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AN EXPLORATION OF CLINICAL PSYCHOLOGISTS' ETHICAL SENSITIVITY

Section A:

Clinical psychologists' ethical decision-making: A review of the empirical literature

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Summary of Portfolio

The focus of the Major Research Project is clinical psychologists' ethical sensitivity.

Section A: A review of the empirical literature examining clinical psychologists' ethical decision-making. Variation was identified in judgements of ethicality, behaviours engaged in and what respondents believed they should and would actually do. Indicating decisions about ethical issues to be complex. The review also identified that within ethical decision-making, ethical sensitivity is a particular gap, as is the process of decision-making. The reviewed surveys relied heavily on vignettes and presenting lists of behaviours for respondents to rate the ethicality of and therefore the links with clinical practice are unclear.

Section B: A qualitative study that explored how potential ethical issues are identified by clinical psychologists. A grounded theory is presented of the process of ethical sensitivity, as described by twelve clinical psychologists during semi-structured interviews. The experience of discomfort is highlighted as key to noticing ethical issues. If attended to, an understanding can be reached of the situation threatening the clinical psychologists' values. The context is key to this process and can facilitate or hinder the process. The clinical implications are discussed with particular reference to service responsibilities. Limitations of this research are noted and areas for future research are identified.

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Section A: Clinical psychologists' ethical decision-making: A review of the empirical literature

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Abstract

It is a matter of public and professional interest that clinical psychologists behave ethically and professional codes provide general descriptions of expected behaviour. Therefore ethical behaviour necessitates that clinicians engage in ethical decision-making. This systematised review sought to identify what is known about clinical psychologists' ethical decision-making. A systematic search identified nineteen papers for review, which all detailed surveys. The reviewed empirical literature identified a particular gap in the area of ethical sensitivity (identifying ethical issues). Several surveys required participants to identify ethical issues but presented them with vignettes, rather than investigating their identification of ethical issues in their own clinical practice. With regards to judgement, the review identified wide variation in individual clinical psychologists' beliefs about what constitutes ethical behaviour and what they would do in practice. Some studies identified clinician factors of age, gender and professional orientation impacted ethical judgement. The literature identified that clinical psychologists are generally motivated to act ethically, with personal morals being a commonly cited rationale for decisions. However a significant proportion of participants believed they would in practice do less than they believed they should. Indicating that factors other than a judgement of the most ethical course of action are considered (e.g. practicalities). The preponderance of surveys in this topic area indicates a need for more in-depth methods to understand these complex ethical decision-making processes.

Key words: Ethical decision-making, ethical practice, clinical psychologists

Introduction

Definitions and guidelines

Society expects healthcare professionals to act ethically (Colnerud, 1997). In the UK this was brought into focus by the Mid Staffordshire enquiry (Francis, 2013).

The terms morals and ethics are used somewhat interchangeably, however they denote two distinct aspects of human thought and behaviour. In the Oxford English Dictionary (2015) ethics are described as related to decisions and actions. Whereas morals are linked with values; the underlying principles that inform ethical behaviour. This review will focus on the decisions and behaviour of clinical psychologists (CPs) so the term ethics will be used.

Many regulatory organisations for psychologists, including in the UK, promote ethical behaviour by publishing guidelines for members (Pettifor, 2004; British Psychological Society (BPS; 2009). The regulatory body for CPs in the UK, the Health and Care Professions Council (HCPC), details standards which are written in 'general terms' that should guide professionals' behaviour (HCPC, 2015, p.2).

Attempts to improve codes to guide decision-making include the Canadian Psychological Association code's ethical principles being arranged hierarchically to assist clinicians when principles conflict (CPA, 2017). The code also aims to educate clinicians to make decisions (Malloy, Hadjistavropoulos, Douaud & Smythe, 2002). The hierarchical code has been found to be more likely to provide a rationale for decisions, but whether this increases consistency in decision-making is unclear (Hadjistavropoulos, 2011; Williams et al., 2012).

As guidelines provide general rules (BPS, 2009, American Psychological Association (APA; 2003) it has been argued these cannot foresee every type of issue (Teo, 2015). Furthermore, organisational requirements for example in military (LoCicero et al., 2016) and

police settings (Zelig, 1988), sometimes appear to contradict ethical values or best practice (Knapp, Gottlieb, Berman & Handelsman, 2007). Therefore, as reference to guidelines may be insufficient to identify required action, CPs must to be able to make decisions about ethical issues (Barnett, Behnke, Rosenthal, & Koocher, 2007; Knapp et al., 2007).

Types of ethical issues encountered

The Critical Incident technique; when participants describe ethical situations they have encountered during the preceding year (Orme & Doerman, 2001; Pettifor & Sawchuk, 2006), and the Ethical Conflict Questionnaire (Morrison, Layton & Newman, 1982) have identified the issues most commonly reported as encountered by CPs and include confidentiality, multiple relationships, competence, organisational demands and avoiding harm (Orme & Doerman, 2001; Pettifor & Sawchuk, 2006; Morrison et al., 1982).

A Norwegian audit of data from a telephone ethics counselling service found in 121 phone calls received over two years, confidentiality was the most frequently discussed issue; followed by issues concerning respect, role conflicts, responsibility and handling of ethical dilemmas (Dalen, 2006).

Some respondents to surveys believed they had not encountered ethical situations (Slack & Wassenaar, 1999; Colnerud, 1997; Orme & Doerman, 2001). It has been suggested these CPs had encountered ethical challenges but had not identified them as such (Orme & Doerman, 2001).

Applying philosophical ideas to ethical decision-making theory

Walsh (2015) highlighted philosophical perspectives dominant within psychology's professional codes are: virtue ethics (moral character and personal integrity), deontology (principles that motivate an action), consequentialism (consequences of actions), relationality (ethic of care for relationships with others) and communitarianism (promoting community

values). These ideas have been used to illustrate different approaches individual professionals may take to decision-making. Rowson (2001, cited in Cross & Wood, 2015) draws on two of these philosophical ideas. Namely, a consequentialist approach and a deontologist approach, as well as defining a pluralist approach (which seeks to find a balance between the former approaches). Cross and Wood (2015) concluded that psychologists must maintain a flexible pluralist approach to decision-making and balance the ethicality of both action and outcome.

Devlin and Magill (2006) identified wide agreement on the underlying principles to base ethical decision-making in healthcare on, namely: respect for individuals' autonomy, nonmaleficence (do no harm), beneficence (act to benefit others) and justice.

It has been argued that principle ethics as set out by Kitchener (1984, cited in Urofsky, Engels & Engebretson, 2009) which includes the moral principles of autonomy, beneficence, nonmaleficence, justice and fidelity when making ethical decisions (i.e. principles to determine action; referred to as deontological by Walsh, 2015) can be utilised in ethical decision-making even in complex situations (Urofsky et al., 2009). However, Kitchener's model did not explain how to prioritise the principles, so counsellors and psychologists must make these decisions themselves (Urofsky et al., 2009). A literature review identified that discussion of the principles in relation to the work of psychologists and counsellors, particularly in textbooks, has not resulted in the use of Kitchener's model in practice (Urofsky et al., 2009).

Hare (1991 cited in Cottone & Claus, 2000) based a theory of ethical decision-making on the premise that absolutism (considering rules and duties) and utilitarianism (obtaining the greatest good for the greatest number) are both drawn on in decision-making. Two levels of decision-making were specified, one termed intuitive (using intuitive values about how to respect clients' rights) and the other critical moral thinking (a higher order process to decide

how to prioritise the competing values generated by intuitive processes). This theory suggests a role for different types of thought, intuitive and more deliberate, and different guiding philosophical principles; absolutism and utilitarianism, but does not explain the process of decision-making (Cottone, 2001).

Whilst there have been several attempts at utilising general philosophical ideas in ethics theory to describe different approaches taken to ethical decision-making, it is currently unclear whether they would be supported by empirical investigation with regards to how professionals make ethical decisions and what values base would produce optimal ethical behaviour (Cottone & Claus, 2000; Rogerson, Gottlieb, Handelsman, Knapp & Younggren, 2011).

Ethical decision-making models

Decision-making models and practical advice have been published to assist with ethical decision-making, too many to review here (including Plante, 1999; Garcia, Cartwright, Winston & Borzuchowska, 2003; Johnson, 2008; Love, Costillo, Welsh & Scott, 2011). Rest's (1984, cited in Rest, 1994) model of ethical decision-making has been particularly influential (Cottone & Claus, 2000). It details four components of the person and process which are required for ethical behaviour: moral sensitivity (recognising ethical decisions to be made), moral judgement (making a morally correct decision), moral motivation (motivation to act ethically) and moral character (ability to complete the morally correct action; Rest, 1984, cited in Rest, 1994). All four components are determined as necessary to ensure ethical behaviour. This model has been criticised in assuming that individuals make ethical decisions in a rational manner, which has limited empirical support and ignores more intuitive modes of thought and decision-making (Betan, 1997; Sonenshein, 2007).

Betan (1997) suggested a model that in addition to the principles-oriented approach taken by Rest (1994) that a hermeneutic perspective (the process of interpretation) should be considered and focuses on the relational context of decision-making in therapy. Betan (1997) believed ethical principles termed universal, are socially constructed (through shared experience and within a specific cultural context). However, this model does not address how professionals are expected to think through the principles and contextual factors to reach a decision.

Another relational model of ethical decision-making was outlined by Cottone (2001), who suggested a socially constructivist approach and did outline a process to follow to make an ethical decision. The steps include obtaining information from those involved, assessing the nature of the relationships, consulting colleagues, negotiating when there is disagreement and responding in a way that reflects a reasonable level of agreement. This theoretical model was not investigated empirically, so it is unclear whether it reflects actual practice.

Additionally, despite models to guide decision-making and consensus regarding appropriate guiding principles, there is evidence of psychologists acting unethically (Fly, van Bark, Weinman, Kitchener & Lang, 1997; Zakrzewski, 2006; Phelan, 2007).

Purpose of this review

The theoretical literature focuses on the general perspective adopted when making ethical decisions or on contributory factors to decision-making. It is unclear how this theoretical literature relates to empirical findings. Ethical guidelines exist but do not always result in ethical behaviour. Ensuring ethical behaviour by CPs is vital for the profession and society, so it is important to ascertain what is known from the empirical literature about how CPs make ethical decisions, to support ethical decision-making in future.

This review will focus on CPs, not other applied psychologists because these represent diverse training routes and role expectations (BPS, 2011) and findings about counselling, educational, occupational, academic or other psychologists may not reflect the experiences of CPs.

Review questions

What is known about CP ethical decision-making from empirical research? Specifically:

1. What do CPs believe to be ethical behaviour?
2. What do CPs do when faced with ethical challenges?
3. Why do CPs not always act ethically?

Method

Type of review

The approach adopted was a systematised review with a systematic search (Grant & Booth, 2009). Whilst a thorough search of the literature was conducted and quality of papers appraised using a consistent framework, due to the nature of the project the review does not meet the full requirements of a systematic review, such as having two reviewers (Grant & Booth, 2009).

Search strategy

Initial broad scoping of the literature enabled the identification of key search terms (see Table 1). Clinical psychology/psychologist was utilised as a specific search phrase and combined with the other search terms using 'and', while all of the other search terms were combined using 'or'.

The electronic databases searched were Psych INFO, Web of Science (social sciences indices) and Google scholar. Following database searches, reference lists of relevant papers were hand searched. Figure 1 illustrates the search strategy using a PRISMA (2009) flow diagram. No cut-off date was set for the searches, to obtain an overview of the empirical literature to date, and the search was updated for the final time in December 2017.

Table 1

Search terms utilised in systematic search of the literature

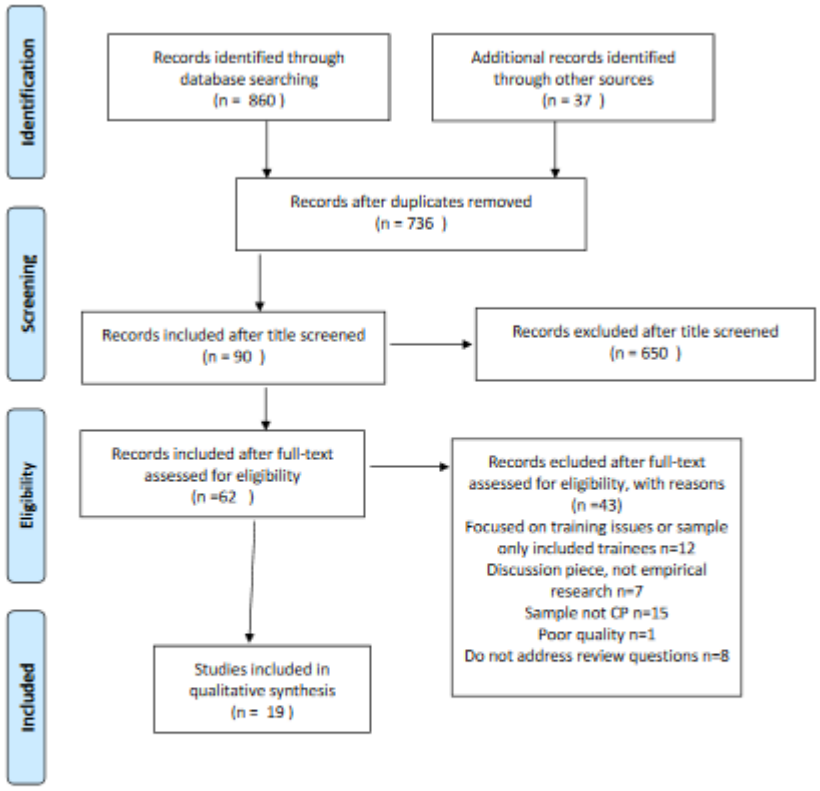
Ethics	Multiple relationships
Moral sensitivity	Dual relationships
Moral judgement	Confidentiality
Clinical psychology/gist	Boundaries

Papers were screened to apply the following criteria, beginning with title and abstract screening to determine relevance to this review, followed by full text review as needed.

