Identifying Factors Associated with Best Practice by Registered Psychologists

Final Report

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In order to improve the ethical and professional conduct of psychologists an understanding of the risk factors associated with poor conduct and how psychologists view ethical dilemmas is important. A greater understanding of psychologists' ethical reasoning will allow one to develop tailored resources that improve training and overall performance of psychologists. This report outlines a study which examines psychologists' understanding of the best and worst responses to ethical dilemmas, as well as factors that may be associated with greater ethical awareness such as gender, years of experience and qualifications.

The Psychology Council of NSW 2014 Annual report provides a breakdown of the type of issues raised in complaints received by the organisation. This is important given that this study attempts to understand the factors associated with psychologists' understanding of ethical dilemmas. Specifically, during the period from June 2013 – June 2014, the board received 168 new complaints, which constitutes approximately 1.34 % of registered psychologists in NSW. The top three reasons for complaints were: (1) clinical care (48 complaints), (2) documentation (28 complaints), (3) boundary violation (17 complaints) and communication (17 complaints). Overall, the council received 95 complaints based on performance, 58 based on conduct issues and 15 based on health issues during this period. In the period from June 2016 – June 2017 the council received 99 complaints based on performance, 109 based on conduct issues and 16 based on health issues, indicating an increase in both performance and health based complaints.

There has been one Australian study which has analysed complaints received by the NSW Health Professionals Registration Board, and this was done for the period between July 2003 to June 2007 (Grenyer and Lewis, 2012). During this period there were 224

psychologists who had complaints lodged against them. The study found that the main predictors of complaints against psychologists were: (i) being male, (ii) age (i.e., being 45 years and older) and (iii) having a postgraduate degree. Although being 45 years and older and having a postgraduate degree were predictors of complaints, these were no longer significant predictors when the analysis controlled for multiple complaints or serious complaints. Further, the authors speculated that psychologists with more experience or higher qualifications are likely to work in areas of psychology that are complex, such as those that involve medico-legal cases. The current study will examine the association between ethical awareness and factors including gender, years of experience and clinical/educational qualifications.

Researchers have attempted to investigate psychologists' ethical awareness by typically employing a series of vignettes that outline ethical dilemmas to which psychologists respond. Politis and Knowles (2013) (an Australian study) examined psychologists' ethical awareness by asking psychologists about their "ethical willingness" and "ethical unwillingness". Ethical willingness refers to agreement between what a psychologist *should* do in a given dilemma and what they say they *would* do. Ethical unwillingness refers to psychologists who differ on what they should do versus what they would do in an ethical dilemma. Thus, the study attempted to better understand psychologists' beliefs of a situation and their behavioural intention.

Politis and Knowles (2013) used ethical dilemmas which outlined psychological services provided under the Better Access to Mental Health Care scheme. To investigate ethical willingness Politis and Knowles (2013) recruited 254 psychologists who completed an online questionnaire consisting of six ethical dilemma vignettes. For each vignette each response option reflected various types of ethical reasoning. Psychologists had to indicate

which option they should and would do. For example, one vignette described a psychologist discovering a client had a diagnosis that is not covered by the scheme (e.g., Borderline Personality Disorder). The options for the vignette were based on factors such as upholding the law (e.g., refer the client back to the General Practitioner indicating the reason why you cannot provide a service under the scheme) and protecting society's interest (e.g., provide the psychological service under Medicare and discuss the differing diagnosis with the GP). The main finding was that when the ethical dilemmas closely aligned with the Code of Conduct, there was a greater degree of agreement between the should do and would do options. However, when the ethical dilemmas were less clear or did not clearly map onto a specific code, there was less agreement between psychologists' would and should options (i.e., greater ethical unwillingness). This study illustrates that psychologists' responses to ethical dilemmas is one way to investigate the ethical decision making process. Further, an important implication of this finding is that additional guidelines to the Code of Conduct may assist practitioners to improve best practice. However, one limitation of this study is that the ethical dilemmas were restricted to psychological services funded by Medicare.

There are several other national and international studies which have examined the degree to which psychologists (or psychotherapists) perceive a specific behaviour (e.g., becoming friends with a former patient, giving a present to a patient) to be ethical or unethical in a variety of countries including Australia (Sullivan, 2002), the Caribbean (Conley, 2013), Italy (Gius & Coin, 2000), Spain (Clemente, Espinosa & Urra, 2011), and the USA (Pope, Tabachnick, Keith-Spiegel, 1987). It is difficult to directly compare perceived ethicality across these studies as they used different types of behaviours and phrasing. Further, none of these studies have examined psychologists' understanding of both best and worst possible responses to ethical dilemmas. The worst response to an ethical dilemma is

important as often a complaint made to the Council or National Board is made in relation to a behaviour that a psychologist should not have engaged in.

In addition, some studies did examine what psychologists found most helpful to guide their ethical practice. Italian psychotherapists found their personal analysis, specialisation school and experience with patients most helpful (Gius & Coin, 2000), whilst civil/penal codes, published research and university were considered to be least useful in guiding their ethical conduct. For Australian psychologists, Sullivan (2005) found that discussions with colleagues, independent reading and Australia Psychologist Society (APS) publications were perceived to be more important sources of information about ethics; whilst State Registration Boards, university coursework and APS staff were perceived to be "*not at all useful"* by a significant number of participants (13%-18%).

To obtain a better understanding of psychologists' ethical awareness of ethical dilemmas, this study will examine both the best and worst responses that can be chosen given a particular ethical dilemma. In addition, factors of gender, years of experience and qualifications will be examined to determine whether these variables are associated with greater ethical awareness. The aims of the present study are to:

1) Compare psychologists' best and worst responses to ethical dilemmas
2) Determine the relationships between ethical awareness and factors including gender, years of experience and clinical/educational qualifications.

Method

Recruitment

Participants were selected using stratified random sampling from the database of psychologists registered with the Australian Health Practitioner Regulation Agency (AHPRA) in New South Wales. The sample was stratified in terms of gender and qualifications. The

contact details of psychologists were obtained through a manual search of the public domain (e.g., private practice websites, yellow pages listing). A total of 631 psychologists were sent a copy of the questionnaire (403 email, 228 hard copies). To increase the rate of response, participation was anonymous. All participants were invited to respond to an online questionnaire that took approximately twenty minutes to complete. In return they had the option of entering a draw to win one of three iPad 4 tablets.

Participants

The final sample consisted of 95[1] individuals (45 Males, 50 Females) yielding a response rate of 15.06%.

