	Top 3
Client's Rights	69.0 (49)	88.7 (63)
Uphold Code	15.5 (11)	77.5 (55)
Personal Values	7.0 (5)	39.4 (28)
Safeguard Therapy	4.2 (3)	53.5 (38)
Reputation	1.4 (1)	7.0 (5)
Intuition	1.4 (1)	5.6 (4)
Society	1.4 (1)	5.6 (4)
Uphold Law	0.0 (0)	8.5 (6)
Client Sue	0.0 (0)	4.2 (3)
Other	0.0 (0)	4.2 (3)
Therapist Sue	0.0 (0)	2.8 (2)
Reprisal-Sup.	0.0 (0)	1.4 (1)
Reprisal-Ther.	0.0 (0)	1.4 (1)
Reprisal-Client	0.0 (0)	0.0 (0)

Note: The numbers in parentheses are base N's for adjacent percentages.

TABLE 5

PERCENTAGE OF PARTICIPANTS WHO RANKED RATIONALES FIRST OR IN TOP 3 IN RESPONSE TO WOULD QUESTION

Rationale	Rank	
	1st	Top 3
Client's Rights	66.2 (47)	90.1 (64)
Uphold Code	11.3 (8)	64.8 (46)
Personal Values	9.9 (7)	40.8 (29)
Safeguard Therapy	4.2 (3)	45.1 (32)
Intuition	2.8 (2)	8.5 (6)
Reputation	1.4 (1)	11.3 (8)
Society	1.4 (1)	7.0 (5)
Other	1.4 (1)	4.2 (3)
Reprisal-Ther	0.0 (0)	7.0 (5)
Uphold Law	0.0 (0)	4.2 (3)
Therapist Sue	0.0 (0)	4.2 (3)
Reprisal-Sup.	0.0 (0)	4.2 (3)
Client Sue	0.0 (0)	2.8 (2)
Reprisal-Client	0.0 (0)	0.0 (0)

Note: The numbers in parentheses are base N's for adjacent percentages.

From the presentation of the data in Tables 4 and 5, it is evident that the same four rationales emerge as most important to subjects in determining both what they should do and what they would do: protecting client's rights, upholding a formal ethical code, safeguarding the therapy process and upholding personal values. Perhaps most notable is the finding that 69% of subjects ranked "protecting client's rights" as the most important factor influencing what they thought

they should do (88.7% ranked it as one of the top three factors influencing their thinking) and 66.2% of subjects ranked "protecting client's rights" as the most important factor influencing what they thought they actually would do in response to the dilemma (90.1% ranked it as one of the top three factors). Thus, in thinking both about what they should and would do in response to the presented dilemmas, consideration of the rights of the client seemed to play a central role in the reasoning process of subjects. Upholding a formal code of ethics also seems central in subjects' thinking about these dilemmas, but only as secondary or tertiary to the rights of the client.

Hypotheses Related to Rationales

Three hypotheses generated for this study pertained to the relationship of codified versus noncodified rationales to participants' responding to the should and would questions. Responses to the closed-ended question regarding what factors participants considered as they responded to the should and would questions were used to generate these categories. The rationale categories were formed in a similar manner as in the Smith et al. (1991) study. That is, two of the rationale categories (upholding the law; upholding a code of ethics) were combined to form the category "codified" rationales. The remainder of

the rationales were included in the "noncodified" rationale category. Included in this category were two rationales, protecting clients rights and safeguarding the therapy process, which Smith et al. (1991) did not include in their study, and which proved to be frequently identified as important by participants in this study. The extent to which these rationales were used at different stages of the reasoning process (should versus would) was examined.

Consistent with previous research, it was hypothesized that codified rationales would be disproportionately used to justify responses to the should question, while noncodified rationales would be disproportionately used to justify responses to the would question. Furthermore, it was hypothesized that a consistency between should and would responses would be associated with codified rationales, and a discrepancy between should and would responses would be associated with noncodified rationales.

Pearson chi-square analyses were conducted in order to test these hypotheses. Contrary to expectation, noncodified rationales were found to be significantly associated with both should, $\underline{X}^2(1) = 33.82$, $\underline{p}. < .0001$, and would, $\underline{X}^2(1) = 42.61$, $\underline{p}. < .0001$, responses. A chi-square analysis using Fisher's exact test was used to test hypotheses regarding

association of the use of codified and noncodified rationales with consistency or discrepancy between should and would responses. Also in contrast to what was hypothesized, a should/would discrepancy was not significantly associated with use of noncodified rationales, and a should/would consistency was not significantly associated with use of codified rationales, $\underline{X}^2(1) = .022$, $\underline{p}. > .15$.

Decision-Making Rationales: Open-Ended Responses

Rationales Used to Justify Responses

Immediately after participants were asked what they thought they should do in response to the presented dilemma, they were asked, in an open-ended format, what factor was most important to them in deciding what course of action they should take. A similar question was asked following the would question. Participants' responses to these questions were coded according to nine categories generated by the researcher after inspecting the data. Categories were developed in order to represent the different factors that participants described as they justified their responses to the should and would questions. Categories were defined on the basis of perceived consistency between types of rationales that were generated across subjects. The name and description of each rationale category is presented in Table 6.

TABLE 6

RATIONALE CATEGORIES

Category Name	Description of Category
Welfare of the Client	Statements which reflect a concern for the well-being of the client. Attention to the client's feelings or reactions to the situation and the responsibility of the respondent to assist her with these feelings.
Empowerment of the Client	Includes statements which emphasize giving the client control in the situation or empowering the client.
Confidentiality	Rationales based on upholding or preserving confidentiality.
Welfare of Other Clients	Statements which convey a concern for the possible impact of the therapist's behavior on other clients.
Need for more information	Rationales that describe uncertainty about the events described, and a need to find out more information before proceeding with a course of action.
Attention to the Therapist	Rationales which consider the welfare or the situation of the therapist involved in the dilemma.
Appeal to a Higher Institution	Statements which make reference to the need for a "higher authority" to resolve the situation. Also, statements which question the appropriateness of the respondent to address the situation him/herself.
Client's Responsibility to take Action	Statements which express that the client should take action or responsibility for the situation herself (but not explicit that this is for therapeutic effects).
Other	Rationales not otherwise categorized.