Papers were included if they detailed empirical studies that focused on (1) qualified CPs ethical decision-making, or an aspect of it, (2) were peer reviewed and (3) published in English.

Studies were excluded if they: (1) comprised discussion or opinion pieces or were theoretical papers. (2) If the paper did not deal with an aspect of CPs' own ethical decision making (EDM). (3) The sample was referred to as 'psychologists', 'licensed psychologists', or only as 'members' of a particular psychological association as it is not known whether these samples included CPs. (4) Similarly, papers were excluded if they only examined training issues, as these deal with issues relating to trainee, rather than qualified, CPs.

Figure 1. PRISMA (2009) flow diagram to show literature search strategy



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

Quality appraisal

As all papers identified used survey method, a checklist to assess the quality of surveys developed by Burns and Kho (2015) was used (see appendix A). This tool was selected as it was recently developed, is specific to surveys and includes items about both research conduct and reporting. A strength of this tool is that particular attention is paid to questionnaire development and response rate (common areas of difficulty for survey research; Frary, 2002; Kelley, Clark, Brown & Sitzia, 2003). However, Burns and Kho (2015) acknowledge that they did not address ethical considerations but explained that completion and return of a questionnaire is usually assumed to convey consent to participate.

Although the table of issues to consider does not state sample representativeness, in the full article readers are prompted to consider this as part of the item regarding response rate.

Burns and Kho (2015) did not specify a scoring system for their checklist and when it has been used elsewhere (e.g. Anderson, Stephenson & Carter, 2017) scores for papers have not been generated. However for comparison of surveys overall scores of adherence to the good practice guidelines have been generated.

Review

Nineteen surveys were identified to review (see Table 2 for an overview). A general critique of the survey approach and an overview of the main strengths and limitations of the reviewed surveys will be outlined, before the study results are presented as follows:

- Section 1 will explore what CPs believe to be ethical behaviour
- Section 2 will examine what CPs do when faced with ethical challenges
- Section 3 will review what CPs believe they should and would do in response to ethical issues
- Section 4 will outline why CPs do not always behave ethically

Table 2

Summary of studies identified to review

	Country	Sample	Response rate	Demographics	Design, procedure and measures	Key relevant results
Tymchuk, Drapkin, Major-Kingsley, Ackerman, Coffman & Baum (1982)	USA	113 CPs	23%	56% eclectic 16% psychoanalytic 15% behavioural 7% humanistic 6% other	Cross-sectional survey design, administered by post, with items on ethics: training, attitudes and knowledge and clinical orientation. 12 vignettes presented and respondents asked if they agreed with decision made and what factors informed their judgement.	Stronger consensus about confidentiality, therapist- client relationship and client dangerousness to others. Weaker consensus about clients' rights to seek or refuse treatment and advertising/misrepresentation issues. Most popular factor perceived to be involved in decisions was clients' interests and least commonly selected was financial concerns for the psychologist.
Faustman (1982)	USA	164 CPs working in private practice	59.9%	Mean 14.89 years clinical practice 40.54% psychodynamic 33.1% eclectic 6.76% behavioural 5.4% Gestalt 4.1% rational emotive-cognitive 2.3% Rogerian 8.1% other	Cross-sectional survey design, administered by post. Comprised 18 items, including questions about debt collection practices. Four vignettes (3 re. fees and 1 re. client risk to mask focus of study) presented which participants rated ethicality of the described clinician behaviour.	41.9% varied fees depending on client income. 33.1% routinely informed clients of limits to confidentiality (66.9% did not). 60.8% had used a debt collection agency and 35.1% had used a lawyer. Re. vignette about a psychologist using debt collection agency as soon as therapy ended: 45.3% definitely ethical, only 2% definitely unethical. 38.5% unrelated to ethics. Re. vignette about using a lawyer and small claims court to retrieve unpaid fees: 57.4% definitely ethical, 2.7% definitely unethical, 26.4% unrelated to ethics. Re. vignette use of debt collection agency after client warned: 59.5% definitely ethical, 3.4% definitely unethical and 25.7% unrelated to ethics.
Bernard, Murphy & Little (1987)	USA	250 members of the Clinical division of the APA	50%	None presented	Cross-sectional survey design, administered by post. Questionnaire included two ethical vignettes, regarding another clinician in a sexual multiple relationship situation and another clinician's alcohol consumption impairing their clinical judgement.	To the sexual vignette 63% respondents they should and would do the same or slightly more than they should. 37% take less direct action than they should. To the alcoholism vignette 74% of respondents' should and would responses matched and 26% would do less. No significant demographic differences.
Borys & Pope (1989)	USA	2133 CPs, psychiatrists and social workers. CPs 42.4% of sample (n=904)	49%	52.4% female, 47.4% male Mean age 48.18 years. Mean experience 16.37 years. 58% psychodynamic 13.1% cognitive 8.3% other 7.9% behavioural 6.8% humanistic 2.4% eclectic 3.5% unstated	Cross-sectional survey design, administered by post. The measure used was the Therapeutic Practices Survey, which listed one off or sustained dual-relationship scenarios. Half the participants rated their beliefs about ethicality of listed behaviours. Half indicated frequency of own engagement in listed behaviours.	Over 50% respondents rated 5 behaviours as never ethical: sex with a current client (98.3%), selling a product to a client (70.8%), sex with a former client (68.4%), inviting clients to a personal social event (63.5%) and providing therapy to an employee (57.9%). Participants with at least 30 years of experience rated dual professional roles as more ethical than respondents with less than 10 years of experience. Female and psychodynamic clinicians viewed dual professional roles as less ethical than male clinicians and those working with other theoretical orientations. Men reported more social and professional dual relationships than women. Psychodynamic therapists reported fewer social, financial and professional dual relationships than other orientations. Humanistic therapists reported highest rates of dual professional relationships.
Wilkins, McGuire, Abbott and Blau (1990)	USA	199 members of the Society of Clinical Psychology, (within the APA)	34% (24.9% usable response rate)	75% male, 25% female. 44% worked privately. Means: age 46, experience 17.4.	Cross-sectional survey design, administered by post. Comprised four vignettes. Closed response options for what should and would do were presented.	No difference in return rates between different person-of-reference questionnaires. Personal closeness to actor in vignette was not found to be associated with should/would ratings. An association was found between restrictiveness of response with most restrictive response if actor is them, least if actor is acquaintance.

Smith, McGuire, Abbott & Blau (1991)	USA	102 mental health practitioners (25% doctoral level; 75% non-doctoral). Included CPs, social workers, counsellors and other MH workers	44%	63% female, 37% male Mean age 40.3 years Mean experience 10.6 years. 45% eclectic, 23% cognitive, 11% psychodynamic, 8% behavioural, 5% other.	Cross-sectional survey design, invited to participate via initial phone call, administered in person and by post. Comprised 10 vignettes (legal or non-legal issues). Eight rationales presented to choose from (two termed as codified: upholding the law; upholding ethical code and six termed as non-codified: intuition; personal moral values; financial need; fear of legal reprisal or reprisal by supervisor, colleague or client; protection of own reputation).	Rationales for should and would responses for legal vignettes were more often codified (more often linked with legal or ethical code instructions). For non-legal vignettes non-codified rationales (which related to feelings and own values) were chosen more frequently for would decisions and codified more often for should decisions. Non-codified rationales were chosen more often when people decided they would do less than they should (researchers deemed this an ethical violation). Indicates that a range of factors may influence ethical decision-making.
Gustafson, McNamara & Jensen (1992)	USA	206 CPs	28.4%	61% male, 39 female Mean age 43.5 years. Mean experience 14.5 years. 42.6% worked privately. 28.8% eclectic, 22% psychodynamic, 18.8% behavioural, 12% systems, 10.5% cognitive	A cross-sectional postal survey with closed and open-response items asked about their actions regarding informed consent. The aims were to identify which risks and benefits participants believed to be important and which were discussed with clients in the process of obtaining informed consent. The closed response items related to 17 proposed risks and benefits of child and family therapy, identified through a literature review. The open-response items asked participants to list additional factors pertinent to clients' decisions regarding whether to enter therapy.	All proposed benefits rated as moderately important to critical. All benefits of therapy were reported to be discussed frequently. A high level of variability in the importance ratings for risks of therapy items and how often participants discussed these with potential clients. The proposed risks rated with the highest importance and most frequently discussed were financial cost and limits to confidentiality. The risks rated as least important were stigma and labelling and respondents rarely initiated discussion of these topics with potential clients. A strong positive correlation was found between all ratings of importance and all estimates of frequency of discussing these with clients. To the open-response items participants most frequently cited the limits of confidentiality, in relation to child and family therapy specifically. Also reported were the issues of client commitment and expectations regarding length of therapy. No differences in which topics were reported to be discussed with clients were found in relation to demographic variables.
Zadik (1993)	Israel	20 CPs, 20 psychiatrists, 20 social workers	Not reported	19 male, 41 women Age range 30-50 years	Cross-sectional survey design, administered in person. Participants presented with seven vignettes that detailed serious risk to others and clinicians were asked if they would maintain confidentiality or share information.	No differences were found in decision-making about breaking confidentiality between the different professionals or between private and public workplaces. Lots of variation between individual participants within all the professional groups.
Gardner & Marzillier (1996)	UK	86 Qualified CPs (49%) 91 Trainee CPs (51%)	77% qualified 76% trainee	Qualified CP 68% women, 32% men; 13% under 30, 40% over 41 Trainee CP 75% women, 25% men; 76% 30 or under	Cross-sectional survey design, administered by post to qualified CPs and by course administrators to trainee CPs. Participants were asked about beliefs and everyday clinical practice regarding confidentiality. 11 items describing behaviours. Rated both ethical acceptability and how frequently they engaged in the behaviour.	70% of qualified CP (and 66% trainee CP) stated they rarely or sometimes disclosed confidential information unintentionally. A small number of CP discussed clients without using their name, a smaller number used clients' names in discussion with their partner or friends. Some also took client files home or left them unattended in an insecure office, with a smaller proportion leaving them unattended in their car. CP rated the ethicality of all these behaviours as lower than they rated their frequency of engaging in them.
Garrett & Davis (1998)	UK	581 CPs (DCP members)	58.8%	61.7% female, 38.3% male. Mean age 39 yrs. 90% worked for NHS, 4% in private practice, 6% in training	Cross-sectional survey design, administered by post. Questionnaire comprised of items about clinical experience, use of physical contact with clients, sexual attraction to clients, sexual contact with clients and knowledge of	83.6% male psychologists and 47.6% of female psychologists reported sexual attraction towards a client. Just over 10% who experienced sexual attraction to clients expressed concern about it. 3.5% reported sexual contact with clients either during or after therapy. Almost a quarter had worked with clients who had been sexually involved with previous