Materials

47 vignettes were constructed from a variety of sources. These were: ethical dilemmas experienced by psychologists working in private practice, private and public hospitals, 26 behaviours reported by Sullivan (2002) for which participants rated a high degree of agreement on ethicality and those that were also difficult to judge, 15 vignettes based on behaviours listed in Pope, Tabachnick and Keith-Spiegel (1987) and 4 vignettes based on ethical dilemmas described in the Psychology Council of NSW Newsletter. Each vignette had 3-5 potential responses to the situations and psychologists had to choose *"What would you do"* and *"What would be the worst thing to do"*. Participants could only choose one response for each question.

These vignettes were sent to a reference group of five experienced clinical psychologists to provide responses to the best and worst possibilities for all 47 vignettes. These psychologists have more than five years of experience,, currently work or have

[1] There were 18 respondents who did not complete the questionnaire or stated they were completing a psychology registration program. These individuals were excluded from all analyses.

worked in roles supervising other psychologists, have written books and articles on ethical dilemmas and/or have managed ethical dilemmas in the workplace. One of the five psychologists works in the United States of America and the others work in Australia. Out of the 47 vignettes, 20 were chosen based on having consensual agreement on the best and worst responses, as well as aligning with the code of ethics (please see Table 1 for agreement of each item, and best and worst responses).

For example, for the vignette below (item 19), all 5 psychologists in the reference group chose response option d as the best possible response and response option a as the worst possible response (Please see Appendix A for all 20 vignettes). Thus, response options d and a were defined as the optimal responses for the best and worst responses, respectively. The consensual judgment of the reference sample was then used to score "correct" responses for the research participants, for both the best and worst categories.

Item 19: Your workplace had a Christmas lunch during which they provided alcoholic beverages. You had a couple of glasses of wine and know from experience that it affects your ability to make judgements. You have a client scheduled at 3pm. What would you do?

a) *Go ahead with the session knowing that you will not fully recover from the effects of the alcohol before your session*
b) *Have a phone consultation instead of an individual face-to-face session.*
c) *Request that your colleague see this client for this one session*
d) *Cancel the session and offer them an appointment for later that week*

Table 1. Agreement between Experienced Psychologists on Ethical Dilemmas for Best and Worst Responses

Vignette #	Descriptor of Ethical Dilemma	Best (%)	Response	Worst(%)	Response
1	Engaging in erotic activity with a client	100	5	100	1
2	Disclosure of HIV status	80	1	100	4
3	Inviting clients to a party or social event	100	4	100	1
4	Receiving information about client from friend	80	2	100	1
5	Telling a client I am sexually attracted to you	100	4	100	2
6	Providing services outside areas of competence	100	4	100	3
7	Giving personal advice on radio and TV	100	2	60	1
8	Signing for hours a supervisee has not earned	100	4	100	2
9	Terminating therapy if client cannot pay	80	5	100	3
10	Providing therapy to one of your friends	100	2	60	4
11	Filing an ethics complaints against a colleague	100	4	100	2
12	Discussing a client by name with friends	100	4	60	1
13	Using self disclosure as a therapy technique	60	4	100	2
14	Going into business with one of your clients	100	4	60	1
15	Borrowing money from a client	100	4	60	3
16	Disclosure of elder abuse	80	2	100	1
17	Seeing a minor client without parental consent	60	1	100	2
18	Lending money to a client	100	1	80	4
19	Doing therapy while under influence of alcohol	100	4	100	1
20	Using an agency affiliation to recruit private clients	80	4	100	1

In addition to the vignettes, several demographic questions were included. These were: gender, workplace sector (private, public), years of experience, area of practice (e.g., metropolitan, rural), frequency of peer/group and individual supervision per year, average hours of clinical practice per week, ease with which they can debrief with a colleague or supervisor, population group they work with (e.g., adults, children, couple, organisation), type of therapy they use (e.g., ACT, CBT, IPT), disorders they treat in their practice and type of registration.

Procedure

Ethics approval was obtained from The University of New South Wales Psychology Human Research Ethics Advisory Panel (Number 2462). The online questionnaire was created on the online platform Qualtrics and the link to the questionnaire was sent to psychologists via email. For participants whose email address could not be determined, hard copies of the questionnaire were sent with a postage reply paid envelope to each psychologist's mailing address. The questionnaire consisted of the 20 vignettes, each with a set of response options, and demographic questions which were placed at the end of the questionnaire. Reminders were emailed to participants who had not replied one month and six months later to increase the response rate.

Results

Demographic Details

Table 2 outlines the demographics details of participating psychologists.

Table 2. Demographic Details of Psychologists

	N(%)
1. Gender	
a. Male	45 (47.4)
b. Female	50 (52.6)
2. Workplace Sector	
a. Public Organisation	25 (26.3)
b. Private Organisation	4 (4.2)
c. Non-Government/Not for Profit	6 (6.3)
d. University	5 (5.3)

e. Private Practice	52 (54.7)
3. Years of Experience	
a. 0 – 4	11 (11.6)
b. 5 – 9	19 (20.0)
c. 10 – 14	17 (17.9)
d. 15 – 19	18 (18.9)
e. 20 +	27 (28.4)
4. Area of Practice	
a. Metropolitan	68 (71.6)
b. Regional	-
c. Rural	24 (25.3)
5. Frequency of Group/Peer Supervision (x Year)	
a. 0 – 3	11 (11.6)
b. 4 – 7	16 (16.8)
c. 8 – 11	28 (29.5)
d. 12 +	37 (38.9)
6. Frequency of Individual Supervision (x Year)	
a. 0 – 3	14 (14.7)
b. 4 – 7	19 (20)
c. 8 – 11	31 (32.6)
d. 12 +	28 (29.5)
7. Clinical Practice (hours per week)	
a. 0 – 8	6 (6.3)
b. 9 – 16	18 (18.9)
c. 17 – 24	37 (38.9)
d. 25 – 32	16 (16.8)
e. 33 +	15 (15.8)
8. Ease of Supervision	
a. Very Easy (Access During Day)	31 (32.6)
b. Somewhat Easy	34 (35.8)
c. Somewhat Difficult	21 (22.1)
d. Very Difficult (Have to Wait Till Monthly Supervision)	6 (6.3)
9. Client Group Psychologists Work With	
a. Children/Adolescents	27 (28.4)
b. Families	16 (16.8)
c. Adults	75 (78.9)
d. Couples	5 (5.3)
e. Organisations	1 (1.1)
10. Primary Type of Therapy Practiced	
a. Acceptance & Commitment Therapy	12 (12.6)
b. Cognitive Behavioural Therapy (CBT)	60 (63.2)
c. Dialectical Behaviour Therapy	1 (1.1)
d. Family Therapy	4 4.2)
e. Humanistic Therapy	6 (6.3)
f. Interpersonal Psychotherapy	7 (7.4)
g. Psychodynamic Psychotherapies	1 (1.1)
11. Disorders Treated	
a. Anxiety Disorder	71 (74.7)
b. Bipolar and Related Disorders	14 (14.7)
c. Depressive Disorders	64 (67.4)
d. Disruptive, Impulse Control & Conduct Disorders	16 (16.8)
e. Dissociative Disorders	4 (4.2)
f. Elimination Disorders	1 (1.1)