The researcher and another graduate student independently sorted the participants' responses into these nine categories, yielding 89.8% agreement (91.4% agreement for rationales in response to "should" question; 88.0% agreement for "would" rationales). Disagreements in coding were discussed and a consensus was reached regarding the appropriate coding for a given response. A breakdown of the percentage of participants identifying each factor as part of their reasoning process is presented in Table 7.

TABLE 7

PERCENTAGE OF FACTORS IDENTIFIED BY PARTICIPANTS AS INFLUENCING THEIR RESPONSES TO DILEMMAS

	Question Asked	
Rationale	Should	Would
Client Welfare	42.3 (30)	35.2 (25)
Confidentiality	38.0 (27)	31.0 (22)
C. Responsibility	21.1 (15)	18.3 (13)
Other Clients	18.3 (13)	11.3 (8)
Other	16.9 (12)	32.9 (23)
Empowerment	14.1 (10)	11.3 (8)
Need more info	11.3 (8)	5.6 (4)
Consider. Ther.	8.5 (6)	7.0 (5)
Higher Authority	7.0 (5)	4.2 (3)

Note: The numbers in parentheses are base N's for adjacent percentages.

Consistent with the data from the closed-ended

questions, a consideration of the welfare and the rights of the client seems to be central to participants' reasoning about the dilemmas, both in terms of what they said they should do and what they said they would do. It is also notable that 21.1% of participants indicated "Client Responsibility" as a rationale for the should question and 18.3% of participants for the would question. This category is comprised of rationales in which the respondent emphasized that it was the responsibility of the client to resolve the dilemma, and not the respondent. In order to be scored in this category, the subject must have given this rationale without indicating a notion of empowering the client by allowing her to make the decision. Many subjects in this sample, therefore, seemed to feel that responding to this dilemma was not their responsibility, but instead the responsibility of the client who was directly involved with the therapist.

Client Centered versus Non-Client Centered Rationales

Data from open-ended questions were also coded and summarized as client centered or non-client centered rationales. The rationales "welfare of the client", "empowerment of the client", and "confidentiality" were combined to form the category "client centered rationales". All other rationales were combined to form

the category "non-client centered rationales". A breakdown of these rationales by question asked and attitude of the client is presented in Table 8.

TABLE 8

PERCENTAGE CLIENT CENTERED RATIONALES BY QUESTION TYPE AND DESCRIBED ATTITUDE OF THE CLIENT

	Described Attitude of Client		
Rationale Type	Angry (n = 25)	Embarrassed (n = 22)	Control (n = 24)
Should			
CC	76.0 (19)	81.8 (18)	75.0 (18)
nCC	24.0 (6)	18.2 (4)	25.0 (6)
Would			
CC	52.0 (13)	68.2 (15)	66.7 (16)
nCC	48.0 (12)	31.8 (7)	33.3 (8)

Note: CC= Client Centered rationales; nCC= Non-Client Centered rationales. The numbers in parentheses are base N's for adjacent percentages.

Overall, it seems that participants more often incorporated client centered rationales into their responses to the should and would questions than non-client centered rationales. There seemed to be in general a slight difference, however, between use of client centered and non-client centered rationales in response to the should and would questions, with use of client centered rationales being greater in the should

than in the would condition. In the would condition respondents seemed to be more equally distributed in terms of which type of rationales they used.

The greatest shift in proportionate use of client centered and non-client centered and rationales from should to would occurs in the angry condition, in which fewer respondents used client centered rationales in response to the would question than in response to the should question. Thus, although in general respondents focused more upon the welfare and/or rights of the client when they formulated what they thought they should do than when they decided what they would do in response to the presented dilemmas, this trend was heightened when the attitude of the client was described as angry and wanting something to be done about the ethical violation. A chi-square analysis was conducted to determine whether use of client centered and non-client centered rationales in response to the should and would questions significantly differed in the angry condition. This analysis indicated that these apparent differences in use of client centered rationales did not reach statistical significance, $\underline{X}^2(1) = 3.12$, $\underline{p}. > .05$.

Spontaneously Generated Alternatives

Interestingly, in response to questions asking participants to identify the most important factor

which influenced their responding, a number of participants spontaneously offered alternative responses to the dilemmas. Often, these alternatives represented a process of responding to the ethical dilemma; in other words, a series of steps was identified as a response to the dilemma. As with rationales represented in responses to this open-ended question, categories for these alternatives were generated and the researcher plus an independent coder sorted responses into these categories, yielding 95.4% agreement (94.7% agreement for alternatives generated in response to the "should" question; 96.0% agreement for alternatives generated in response to the "would" question). It was possible for one participant to generate more than one alternative in their response. A description of the five different categories is presented in Table 9, and a description of the frequency with which these alternatives were generated for each response choice is presented in Table 10.

TABLE 9

CATEGORIES OF ALTERNATIVES

Category name	Description
Consultation	The respondent indicates that s/he would seek consultation about how to respond to the dilemma.
Consent	The respondent indicates that s/he would implement a certain course of action (e.g., would confront the therapist involved), but would first get the client's consent.
Further Action: Therapist	The respondent indicates that s/he would approach the therapist involved in the situation, and would take further action if he doesn't respond to being approached.
Further Action: of Client	The respondent indicates a course action (e.g., counsel the client regarding actions she could take) then notes that if the client chooses not to take further action, then the respondent would take further action (e.g., report the therapist).
Other:	Some other alternative course of action is specified. Examples of "other" alternative courses of action: let the therapist know that you are reporting him prior to doing so; spend more time on the issue before taking formal steps (talk about it more with the client, informally gather information about the allegations from the client/therapist/other therapists); rule out the possibility of the client having a personality disorder before taking steps; contact the therapist's boss so that the boss could monitor the therapist's recovery;