				Mean qualified experience 11 yrs. 57% cognitive or behavioural, 18.6% psychodynamic, 10.9% systemic, 8.5% humanistic. But 74.4% integrative.	clients having had sexual contact with other psychologists. Expected to define sexual contact themselves.	therapists. Almost two fifths had become aware (through sources other than clients) of other CPs who had sexual contact with clients. Three variables correlated with sexual contact with clients: homosexual orientation, sexual involvement with course tutors during clinical training and longer period since qualifying. 12 had sexual contact with previous clients, 6 with current clients and 1 with both discharged and current clients. 17 reported having previously disclosed this to: colleagues (13), friends or partners (12), own therapist (4), managers (5) and supervisors (3). Three had married or moved in with the client/partner.
Garrett (1999)	UK	581 CPs (DCP members)	58.8%	As above (same data as Garrett & Davis, 1998).	Cross-sectional survey design, administered by post. This paper presents the qualitative data from open ended items included in the survey described by Garrett & Davis (1998)	Content analysis identification participants' perceived reasons for not pursuing sexual contact with clients. Ethical reasons were most common (690 out of a total of 999 responses), with 264 (26%) responses citing professional values/ethics and 175 (18%) personal values/ethics. 47 respondents gave their only reason as they did not want to engage in sexual relations with a client. Others included fear of negative professional consequences (35 reasons), fear of negative personal consequences (69 reasons) and lack of opportunity (18 reasons). Regarding not acting to prevent another CP having sexual contact with a client, most common perceived reason was action had already been taken (86 reasons of 179), other reasons included it being only hearsay (37 reasons), did not believe it was their responsibility to act (31 reasons), it was not current (24 reasons), it is not harmful to the patient (6) and believed the psychologist would not do it again (7).
Yarhouse & DeVries (2000)	USA	156 CPs and Counselling Psychologists (48.8% CPs, n= 76)	53% (39% usable response rate)	35.9% female, 64.1% male. Mean age 50.5 years. 32.5% worked privately, 28.5% in university, 14.6% in hospitals, 5.9% clinics, 1.9% community centres, 16% other. 38.7% eclectic, 25% cognitive, 12.2% psychodynamic, 1.9% systemic, 1.9% feminist, 1.9% behavioural, 17.9% other.	Cross-sectional survey design, administered by post. The questionnaire listed 50 behaviours and asked to what extent clinicians engage in them and how ethical they believe them to be, both on a 5-point scale.	Most commonly occurring behaviours included giving information to clients about the service, having knowledge of relevant legislation about abuse of older adults, getting clients to provide written consent, informing clients of right to withdraw from treatment and discussing issues of death, dying and loss. Least commonly reported behaviours included discussing a client by name with friends, not explaining fee structure and giving information to another adult without client's written consent. Demographics linked with higher ethical behaviour scores were having completed coursework relating to aging, specialising in working with older adults and work with older adults being 20% or more of overall workload. Demographics associated with higher ethical belief scores were gender, specialising in working with older adults and training in systemic approaches. The most helpful sources of information to identify and respond to ethical issues were perceived to be: their own religious or spiritual beliefs (57% rated as a good or excellent), colleagues (54% good or excellent), work experience (45%), CPD training sessions or workshops (43%) and published papers (35%). The least helpful sources of information were believed to be graduate training courses (49% rated as poor or terrible), licensing boards (37% rated as poor or terrible), pre-training internships (37%), ethics committees (31%) and laws (30%).
Schenck, Lyman & Bodin (2000)	USA	237 members of APA sections: Clinical Psychology; Child, Youth & Family Services, Clinical Child Psychology.	40% (33% usable)	51% female, 49% male. 2% age 20-29; 30% age 30-39, 37% age 40-49, 21% 50-59, 10% >60 15% cognitive, 40% eclectic, 17% behavioural, 11% systemic, 14% psychodynamic, 3% other. 46% private practice, 7% community MH centre,	Cross-sectional survey design, administered by post. Questionnaire about corporal punishment of children (specifically spanking). Items about current research, own family background, attitudes towards it and ethical beliefs about recommending it, beliefs about colleagues' behaviour, views on the usefulness of potential APA guidelines	70% respondents would never suggest parents use spanking. 30% would recommend it rarely or sometimes. 33% reported recommending it is definitely not ethical. 52% believe it's ethical under rare circumstances and 6% that it is ethical under many circumstances or definitely ethical. 9% did not know if it is ethical. Participants less likely to recommend it with parents with a history of suspected or known child abuse, or whose children had been abused by others. An association was found between those who believed research shows negative outcomes of corporal punishment and them being less likely to recommend it. Only significant correlation between demographics and likelihood of recommending this approach was those younger than 40 were less likely to have used it with their own

		(84% CPs general or child CPs; n=199).		19% hospitals, 11% academic, 3% school.	and concerns about professional liability. Rated on a 5-point scale.	children. Another link was found between those who had used this approach with their own children and them being more likely to recommend it to clients.
Buckloh & Roberts (2001)	USA	252 child and pediatric CPs	31.5%	52.6% female, 47.4% male. Mean age 44.66 years. Median qualified experience 11-15 years. 40.4% worked in a hospital, 42% in private practice, 21.2% various community settings, 2.4% MH hospital, 12.4% other. 93% treated clients under managed care insurance.	Cross-sectional survey design, administered by post. 24 items about attitudes towards managed care and three vignettes about related ethical challenges. Participants were asked what they should and would do and their reasons for responses (responses and rationales chosen from provided options).	Differences were found between what respondents believed they should and would do, and what they actually did. Participants' responses were most consistent for the confidentiality vignette in terms of what they should, would and actually did in similar situations; indicates ethical willingness regarding confidentiality. A large proportion of participants wanted to let the client decide what to do (67.3% should, 69.2% would, 64.3% had). Responses varied more to vignettes about restriction of services due to clients' inability to pay and whether they should provide an incorrect diagnosis for the client to receive a service. About a quarter reported having given an incorrect diagnosis in their clinical work. Consistency between should and did responses was lower across vignettes than consistency between should and would responses and would and actually did responses. I.e. largest difference between what they believed the ideal response to be and what they have actually done in practice.
Lamb, Catanzaro & Moorman (2004)	USA	298 respondents (52% CP, n=155 and 46% counselling psychologists, n=137, 2% not stated, n=6).	31%	57% female, 42% male. 95% Caucasian. Mean experience 16.23 years. 60% in private practice, 9% university counsellors, 8% academics, 23% various settings.	Cross-sectional survey design, administered by post. Asked about sexual relationships with clients, students and supervisee. 7 non-sexual multiple relationships listed and asked which they had needed to discuss with clients/students/supervisee. Asked how they have recognised possible sexual relationships and why they did not act (selected from 11 possible reasons).	Professional, collegial and supervisory new relationships were discussed more often with supervisees. Social, business and religious affiliation relationships were discussed most frequently with clients. Discussions more common to have to discuss new relationships with previous clients/supervisees/students than current ones. Most common relationships discussed with current clients were social and religious affiliation. Regarding sexual multiple relationships and the actions taken, only 2 options selected frequently by participants. These were: that they thought about initiating something but did not act (45%), the other person initiated a potential sexual relationship but the respondent was not interested (39%). Most frequent perceived reason for not acting was their own ethics/values/morals (89% with clients, 47% supervisees, 39% students). Other rationales selected by at least 50% of respondents were that clients are always a client, it being prohibited and the power differential between them.
Kitson & Sperlinger (2007)	UK	424 members of the Division of Clinical Psychology, within the BPS	43.4% (42.4% usable)	69.1% female; 30.9% male. Mean age 42.99 years. Mean experience 13.95 years. 41.3% cognitive-behavioural orientation, 40.1% integrative, 8% systemic and 6.8% psychodynamic. 87.9% in NHS and 3.5% worked independently.	Cross-sectional survey design, administered by post. Participants rated appropriateness of various actions in vignettes on a five-point Likert scale. Also 38 items on attitudes towards navigating dual relationships, 13 about training and supervision and 16 about work experience. Reliability was checked by 16 CP repeating the questionnaire a few weeks later.	Dual relationships were overall rated as appropriate in only limited circumstances. Most consensus about sexual relationships with clients or colleagues being inappropriate. Those who view dual relationships as inappropriate were more likely to be: female, young, more recently qualified, have more supervision, work psychodynamically, experienced personal therapy, work in an urban setting and not live in same area as they work in. Years of experience was linked with the largest variation in attitude scores. Replies about whether respondents discuss out of therapy contact and how to manage it: 33.7% never, 40% rarely, 19.6% sometimes, 4.1% often, 2.6% always. 88% reported receiving a moderate amount or less of teaching on ethics during training (84.8% moderate or less post-training) and 59.7% that this was inadequate (49.4% inadequate post-training).
Taylor, McMinn, Bufford & Chang (2010)	USA	695 trainee and qualified CPs (9% qualified CPs, n= 63, 91% psychology	67% completi on rate of those who	84% female, 16% male. Mean age 29 years. 81% European American, 4% Latino American, 4% African American, 2% Asian American, 2%	Cross-sectional survey design, invited to participate via email and administered online. 14 questions about online behaviour, beliefs about ethicality of their actions, social networking use, use of privacy settings, if the APA should publish	77% had a page on a social networking site and 85% of them used the privacy settings to protect their information. Younger participants significantly more likely to use social networking than older respondents. The most common online behaviours were rejecting or ignoring attempted contact online from a client and then posting photos or videos online. Least likely to discuss online activities with clients.

		graduate students, n= 632)	viewed website	multiracial, 1% Native American, 5% other, 1% not reported.	ethical guidelines relating to social networking sites and if they had considered ethics and safety (9 rated on five-point Likert scales). One open-ended question asking for a description of a challenging or interesting interaction with a client about their online behaviour.	Over half (n=407) had thought about the impact of using social networking sites on their work somewhat or quite a lot. Only 56 had not considered the impact. No clear agreement on whether the APA should publish guidelines, with a slight increase in younger respondents believing they should compared to older respondents. 100 individuals described a challenging or interesting client interaction about online behaviour. Common themes included finding out that they had mutual friends, finding clients on dating sites, blogs about suicidal or homicidal thoughts and clients requesting email contact because they do not have a phone.
Politis & Knowles (2013)	Australia	237 psychologists (31% CP, n=73)	Not possible to calculate	84.4% female, 15.6% male Mean age 46 years 63% registered as generalist psychologists, 31% clinical psychologists, 6% not registered with Medicare. 53% in private practice, 33% private practice and another setting, 12% non-private practice, 1% academics.	Cross-sectional survey design, invited to participate via email and administered online. Online survey with 6 vignettes describing ethical dilemmas related to Medicare funding. Selected from a range of options about what they would and should do and their reasons for why they would do what they selected.	There was more consensus for vignettes about reporting, psychologists' competence and record keeping. A broader range of responses were gathered for vignettes about client preferred treatment, best treatment and accurate diagnosis. Ethical willingness (match between each individuals would and should answers) varied between vignettes, from 45% about diagnosis to 83% regarding record keeping and noting they had done work not funded by Medicare. Ethical willingness was higher (i.e. what they said they would do better matched what they said they should do) when the dilemma was clearly related to the ethics code. Five factors that were given as reasons for their decisions of what they would do were: following the APS code, legality, Medicare rules, best interests of client and best practice. Other factors were the psychologists' competence, client choice, inter-professional communication, doing what is right and considering everyone's needs.
Ferencz-Kaddari, Shifman & Koslowsky (2016)	Israel	395 CP	At lectures 37% Overall unknown as online as well	Relationship dilemma respondents 81.9% female, 18.1% male. Mean age 42.6 years. Money dilemma respondents 80.5% female, 19.5% male. Mean age 43.1 years. (Population demographics: Israeli Health Ministry psychologists 73% female, mean age 42 years)	Given either a vignette about a dual relationship dilemma (226 completed this) or a financial dilemma (169 completed this). Adapted a scale from Azjen (1971) and constructed items on the psychologist continuing treatment, items also covered: intention, attitudes towards treating client, subjective norm, perceived behavioural control, and moral/professional commitment to treat.	Attitudes were perceived to be the most important predictor for intended behaviour in both dilemmas (with the more positive the attitudes are towards treating the client, the stronger the intention to do so was). Strong positive correlations were found between psychologists' behavioural intention and attitude, subjective norm and perceived behavioural control. The results overall supported that the theory of planned behaviour applies to psychologists' behavioural intentions (i.e. what they decide to do) in ethical situations. It was also concluded that by considering morality or professional commitment the model's prediction accuracy increased.

MH = mental health

Critique

All identified papers reported cross-sectional surveys, which provide a topic overview at a particular time. A strength of this approach is the potential for high numbers of participants. Limitations of surveys include that they are unable to obtain detailed or in-depth information and cross-sectional surveys cannot ascertain causation between factors because they are not longitudinal (Kelley et al., 2003). Seven surveys supplemented closed-response items with open-response items which increased the richness of some of the findings (Tymchuk, Drapkin, Major-Kingsley, Ackerman, Coffman & Baum, 1982; Wilkins, McGuire, Abbott & Blau, 1990; Gustafson, McNamara & Jensen, 1992; Gardner & Marzillier, 1996; Garrett, 1999; Taylor, McMinn, Bufford & Chang, 2010; Politis & Knowles, 2013).

As only some people choose to respond to survey invitations, responders may represent a subset of the group investigated. This could reduce generalisability of findings (Kelley et al., 2003). Garrett (1999) highlighted that some respondents who indicated relevant experiences within other parts of the survey did not complete the open-ended questions. The other surveys did not examine non-response bias or features of non-responders. Conversely, rates of unethical behaviour may have been artificially inflated if mostly those who had experienced relevant incidents responded and not those who had experienced ethical behaviour (Kitson & Sperlinger, 2007).

Table 3 provides detailed information on the strengths and limitations of reviewed studies. In summary, much of the reviewed literature specified the aims and population of interest. Only seven studies achieved the arguably acceptable response rate of over 56% (Cook, Dickinson & Eccles, 2009). This may be due to researchers generally not having employed strategies to improve response rates. Ethical behaviour is a sensitive topic to

research due to potential misconduct implications (Sieber & Stanley, 1988 cited in Lee & Renzetti, 1990). Therefore, findings may have been impacted by social desirability bias (Borys & Pope, 1989; Van de Mortel, 2008) and may explain why response rates were frequently low. However, most studies that provided detailed demographic information showed the samples were broadly comparable to targeted populations.