g. Feeding and Eating Disorders	6 (6.3)
h. Gender Dysphoria	2 (2.1)
i. Medication Induced Movement Disorder	-
j. Neurocognitive Disorders	3 (3.2)
k. Neurodevelopmental Disorders	9 (9.5)
l. Obsessive Compulsive & Related Disorders	19 (20.0)
m. Paraphilic Disorders	-
n. Personality Disorders	25 (26.3)
o. Schizophrenia Spectrum & Psychotic Disorders	10 (10.5)
p. Sexual Dysfunctions	2 (2.1)
q. Sleep Disorders	9 (9.5)
r. Somatic Symptom & Related Disorders	12 (12.6)
s. Substance Related & Addictive Disorders	18 (18.9)
t. Trauma & Stressor Related Disorders	55 (57.9)
u. Other	11 (1..6)
12. Type of Registration	
a. Registered Psychologist	46 (48.4)
b. Clinical Psychologist	44 (46.3)
c. Counselling Psychologist	2 (2.1)

Description of Best and Worst Responses Proportion Correct

Table 3 includes the best and worst percentage correct and distribution of responses for each vignette. Participants' best and worst responses were used to calculate a total percentage correct for each category. Overall, psychologists performed better (i.e., their responses were more concordant with those of the reference group) for best responses (82.54% correct) than for worst responses (68.11% correct; t =13.49, p <.05). Furthermore, performance on the individual items differed for the best and worst response. For best responses, psychologists performed the best on items such as "Discussing a client by name with friends" (100%) and "Lending money to a client" (100%), and worst on items such as "Providing personal advice on radio" and TV (29.8%) and "Seeing minor without parental consent" (8.6%). For worst responses, performance was best on items such as "Doing therapy while under influence of alcohol" (95.7%) and "Using self-disclosure as a therapy technique" (93.5%) and worst on items such as "Borrowing money from a client" (29.3%) and "Going into business with a client" (22.8%). Further, for best responses there tended to be a ceiling effect with performance being over 80% correct on more than 15 items whereas

for worst responses only 8 items had over 80% correct). This asymmetry suggests that psychologists find it more difficult to identify the worst responses than they do the best responses.

Tables 4 – 6 describe the best and worst responses percentage correct broken down by the factors of qualifications, gender and years of experience. For best responses, clinical psychologists tended to have more items for which they performed over 90% (14 of 20 items) compared to other psychologists (10 of 20 items). Psychologists with over 10 years of experience appeared to perform slightly worse than those with 10 or less years of experience on the identification of both best (84% vs. 81%) and worst (71% vs. 66%) responses.

Table 3. Identification of Best and Worst Responses Percentage Correct and Distribution of Responses for Vignettes

	Best Responses					Worst Responses				
Vignette #	**M % Correct (SD)**	**% Endorsing Alternative Responses (Response selected)**				**M % Correct (SD)**	**% Endorsing Alternative Responses (Response selected)**			
1	96.8 (0.18)	3.2 (4)				76.6 (0.43)	14.9 (3)	5.3 (4)	3.2 (2)	
2	73.4 (0.44)	18.1 (2)	8.5 (3)			80.6 (0.40)	19.4 (3)			
3	89.5 (0.31)	10.5 (4)				91.5 (0.28)	8.5 (2)			
4	52.1 (0.50)	34 (3)	13.8 (1)			81.9 (0.39)	11.7 (2)	6.4 (3)		
5	87.4 (0.33)	12.6 (4)				80.9 (0.40)	16 (1)	2.1 (3)	1.1 (4)	
6	91.6 (0.28)	5.3 (1)	2.1 (3)	1.1 (2)		80 (0.40)	12.8 (2)	5.3 (1)	1.1 (4)	
7	29.8 (0.46)	52.1 (3)	11.7 (1)	6.4 (4)		54.3 (0.50)	30.4 (4)	12 (2)	3.3 (3)	
8	98.9 (0.10)	1.1 (3)				72.3 (0.45)	14.9 (1)	12.8 (3)		
9	86.3 (0.35)	5.3 (1)	3.2 (2)	3.2 (4)	2.1 (3)	46.8 (0.50)	24.5 (1)	18.1 (4)	9.6 (2)	1.1 (5)
10	93.6 (0.25)	5.3 (3)	1.1 (4)			63.4 (0.48)	30.1 (1)	6.5 (2)		
11	93.7 (0.24)	5.3 (1)	1.1 (3)			86.2 (0.35)	11.7 (1)	1.1 (3)	1.1 (4)	
12	100 (0.00)					72 (0.45)	28 (3)			
13	72.6 (0.45)	18.9 (1)	8.4 (3)			93.5 (0.25)	6.5 (3)			
14	93.6 (0.25)	5.3 (3)	1.1 (1)			22.8 (0.42)	77.2 (2)			
15	96.8 (0.18)	2.2 (1)	1.1 (3)			29.3 (0.46)	59.8 (2)	10.9 (1)		
16	94.6 (0.23)	3.3 (1)	2.2 (3)			44.6 (0.50)	28.3 (4)	27.2 (3)		
17	8.6 (0.28)	63.4 (3)	26.9 (2)			45.1 (0.50)	48.4 (1)	6.6 (3)		
18	100 (0.00)					67.4 (0.47)	16.3 (2)	16.3 (3)		
19	96.8 (0.18)	2.2 (3)	1.1 (1)			95.7 (0.21)	2.2 (2)	1.1 (3)	1.1 (4)	
20	94.6 (0.23)	4.3 (2)	1.1 (2)			77.2 (0.42)	22.8 (2)			

Note. For each vignette, there was different number of responses (ranging from 3 – 5). % Endorsing Alternative Responses is a rank ordering of responses from most to least chosen with the corresponding percentage.