TABLE 10

PERCENTAGE OF ALTERNATIVES
GENERATED FOR EACH RESPONSE CHOICE

Alt. Generated	Response Choice 2 (n = 4)	3 (n = 86)	4 (n = 27)	5 (n = 25)
Consult	0.0 (0)	7.0 (6)	11.1 (3)	4.0 (1)
Consent	0.0 (0)	10.5 (9)	33.3 (9)	0.0 (0)
FA: Ther.	0.0 (0)	0.0 (0)	22.2 (6)	0.0 (0)
FA: Client	0.0 (0)	9.3 (8)	0.0 (0)	0.0 (0)
Other	0.0 (0)	11.6 (10)	4.5 (6)	12.0 (3)

Note: Response choice frequencies are collapsed across should and would questions. Thus, each subject contributed two responses for a total of 142 responses. The numbers in parentheses are base N's for adjacent percentages. 2= Help the client with any negative effects, but do nothing further; 3= Help the client with any negative effects and counsel the client regarding actions that she could take in the form of an ethical complaint; 4= Help the client with any negative effects and approach the therapist involved to discuss your knowledge of his behavior with your client; 5= Help the client with any negative effects and report the therapist to the appropriate ethics committee.

A total of 24 (33.8%) participants generated alternatives when describing what they thought they should do, and 30 (42.3%) respondents generated alternatives when describing what they actually thought they would do. As indicated in Table 10, respondents generated alternative solutions to the presented dilemma primarily when they indicated response choice 3 or 4 as the course of action that they might take in

response to the dilemma. Thus, respondents were most likely to qualify responses which indicated counseling the client regarding actions that she could take or approaching the therapist involved in the situation.

Thirty-three percent of respondents who indicated that they should and/or would approach the therapist involved in the dilemma indicated that they would obtain the client's consent before doing so. Twenty-two percent of subjects who chose response 4 indicated that if they approached the therapist and he did not respond to the approach, they would take further action (perhaps similar to the action delineated in response choice 5, reporting the therapist to the appropriate ethics committee). Thus, a large percentage of respondents who chose response choice 4 identified this response as part of a sequence of responding to the presented ethical dilemmas.

Similarly, a smaller but still notable percentage of respondents included response choice 3 as one of a series of steps in response to the presented dilemmas. Of those participants who said that they should and/or would counsel the client regarding actions she could take, 10.5% indicated that they would obtain her consent before doing anything else. Of respondents who selected response choice 3, 9.3% indicated that if the client did not take further action in this situation,

they would.

It is noteworthy that none of those participants who indicated that they should and/or would report the violating therapist to the appropriate ethics committee indicated that they would first obtain the consent of the client to do so. Presumably, respondents who chose this course of action would have also identified this course of action as the end stage of a series of steps in response to the ethical dilemma. For example, they might have indicated that they would first counsel the client about actions that she could take and then approach or report the therapist if she did not take further action. Or, respondents could have indicated that they would approach the therapist involved first, then report him if he did not respond to the approach. This, however, was not the case. None of the respondents who indicated that they should and/or would report the therapist indicated that they would take this more restrictive action as a part of a series of steps which included obtaining the client's consent, counseling the client about actions she could take or approaching the therapist involved.

CHAPTER IV

DISCUSSION

Should versus Would Discrepancy

This study was conducted as a replication and extension of prior research in the area of ethical decision making about dilemmas in clinical psychology. A first set of hypotheses pertained to participants' responses to questions asking what they should and would do in response to the presented dilemmas. Specifically, it was hypothesized that: 1) there would be a significant difference between what respondents said they should do and what they said they would do; 2) participants would respond overall more restrictively to dilemmas which depicted an angry and open client as compared to dilemmas which depicted an embarrassed and hesitant client; and, 3) there would be a greater discrepancy between what respondents said they should do and what they said they would do when the client in the dilemma was depicted as angry, open and suggesting that the therapist should not get away with treating clients in this manner. Only the first of these hypotheses was clearly supported.

In this sample of graduate students, there was a

significant difference between what respondents said they should and would do, with respondents indicating that they would follow a less restrictive course of action than what they identified they should do in response to the presented dilemmas. This finding suggests that in some cases, clinical psychology graduate students indicate that they would not do what they think is the ethically ideal course of action. This is consistent with previous research in this area which suggests that this is the case with both clinical psychology graduate students and practicing clinicians (Bernard & Jara, 1986; Bernard, Murphy & Little, 1987; Smith, McGuire, Abbott & Blau, 1991; Wilkins, McGuire, Abbott & Blau, 1990).

In this study, however, it is important to note that only 14% of participants indicated that they would do something less than what they indicated they should do. This is in contrast to findings in previous studies in this area, which document greater percentages of clinical psychology graduate students and practicing clinicians indicating that they would do less than what they said they should do in response to hypothetical scenarios. In the Bernard and Jara (1986) study, for example, for both the sexual and the alcohol scenarios at least 50% of the graduate student respondents indicated that they would do less than what they said

they should do. Bernard, Murphy and Little (1987) found that for the sexual scenario, 37% of practicing clinicians indicated that they would do less than what they said they should do. For the alcohol scenario, they found that 26% of respondents indicated they would do less than what they said they should do. Thus, the results of this study were consistent with findings from previous research in this area in that a significant difference was found between what participants said they should and would do when responses were translated into an ordinal scale and analyzed using an analysis of variance procedure; however, the actual percentage of respondents making a shift from should to would was very low. In comparison to participants in previous studies, participants in this study seemed to have less of a tendency to indicate that they would do less than what they said they should do in response to the presented dilemma.

These differing results can be explained in a few different ways. First, the procedure for this study was different from previous research in this area, in that the researcher was in the same room with respondents as they filled out the questionnaire. In previous studies (Bernard & Jara, 1986; Bernard, Murphy & Little, 1987) questionnaires were sent out to participants, who completed them and sent them back to the researcher.

Thus, the presence of the researcher in this study as the participants were responding to dilemmas may have created a demand for a certain type of responding which was not created in other studies; in this case, participants may have felt a demand to respond consistently for what they thought they should and would do.