Fifteen papers provided questionnaire formatting information, which would help with replication but only three were piloted. Information about questionnaire design and item generation was generally limited. Whilst most (n=16) papers reported results and analytical methods clearly, many did not address how they dealt with missing data.

As all reviewed studies used survey method, they are therefore susceptible to the same limitations. This is a weakness of the research conducted to date on CPs' ethical decision-making. Overall the quality evaluation found that the following papers were of particularly poor quality: Zadik (1993); Smith, McGuire, Abbott and Blau (1991) and Faustman (1982) and these results should be interpreted with caution. The studies that were comparatively good quality were: Kitson and Sperlinger (2007); Buckloh and Roberts (2001); Yarhouse and DeVries (2000).

What was identified via these surveys will now be described. When the strengths or limitations of reviewed studies vary from this overview critique it will be highlighted alongside presentation of the relevant findings.

Table 3

Quality appraisal using Burns & Kho (2015)

		Schenck, Lyman & Bodin (2000)	Yarhouse & DeVries (2000)	Gustafson, McNamara & Jensen (1992)	Gardner & Marzillier (1996)	Tymchuk, Drapkin, Major-Kingsley, Ackerman, Coffman & Baum (1982)
1. Clear research question?	1a. Does the research question specify the type of respondents, topic of interest and primary and secondary research questions?	Yes	Yes	Yes	Yes	Yes
2. Target population defined and sample representative?	2a. Target population specified?	Yes	Yes	Yes	Yes	Yes
	2b. Sampling frame specified?	Yes	Yes	Yes	Yes	Yes
3. Systematic approach to questionnaire development?	3a. Was it reported how items generated and reduced?	No	Yes	Partially	Partially	Partially
	3b. Was questionnaire formatting specified?	Yes	Yes	Yes	Yes	Partially
	3c. Were individual questions pretested?	No	Yes (in previous surveys)	No	No	Yes
4. Was the questionnaire tested?	4a. Was the entire questionnaire pilot tested?	No	No	No	No	Partially (vignettes)
	4b. Were any clinometric properties (face validity or clinical sensibility testing, content validity, inter- or intra-rater reliability) evaluated and reported?	No	Yes (scale reliability)	No	No	No
5. Were questionnaires administered in a manner that limited both response and nonresponse bias?	5a. Was the method of questionnaire administration appropriate for the research objective or question posed?	Yes	Yes	Yes	Yes	Yes
	5b. Were additional details regarding prenotification, use of a cover letter and an incentive for questionnaire completion provided?	Yes	Yes	No	Yes	No
6. Was the response rate reported, and were strategies used to optimize the response rate?	6a. Was the response rate reported (alternatively, were techniques used to assess nonresponse bias)?	Yes	Yes	Yes	Yes	Yes
	6b. Was the response rate defined?	No	No	No	Yes	No
	6c. Were strategies used to enhance the response rate (including sending of reminders)?	Yes	Yes	Yes	Yes	No
	6d. Was the sample size justified?	No	No	Yes	Yes	No
7. Were the results clearly and transparently reported?	7a. Does the survey report address the research question(s) posed or the survey objectives?	Yes	Yes	Yes	Yes	Yes
	7b. Were methods for handling missing data reported?	No	Yes	No	No	No
	7c. Were demographic data of the survey respondents provided?	Yes	Yes	Yes	Yes	Partially (theoretical orientation)
	7d. Were the analytical methods clear?	Yes	Yes	Yes	Partially	Partially
	7e. Were the results succinctly summarized?	Yes	Yes	Yes	Yes	Yes
	7f. Did the authors' interpretation of the results align with the data presented?	Yes	Partially	Yes	Yes	Partially
	7g. Were the implications of the results stated?	Yes	Yes	Yes	Yes	Yes

	7h. Was the questionnaire provided in its entirety (electronically or in print)?	Partially (full wording)	No	No	No		Partially (vignette full wording)	
Score	Scoring yes=2 partially =1 no=0	29	35	29	32		25	

		Faustman (1982)	Buckloh & Roberts (2001)	Taylor, McMinn, Bufford & Chang (2010)	Smith, McGuire, Abbott & Blau (1991)	Bernard, Murphy & Little (1987)	Kitson & Sperlinger (2007)	Borys & Pope (1989)
1. Clear research question?	1a. Does the research question specify the type of respondents, topic of interest and primary and secondary research questions?	Partially (no secondary)	Yes	Yes	Yes	Partially	Yes	No
2. Target population defined and sample representative?	2a. Target population specified?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2b. Sampling frame specified?	Partially (private practice)	Yes	Yes	Yes	Yes	Yes	Yes
3. Systematic approach to questionnaire development?	3a. Was it reported how items generated and reduced?	No	Partially	Partially	Partially (not rationale options)	No	Yes	Partially (not reduced)
	3b. Was questionnaire formatting specified?	No	Yes	Yes	No	Yes	Yes	Yes
	3c. Were individual questions pretested?	No	Yes	No	No	No	No	No
4. Was the questionnaire tested?	4a. Was the entire questionnaire pilot tested?	No	Yes	No	No (but vignettes used before)	No (but replication of earlier study)	Yes (in previous study)	No
	4b. Were any clinometric properties (face validity or clinical sensibility testing, content validity, inter- or intra-rater reliability) evaluated and reported?	No	Yes (vignette external validity)	No	No	No	Yes (test-retest reliability)	Yes (social desirability bias – none found)
5. Were questionnaires administered in a manner that limited both response and nonresponse bias?	5a. Was the method of questionnaire administration appropriate for the research objective or question posed?	Yes	Yes	Yes	Partially (some returned questionnaires in person; no mention of anonymity)	Yes	Yes	Yes
	5b. Were additional details regarding prenotification, use of a cover letter and an incentive for questionnaire completion provided?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6. Was the response rate reported, and were strategies used to optimize the response rate?	6a. Was the response rate reported (alternatively, were techniques used to assess nonresponse bias)?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	6b. Was the response rate defined?	No	No	Yes	No	No	Yes	No
	6c. Were strategies used to enhance the response rate (including sending of reminders)?	No	Partially (no reminder)	No	No	Yes (anonymity)	Yes (anonymity)	Yes (anonymity)
	6d. Was the sample size justified?	No	Yes	No	No	Yes	Yes	No
7. Were the results clearly and transparently reported?	7a. Does the survey report address the research question(s) posed or the survey objectives?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	7b. Were methods for handling missing data reported?	Yes (Qs excluded)	No	No	No	No	No	Yes
	7c. Were demographic data of the survey respondents provided?	Partially (not gender)	Yes	Yes	Yes	No	Yes	Yes
	7d. Were the analytical methods clear?	Yes	Yes	Yes	Partially	Yes	Yes	Yes
	7e. Were the results succinctly summarized?	Yes	Yes	Yes	Partially	Yes	Yes	Yes
	7f. Did the authors' interpretation of the results align with the data presented?	Yes	Yes	Yes	Yes	Yes	Yes	Partially
	7g. Were the implications of the results stated?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	7h. Was the questionnaire provided in its entirety (electronically or in print)?	No	Partially (vignette part)	No	No but readers invited to request it	No	No	No
Score	Scoring yes=2 partially =1 no=0	23	37	29	22	27	38	30

		Garrett (1999)	Wilkins, McGuire, Abbott & Blau (1990)	Zadik (1993)	Ferencz-Kaddari, Shifman & Koslowsky (2016)	Lamb, Catanzaro & Moorman (2004)	Garrett & Davis (1998)	Politis & Knowles (2013)
1. Clear research question?	1a. Does the research question specify the type of respondents, topic of interest and primary and secondary research questions?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Target population defined and sample representative?	2a. Target population specified?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2b. Sampling frame specified?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Systematic approach to questionnaire development?	3a. Was it reported how items generated and reduced?	Partially	Yes	No	Yes	Partially	Partially (not reduced)	Partially (vignettes)
	3b. Was questionnaire formatting specified?	Yes	Yes	Yes	Yes	Yes	No	No
	3c. Were individual questions pretested?	No	No	No	Yes	No	No	No
4. Was the questionnaire tested?	4a. Was the entire questionnaire pilot tested?	No	No (replication of study; some items new)	No	Yes	No	No	No
	4b. Were any clinometric properties (face validity or clinical sensibility testing, content validity, inter- or intra-rater reliability) evaluated and reported?	Yes (Intra and inter-rater reliability)	No	No	Yes (face validity)	No	No	No
5. Were questionnaires administered in a manner that limited both response and nonresponse bias?	5a. Was the method of questionnaire administration appropriate for the research objective or question posed?	Yes	Yes	Partially	Yes	Yes	Yes	Yes
	5b. Were additional details regarding prenotification, use of a cover letter and an incentive for questionnaire completion provided?	Yes	Yes	No	No	Yes	Yes	Partially
6. Was the response rate reported, and were strategies used to optimize the response rate?	6a. Was the response rate reported (alternatively, were techniques used to assess nonresponse bias)?	Yes	Yes	No	Partially (conference recruitment not online)	Yes	Yes	No. Not possible to calculate
	6b. Was the response rate defined?	No	No	No	No	No	No	No
	6c. Were strategies used to enhance the response rate (including sending of reminders)?	No	Yes	No	No	Yes (anonymity)	Yes (anonymity)	No
	6d. Was the sample size justified?	No	Yes	No	Yes	Yes	Partially (not age)	Yes
7. Were the results clearly and transparently reported?	7a. Does the survey report address the research question(s) posed or the survey objectives?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	7b. Were methods for handling missing data reported?	No	Yes (Qs excluded)	No	No	No	No	Partially
	7c. Were demographic data of the survey respondents provided?	Yes	Yes	No	Yes	Yes	Yes	Yes
	7d. Were the analytical methods clear?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	7e. Were the results succinctly summarized?	Partially	Yes	Yes	Yes	Yes	Partially	Yes
	7f. Did the authors' interpretation of the results align with the data presented?	Yes	Yes	No	Yes	Yes	Yes	Yes
	7g. Were the implications of the results stated?	Yes	Partially	No	Yes	Yes	Yes	Yes
	7h. Was the questionnaire provided in its entirety (electronically or in print)?	No	No	Yes	No	No	No	Partially (vignette wording)
Score	Scoring yes=2 partially =1 no=0 total (percentage %)	28	33	17	33	31	27	26

Q – Questionnaires

Section 1. What do CPs believe to be ethical behaviour?

This section explores what CPs believe to be ethical behaviour, as identified by the reviewed surveys.

Tymchuk et al. (1982) investigated consensus between 113 CPs regarding their judgement of the ethicality of behaviours described in 12 vignettes. Strongest consensus was found for vignettes that described issues of maintaining confidentiality, the client-therapist relationship and disclosure of risk to others. It was concluded that CPs can easily recognise the appropriate action in these situations. It should be noted that the response rate for this survey was particularly low at 23% and, as theoretical orientation was the only demographic information presented it is not possible to determine the representativeness of the sample.

The views of 156 CPs regarding working with older adults in the US were gathered by Yarhouse and DeVries (2000) (reported behaviour is discussed in section 2a). Participants rated the ethicality of 50 behaviours on a 5-point scale. The behaviours CPs most commonly believed to be ethical were obtaining consent and the duty to share information. The behaviours that the largest proportion of CPs believed to be unethical, were discussing a client by name with friends and completing a neuropsychological assessment without specialist training. The clinician factors associated with more conservative ethical beliefs were being female, specialising in older adult work and having received systemic training. The pre-testing of questions and consideration of scale reliability were particular strengths of this survey.

Participants also rated the ethicality of three vignettes about debt collection; presented in Table 4 (Faustman, 1982). Startlingly most participants viewed the actions as ethical or unrelated to ethics which the authors highlight as incorrect, against APA guidelines and indicating poor awareness of legal and ethical issues (Faustman, 1982). It may be that there

would now be greater awareness amongst CPs about the ethical considerations with these decisions, so it would benefit from replication.

Table 4

Ethicality ratings of debt collection strategies (Faustman, 1982)

Vignettes	Unrelated to ethics	definitely unethical	somewhat unethical	somewhat ethical	definitely ethical
Using debt collection agency immediately after therapy ended	38.5%	2%	8.8%	5.4%	45.3%
Using a lawyer and the small claims court	26.4%	2.7%	7.4%	6.1%	57.4%
Use of debt collection agency after the psychologist warned the client	25.7%	3.4%	8.8%	2.7%	59.5%

Beliefs regarding confidentiality were explored in a survey of 86 qualified and 91 trainee UK CPs (alongside practice, discussed in section 2a) (Gardner & Marzillier, 1996).