Table 4. Identification of Best and Worst Responses Percentage Correct for Clinical Psychologists and Psychologists

	Best Responses (% Correct)		Worst Responses (% Correct)	
Vignette #	Clinical Psychologist	Psychologist	Clinical Psychologist	Psychologist
1	100	93.9	84.8	68.8
2	73.9	72.9	82.6	78.7
3	91.3	87.8	95.7	87.5
4	52.2	52.1	80.4	83.3
5	93.5	81.6	80.4	81.3
6	95.7	87.8	78.3	83.3
7	35.6	24.5	47.7	60.4
8	100	98	78.3	66.7
9	84.8	87.8	45.7	47.9
10	91.1	95.9	60	66.7
11	93.5	93.9	89.1	83.3
12	100	100	71.1	72.9
13	71.7	73.5	91.3	95.7
14	100	87.8	26.7	19.1
15	97.8	95.8	24.4	34
16	93.2	95.8	33.3	55.3
17	6.7	10.4	50	40.4
18	100	100	66.7	68.1
19	97.8	95.8	93.3	97.9
20	93.3	95.8	82.2	72.3

Table 5. Identification of Best and Worst Responses Percentage Correct for Males and Females

Vignette #	Best Responses (% Correct)		Worst Responses (% Correct)	
	Male	Female	Male	Female
1	97.8	96	75	78
2	84.4	63.3	81.8	79.6
3	82.2	96	97.7	86
4	54.5	50	79.5	84
5	91.1	84	77.3	84
6	91.1	92	68.2	92
7	36.4	24	41.9	65.3
8	97.8	100	75	70
9	88.9	84	52.3	42
10	88.6	98	74.4	54
11	97.8	90	88.6	84
12	100	100	67.4	76
13	77.8	68	95.5	91.8
14	93.2	94	18.6	26.5
15	95.5	98	30.2	28.6
16	93	95.9	41.9	46.9
17	9.1	8.2	44.2	45.8
18	100	100	60.5	73.5
19	97.7	95.9	93	98
20	95.5	93.9	81.4	73.5

Table 6. Identification of Best and Worst Responses Percentage Correct for Years of Experience

Vignette #	Best Responses 0 – 4	5 – 9	10 – 14	15 – 19	20	Worst Responses 0 – 4	5 – 9	10 – 14	15 – 19	20
1	100	100	100	94.4	92.6	72.7	63.2	82.4	82.4	77.8
2	72.7	61.1	88.2	61.1	77.8	72.7	77.8	76.5	88.2	81.5
3	90.9	89.5	88.2	100	85.2	100	94.7	88.2	88.2	88.9
4	54.5	73.7	52.9	38.9	46.2	90.9	100	82.4	76.5	70.4
5	90.9	89.5	70.6	88.9	92.6	90.9	78.9	82.4	70.6	81.5
6	81.8	89.5	100	88.9	92.6	90.9	89.5	88.2	82.4	66.7
7	36.4	31.6	29.4	11.1	34.6	63.6	57.9	37.5	70.6	50
8	100	94.7	100	100	100	100	78.9	64.7	70.6	66.7
9	90.9	78.9	88.2	88.9	88.9	27.3	52.6	41.2	35.3	59.3
10	90.9	89.5	100	94.4	92.3	81.8	68.4	58.8	64.7	50
11	90.9	100	88.2	83.3	100	100	94.7	88.2	70.6	88.9
12	100	100	100	100	100	63.6	72.2	76.5	76.5	70.4
13	81.8	89.5	58.8	61.1	70.4	100	94.7	88.2	88.2	96.2
14	100	89.5	94.1	100	88.9	9.1	26.3	11.8	17.6	38.5
15	100	100	100	94.4	92.6	18.2	36.8	11.8	35.3	37
16	90.9	94.7	94.1	94.4	96.2	54.5	47.4	29.4	47.1	48.1
17	9.1	5.3	0	11.1	14.8	63.6	36.8	37.5	47.1	44.4
18	100	100	100	100	100	54.5	68.4	76.5	70.6	63
19	100	100	100	94.4	92.6	100	94.7	94.1	100	92.6
20	100	100	94.1	88.9	92.6	63.6	89	76.5	64.7	81.5

Inferential Analyses of Best and Worst Responses Proportion Correct

This section describes results obtained from inferential analyses. Table 7 includes Pearson correlations between each of the demographic variables and the best and worst responses proportion correct. Simultaneous regression analysis was conducted to determine if any of the demographic variables predicted best and worst responses.

For best responses (proportion correct), frequency of peer/group supervision had a significant standardised regression coefficient ($\beta=.25$, $p=.028$) such that the more supervision a psychologist had the better they performed and explained about 5 per cent of the variance in the variable. Interestingly, for worst responses the demographic variable of peer/group supervision did not account for any variance, nor did any other variable ($p>.05$). Gender, qualifications and years of experience were not significant predictors of the percentage correct identification of either best or worst responses.

Domain Specific and Non-Domain Specific Vignettes

In each area of clinical practice (e.g., working with rural communities) the issues of multiple relationships, competency and confidentiality often arise as ethical dilemmas. To determine if clinical area of practice can influence ethical decision making, each of the vignettes was classified as either being specific to an area of clinical practice (i.e., domain specific - e.g., disclosure when dealing with those with HIV, confidentiality issues when working in a rural area) or general and therefore could be encountered by any psychologist working in a variety of clinical areas (i.e., domain non-specific – e.g., terminating therapy if a client cannot pay, providing therapy to your friend). In total eight vignettes were classified as domain specific (items: 2,4,6,7,13,16,17,20) and twelve vignettes were classified as domain non-specific (items 1,3,5,8,9,10,11,12,14,15,18,19). Table 8 shows the correlations

between each of the demographic variables and both best and worst responses for domain specific and domain non-specific vignettes.

For domain specific best responses, gender (β= -.28, p =.01) had a significant standardised coefficient such that males performed better than females and explained 7 per cent of the variance in the dependent measure. Frequency of peer/group supervision (β=.27, p = 0.02) had a significant standardised regression coefficient such that those who attended peer supervision performed better and explained 6 per cent of the variance. For domain non-specific best responses, the standardised regression coefficient for type of registration approached significance (β= .238, p = .053) , such that those with a clinical psychology endorsement performed better than those without an endorsement.