The different percentage of discrepancies in this study as compared to previous studies might also be due to the effects of a recently increased attention to training in ethics in graduate training, and for this sample, a relatively greater proportion of participants who have received formal training in ethics. For example, Wilkins et al. (1990) noted that in their sample, 47% of participants received ethics training in one or two formal classes (Bernard and associates did not report in their studies the number or percentage of respondents who received any degree of education in ethics). In comparison, 79% of this sample indicated that they had taken a formal ethics class. Thus, this coursework may have sensitized students to their biases and tendencies in responding to ethical dilemmas, and may have contributed to more consistent responding across different stages of the ethical decision making process.

As in previous research, participants indicated

what they should and would do in response to two different dilemmas involving the inappropriate behavior of a colleague. There were no significant differences in participants' overall level of restrictiveness in responding or in the discrepancy between should and would responses between the two different dilemmas. In other words, participants responded equally restrictively to a dilemma involving inappropriate behavior of a colleague due to the influence of alcohol as to a dilemma involving the sexually inappropriate behavior of a colleague. This finding is noteworthy given previous findings in similar research which suggest that psychologists differentially respond to these dilemmas, with more restrictive responses to the sexual dilemma (Wilkins et al. 1990). In addition, this finding is surprising given the attention in the literature to sexual behavior and the clear statement in the ethical codes that this behavior is unethical.

One way in which this study expanded upon previous research in this area was by the manipulation of the described attitude of the client as angry, embarrassed or not described as she related information about the ethical violation of another therapist. This manipulation, however, did not significantly impact the discrepancy between what respondents said they should and would do or the overall restrictiveness of

responses. Instead, the discrepancy between what respondents said they should and would do occurred no matter what the described attitude of the client. The findings of this study, then, perhaps suggest that this discrepancy phenomena is pervasive across different types of ethical dilemmas and across different situational aspects of those dilemmas.

Participants' confidence in their response choices was also investigated in this study. As participants considered what they should and would do, their levels of confidence seemed to be equally high. That is, they were just as confident in deciding what was the ethically ideal course of action as they were in deciding how they would actually respond to the dilemma. Confidence ratings suggested that across dilemma and attitude types, participants were moderately to very confident in their responses to both the should and the would questions.

The specific findings of this study, however, must be viewed in light of the study's limitations. With respect to the impact of the described attitude of the client on participants' responses to the presented dilemmas, results should be considered in light of the number of participants in the study. A power analysis was conducted in order to determine whether the number of respondents per cell was adequate to detect a

significant difference between the different attitude and dilemma types with respect to restrictiveness of response. This analysis suggested that for 90% power, eight participants in each cell were necessary to detect an effect size of 1.20. Thus, for the size of effect that would be meaningful for this study, the number of participants in this study was adequate to detect a significant effect.

Another limitation of this investigation was the lack of a manipulation check to ascertain whether the manipulated attitude of the client was salient to participants. It is possible that more provided information about the client or a more clearly described attitude of the client would have contributed to a more potent effect of client's attitude on restrictiveness of responding. Lack of significant differences in responding between the different attitude types in this study might then be due to a failure to clearly differentiate between different attitudes that a client may have in reporting this information.

Rationales for Responses

In order to further expand upon research in this area, this study explored the ethical decision making process of participants with qualitative analyses of data gathered in response to open- and closed-ended

questions. Several aspects about the way in which participants responded to dilemmas were highlighted in these analyses. First, in participants' decision making process a consideration of the rights of the client seemed to be central, regardless of how the attitude of the client was described and regardless of whether respondents were considering what they should do or what they would do. Thus, in terms of Rest's (1984) model, a general consideration of the client may impact both the formulation of the ethically ideal response to a situation and the execution of a plan of action.

There was some evidence that factors other than the welfare or the rights of the client become slightly more important as respondents decided what they actually would do in response to the dilemma. The data from this study suggest that "survival" factors, as Haas, Malouf and Mayerson (1988) called them, such as protecting one's own interests, may become more important to an individual when considering what course of action s/he actually would take in response to an ethical dilemma.

These findings suggest that, in general, graduate students in clinical psychology are sensitive to the client in responding to ethical dilemmas, but that this sensitivity might play a role of somewhat lesser importance as they decide what course of action they

will actually implement in response to an ethical dilemma. Again, in terms of Rest's (1984) model, in implementing a course of action, there may be a tendency for an individual's own interests to become relatively more salient or important as compared to when s/he considers what the ethically ideal response to a dilemma might be. In addition, it seems that sensitivity to the client is not associated with one specific course of action in response to an ethical dilemma, but instead that consideration of the rights and welfare of the client may result in several different courses of action that are each ethically defensible.

This study also provides some evidence to suggest that the attitude of the client has some impact on the way that an individual therapist might reason about dilemmas, such as those presented in this study. When a client is angry and demanding that something be done about the situation, a therapist might be more apt to shift from a concern for the client when formulating the ethically ideal response to a dilemma to a concern with other factors when deciding what course of action to actually implement. It is important to keep in mind, however, that these apparent trends were not statistically significant. Further investigation may be needed to explore this issue in more depth.

In addition to hypotheses regarding participants' response choices to the presented dilemmas, three specific hypotheses were tested regarding the rationales that participants incorporated into their reasoning about what they said they should and would do. The fourth, fifth and sixth hypotheses of this study pertained to the use of codified and noncodified rationales and included the following: 4) codified rationales would be associated with what respondents said they should do; 5) codified rationales would be associated with a consistency between should and would responses; and, 6) noncodified rationales would be associated with a discrepancy between should and would responses. Contrary to expectation, codified rationales were not found to be significantly associated with responses to the should question or to a consistency between should and would responses. Instead, noncodified rationales were used disproportionately over codified rationales whether participants were responding to the should or would questions. In other words, participants identified noncodified rationales as important in their decision making process both as they considered what they should and would do in response to the dilemmas. Also contrary to what was hypothesized, neither discrepancy nor consistency between should and would responses were found to be

significantly more associated with use of a particular type of rationale.