Participants rated the ethicality of 11 confidentiality related behaviours. Participants rated discussing clients with names as the least ethical behaviour. More lenient ethicality scores were given for discussing clients with partners (compared with friends or in public) and taking files home (rather than leaving them in a car or unlocked office). It was concluded that CPs believe these behaviours are appropriate under some circumstances. However, in which situations this would be justifiable was not explored. Another limitation of the detail the findings can be reviewed in, is that mean belief scores were presented only in graphs, without the figures to refer to.

Schenk, Lyman and Bodin, (2000) investigated 199 US CPs' beliefs about the ethicality of recommending parents use spanking to discipline children (frequency of recommending this is discussed in section 2a). Thirty three per cent believed it is definitely not ethical, 52% that it is ethical on rare occasions and 6% that it is definitely or under many circumstances ethical. The authors argued corporal punishment for children is unethical and that it is worrying that over half the participants believed it to be an ethical recommendation at least rarely. These results highlight a range of attitudes held by CPs in relation to a currently controversial approach to parenting.

Borys and Pope (1989) investigated the attitudes of 904 US CPs (alongside psychiatrists and social workers), and Kitson and Sperlinger (2007) explored attitudes of 424 British CPs, towards multiple relationships. Although it is not possible to separate the CPs' data from the psychiatrists' and social workers' data also gathered by Borys and Pope (1982), the similarities with Kitson and Sperlinger's (2007) results indicate the results are likely to be relevant to CPs. Multiple relationships are defined as occurring when a psychologist in a professional relationship with a person is also known to them in another role. It includes relationships (personal or professional) the CP has with close relatives of clients (APA, 2003). Overall participants believed dual relationships to be appropriate only in limited

circumstances. There was strong consensus in both surveys regarding the inappropriateness of multiple relationships of a sexual nature (Kitson & Sperlinger, 2007; Borys & Pope, 1982). In both surveys, those who viewed multiple relationships as less appropriate were more likely to be female, younger, have less experience and report their main theoretical orientation as psychodynamic. Participants who rated dual relationships as more ethical were those living and working in the same geographical area. The findings also highlight that CPs opinions vary about what is ethical behaviour.

In summary, CPs are more likely to agree about the appropriate course of action in situations involving confidentiality, harm to others, boundary issues with clients and sexual multiple relationships, than other issues such as test security. They also indicate that CPs sometimes believe it is ethical to behave in ways prohibited by ethical guidelines, or that may be viewed as potentially harmful. However, without knowing the detail of what instances participants may believe these behaviours to be ethical in, it is difficult to draw conclusions regarding the appropriateness of ethicality beliefs. Also, given the data are now between 17 and 35 years old, current opinions may differ. Overall, these results indicate that judgements of ethicality about clinical practice is a complex area and CPs appear to consider a variety of situational factors when making these decisions.

Section 2. What do CPs do when faced with ethical challenges?

The studies investigated CPs' responses to ethical challenges by asking about engagement in listed behaviours (n=8) or asking participants what they would do in situations described in vignettes (n=2).

2a. Studies that asked about CPs' engagement in presented behaviours

One study that asked CPs to report their actual behaviour from a given list, gathered data from 581 CPs in the UK about sexual relationships with clients (Garrett & Davis, 1998).

The qualitative data from the same survey were reported by Garrett (1999) (reviewed in section 4a). A small but notable proportion of participants (3.5%) reported sexual contact with clients during or after therapy (Garrett & Davis, 1998). CPs who reported sexual contact with clients had been qualified for longer and were more likely to be male. A small proportion had worked with clients who had been sexually involved with a previous CP (4.3%) but almost two fifths (38%) were aware (through sources other than clients) of CPs who had had sexual contact with clients. Whilst asking for knowledge about other CPs' behaviour may address social desirability response bias (Arnold & Feldman, 1981), third-party knowledge may be unreliable and may artificially inflate results, particularly as more than one participant may have reported the same incident (Zakrzewski, 2006). Additionally, as discussed previously, surveys are susceptible to low response rates. Therefore the figure of 3.5% may be an underestimate of the prevalence of sexual contact with clients.

Gardner and Marzillier (1996) asked 91 trainee and 86 qualified CPs how often they engaged in 11 confidentiality related behaviours. Qualified CPs reported discussing clients outside work without names more frequently than with names. They had discussed clients most often with their partner. They reported more often having taken files home, compared with leaving them in an unlocked office and were even less likely to leave them in a car. The frequency of these behaviours or the proportion of the sample who reported them is not presented in the paper, which limits the conclusions that can be drawn here. The frequency of unintentional disclosures was presented (table 5) and 70% reported at least rarely unintentionally disclosing confidential information. Participants' beliefs about the ethicality of presented behaviours indicated they thought these to generally be unethical (see section 1). Therefore, the authors concluded that CPs behave in ways that they know to be unethical.

Table 5

Frequency of qualified CPs unintentional disclosure of confidential information (Gardner & Marzillier, 1996).

Behaviour	Qualified CP (%)				
	Never	Rarely	Sometimes	Often	Very often
Unintentionally disclose confidential information	29	62	8	0	0

Yarhouse and DeVries (2000) asked about the frequency with which 156 CPs (and 17 counselling psychologists) engaged in 50 behaviours when working with older adults, to investigate their preparedness for work with this client group (beliefs about the ethicality of the behaviours were discussed in section 1). The rates of proactive ethical behaviours were higher than the frequency of reported unethical behaviours (see Tables 6 and 7). The demographics associated with higher frequencies of ethical behaviours were more experience of and training in working with older adults. Whilst cross-sectional data cannot provide the basis for causational conclusions, it may be that from these experiences CPs are more aware of the additional needs of this client group.

Table 6

The five most commonly reported behaviours (Yarhouse & DeVries, 2000)

	Percentage who very often engaged in the behaviour	Percentage who fairly often engaged in the behaviour
Given information to older adult clients about the nature of services being provided to them	53	28
Had knowledge of relevant reporting of elder abuse laws	61	16
Promoted awareness and use of community networks for older adults	46	24
Had older adults sign a written consent form	59	10
Maintained professional knowledge relevant to work with the elderly	35	34

Table 7

The five least commonly reported behaviours (Yarhouse & DeVries, 2000)

	Percentage who never engaged in the behaviour	Percentage who rarely engaged in the behaviour
Discussed a client by name with friends	96	4
Did not disclose fee structure	91	5

Completed a neuropsychological assessment without specialised training	92	4
Denied a client access to his/her testing report	86	10
Terminated therapy when client could not pay	82	12

Another study that investigated CPs' behaviour in response to ethical challenges with a specific client group asked about recommending spanking to parents as a disciplinary strategy (Schenk et al., 2000; Ethicality beliefs about spanking are discussed in section 1). Over two thirds of respondents (70%) reported they would never suggest spanking. One third (30%) would recommend spanking rarely or sometimes. The authors argue it is not desirable that some CPs would recommend spanking (Schenk et al., 2000). However, as predicted behaviour was measured rather than actual behaviour, it may be that in practice fewer than 30% respondents would recommend this approach.

In one of the oldest studies reviewed, Faustman (1982) aimed to find out about US CPs' use of debt collection strategies. Most participants (60.8%) had used a debt-collection agency but only half of them (48.9%) had obtained consent from clients about the limits of confidentiality.

Two studies investigated behaviour in response to ethical challenges by asking how frequently CPs discussed presented topics with clients. One survey explored the practices of 206 CPs working with children with regards to obtaining informed consent (Gustafson et al., 1992). CPs rated how frequently they initiated discussion of 17 proposed benefits and risks of therapy with clients and rated importance of them. All benefits were rated as important and

discussed frequently. The importance and discussion frequency for the risks varied; those rated as most important and most commonly discussed were financial cost and limits to confidentiality. The least important and least frequently discussed risks were stigma and labelling. It was concluded that CPs were more likely to view as important and discuss issues relevant to themselves, which may not reflect what is important for clients. Whilst CPs' importance ratings of benefits and risks of therapy was correlated with frequency of initiating discussion of these topics, this only demonstrates internal consistency; when participants stated an issue is important, they stated they frequently inform clients about it. The authors acknowledged this does not provide evidence of CPs' actual behaviour.

The second study that used frequency of discussion as a measurement of clinician action sought to understand how 155 US CPs and 137 counselling psychologists manage multiple relationship situations (Lamb, Catanzaro & Moorman, 2004). Respondents reported most often discussing social events (676 times), followed by professional relationships (301 times), and infrequently discussed business or financial relationships (41 times). Discussions were more often initiated with clients or supervisees than with students. It is not possible to separate the CPs' data from that of the counselling psychologists, therefore findings should be considered cautiously. A limitation of this approach is that CPs may manage potential multiple relationships in ways other than discussion, which is not captured.

The most recent study about multiple relationships explored 695 CPs' (9%) and trainee CPs' (91%) use of social networking websites (Taylor et al., 2010). Social networking sites pose ethical issues such as potential personal disclosure. Seventy seven percent of respondents had a page on a social networking site and one of the most common behaviours reported was rejecting or ignoring client contact online. This indicates that when faced with attempted client contact outside work, CPs often attempted to not engage in this. Of those

using social networking, 85% used privacy settings to protect their information; indicating most took steps to protect against unintentional self-disclosure but some did not.

2b. Studies that used vignettes to investigate how CPs believe they would act

Buckloh and Roberts (2001) investigated what 252 CPs working with children would do in response to three vignettes describing ethical issues that may occur when working with managed care systems; a US health insurance strategy aimed at reducing costs by restricting treatment options. The vignettes related to confidentiality, premature cessation of therapy and differential diagnosis to obtain funding. Across vignettes the most popular response was to let the family decide what to do (see table 8). No participant would send a report without consent or stop treatment prematurely. A quarter reported previously having given an incorrect diagnosis to obtain funding (25.9%). These findings suggest that CPs may engage in action prohibited by guidelines but which could be argued to be ethical when client need is considered. The results also highlight CPs believe they would work in partnership with clients to decide responses to ethically complex situations; arguably an ethically more important consideration. A strength of this study was the high number of CPs surveyed. Although this survey was conducted in the USA, it is becoming more relevant for UK psychologists to consider ethical issues related to non-publicly funded services.

Table 8

Buckloh and Roberts (2001) respondent decisions

Vignette (description)	Let the family decide			Reduce fees or agree payment plan with family		
	Should	Would	Have	Should	Would	Have
Vignette 1 Confidentiality (report requested without prior consent)	67.2%	69.2%	64.3%	n/a	n/a	n/a
Vignette 2 Restriction of services (request for further sessions declined by insurer)	38.1%	36.5%	40.5%	21.1%	25.8%	27% did
Vignette 3 Misdiagnosis (considering alternative diagnosis for treatment funding)	37.3%	32.1%	27.8%	n/a	n/a	n/a

Zadik (1993) conducted a brief survey to compare the decision-making of 20 Israeli CPs, 20 psychiatrists and 20 social workers about when to break confidentiality when presented with vignettes detailing sexual abuse, a threat of suicide or arson. CPs made 14 decisions and they decided to keep confidentiality a mean of 7.1 times. However, the range was from zero to 14, indicating some would keep confidentiality every time and some would share information every time. This wide variation within the group of CPs, coupled with no difference in decisions between the professional groups led the authors to conclude that decisions varied due to individual attributes. It is concerning that some CPs believed they would not share information regarding significant risk to others. However, these results cannot be generalised beyond this sample as it only comprised 20 CPs.

In summary, when faced with ethical challenges, most CPs believe in ways that would be considered ethical. Additionally, many CPs take proactive steps to try to avoid ethical problems, such as holding conversations about possible multiple relationship situations and trying to maintain privacy when using social networking websites. However, a minority of CPs report behaviour that would generally be considered unethical, such as sexual relationships with clients, putting confidentiality at risk by discussing clients outside work, neglecting specific needs of a client group such as older adults potentially requiring more explanation and information, recommending a potentially harmful intervention such as spanking and neglecting to hold full discussions about possible risks of work such as confidentiality limits. The surveys also identified sometimes wide variation in CPs' behaviour.

The studies make broad conclusions about general behaviour and what is generally appropriate or not. However, the findings indicate that the situations dealt with and decisions made are nuanced, as indicated by findings about how to manage various forms of private healthcare funding. Therefore, without detailed analysis of the specific situation, it is difficult to determine the ethicality of CPs' behaviour, which is something that is less likely to be ascertained using surveys.

Section 3. Exploring what CPs believe they should and would do

What CPs believe they should do and what they report they actually would do when faced with a dilemma was investigated in three surveys. Two studies sought to build on the findings of Bernard and Jara (1986). When trainee CPs were presented with vignettes that described a colleagues' ethical violation. The responses of approximately half their sample indicated that they believed they would do less than they thought they ethically should.

Bernard et al. (1987) replicated Bernard and Jara's (1986) study with 250 qualified CPs. In response to a vignette describing a colleague's sexual relationship with a client almost two thirds (63%) of respondents stated they would do what they believed they should (or would take slightly more direct action than thought they should), whilst 37% reported they would take less direct action than they believed they should. Another vignette described alcoholism impacting clinical judgement, to which 74% of participants' should and would responses matched and 26% would do less than they believed would be the ethical course of action. These findings indicate that a quarter to a third of qualified CPs would do less than they believed they should, which is a lower proportion than in the trainee CP sample but still a significant number.