For domain specific worst responses, type of therapy (β=.28, p = 0.01) had a significant standardised regression coefficient and explained approximately 7 per cent of variance in the variable, such that those who endorsed practicing humanistic therapy performed better than other types of therapy. There were no significant coefficients for domain non-specific worst responses.

Table 7. Pearson correlations between demographic variables and the percentage correct identification of best and worst responses

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Gender	-	0.15	-0.20	-0.14	0.08	-0.06	-0.19	-0.12	0.00	-0.07	0.06	-0.10	-0.16	0.08
2. Workplace Sector		-	-0.02	0.05	-0.15	-0.01	**-.21***	0.11	-0.11	0.12	-0.06	**-.27****	-0.05	0.01
3. Years of experience			-	0.05	-0.07	-0.16	-0.12	0.07	-0.18	0.17	-0.09	0.16	-0.12	-0.12
4. Area of Practice				-	-0.09	0.19	0.00	-0.01	-0.16	0.02	0.00	-0.10	0.03	0.15
5. Frequency of Group/Peer Supervision (x Year)					-	0.01	0.17	**-.30****	0.16	0.05	0.16	0.07	**.26***	-0.10
6. Frequency of Individual Supervision (x Year)						-	0.12	-0.09	0.04	-0.09	0.04	0.05	0.18	0.02
7. Clinical Practice (hours per week)							-	-0.06	0.09	0.18	0.04	0.18	0.18	0.00
8. Ease of Supervision								-	-0.19	0.07	-0.07	**-.27***	-0.12	-0.10
9. Client Group Psychologists Work With									-	-0.08	**.35****	0.07	-0.01	0.06
10. Primary Type of Therapy Practiced										-	0.14	-0.13	0.12	0.03
11. Disorders Treated											-	-0.03	-0.04	0.03
12. Type of Registration												-	0.16	0.00
13. Best Proportion Correct													-	**.29****
14. Worst Proportion Correct														-

Table 8. Pearson correlations between demographic variables and percentage correct identification of best and worst responses for domain specific and domain non-specific vignettes

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Gender	-	0.15	-0.20	-0.14	0.08	-0.06	-0.19	-0.12	0.00	-0.07	0.06	-0.10	**-.24***	0.03	0.16	-0.03
2. Workplace Sector		-	-0.02	0.05	-0.15	-0.01	**-.21***	0.11	-0.11	0.12	-0.06	**-.27****	-0.03	-0.04	0.19	-0.16
3. Years of experience			-	0.05	-0.07	-0.16	-0.12	0.07	-0.18	0.17	-0.09	0.16	-0.10	-0.07	-0.15	-0.03
4. Area of Practice				-	-0.09	0.19	0.00	-0.01	-0.16	0.02	0.00	-0.10	0.07	-0.03	0.13	0.09
5. Frequency of Group/Peer Supervision (x Year)					-	0.01	0.17	**-.30****	0.16	0.05	0.16	0.07	**.27****	0.10	-0.13	-0.01
6. Frequency of Individual Supervision (x Year)						-	0.12	-0.09	0.04	-0.09	0.04	0.05	0.12	0.13	0.16	-0.13
7. Clinical Practice (hrs. per wk.)							-	-0.06	0.09	0.18	0.04	0.18	**.25***	0.00	-0.03	0.03
8. Ease of Supervision								-	-0.19	0.07	-0.07	**-.27***	-0.12	-0.05	-0.12	-0.03
9. Client Group Psychologists Work With									-	-0.08	**.35****	0.07	-0.03	0.02	0.01	0.07
10. Primary Type of Therapy Practiced										-	0.14	-0.13	0.08	0.09	**.23***	-0.18
11. Disorders Treated											-	-0.03	-0.08	0.04	0.12	-0.07
12. Type of Registration												-	0.07	0.18	-0.06	0.05
13. Best Domain Specific													-	0.05	0.14	0.17
14. Best Domain Non-Specific														-	**.30****	0.01
15. Worst Domain Specific															-	0.03
16. Worst Domain Non-Specific																-

Summary, Limitations and Recommendations

The present study found a clear asymmetry in psychologists' ability to correctly identify the best response versus the worst response to a series of ethical dilemmas, with psychologists showing better performance when identifying the best responses than when identifying the worst responses. This could be due to psychologists tending to consider "*what I should do in this situation"* rather than "*what I should avoid doing in this situation".* Further, the worst performing vignettes on both best and worst responses are similar to the Psychology Council of New South Wales 2014 Report of receiving high number of complaints regarding psychologists' boundary violations and clinical care. Poor awareness of ethical dilemmas may be associated with behaviours that potentially lead to misconduct. Hence, an important implication is that being able to identify the worst possible response in a situation could potentially decrease the likelihood of a psychologist engaging in that behaviour and hence, avoiding misconduct.

A novel finding of the present study was that psychologists who engaged in more peer supervision were also more likely to perform better on the ethical vignettes. This is factor that has not been previously explored in prior literature (e.g. Sullivan, 2005; Politis & Knowles, 2013). This finding suggests that ethical awareness and behaviours can be improved by reflecting on clinical cases and professional conduct with peers. Indeed, it may be just as important as attending professional development.

Interestingly, males tended to perform better on domain specific ethical vignettes compared to females. This is in contrast to the finding of Grenyer and Lewis (2012) that being male was associated with being subject to more complaints to the NSW Registration Board. One reason for this could be that in this study, more males tended to work in public organisations than females (34.9% vs. 20.4% respectively). Public organisation roles tend to

be specific to a clinical area (e.g., mental health, chronic pain, cancer etc.) and as such males may have acquired greater competency in areas that are specific to a clinical area. In contrast females are more likely to work in private practice than males (63.3% vs. 48.8% respectively) and are more likely to see a variety of clinical presentations. However, multiple regression analysis showed that gender remained a significant predictor of domain specific best responses when controlling for sector [2]. Future research could further elucidate the relationship between gender and ethical dilemmas by requesting psychologists to provide their reasoning to each response.

An unexpected finding was that those who endorsed humanistic therapy were more likely to perform better than other types of therapist on worst domain specific responses. It may be the case that those who employ a humanistic approach to therapy are more likely to consider the relationship with their clients prior to making a decision regarding ethical dilemmas and consequently, are perhaps more likely to make optimal ethical decisions. Alternatively, it may also be the case that this finding is an instance of a false positive error as only 6 psychologists (6.7%) endorsed humanistic therapy as their primary modality compared to 59 psychologists (65.6%) who endorsed cognitive behavioural therapy.