Results from the chi-square analyses regarding the use of codified rationales are tentative, however, due to the limitations of the use of this type of analysis with this data. As suggested in Hayes (1988), an assumption for the use of the chi-square test is that the expected frequency for each cell in the contingency table is at least five. The expected frequencies for the categories in the analysis regarding use of codified and noncodified rationales with a discrepancy or consistency between should and would responses, however, violate this assumption. Thus, although Fisher's exact test was applied to correct for this violated assumption, conclusions from these analyses should be carefully drawn, and replication of these findings with a larger sample is necessary.

Findings from these analyses should also be interpreted carefully, since the categories of rationales compared in this study were generated by the researcher, and could reflect a bias toward the coding of only certain types of responses. In this study, for example, additional categories of rationales were added to the list of possible rationales used to justify should and would responses adapted from the Smith et al. (1991) study, which initially documented the

association of codified rationales with "should" responses and with consistency between "should" and "would" responses. Two of the rationales added to this list were categorized in this study to be client centered and non-codified: upholding the client's rights and safeguarding the therapy process. The lack of use of codified rationales by respondents in this study, then, can perhaps be accounted for by the fact that the majority of the respondents indicated the primary importance of one of these two client centered rationales. These factors could have just as easily been categorized as "codified" rationales, however, if they were represented differently in the list of alternative rationales (e.g., upholding a formal code of confidentiality).

This ambiguity in coding the different factors which influence participants' responding to ethical dilemmas perhaps intimates the complex nature of the ethical decision making process. While the colleague depicted in the dilemma presented in this study is clearly engaging in unethical behavior, the ethical codes are also clear about protecting the rights of the client. In identifying the protection of these rights as important in the decision making process, participants may be relying on that part of the code which discusses privacy and confidentiality. In this

case, less restrictive responding or a reluctance to take a more direct action may not represent unethical behavior, but instead may represent an attempt on the part of the respondent to balance obligations to fulfill different ethical responsibilities outlined in informal or formal codes such as the APA Principles. For example, for the dilemmas presented in this study, one might construe a responsibility on the part of the responding clinician to address the unethical behavior of the offending colleague. One might also consider, however, that the clinician has an obligation to respect the privacy and confidentiality of the reporting client. Depending upon the attitude and the wishes of the client involved, these responsibilities might come into conflict. Data from this study suggest that students weighed the responsibility to the client most heavily. When offered a choice between "upholding a formal ethical code" and "upholding the rights of the client", respondents seemed to indicate that respecting the rights of the client was of primary importance, whether or not it was incorporated into a formal code.

Participants also seemed to evidence a process of ethical decision making in their responses to open-ended questions about their reasoning about dilemmas. This was suggested by the alternative courses of action that participants spontaneously generated in response

to the presented ethical dilemmas. These alternatives suggested that graduate students may respond to an ethical dilemma in a series of steps, and that the course of action implemented may be modified according to the consequences that result from each step taken. For example, the following contingency plan can be formulated by combining several participants' generated alternative responses to the presented dilemmas: 1) counsel the client regarding actions that she could take in the form of an ethical complaint; if the client does not take further action, 2) obtain her consent to approach the therapist involved and 3) approach the therapist; if the therapist does not respond to the approach, 4) report the therapist to the appropriate ethics committee.

Several participants identified part or all of this contingency plan as the way in which they would respond to the presented dilemmas. Thus, it seems that just as reasoning about ethical dilemmas can be considered a process, behaviorally responding to an ethical dilemma might also be viewed as a process and not as a single response. The initial response of an individual to an ethical dilemma, then, may be viewed not as the final step in the decision making process, but instead as the beginning step in a process of the individual interacting with the ethically problematic

situation toward resolution.

It should be emphasized, that the foregoing conclusions followed from exploratory analyses of the data, and so are only tentative. It is possible that the trends and patterns which emerged from this analysis of these data are specific to this sample and not generalizable to the general population of clinical psychology graduate students or clinicians. In addition, reported differences between rationales used in response to should and would questions and in the different attitude conditions may not be statistically significant differences. As with the caveats mentioned with respect to the chi-square and ANOVA analyses, replication of these findings is necessary, especially with designs that might allow for quantitative comparisons between categories of rationales and generated responses to dilemmas.

Implications for Future Research

In addition to replication of some of these preliminary analyses/results, there are several implications for future research which follow from the results of this study. First, closed-ended formats seem inadequate to accurately characterize the way in which individuals reason about and respond to ethical dilemmas. As evidenced in this study, closed ended formats with respect to what course of action an

individual might take and the rationale for this action force individuals to make a choice. The meaning of the indicated choice, however, is unclear. In this study, for example, two individuals considering any part of the previously described contingency plan as a course of action may have indicated for the closed ended question any of three different responses. In this case, the overall "restrictiveness" of a response becomes meaningless, because it is impossible to tell from the subject's indicated course of action what course of action they are really considering.

Open-ended formats allow for such explication of a decision making process and process of behavioral responses to a given dilemma. Furthermore, qualitative analyses allow for unexpected patterns in the data to emerge, such as the spontaneously generated alternatives in this study. At this stage of inquiry into the ethical decision making process about dilemmas encountered in clinical practice, it might be useful to examine data in this way. Replication of patterns of results with experimental design, however, is also recommended, in order to compare the relative influence of different factors on the ethical reasoning and behaving process. Future qualitative and quantitative analyses might further explore the different situational parameters (such as characteristics of the

individuals involved in the dilemma and of the respondent) which affect the ways in which individuals think about and respond to ethical dilemmas. Future research in this area might also examine perceived consequences to different responses to dilemmas, the ways in which these consequences affect the execution of a planned course of action, and how a specific course of action fits into a more general contingency plan of action.

Conclusions

This study replicated previous findings in professional ethical decision making research, in that there was a significant difference between what psychology graduate students said they should and would do in response to two scenarios depicting the unethical behavior of a colleague. Participants tended to identify a less direct response as what they actually would do in response to a dilemma as compared to what they specified was the ethically ideal response to the situation. As was noted, however, a majority of respondents (86%) indicated that they would do what they indicated was the ethically ideal response to the situation.