In order to further build on Bernard and Jara's (1986) findings Wilkins et al., (1990) examined whether 199 CPs' closeness to the situation changed their decisions, by changing the actor in the four vignettes to be themselves, a close friend, colleague or professional acquaintance. Statistical analysis (ANOVA) identified that participants believed they would do significantly less than they thought they should do across all person of reference conditions. Participants chose more restrictive options when the person in the vignette was them and the least restrictive when they were an acquaintance. These results indicate that CPs once again predicted they would do less than they believed they should. A strength of this study was that 75% of respondents were male, so the gender ratio was similar to the target population. Furthermore, these two surveys used methodology replicated from Bernard and Jara (1986) and the consistency of results indicate its reliability.

Politis and Knowles (2013) used six vignettes to investigate what 237 psychologists (including 73 CPs) believed they should and would do about ethical issues raised by Medicare (Australian private healthcare funding system). The reasons that informed their decision-making were also investigated (see section 4a). Regarding record-keeping, most

believed they should (38%) and would (48%) accurately report their work, including that not funded by Medicare. Regarding competency, most believed they should and would refer the client to another psychologist (50% should, 50% would) or back to the GP (37% should, 29% would). The authors examined decision consistency between CPs, with 80% participant agreement taken as indicating consensus on ethical willingness (most CPs agreeing they would do what they believed they should). Consensus was reached for two vignettes: record keeping (83% consensus) and competency (81% consensus), which the authors highlighted are issues easily relatable to ethics codes.

These studies indicate whilst many CPs hope they would behave as they believe they should when met with ethical challenges, some predict they would do less. The areas that CPs are most likely to act as ethically as they believe they should are those of record-keeping and competency; which have clear requirements in professional codes.

Section 4. Reasons for CPs' behaviour in ethical situations

Several studies explored why CPs chose to act as they did. Reviewing these findings will contribute to answering the third review question of why CPs do not always act ethically.

4a. CPs' reported rationales for why they chose to act as they did

Several studies explored CPs' reasons for not engaging in sexual relationships with clients, trainees or supervisees. Participants' own ethics, values or morals accounted for 690 of the 999 reasons (69%) given in a UK survey of 581 CPs (Garrett, 1999). However, a few participants also cited a lack of opportunity (n=18). Regarding not reporting sexual contact between other CPs and clients, the most commonly cited reason was because action had already been taken (86 of 222 responses) or because they had no evidence (37 of 222 responses). Only 4 of 222 responses cited fear of retaliation as preventing them from reporting another CP, however it seems likely that this would more commonly be one

consideration. In a US survey of 155 CPs personal ethics and morals were also attributed to rationales given for not pursuing a sexual or non-sexual dual relationship with clients (89% of rationales), supervisees (47%) and students (39%; Lamb et al., 2004). These rationales should be interpreted with caution as they may be impacted by social desirability effects, as discussed previously.

The likely repercussions for the CP (Garrett, 1999) and it being prohibited were also frequently cited reasons for not having engaged in sexual relationships with clients (in 55% rationales), supervisees (23% rationales) and students (16% rationales; Lamb et al., 2004). One conclusion that may be implied is that if a CP's personal morals do not extend to clear boundaries between personal and professional relationships they may engage in sexual multiple relationships. Additionally, if they believe there are no likely repercussions for themselves, this may also lead to this behaviour.

Participants were also asked for the reasons involved in decision-making in response to vignettes that described ethical dilemmas related to Medicare healthcare funding in Australia (Politis & Knowles, 2013). Participants commonly cited five factors they believed were involved across all vignettes. These were: following APS code, legality, Medicare rules, client's best interests and best practice. Other factors they reported considering included the psychologist's competence, client choice, inter-professional communication and doing what is right. This suggests that CPs believe various factors are involved in their own ethical decision-making; indicating multiple reasons their behaviour may not be viewed as ethical with reference to professional codes, if other factors such as clients' best interests take precedence in that decision.

Similarly, Smith et al., (1991) found that personal values and practicalities were more common rationales when participants stated they would do less than they believed they

should for vignettes describing legal issues. This suggests that personal values and practicalities may be why clinicians do not always act in ways indicated by legal requirements. However, although the sample size of 102 is good, the number of CPs included was small at a maximum of 26. Additionally the gender balance is markedly different to that of the 2016 membership of the APA division for CPs, which provides a broad comparison of the target population. These factors reduce the generalisability of these findings to the population of CPs.

The constraints on maintaining confidentiality were explored using open-ended items in Gardner and Marzillier's (1996) survey. Four categories of constraints on maintaining confidentiality were identified from participants' responses: practicalities, the urge to talk to offload, job demands (such as working in multiple settings), and professional liaison (including duty to warn). Further indicating that a range of factors may inhibit ethical behaviour.

These findings indicate that CPs do not always act on the requirements outlined in the professional ethical codes, as ethical decision-making involves consideration of a number of additional factors and commonly involves consideration of personal values and practicalities. With regards to the third review question, these findings highlight a number of possible reasons that CPs may not always act ethically; including practical factors getting in the way (e.g. not having lockable storage) and if an individual's personal values do not prohibit what most professionals would consider to be unethical behaviour.

4b. Evaluating a model to explain CPs' intended actions

Ferencz-Kaddari, Shifman and Koslowsky (2016) investigated whether a model based on the theory of planned behaviour explained CPs' behavioural intentions in ethical situations. Vignettes described a dual relationship dilemma (226 completed this) or a

financial dilemma (169 completed this) and participants rated intentions and attitudes on a scale adapted from Azjen (1971). Intending to act ethically was correlated with an ethical attitude towards clients, agreement with what others would advise (subjective norm), perceived behavioural control and a belief in a moral or professional duty. The authors concluded the theory of planned behaviour applies to CPs' intentions in ethical situations and including moral/professional commitment improved the model's predictive accuracy. These results should be interpreted cautiously however, as behavioural intention cannot be assumed to correlate with actual behaviour (Ferencz-Kaddari et al., 2016).

Discussion

Nineteen empirical papers were reviewed to ascertain what is known about CPs' ethical decision-making as it was unclear how theoretical descriptions relate to clinical practice. As Rest's (1994) model provides a broad overview of the process of ethical decision-making, the findings will be structured by the four factors, enabling some critique of it. Practical implications will be outlined with reference to the review aims.

Moral sensitivity

Reference to moral sensitivity; identifying ethical components of a situation and possible responses (Rest, 1994), highlights a gap in the reviewed literature. Several surveys provided vignettes or pre-determined response options but whether CPs can freely identify the ethics of a given situation or possible actions was not addressed. Additionally, asking CPs how often they discuss issues (e.g. multiple relationships; Lamb et al., 2004) does not capture whether they identified all relevant situations to discuss, and discussed them, or if they missed relevant situations, so moral sensitivity cannot be determined. In other research, beyond the scope of this review, some CPs reported having not encountered ethical situations which suggests variability in the ability to interpret ethical components of situations (Orme &

Doerman, 2001). One survey reviewed here identified that over a third of CPs viewed one presented situation as unrelated to ethics, despite being clearly in conflict with professional codes (Faustman, 1982). Whilst this should be viewed cautiously as the survey was of poor quality, it too suggests moral sensitivity varies.

Other findings linked with moral sensitivity include that CPs believe multiple relationships to be appropriate in limited circumstances (Borys & Pope, 1982; Kitson & Sperlinger, 2007); indicating interpretations are based on situational nuances. However, the various circumstances were not specified, so the interpretations' appropriateness cannot be ascertained. Also, respondents' attribution of greater importance to risks of therapy that were relevant to themselves, than to those relating to risk for clients (Gustafson et al., 1992) suggests a potential failure in CPs interpreting the impact of their actions on others (Rest, 1994).

Moral judgement

Participants rated ethicality of behaviours in several surveys. One good-quality survey found CPs usually rated the ethical and unethical behaviours appropriately (in coherence with professional codes) (Yarhouse & DeVries, 2000). However, in common with many of the reviewed papers, they found variation across CPs' results, with varied understandings of what constitutes ethical behaviour (Yarhouse & DeVries, 2000; Tymchuk et al., 1982; Schenk et al., 2000). Although consensus was generally higher for sexual multiple relationships (Borys & Pope, 1982; Kitson & Sperlinger, 2007) and confidentiality (Gardner & Marzillier, 1996; Yarhous & DeVries, 2000). The finding that CPs often want to involve clients in decisions about their care that involve competing ethical principles (e.g. adherence to funding guidelines and considering clients' best interests; Buckloh & Roberts, 2001), could be argued to demonstrate high levels of moral judgement.

Some studies identified clinician characteristics associated with different types of ethicality judgements. Specifically, younger women, more recently qualified, who worked psychodynamically were more likely to have conservative (cautious) ethical beliefs (Borys & Pope, 1989; Kitson & Sperlinger, 2007).

Moral motivation

The concept of moral motivation; prioritising moral values over competing factors (Rest, 1994) was investigated by comparing what CPs believe they should do with what they predicted they would do. Whilst a significant proportion of respondents would do less than they believed they should (Bernard et al., 1987; Wilkins et al., 1990; Politis & Knowles, 2013), suggesting they did not prioritise ethicality, the most recent results indicated more consistency across 'should' and 'would' responses (Politis & Knowles, 2013). This may indicate improved ethical awareness and practice; it may also have been because the vignettes and response options were more ecologically valid. This survey also found greater consensus about appropriate actions in situations involving record keeping and competency, indicating CPs are more likely to act as they believe they should when situations are clearly related to professional codes.

Personal morals was one of the most commonly cited rationales for decisions (Garrett, 1999; Lamb et al., 2004). Additionally, belief in a professional or moral duty to treat a client correlated strongly with intention to do so (Ferencz-Kaddari et al., 2016), suggesting CPs often prioritise moral values over other considerations. However, possible negative repercussions, together with prohibition, were cited by around half of participants for not engaging in sexual multiple relationships (Lamb et al., 2004), indicating that morals may not always be the highest motivating factor.

Moral character

Moral character, as outlined by Rest (1994) - being psychologically strong enough to see an ethical decision through to action - does not take account of the competing ethical principles inherent within some decisions. Additionally, several findings indicated that acting ethically is likely to be impacted by a range of situational factors, particularly if CPs believe they lack control over the actions they can take (Ferencz-Kaddari et al., 2016).

The surveys that examined rationales for decisions highlighted the many factors CPs have to negotiate in order to act ethically. As well as consideration of what is right, CPs more commonly cited their professional code, legality, funding provider rules, best interests and best practice (Politis & Knowles, 2013). Elsewhere, constraints against maintaining confidentiality reported included practicalities and wanting to offload (Gardner & Marzillier, 1996).

Links with review questions

In relation to the questions this review aimed to answer, the following conclusions can be drawn.

1. What do CPs believe to be ethical behaviour?

The reviewed surveys indicate that for any behaviour, even that which many would deem unarguably problematic, such as recommending parents spank their children, there are in fact a huge range in beliefs among CPs about the ethicality of these behaviours. Whilst studies identified clients' best interests were often considered, (which links with the underlying principles in healthcare outlined by Devlin and Magill (2006) of respect for individuals' autonomy, do no harm, beneficence and justice) how these are applied in practice varies. Also it suggests that both absolutism and utilitarianism are likely drawn on in decision-making (Hare, 1991 cited in Cottone & Claus, 2000) but it remains unclear how this process unfolds.

2. What do CPs do when faced with ethical challenges?

Whilst most CPs surveyed behave in ethically defensible ways, there is evidence that a subset of the profession engage in actions which are arguably unethical (e.g. sexual relationships with clients) or promote ethically questionable interventions. There were differences between what CPs stated they should and would do in situations. Some evidence has been found of intentions predicting behaviour (Eccles et al., 2006), indicating these findings may reflect actual behaviour although this cannot be determined from the reviewed studies (Noar, 2014). Also, variability in the positions taken by CPs has been found in relation to factors other than ethics, such as religious values (Baker & Wang, 2004), suggesting wide flexibility in CPs' behaviour and which fits with Cross and Wood's (2015) recommendation of flexibility to utilise a pluralist decision-making approach.

3. Why do CPs not always act ethically?

Many CPs strive to behave ethically, however they also acknowledge the likelihood they would do less than they believe they should, when confronted with challenges. The reasons for this appear to be situational (practical considerations, ethics codes, law, best practice) and individual (experience, professional background, gender, values, personal experiences, competence), indicating cultural context is relevant, as previously suggested (Betan, 1997).

The model investigated by Ferencz-Kaddari et al., (2016) indicates a role for clinicians' beliefs about their duty to act ethically, the consideration of what others would advise, as well as perceived behavioural control, indicating CPs must feel they have some degree of professional autonomy to facilitate ethical behaviour. This fits with previous suggestions that ethical decision-making is based on a wide range of factors, including those termed non-rational (Betan & Stanton, 1999; Rogerson, et al., 2011).