Limitations and Future Directions

This study utilised the opinions of five experienced clinical psychologists to determine the best and worst responses to the ethical dilemmas upon which psychologists' performance was compared. The optimal best and worst responses may have been different if other expert psychologists' opinions were sought. It is difficult to set an "objective" standard to which psychologists' responses can be compared to, particularly for ethical dilemmas which are ambiguous in nature. Future research would therefore benefit from

[2] $t(89) = -2.34$, $p < .05$

investigating why psychologists choose the particular options they endorse in order to foster better ethical reasoning.

Another limitation of this study is that it is not clear whether psychologists' identification of best and worst responses would accurately correspond to the behaviours they would engage if they themselves were to be that given situation. It is possible that the responses provided by psychologists to each vignette represents a demand characteristic such that they have provided favourable answers rather than what they would have done in that situation. Future research could benefit from more robust methodology such as requesting psychologists to respond by asking both what they *should do* and *would do* for each vignette, as well as asking psychologists if they have been in situations similar to that described in ethical dilemmas and how they responded.

The response rate for this study was 15.06%, which is lower than other similar studies conducted in Australia (e.g., Sullivan, 2005 reported a response rate of 30%). This may be due to how contact details were obtained. Specifically, questionnaires were sent to psychologists' email or postal addresses which were publically available and as such these addresses may not have been current or valid. Past research has sent questionnaires to psychologists' nominated contact details which were provided by the collaborating organisation (e.g., Sullivan, 2002 mailed questionnaires to all members of the Australian Psychological Society) and may account for the higher response rate.

A final limitation of this study is that although attempts were made to stratify the sample, it is possible that those who participated in the study are those who are most interested in ethical dilemmas. Consequently, there may be a selection bias within the sample and the data may not necessarily be representative of all psychologists in New South Wales.

Recommendations

- Psychologists would benefit from further discourse and resources made available on what would be the worst possible outcome in ethical dilemmas. This would allow them to understand what not to do and potentially decrease unethical behaviours.
- Supervision (particularly peer and/or group) should be made a crucial part of practicing as a psychologist, similar to professional development to improve ethical and professional behaviours.
- Structured resources around ambiguous ethical dilemmas (e.g., issues around consent for children aged 15-16 years) may assist psychologists to make more informed decisions.
- To improve performance (professional and ethical), core competencies for each clinical area are required.

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Appendix A Ethics and Psychologist Questionnaire

Please choose ONE response for ***What would you do?*** and ONE response for ***What would be the worst thing to do?*** Do NOT choose the same response for each column

Your partner of 30 years recently passed away. Your family live interstate and you have been feeling isolated and lonely for the past few months. Your client has also recently experienced a significant loss and invites you to dinner at their place. You realize that you have begun to have feelings towards your client and believe that dinner might lead to sexual intimacy.		
	What would you do?	**What would be the worst thing to do?**
Accept the invitation as you are planning to retire from the profession in the near future		
Decline the invitation and suggest coffee at the local café to provide your client with additional support		
Decline the invitation and try to discharge your client as quickly as possible so you can begin a relationship		
Decline the invitation and terminate therapy as soon as possible		
Decline the invitation and seek clinical supervision prior to the next session in order to attempt to understand where your feelings towards your client are coming from. In addition, liaise with the supervisor to formulate a plan of action in relation to the client		

You are counselling a gay man who has been diagnosed as HIV positive. He has not told his lover, with whom he is not practicing safe sex. His lover is known to have tested negative for the virus. Your client is afraid to tell his lover because he fears that he may reject him. You feel that this decision puts the lover at considerable risk, and you feel responsible for this.		
	What would you do?	**What would be the worst thing to do?**
Ask your client to disclose this information to his partner		
Ask your client to practice safe sex		
Break confidentiality and inform the partner yourself		
Do nothing		

Please choose ONE response for ***What would you do?*** and ONE response for ***What would be the worst thing to do?*** Do NOT choose the same response for each column.

Your client has become socially isolated after a recent divorce and estrangement from his children, and has been severely depressed over the last month. You encourage him to spend time with his friends and acquaintances, however he is finding it difficult to initiate the process. You know he enjoys lawn bowls and you regularly attend your local club to play lawn bowls. You are considering inviting him to your local club as you sympathise with his situation.		
	What would you do?	**What would be the worst thing to do?**
Invite him to one of your game at your local club and hope his depression improves quickly		
Make him aware of the games played at your local club, and that you attend it and hint that he should attend the club		
Investigate whether there is a place for playing lawn bowls in his area and inform the client		
Do not to invite your client to your local club and explore the reasons behind why he is finding it difficult to initiate activities		

You live in a small rural town and while at the local farmer's market with a group of friends one of your neighbours approaches you. You know him to be a good friend of a patient of yours whom you are treating for depression and anxiety. He says that he has very important information about your patient that he wishes to tell you, that he says will be critical to the therapeutic work you are doing.		
	What would you do?	**What would be the worst thing to do?**
Listen to what your client's friend has to say		
Apologise and state that you cannot listen to this information without the consent of your client		
Suggest that he discusses this information with his friend before coming to you		

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Please choose ONE response for ***What would you do?*** and ONE response for ***What would be the worst thing to do?*** Do NOT choose the same response for each column.

You are currently seeing a client with low self-esteem who works in the television industry. Your colleagues often make passing remarks on your client's good looks and recently you notice that you are beginning to become sexually attracted to this client.		
	What would you do?	**What would be the worst thing to do?**
Tell the client you are sexually attracted to them and this is the reason why you can no longer continue to treat them		
Tell the client you are sexually attracted to them and continue with treatment		
Refer the client to your colleague and tell the client your colleague has expertise in the area of low self-esteem		
Continue treating the client and in the meantime seek your own clinical supervision to address these feelings		

As a psychologist you have seen numerous cases including adults, children and families. You are in the process of expanding your practice and get a referral for couples therapy for a homosexual couple, which is outside your area of practice.		
	What would you do?	**What would be the worst thing to do?**
Take the referral as you have completed a recent workshop on couples therapy.		
Take the referral and ask your colleague how they conduct couples therapy		
Take the referral and hope that it is similar to family therapy		
You decide not to take the referral and refer them on to your colleague who has expertise in the area.		