The significant difference for should responses versus would responses was found both for a dilemma involving the sexually inappropriate behavior of a

colleague as well as for the adverse effect of a colleague's consumption of alcohol on therapy sessions. In an extension of previous research in this area, more information was provided in the scenario about the attitude of the client in reporting this unethical behavior. The should/would discrepancy was found across the three attitude conditions included (angry, embarrassed, not described) and participants seemed to respond equally restrictively to dilemmas whether the client was described as angry or embarrassed or not described.

Although participants responses seemed not to be differentially impacted by the described attitude of the client, participants did tend to focus on the interests of the client in thinking about and responding to the dilemmas. The type of rationale (codified versus noncodified, client centered versus non-client centered) that participants utilized did not seem to systematically vary with different stages of the reasoning process. Instead, students seemed to consistently focus on the welfare or rights of the client in the scenario as they thought about what they should and would do in response to the dilemma. Thus, consideration of the client seems to be an important part of the ethical reasoning and behaving process in clinical ethical decision making. Future research might

explore the specific aspects of the client or client's rights/welfare that are salient to psychologists and psychology graduate students as they respond to ethical dilemmas.

As indicated, this consideration of the client represents a clear part of our ethical code that may come into conflict with other parts of the code. Students may engage in a multi-staged process of reasoning about and responding to ethical dilemmas which represents an attempt to work toward a resolution of the situation which balances different responsibilities outlined in the code.

APPENDICES

APPENDIX A

DILEMMAS WRITTEN IN ALTERNATE FORMS

ALCOHOL DILEMMA
Version 1 (angry client)

Ms. R, a 32-year-old woman, has recently been referred to you. You have had about five sessions with her, in which time you have established good rapport. During the course of a therapy session one day, Ms. R angrily tells you about sessions with her previous therapist in which she could tell that he had been drinking. She recounts times when she felt uncomfortable because his speech was slurred and she could smell alcohol on his breath. She says that at these times, he would come to sessions late or end sessions early. As she describes these sessions she seems very open and angry about the experience. She says that she feels like he shouldn't be able to get away with treating clients like that. Ms. R indicates that you are the only person that she has told this to. You feel confident that your client is giving an honest account of her experience.

ALCOHOL DILEMMA
Version 2 (embarrassed client)

Ms. R, a 32-year-old woman, has recently been referred to you. You have had about five sessions with her, in which time you have established good rapport. During the course of a therapy session one day, Ms. R tearfully tells you about sessions with her previous therapist in which she could tell that he had been drinking. She recounts times when she felt uncomfortable because his speech was slurred and she could smell alcohol on his breath. She says that at these times, he would come to sessions late or end sessions early. As she describes these sessions she seems very hesitant and embarrassed about the experience. She says that she really doesn't want anyone to know about this. Ms. R indicates that you are the only person that she has told this to. You feel confident that your client is giving an honest account of her experience.

ALCOHOL DILEMMA
Control Version (client not described)

Ms. R, a 32-year-old woman, has recently been referred to you. You have had about five sessions with her, in which time you have established good rapport. During the course of a therapy session one day, Ms. R tells you about sessions with her previous therapist in which she could tell that he had been drinking. She recounts times when she felt uncomfortable because his speech was slurred and she could smell alcohol on his breath. She says that at these times, he would come to sessions late or end sessions early. Ms. R indicates that you are the only person that she has told this to. You feel confident that your client is giving an honest account of her experience.

SEXUAL DILEMMA
Version 1 (angry client)

Ms. R, a 32-year-old woman, has recently been referred to you. You have had about five sessions with her, in which time you have established good rapport. During the course of a therapy session one day, Ms. R angrily tells you that her previous therapist made repeated sexual advances toward her. She recounts sessions during which he said that he was attracted to her and was interested in having a personal relationship with her. She says that it made her feel uncomfortable when he touched her in erotic ways and suggested that they end sessions early to go out for a drink. As she describes these sessions she seems very open and angry about the experience. She says that she feels like he shouldn't be able to get away with treating clients like that. Ms. R indicates that you are the only person that she has told this to. You feel confident that your client is giving an honest account of her experience.

SEXUAL DILEMMA
Version 2 (embarrassed client)

Ms. R, a 32-year-old woman, has recently been referred to you. You have had about five sessions with her, in which time you have established good rapport. During the course of a therapy session one day, Ms. R tearfully tells you that her previous therapist made repeated sexual advances toward her. She recounts sessions during which he said that he was attracted to her and was interested in having a personal relationship with her. She says that it made her feel uncomfortable when he touched her in erotic ways and suggested that they end sessions early to go out for a drink. As she describes these sessions she seems very hesitant and embarrassed about the experience. She says that she really doesn't want anyone to know about this. Ms. R indicates that you are the only person that she has told this to. You feel confident that your client is giving an honest account of her experience.

SEXUAL DILEMMA
Control Version (client not described)

Ms. R, a 32-year-old woman, has recently been referred to you. You have had about five sessions with her, in which time you have established good rapport. During the course of a therapy session one day, Ms. R tells you that her previous therapist made repeated sexual advances toward her. She recounts sessions during which he said that he was attracted to her and was interested in having a personal relationship with her. She says that it made her feel uncomfortable when he touched her in erotic ways and suggested that they end sessions early to go out for a drink. Ms. R indicates that you are the only person that she has told this to. You feel confident that your client is giving an honest account of her experience.

APPENDIX B

CONTACT LETTER

Dear Dr, X,

I am a graduate student in the clinical psychology program at Loyola University of Chicago and am currently working on my master's thesis under the direction of Dr. Patricia Rupert. This project involves collecting data from graduate students in clinical psychology. Thus, I am writing to you in order to ask if I might be able to recruit students in your program to participate in my thesis study.

The study involves decision making about ethical dilemmas that psychologists might encounter in clinical practice. Students would be asked to fill out a questionnaire which describes an ethical dilemma and asks several questions about that dilemma. The total participation time would be approximately half an hour to 45 minutes. I would like to contact students in your program individually or in groups, if possible, so that I may explain the nature of the project and invite them to participate. For those who agree to participate, I would like to present the questionnaire in person and then take time afterward to briefly tell them about the study and answer any questions that they might have.