In terms of the overarching review question of what is known about CPs' ethical decision-making, the results highlight this whole process has not been explored in depth, indicating a deficit in the literature remains in understanding how CPs make ethical decisions.

Clinical implications

The varied issues investigated highlight that ethics permeate the whole range of CP work. The findings indicate CPs do not always work within guidelines (including financial, clinical recommendations and professional behaviour). The results demonstrate the factors involved in ethical decision-making include personal values and professional and legal requirements. Training and continuing professional development should attend to how CPs consider these varied factors. Additionally, ensuring attention is paid to boundary awareness could be helpful (Borys & Pope, 1989; Kitson & Sperlinger, 2007).

Future research

All the papers used surveys so were susceptible to similar limitations. Additionally, the research gathered data on what CP identify as ethical issues but not the process of *how* they identify them. More in-depth research methods, such as interviews could determine how CPs experience ethical challenges (Kitson & Sperlinger, 2007).

With regards to moral judgement, future research could focus on everyday practice, rather than using vignettes to make inferences about decision-making (Pettifor & Sawchuk, 2006). This could also clarify what situational factors are relevant and when moral character is and is not demonstrated.

Regarding moral motivation, the studies indicate CPs are usually motivated to act ethically and often cited personal morals as rationales. In future, what these underlying values and moral beliefs are could be explored.

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Section B: 'A kind of uncomfortableness': Clinical psychologists' ethical sensitivity in clinical practice

Word Count: 7916

Report prepared for submission to
The Journal of Mental Health Training, Education and Practice.

Purpose: To understand how clinical psychologists identify ethical issues. The specific aims were to describe the process of ethical sensitivity and examine how clinical psychologists identify a need to engage in ethical decision-making.

Design: A qualitative design was adopted using Grounded Theory method.

Findings: Twelve clinical psychologists participated in semi-structured interviews. A model of how participants identified ethical issues was developed. The three core categories were discomfort, conscious realisation of an ethical problem and the impact of context on the assessment of the situation. The service context, specifically the balance of service demands to resources resulted in either thinking space or restricted thinking. Thinking space enabled participants to attend to their discomfort, understand its cause and identify a clash with their values. This process of ethical sensitivity being facilitated led to a restored sense of coherence with participants' values. When the context restricted thinking this resulted in an ongoing emotional burden. Participants described this as unsustainable long-term and it had led several to changing jobs, reducing their hours or leaving the national healthcare service altogether to work for private providers or in independent private practice.

Value: The paper details an empirically developed theory of clinical psychologists' ethical sensitivity. It describes the process experienced by practising clinical psychologists when noticing potential ethical issues in their work practice. Limitations are discussed and practical recommendations made for mental health services, clinical psychologists and supervisors.

Article Classification: Research paper

Key words: ethical decision-making, ethical sensitivity, moral sensitivity, clinical psychology, grounded theory.

Word count: 247

Introduction

Clinical psychologists are expected to maintain ethical standards (Health and Care Professions Council; HCPC, 2015). However, research has identified that psychologists do not always act ethically (e.g. Fly, van Bark, Weinman, Kitchener & Lang, 1997; Zakrzewski, 2006; January, Meyerson, Reddy, Docherty & Klonoff, 2014). This problem is also highlighted by complaints to professional regulatory organisations (Pilgrim, 2002) and expulsions from professional organisations on ethical grounds (Phelan, 2007) which have sometimes been widely publicised (Sheppard, 2017).

Ethical sensitivity in ethical decision-making theory

In an influential theory Rest (1984 cited in Rest, 1994) cited four components as necessary for ethical behaviour. These are moral sensitivity (identification of issue; assessment of its impact on other people), moral judgement (making a moral decision), moral motivation (being motivated to behave morally) and moral character (being able to overcome challenges to see a moral decision through to action).

It has been suggested that wider discussions of ethical theory have neglected to examine the process of perceiving moral components of situations (Blum, 1991), with theory instead focused on principles that guide behaviour, on choices that are made and on what is the right action, (Blum, 1991). For example the hermeneutic model of ethical decision-making, (Betan 1997) stated, "Assuming the therapist in the situation is aware that the situation presents an ethical concern, the next step is to decide on an ethical intervention…" (p. 358). Whilst there is an implicit acknowledgement within this statement that some therapists may not identify an ethical concern within the situation, there is no attempt to explore how a person may or may not identify an ethical issue.

Similarly, Cottone's (2001) social constructivism model of ethical decision-making (in counselling) does not attend to how an issue is initially identified by professionals. It has as its starting point: "At critical moments, such as when a concern arises or when there has been an accusation or enquiry, the ethically sensitive professional operating from a social constructivism mode would take several steps…" (p. 43). This does not define how a concern may be identified or who may have noticed an ethical issue to make an accusation or enquiry.

The theoretical ethical literature has also been criticised for generally assuming that clinicians adopt a rational and precise approach to decision-making, whilst the emotional aspects of decision-making are neglected (Betan & Stanton, 1999; Rogerson, Gottlieb, Handelsman, Knapp & Younggren, 2011). Furthermore, it has been highlighted that many theoretical models have not been investigated empirically (Cottone & Claus, 2000; Rogerson et al., 2011).

Empirical findings on ethical sensitivity

Existing empirical research on CPs' ethical sensitivity (how they identify ethical issues) has not been identified by the author. Research has been conducted on the types of ethical issues commonly encountered, including a series of international surveys which asked psychologists to describe an ethically troubling incident encountered during the previous year (Pettifor & Sawchuk, 2006). Confidentiality and dual relationship issues were the most frequently described in the 2698 responses. In some of the reviewed surveys some respondents stated they had not encountered ethical issues (including in Slack & Wassenaar, 1999; Colnerud, 1997; Orme & Doerman, 2001). It was concluded that they were likely to have encountered similar situations to other respondents but had not identified them as ethical in nature. Furthermore, this research did not explore *how* CPs identify ethical issues, which may have indicated why some CPs reported not having encountered ethical issues. How

ethical problems are identified during CPs' work practice has been identified previously as an area that requires further investigation (Pettifor & Sawchuk, 2006).

Research with other healthcare professionals, namely 754 Swedish psychiatrists and 116 Finnish physiotherapists has identified variation in the perception of ethical problems (Lützén, Evertzon, & Nordin, 1997; Kulju, Suhonen, & Leino-Kilpi, 2013). The psychiatrists completed the Moral Sensitivity Questionnaire (Lützén & Nordin, 1994) which asks respondents what personal moral assumptions may affect ethical decision-making. Differences were found between psychiatrists' opinions in association with various demographic factors (gender, age, experience, and clinical specialism), which suggests those factors may be associated with different ways of identifying moral issues (Lützén et al., 1997). Most physiotherapists reported encountering issues weekly, whilst 12% said daily and 16% rarely or never. Whilst some variation would be expected in different work settings, the findings indicate that professionals may vary in their ethical awareness and sensitivity in their practice (Kulju et al., 2013).

Recommendations and decision-making tools

There is a significant body of literature on maintaining ethical practice in clinical psychology and related fields, such as counselling. It includes suggestions for decision-making processes (such as a mnemonic to aid identification of an ethical issue; Moffett, Becker & Patton, 2014), strategies to avoid legal and ethical difficulties (Plante, 1999) and guidelines for providing ethical consultation (Gottlieb, Handelsman & Knapp, 2013). Whilst these appear to be practical strategies to develop ethical sensitivity, for the tools to be utilised an individual needs to firstly identify a potential ethical issue and decide there is a need to consider it further.

A review of 20 ethical decision-making models highlighted the lack of clarity with regard to moral sensitivity, as this was a significant area of variability between the models (Park, 2012). Three models, including one aimed at psychologists (Tymchuk, 1986, cited in Park, 2012), did not mention identification at all. The remaining detailed various steps involved linked with perceiving a problem, gathering information and confirming a need to engage in EDM (Park, 2012). A model based on integrating these six existing models, with the aim of providing a tool to support decision-making was pilot tested with 67 nursing students. Whilst the students reported the model helped them reach a decision and they had more confidence in decisions reached with support of the model, this was tested in groups in a classroom setting using vignettes. It was not investigated how decisions were being made during clinical practice by nurses and it is not known when they might have turned to this tool during their clinical work.

The Canadian Code of Ethics for Psychologists includes a decision-making model that outlines a series of steps to follow (Canadian Psychological Association; CPA, 2017). An earlier format of this model was presented alongside discussion of its theoretical grounding by Hadjistavropoulos and Malloy (2000). Regarding identification of an issue, it states "Here the psychologist is expected to identify the ethical dilemma and consider the CPA code's principles and standards that are important to the situation." (p. 110). It does not discuss *how* psychologists would identify a dilemma. It was also noted that the model and recommendations had not been tested empirically (Hadjistavropoulos & Malloy, 2000).

Rationale

"…ethical lapses result from our lack of consciousness or neglect" (Walsh, 2015, p. 69).

Sternberg (2012) suggested unethical behaviour may occur when individuals fail to recognise or define an issue as ethical. It has even been argued that a professional's inability to recognise ethical issues may be more problematic than consciously choosing to behave in an unethical manner (Hall, 1975 cited in Jordan, 2007). Therefore, understanding how CPs recognise potential ethical issues in their clinical practice is an important gap in the literature to address.

Definitions

The term moral sensitivity is generally used to refer to the "…ability to notice moral features present in a situation" (Lovett & Jordan, 2010, p. 175). Morality being the underlying principles or values that guide judgements of what is ethical (right) behaviour (Oxford Dictionary of English, 2015).

"Ethical sensitivity may be defined as that which enables professionals to recognize, interpret and respond appropriately to the concerns of those receiving professional services." (Weaver, Morse & Mitcham, 2008, p.607). Whilst it could be argued that ethical considerations extend beyond the interests of service users (to staff and the public), this definition does reflect that ethics are concerned with actions in relation to underlying moral values. As this research is concerned with CPs' professional behaviour, the term ethical sensitivity will be used.

Research questions

The present study aimed to understand the process of CPs' ethical sensitivity. Specifically:

1. How do CPs first identify an ethical issue?

2. What process occurs when CPs notice a potential ethical issue?

Method

Design

A qualitative design using a Grounded Theory (GT) method was used. This approach is well-suited to exploring under-investigated topics and social processes (Fletcher, 2017; Birks & Mills, 2011). GT also results in an explanatory theory (Corbin & Strauss, 2015), rooted in the experiences of participants. It therefore provides a useful method of contributing to the existing field of research on ethical sensitivity which currently lacks both thorough theoretical exploration and empirical investigation of this concept in the field of clinical psychology.

Critical realist perspective

This research took a critical realist epistemological perspective. From this position it is understood a truth exists separate from any one individual's perception of reality (Kempster & Parry, 2011; Redman-MacLaren & Mills, 2015). Then, through individuals' interactions and interpretations of this phenomena an understanding is constructed. With regards to topic of ethical decision-making, there exists a shared reality in the requirements of CPs to act within a professional code of ethics, which is understood differently by individuals as they interact with and interpret ethics.

The context of the process examined is key to understanding it (Redman-MacLaren & Mills, 2015), both in the acknowledgement that the researcher's own perspective impacts on the process of research and that the understanding gained will be relevant to the time and place in which the research is situated.

Ethical considerations

The research proposal was reviewed by the Salomons Centre (Canterbury Christ Church University) ethics panel and approval granted (see Appendix B.). The research was registered with the Research and Development Department within an NHS Trust and permission granted to conduct recruitment and interviews with CPs employed there (see Appendix C).

The Code of Ethics for Human Research (British Psychological Society, 2014) was adhered to throughout the research process. Informed consent was obtained for participation and participants were informed of their right to withdraw from the study (Appendix D; Appendix E).

Particular attention was paid by the researcher to the possibility of the research topic causing participants stress and they were not asked to discuss any current ethical issues. Participants were informed about the researcher's responsibility to report disclosures of unethical practice (Appendix D).

Participants

The experiences of qualified CPs were sought, to inform development of a theory of the process of identifying ethical issues in clinical practice, rather than the process of learning how to do this. Therefore trainee CPs were excluded from this research.

Initially, purposive sampling was used by emailing the project advert (Appendix F) to CPs from a contact list provided by one NHS Trust. The advert was also distributed at relevant conferences.

Once categories began to develop from the data analysis, specifically around the importance of gaining clinical experience, theoretical sampling was employed (Charmaz, 2014). Permission was obtained from the Salomons Centre Ethics Panel to distribute the advert to CPs known to the project supervisors, the researcher and previous participants (see Appendix G). Recruitment was also widened to include the second NHS Trust (see Appendix H). CPs with under five years' post-qualification experience and those of at least 15 years of experience were sought. Additionally, theoretical sampling also facilitated the exploration of whether gender impacts on ethical sensitivity as differences in ethical behaviour across different genders have been indicated by previous research findings (Yarhouse & DeVries, 2000; Kitson & Sperlinger, 2007; Borys & Pope, 1982; Garrett & Davis, 1998). The experiences of non-female CPs were sought after initial sampling had only recruited female participants.