You have been working in the area of chronic illness for over 10 years and have been asked by a prominent radio station to provide commentary on the latest psychological treatment approaches to chronic illnesses. You have attended numerous workshops to update your knowledge and skills, however, you have never conducted research in this area.		
	What would you do?	**What would be the worst thing to do?**
Accept the invitation for the interview and plan to read recent journal articles to update your knowledge of treatment approaches		
Accept the invitation and inform the station of your knowledge and experience		
Decline the invitation and recommend your colleague who has done research in the area		
Decline the invitation		

Please choose ONE response for ***What would you do?*** and ONE response for ***What would be the worst thing to do?*** Do NOT choose the same response for each column

Your supervisee plans to submit their application to become a registered psychologist in the next week as they need to start working as soon as possible due to personal circumstances. They require 50 more clinical hours to meet the criteria and currently the service in which they are completing their placement has very few new referrals.		
	What would you do?	**What would be the worst thing to do?**
Sign for the additional hours knowing the supervisee is competent and has acquired the necessary knowledge		
Sign for the additional hours being uncertain whether the supervisee is competent		
Sign for the additional hours and ask your supervisee to create a formulation for a few of your clients that were not seen by your supervisee, as an alternative method to make up for these additional hours		
Ask your supervisee to delay submission of the application for a month to obtain the additional 50 hours		

You receive a new referral for a client with a long-standing history of anxiety. The GP has written that the client has financial limitations and will not be able to afford additional sessions out of pocket beyond the 10 sessions covered under Medicare. You suspect that treatment will take longer than 10 sessions.		
	What would you do?	**What would be the worst thing to do?**
Take on the referral and see how the client progresses after 10 sessions		
See the client for 10 sessions and then refer them to the community mental health team		
See the client for 10 sessions and then ask your new provisionally registered psychologist to see the client for no fee		
Decline the referral and inform the client's GP you cannot take on this case at the present time		
Inform the client of the fee charged at your clinic and the amount they would be out of pocket after the 10th session and allow them to make the decision		

Please choose ONE response for ***What would you do?*** and ONE response for ***What would be the worst thing to do?*** Do NOT choose the same response for each column.

You meet with one of your friends that you haven't seen in over 6 months. She has recently experienced significant life stressors including the loss of her job putting her under significant financial stress. You can see that she might lapse into a depressive episode and are greatly concerned about her. She recognises that she needs to see someone regarding her psychological health but is not willing to get help from a psychologist she does not know. She asks you whether you could provide therapy until she finds a new job.		
	What would you do?	**What would be the worst thing to do?**
Tell your friend that you can provide psychological therapy until she finds a new job as you are extremely concerned about her		
Say no, you cannot provide therapy, continue to provide support and recommend one of your colleagues		
Tell your friend that you can join her in therapy for the first few sessions until she becomes comfortable with the therapist.		
Turn your time with your friend into psychological therapy without explicitly letting your friend know		

You begin to notice that your colleague at work has been coming to work drowsy and has at times slurred their speech whilst speaking with you. As you walk out of the building you hear one of their client's complaining over the phone that their therapist fell asleep in their session.		
	What would you do?	**What would be the worst thing to do?**
As soon as you go home contact AHPRA regarding the behaviours of your colleague		
Don't do anything as you barely know them and you believe that your colleague has been having a bad year		
Confront your colleague the next day and ask them to explain themselves		
Request a meeting with your colleague as soon as possible and in the meantime consult a senior colleague whom you trust on how best to approach this situation.		

You are at dinner with your friends and the topic of work comes up. You haven't had peer supervision and have had a difficult week.		
	What would you do?	**What would be the worst thing to do?**
Discuss your cases by referring to your clients by their first name but without disclosing their surname.		
Discuss your cases by referring to your clients by a pseudonym		
Discuss your cases by referring to your clients by their first and last initials		
Catch yourself and change the topic		

Please choose ONE response for ***What would you do?*** and ONE response for ***What would be the worst thing to do?*** Do NOT choose the same response for each column.

You have a client who is refugee in Australia and has a long-standing issue with trusting those in positions of power. The client is reluctant to disclose information to you as he feels you will misuse the information.		
	What would you do?	**What would be the worst thing to do?**
In order to build trust, disclose relatively public information such as where you have trained and worked		
In order to build trust, disclose personal information including information about your family, and your opinion on political issues relevant to the client		
Continue therapy as usual and do not self-disclose any information		
Continue therapy as usual and ensure you have a reasonable rationale every time you self-disclose		

You have been thinking of setting up a website advertising your psychological services along with resources for your clients. Your client of two years tells you that she has just finished a course in web design, is seeking to start a web design company and asks you whether you know anyone who is currently looking to design a website. You are extremely tempted by this prospect.		
	What would you do?	**What would be the worst thing to do?**
Tell her you are interested in setting up a website and you want to enter a business relationship with her; however, you can no longer treat her as a client and ask her to see another psychologist		
Continue therapy with her and use some of these sessions to understand how to set up your website to avoid entering a business relationship with her.		
Decline the offer and ask her if she is in contact with her peers who are also in the web design industry and ask for their contact details		
Decline the offer		

Please choose ONE response for ***What would you do?*** and ONE response for ***What would be the worst thing to do?*** Do NOT choose the same response for each column.

After your final session of the day you have to get to an important meeting in the city centre. During the session you realise that you do not have change to pay for parking and do not have time to get change. You do not want to be late for the meeting and are considering whether you should ask your client if they have change for a bank note.		
	What would you do?	**What would be the worst thing to do?**
Ask the client for coins and hope you have a bank note you can give your client in exchange		
Ask your client for coins and tell them you will pay them back next session		
Ask your client for coins and tell them you will deduct that amount from their session fee		
Do not ask your client for coins and hope that there is a store nearby where you can obtain change		

You are currently working with a 70-year old elderly male who presents with an acute stress reaction to a traumatic situation. He was recently an inpatient at a hospital recovering from dehydration. During one of your sessions, he reveals to you that the traumatic experience occurred at the hospital and that he felt physically violated. He does not want to disclose this information to anyone else in fear of what may occur afterwards.		
	What would you do?	**What would be the worst thing to do?**
Do nothing		
Encourage the client to report it to the hospital and/or police		
You break confidentiality and report it to the manager of the hospital		
You break confidentiality and inform the client's next of kin		

You are a psychologist working with children and adolescents in the community. One afternoon, a young adolescent male comes in for therapy regarding anxiety he is experiencing at school. He is turning 15 years old and does not want you to inform his parents as he is embarrassed.		
	What would you do?	**What would be the worst thing to do?**
He has demonstrated maturity and thus does not require the consent of his parents and so you take him on as your client		
Explain to him that you are obligated to inform his parents as he is considered a minor in the eyes of the law		
Although he has demonstrated maturity and thus does not require the consent of his parents you tell him that the most effective way to manage his anxiety is by engaging his immediate support network, which is his family		

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Please choose ONE response for ***What would you do?*** and ONE response for ***What would be the worst thing to do?*** Do NOT choose the same response for each column.