I realize that you get a number of requests from graduate students who wish to conduct research projects. This project, however, requires a minimal amount of time for students and involves important ethical issues. As such, it will hopefully be a learning experience for those who participate. Both Dr. Rupert and I are willing to work with you in order to maximize this as a learning experience.

I am hoping to begin collecting data for this project in March, 1993, and finish collecting data in May, 1993. I will be calling you in a week or so to discuss this project with you further. At that time, if you are open to participation in this study, I will forward additional materials to you.

Sincerely,

Jeanne Piette
Clinical Psychology Graduate Student

APPENDIX C

GENERAL INFORMATION AND CONSENT FORM

Dear fellow Graduate Student:

I am conducting a study for my master's thesis which investigates the ethical decision making of clinical psychology graduate students about dilemmas that they might encounter in clinical practice. For this study, you will be asked to complete a questionnaire which describes an ethical dilemma and asks several questions about that dilemma. The total participation time will be approximately 30-45 minutes.

You will not be asked to put your name on any material related to this project. As a result, your responses will be completely anonymous.

Through your participation in this study, you will be helping me to complete my master's thesis. In addition, because the study deals with significant ethical issues in clinical psychology, I hope that this project will provide an opportunity for you to gain insight into your own ethical decision making and further your knowledge about the decision making tendencies of others within your profession.

Your participation in this project is completely voluntary. Should you decide at any point to discontinue your participation, for whatever reason, you may feel free to do so.

I appreciate your taking time to participate in this study.

Sincerely,

Jeanne Piette
Clinical Psychology Graduate Student

I have read the general information about Project Ethics. I understand that the project will involve completing a questionnaire, will take about 30-45 minutes, and will be completely anonymous. I agree to participate in Project Ethics.

_____ _____

Signature Date

APPENDIX D

QUESTIONNAIRE

INSTRUCTIONS:

In this questionnaire, you will be presented with an ethical dilemma. We would like you to put yourself in the position of a practicing clinical psychologist to whom a client has been recently referred. We will be asking you to respond to the dilemma. We are interested in your decisions and your reasoning about this dilemma. For your information, we are including a copy of the general ethical principles and ethical standards that might be relevant to the dilemma that you are considering. Your responses to the presented scenario may take into account these ethical principles as well as personal life experience, understanding of the specific situation, personal values or interests, legal codes, or anything else that may be helpful to you in formulating a response.

Please complete the following as it applies to you.

Gender: M F

Age: ____

Ethnicity:
____African-American
____Asian/Pacific Islander
____Caucasian
____Latino/Latina
____Other: Please specify_____

Program in which you are enrolled:
____Psy.D.
____Ph.D.

Year in graduate school: ____

Amount of clinical experience:
Duration (months completed) ____
Type of placement (please check all that apply):

Setting	Client population
____in-patient	____adult
____out-patient	____child
____day treatment	____family
	____couples
	____group

At this point in your training, what theoretical orientation is most representative of your viewpoint:
____Psychodynamic
____Behavioral
____Cognitive
____Humanistic
____Eclectic
____Other: Please specify _____

Check all the forms of ethical training that you have received:
____Formal ethics class in graduate school
____Periodic discussion within the context of general clinical courses in graduate training
____Informal discussion with supervisor/other trainees during a clinical placement
____One or two continuing education courses/seminars
____Three or more continuing education courses/seminars
____Discussion with colleagues
____Independent reading
____Other: Please specify _____

Please read the following scenario, and imagine that you are the clinician to whom Ms. R has been referred:

Ms. R, a 32-year-old woman, has recently been referred to you. You have had about five sessions with her, in which time you have established good rapport. During the course of a therapy session one day, Ms. R tearfully tells you about sessions with her previous therapist in which she could tell that he had been drinking. She recounts times when she felt uncomfortable because his speech was slurred and she could smell alcohol on his breath. She says that at these times, he would come to sessions late or end sessions early. As she describes these sessions she seems very hesitant and embarrassed about the experience. She says that she really doesn't want anyone to know about this. Ms. R indicates that you are the only person that she has told this to. You feel confident that your client is giving an honest account of her experience.

I. Please answer the following questions which refer to the scenario described on the previous page.

A. The following is a list of possible responses to the scenario previously described. Please consider what you think you should do in response to this situation. Choose the one alternative that you think is the most ethical response.

____1. Do nothing.
____2. Help the client with any negative effects from the experience, but do nothing further.
____3. Help the client with any negative effects from the experience and counsel the client regarding actions that she could take in the form of an ethical complaint.
____4. Help the client with any negative effects from the experience. In addition, approach the therapist that is involved and discuss with him your knowledge of his behavior with your client.
____5. Help the client with any negative effects from the experience and report the therapist to the appropriate ethics committee.

Please rate your confidence that this choice is the most ethical choice:

1	2	3	4	5
not confident	a little confident	moderately confident	very confident	completely confident

You were presented with a number of alternative responses to the previously described dilemma, and you selected one course of action that represented what you thought you should do in response to this situation. What was the most important factor that made you choose the response that you did instead of other possible responses? Please explain, as clearly as possible, your reasoning process as to why this is the most ethical response.

B. The following is the same list of possible responses to the scenario previously described. Earlier, you chose a response which represented what you thought you should do in response to the dilemma. Now we would like you to consider what you think you would do if you were actually confronted with this situation. Choose the one alternative that you think best corresponds to what you actually would do.

____1. Do nothing.
____2. Help the client with any negative effects from the experience, but do nothing further.
____3. Help the client with any negative effects from the experience and counsel the client regarding actions that she could take in the form of an ethical complaint.
____4. Help the client with any negative effects from the experience. In addition, approach the therapist that is involved and discuss with him your knowledge of his behavior with your client.
____5. Help the client with any negative effects from the experience and report the therapist to the appropriate ethics committee.

Please rate your confidence that this is the choice that you would make if you were really confronted with this decision:

1	2	3	4	5
not confident	a little confident	moderately confident	very confident	completely confident

You were presented with a number of alternative responses to the previously described dilemma, and you selected one course of action that described what you thought you would do if you were actually confronted with this situation. What was the most important factor that made you choose the response that you did instead of other possible responses? Please explain, as clearly as possible, your reasoning process as to why this response is what you think you would do if actually confronted with this situation.

Some research suggests that in responding to ethical dilemmas, psychologists and psychology graduate students often indicate that they would do something different than what they say they should do. This may have been the case for you. If you indicated that you would do something different than what you indicated you thought you should do, please describe the most important reason for doing so. If you did not indicate that you would do something different from what you said you should do, please check the following statement: ___This question does not apply to me.

II. In the first section, you indicated courses of action that represented what you thought you should do and would do in response to a dilemma. Now, with more structured questions, we would like to ask about some of the things that might have influenced your responses. In the first sub-section (A), the questions refer to what you thought you should do in response to the dilemma. In the second sub-section (B), the questions refer to what you think you would do if actually confronted with the situation.

A. SHOULD

Your action in the previously described scenario could have affected a number of others. Some of the people whose interests you may feel are important to protect are listed below. Please indicate whose interests you considered as you decided what you should do (check all that apply), then rank the interests of the people/institutions that you checked in order of importance (1=most important, 2=second most important, etc.):

____the client
____your own
____her previous therapist
____other clients
____the profession
____the agency in which you work

The following list is comprised of possible factors which may have influenced what you thought you should do in response to this dilemma. Please rank the three factors which most influenced your decision regarding the ethically ideal course of action (1=most influential, 2=second most influential, 3=third most influential):

____Upholding the law
____Upholding a code of ethics
____Unable to identify a specific reason/it just feels right (intuition)
____Upholding personal moral values/standards
____Fear of legal reprisal; malpractice action filed by the client
____Fear of legal reprisal; being sued by the therapist involved
____Fear of verbal/social reprisal by supervisor
____Fear of verbal/social reprisal by the therapist involved
____Fear of verbal/social reprisal by the client
____Protection of personal/professional reputation
____Protecting society's interests
____Protecting clients' rights
____Safeguarding the therapy process
____Other. Please specify _____

B. WOULD

As you decided what you would actually do in this situation, whose interests did you think were important to protect? Please indicate whose interests you considered as you decided what you would do (check all that apply), then rank the interests of the people/institutions that you checked in order of importance (1=most important, 2=second most important, etc.):

____the client
____your own
____her previous therapist
____other clients
____the profession
____the agency in which you work

Please rank the following factors again. This time, rank the three factors which most influenced your decision about what you believe you would do if actually confronted with the previously presented scenario (1=most influential, 2=second most influential, 3=third most influential):

____Upholding the law
____Upholding a code of ethics
____Unable to identify a specific reason/it just feels right (intuition)
____Upholding personal moral values/standards
____Fear of legal reprisal; malpractice action filed by the client
____Fear of legal reprisal; being sued by the therapist involved
____Fear of verbal/social reprisal by supervisor
____Fear of verbal/social reprisal by the therapist involved
____Fear of verbal/social reprisal by the client
____Protection of personal/professional reputation
____Protecting society's interests
____Protecting clients' rights
____Safeguarding the therapy process
____Other. Please specify _____
____Upholding the law
____Upholding a code of ethics
____Unable to identify a specific reason/it just feels

Were you familiar with APA's Ethical Principles of Psychologists and Code of Conduct (revised 1992) prior to this study? ___Yes ___No

Did you refer to the provided Ethical Principles as you responded to the items in this questionnaire?
___Yes ___No

-END-

Thank you for taking time to complete this questionnaire. Please return this questionnaire to the researcher and she will give you a debriefing form.

APPENDIX E

DEBRIEFING FORM

Thank you for participating in this study. This study is attempting to replicate findings of previous research conducted with both clinical psychologists and psychology graduate students. For both populations, this research noted that there was frequently a discrepancy between what subjects said they should do in response to a presented dilemma, and what they thought they actually would do if confronted with the dilemma. This study is also expanding upon previous research by exploring potential influences on the discrepancy between what subjects say they should and would do. All subjects in this study received a dilemma which depicted a client reporting to her current therapist the unethical behavior of her former therapist. These scenarios were manipulated, however, such that some subjects received scenarios which did not describe the attitude of the client in reporting this information while some subjects received scenarios that described an "angry" client or a "tearful" client. The added information of the client's attitude was expected to influence the way in which subjects responded to questions about what they should and would do in this situation.

If you would like further information about the results of this study, please provide your name and address on the attached sheet and return it to the researcher. She will provide you with this information when it is available.

If you are interested in learning more about ethical decision making or about the ethical decisions of psychologists, the following references may be helpful:

Bernard, J. L. & Jara, C. S. (1986). The failure of psychology graduate students to apply understood ethical principles. Professional Psychology: Research and Practice, 17, 313-315.

Bernard, J. L., Murphy, M. & Little, M. (1987). The failure of clinical psychologists to apply understood ethical principles. Professional Psychology: Research and Practice, 18, 489-491.

Pope, K. S. & Velter, V. A. (1992). Ethical dilemmas encountered by members of the American Psychological Association. American Psychologist, 47, 397-411.

Rest, J. R. (1984). Research on moral development: Implications for training counseling psychologists. The Counseling Psychologist, 47, 397-411.

I would like further information about the results of this study.

Name_____

Address_____

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VITA

The author, Jeanne Piette, was born in Waukesha, Wisconsin on May 16, 1969.

In August, 1987, Ms. Piette entered Marquette University of Milwaukee, where she graduated magna cum laude with the degree of Bachelor of Arts in Psychology in May, 1991. While attending Marquette University, Ms. Piette was awarded membership in Psy Chi National Psychology Honors Society and was recognized as a National Dean's List Student.

In August, 1991, Ms. Piette was granted and assistantship in psychology at Loyola University of Chicago, enabling her to complete the Master of Arts in May, 1994.

APPROVAL SHEET

The thesis submitted by Jeanne M. Piette has been read and approved by the following committee:

Dr. Patricia Rupert, Director
Associate Professor of Psychology
Loyola University of Chicago

Dr. Karen Wills
Assistant Professor of Psychology
Loyola University of Chicago

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

April 15, 1994
Date

Patricia Rupert
Director's Signature