You have been treating a client with anxiety under the Better Access to Mental Health Care Initiative, who is currently homeless. In the session he mentions how it has been a particularly difficult time for him and asks whether he could borrow $25 from you to manage over the next week. He says that he will pay you back.		
	What would you do?	**What would be the worst thing to do?**
Politely decline and provide details of services that will allow his current financial needs to be met.		
Politely decline and provide him with information on a pawn shop he could obtain money from		
Lend your client the money and request that he pay you back within the next month		
Give your client the money and tell him that he does not have to pay it back		

Your workplace had a Christmas lunch during which they provided alcoholic beverages. You had a couple of glasses of wine and know from experience that it affects your ability to make judgements. You have a client scheduled at 3pm.		
	What would you do?	**What would be the worst thing to do?**
Go ahead with the session knowing that you will not fully recover from the effects of the alcohol before your session		
Have a phone consultation instead of an individual face-to-face session.		
Request that your colleague see this client for this one session		
Cancel the session and offer them an appointment for later that week		

You have recently been employed by a publicly well-known organisation in the country and are also seeing private clients one day a week. The organisation has permitted you to see private clients in your office whilst not working for the organisation.		
	What would you do?	**What would be the worst thing to do?**
Use your affiliation and status with the organisation to recruit new clients		
Include your new employment with the organisation on your private practice business card and use your business cards for marketing purposes		
Don't include your employment with the organisation on your private practice business card and use your business cards for marketing purposes		
Inform your new clients that your work with the organisation is independent of the work you do with your clients and continue to recruit new clients as you previously did		

1. Gender
   - ❑ Male
   - ❑ Female
2. Which sector do you mostly work in?
   - ❑ Public Organisation (e.g., NSW hospitals, NSW government)
   - ❑ Private Organisation (e.g., Private hospitals)
   - ❑ Non – Government / Not for Profit Organisation
   - ❑ University
   - ❑ Private Practice
3. How many years of experience do you have after becoming a registered psychologist?
   - ❑ 0 – 4 years
   - ❑ 5 – 9 years
   - ❑ 10 – 14 years
   - ❑ 15 – 19 years
   - ❑ 20 years +
4. Which area do you primarily practice in? (Please choose only ONE option)
   - ❑ Metropolitan
   - ❑ Rural
   - ❑ Remote
5. How many times a year to do you engage in peer or group supervision?
   - ❑ 0 – 3
   - ❑ 4 – 7
   - ❑ 8 – 11
   - ❑ 12 +
6. How many times a year do you engage in individual supervision
   - ❑ 0 – 3
   - ❑ 4 – 7
   - ❑ 8 – 11
   - ❑ 12 +
7. How many hours of clinical practice do you engage in over an average week?
   - ❑ 0 – 8 hours
   - ❑ 9 – 16 hours
   - ❑ 17 – 24 hours
   - ❑ 25 – 32 hours
   - ❑ 33 hours +
8. If on a given day you have had to deal with a complex case on a given day how easy is it for you to either debrief with a colleague or obtain supervision?
   - ❑ Very easy (e.g., I work within a team and have access to them during the day)
   - ❑ Somewhat easy
   - ❑ Somewhat difficulty
   - ❑ Very difficulty (e.g., I have to wait until my monthly peer group/ individual supervision)
9. Do you mostly work with:
   - ❑ Children and/ or adolescents
   - ❑ Families
   - ❑ Adults
   - ❑ Couples

- ❑ Organisations

10. Which type of therapy do you mostly use in your practice? (Please choose only ONE option)
    - ❑ Acceptance and Commitment Therapy
    - ❑ Cognitive Behavioural Therapy (including Mindfulness Based Cognitive Therapy)
    - ❑ Dialectical Behaviour Therapy
    - ❑ Family Therapy
    - ❑ Interpersonal Psychotherapy
    - ❑ Psychodynamic Psychotherapies
    - ❑ Humanistic Therapy
11. Which area do you mostly work in:
    - ❑ Anxiety Disorders
    - ❑ Bipolar and Related Disorders
    - ❑ Depressive Disorders
    - ❑ Disruptive, Impulse Control and Conduct Disorders (e.g., Oppositional Defiant Disorder, Conduct Disorder)
    - ❑ Dissociative Disorders (e.g., Dissociative Identity Disorder, Dissociative Amnesia)
    - ❑ Elimination Disorders (Enuresis, Encopresis)
    - ❑ Feeding and Eating Disorders (e.g., Pica, Anorexia Nervosa)
    - ❑ Gender Dysphoria
    - ❑ Medication Induced Movement Disorder and Other Adverse Effects of Medication (e.g., neuroleptic induced parkinsonism)
    - ❑ Neurocognitive Disorders (e.g., Delirium)
    - ❑ Neurodevelopmental Disorders (e.g., intellectual disability)
    - ❑ Obsessive Compulsive and Related Disorders
    - ❑ Paraphilic Disorders
    - ❑ Personality Disorders
    - ❑ Schizophrenia Spectrum and Other Psychotic Disorders
    - ❑ Sexual Dysfunctions
    - ❑ Sleep Disorders
    - ❑ Somatic Symptom and Related Disorders
    - ❑ Substance Related and Addictive Disorders
    - ❑ Trauma and Stressor Related Disorders
    - ❑ Other
12. Which type of registration do you currently hold with AHPRA? (If you hold more than one, choose the area in which you predominantly work in)
    - ❑ Registered Psychologist
    - ❑ Registered Psychologist (Completing Masters Program)
    - ❑ Registered Psychologist Completing Registrar Program)
    - ❑ Community Psychology
    - ❑ Clinical Neuropsychology
    - ❑ Clinical Psychology
    - ❑ Counselling Psychology
    - ❑ Educational and Developmental Psychology
    - ❑ Forensic Psychology

- ❑ Health Psychology
- ❑ Organizational Psychology
- ❑ Sport and Exercise Psychology