Participant recruitment

CPs who expressed an interest in participating were emailed the information sheet (Appendix D) and consent form (Appendix E) and contacted the researcher to arrange an interview. Participants were provided with printed copies of the information sheet and consent form and offered the opportunity to ask questions prior to the interview. Participants were also invited to complete a Demographics Form (Appendix I) and encouraged to complete only those sections they felt comfortable to.

Data collection

The interviews were semi-structured with the interview guides (Appendix J) used as a starting point. Participants were enabled to freely share their experiences and opinion to ensure the researcher's beliefs did not constrain the data collection. Interviews lasted between 36 and 75 minutes, were audio recorded and transcribed.

It has traditionally been an aim of GT to collect data until theoretical saturation is reached (Corbin & Strauss, 2015). However, it has been suggested this can never be realised and instead *sufficient sampling* was sought in the present study. This was determined to have been achieved once the major categories were specific, well-integrated (Corbin & Strauss, 2015) and could accommodate new data without further development (Dey, 1999).

Data analysis

As required by GT, data analysis was concurrent with data collection. The analytical strategies outlined in Table 9 were employed using a constant comparative approach (Corbin & Strauss, 2015; Charmaz, 2014, Birks & Mills, 2011) and recorded using Atlas.ti analysis software.

Table 9

Grounded theory data analysis strategies utilised

Stage of analysis	Corresponding interviews	Description of key data analysis strategies
Initial	Interviews 1-4	Transcript read through for re-familiarisation with data. Detailed line by line coding; kept close to the text by using in-vivo and descriptive codes (Birks & Mills, 2011). Resulted in approximately 1400 codes due to endeavouring to stay close to the data and not choose a direction too quickly. Memos were written, which enabled category development. Memos and research diary entries also identified questions to raise in subsequent interviews.
Focused	Interviews 5-7	Initial codes reviewed to search for near matches / duplicates and patterns. This resulted in 360 codes which

		were re-examined along with surrounding excerpts from the data to consider the context (Charmaz, 2014). Focused coding of interviews 5-7 with sections of text (groups of sentences as opposed to individual sentences/groups of words as with the initial coding) were coded and categories started to be developed. Diagrams were generated, along with memos, to explore the links between categories and search for core categories see appendices M, N & O (Corbin & Strauss, 2015). The search for process in the data was facilitated by using gerunds; a noun form of a verb which emphasises action (Charmaz, 2014 cited in Birks & Mills, 2011). The categories were further developed by exploring emerging ideas with participants.
Theoretical sampling	Initiated at interview 6	Theoretical sampling was initiated as there was frequent repetition within the data gathered by interview 6. The interview guide was reviewed and amended (see Appendix J).
Theory development	Interviews 8-12	The data were inspected to search for gaps or remaining questions. Memos were written to link categories through processes. Theoretical sampling sought participants who were non-female, had less than 5 years or longer than 15 years of experience and those who had remained working in the NHS. Constant comparative approach was used by returning to earlier interviews to develop categories and processes.
Refining the theory	Interview 12 onwards	After twelve interviews, theoretical sufficiency was judged to have been reached. The final part of the data analysis focused on fully integrating the theory. The constant comparative method, moving between open and focused, low-level descriptive coding and high-level analysis, as well as between different sets of data (interview transcripts) was maintained to ensure that the developing high-level theoretical categories remained grounded in the data. Use of diagrams was key at this stage.

	Drafting initial versions of the results section supported further clarification of the developing theory.

Quality assurance

Personal reflexivity, including identification and reporting of researcher beliefs is recommended to support the quality of qualitative research (Yardley, 2000). Prior to data collection a reflective exercise to examine the researcher's assumptions (Activity 1.1 from Birks & Mills, 2011) and a bracketing interview with a colleague were completed. These exercises and further examination of the researcher's potential biases and experience of the research process were recorded in a research diary (Appendix K). Views identified included a belief in the importance of emotions in recognising ethical problems and a strong personal motivation to maintain ethical practice. Efforts were made to ensure interviews were conducted in a balanced way by initially not asking in depth about the role of emotions. Once this area emerged as key for participants, the interview guide was amended to more fully explore the contribution of emotional response to ethical sensitivity. These opinions were also discussed within supervision, particularly in relation to the emerging theory.

A review in supervision of the initial coding identified improvements to be made and it was re-coded using smaller sections of data and increased in-vivo coding. Discussions regarding theory development focussed on the key findings to facilitate a move away from a submersion in the detail of the data, to identify the higher-level, overarching processes (Corbin & Strauss, 2015).

Respondent validation was considered throughout data analysis, using in-vivo coding to remain grounded in the data and discussing developing concepts with subsequent participants (Birks & Mills, 2011).

Results

Twelve participants were interviewed. All were practicing CPs (post-qualification experience ranged from 1 to 33 years) and so met the inclusion criteria. Participants represented a range of seniority levels (band 7 to upper band 8 levels), service settings (NHS, private healthcare service and independent practice) and worked with varied client groups across the lifespan, including learning disability teams and specialist services. Eleven participants identified as White (10 British; one non-British) and one participant as Asian British. A range of genders were represented (five female, three male, one non-binary and one not stated).

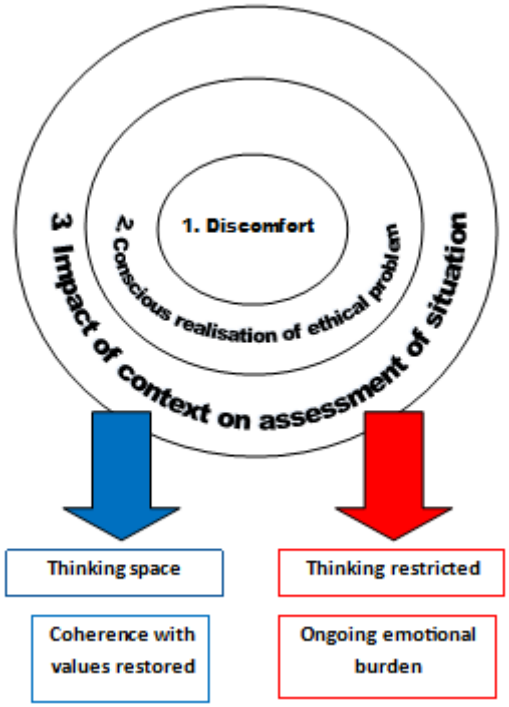
Table 10

Table to show length of participants' post-qualification experience

Length of experience	1-3 years	4-10 years	11-20 years	21-33 years
Number of participants	5	1	3	3

Model overview and conceptual results

Figure 2. The process of ethical sensitivity in action



This study indicates that the noticing of a potential ethical issue during the course of a CP's work starts with an internal feeling of 'discomfort' (part 1). The CPs interviewed described a process that occurs when they attend to this "gut reaction" (P.2), during which they developed a 'conscious realisation of an ethical problem' (part 2) and began to be able to articulate their concern.

The experience of discomfort and the conscious realisation of an ethical problem both occur within the CP's internal experience. As the CPs' understanding of the cause of their discomfort deepened, the context they were in impacted on their assessment of the perceived issue (part 3). Key contextual factors included service demands and resources.

Contexts that provided 'thinking space' enabled the full assessment of the situation and gave the CPs the opportunity to embark on a process of ethical decision-making, i.e.

deciding the right way forward. This resulted in the CPs' sense of 'coherence with their values (the various aspects of wanting to do what is right) being restored'. Conversely, in other contexts 'thinking was restricted'. In these contexts the interviewees described being left with an 'ongoing emotional burden'. They had internally noticed the ethical issue but the external context prevented them from fully assessing the impact on others and being able to decide the most appropriate course of action.

Detailed results

Table 10 in Appendix L provides a detailed overview of the categories and subcategories.

1. First stage of ethical sensitivity: Discomfort

That kind of uncomfortableness… (P.1)

The initial noticing of a potential ethical issue was experienced internally by the CP as a 'gut feeling' or 'intuitive knowing' that something was not right. This was an emotional and physical reaction; often one of anxiety.

…not a fully-fledged emotion that one can feel…I might have some discomfort, a feeling of discomfort or a feeling of that something doesn't feel quite right here. (P.7)

…it is the gut reaction, it's your gut, you know, does that feel comfortable or is it err, what feeling does that produce in you. (P.2)

For some, this experience began as a subtle discomfort and an inkling that something about the situation was uncomfortable, that grew over time. In other situations it began as an acute emotional response, such as severe anxiety, that was immediately noticeable and sometimes linked with an urgent need to attend to the situation. The category 'discomfort' is

a core category. It was the feeling of 'discomfort' that enabled the participants to notice a potential ethical issue. Emotional discomfort was the signal that the perceived issue posed an ethical challenge.

2. Second stage of ethical sensitivity: Attending to the discomfort to arrive at a conscious realisation of an ethical problem

After the initial noticing of discomfort, participants engaged in a process through which a conscious realisation of the presence of an ethical problem occurred and an understanding of the situation as jarring with their values was reached. This understanding enabled participants to be able to articulate the source of their discomfort in situations that were firstly felt and then cognitively understood to be unethical. This process appeared to be mediated by various personal factors, including values, time and openness to noticing. Differing qualities of these factors (positive or negative) either assisted or suppressed the cognitive process of forming a conscious understanding.

I think that is at the heart of the anxiety that I've been speaking about and that we've been talking about and also that kind of, yeah, the discomfort of realising, I'm acting in a way that doesn't necessarily fit with my ethical guidelines.(P.9)

Along with discomfort, the category of 'fundamental basic principles' was particularly strong. Participants often explained their belief that these values and principles are core to working ethically. A situation that puts these core values and principles at risk caused participants to experience an intense feeling of discomfort.

It's like sticking, it's like jarring with your belief system or something. It's like erm, it just doesn't fit. There's something that's not quite right and then you worry about it and then maybe you do get that discomfort. (P.11)

The felt response is the key attribute that makes these situations stand out. It is not merely a technical problem that one does not know the answer to, it is an ethical issue that at its root is about the core personal values that CPs hold as centrally important being compromised.

I think the emotional discomfort there is when it's challenged, so if you're finding it difficult to implement what you know you should be doing… (P.3)

The values that participants discussed as being of central importance to them included considering clients' best interests and trying to do the best one can.

Things to do with sort of compassion and empathy and sensitivity I think are core in terms of thinking about how you work with someone, how you make decisions when it gets tricky as well. (P.4)

This realisation becoming conscious and making sense of the feeling to understand what was generating it, meant the participants were able to verbalise to themselves but importantly also to others, what was wrong in the situation. Specifically, what they perceived to be compromising their values as a CP. They did not necessarily fully understand their emotional response, but they had enough understanding of it as potentially impacting on others and requiring thought to decide their next actions to initiate these conversations to facilitate their deepening understanding.

But I think it's important to be able to take those things and actually then be able to kind of articulate exactly what it is that arouses those emotions because an emotion doesn't you know, you can't take an emotion to HR. (P.11)

This second stage, of developing conscious understanding that there was a potential ethical problem, is an internal psychological process. A number of personal factors impacted

on this stage. As already mentioned, the key personal context was the CPs' own value system. Additionally the CPs explained it was necessary to be open to the possibility of perceiving a problem during the course of their work.

The going beyond I think requires an openness to other things that might be giving you an, indicating to you that there are some other options to consider. (P.7)

There was an emotional price to participants for noticing ethical issues and thinking about them required effort; it would have been easier to shut off from noticing problems and not strive to act ethically. However, this "going beyond" was motivated by the strong desire to 'maintain a sense of personal integrity', through working in coherence with their values as a person and a professional. This desire was what participants cited as driving them to attend to their discomfort and understand its cause.

...so you can either ignore that or for your own integrity be true to - and it is really unpleasant if you don't respond to what you think is the right thing to do and are proved right. It's a horrible feeling because you feel like you've done something wrong in a quite personal way. (P.7)

Participants spoke about the importance of their personal values and beliefs but explained that if their personal beliefs clashed with the expectations of them as a professional then they consciously held those beliefs in the background, in order to promote their profession-based values. This was commonly discussed with reference to personal religious beliefs and affiliations.

...so I felt like I was okay in keeping it separate so my belief is…you know, it would upset me if this was my situation but thinking around what values and his needs as well. (P.1).

Additional personal factors that impacted on to what extent participants attended to the feelings of discomfort included other considerations competing for the CPs attention, such as practical considerations related to the service, personal life experiences (for example bereavement) and ongoing personal life considerations which reduced the time available to them to consciously attend to their feelings.

Because I've got kids and running the service, it's quite hard to stop and think and then sometimes at night I'll wake up and think, 'oh! I need to be thinking about that one a bit more'. (P.5)

Participants described that over time, as they have gained experience, they have developed an 'increasing ability to sit with discomfort'. The more experienced clinicians had developed trust in their own ability to notice any feelings of discomfort. This did not reduce the discomfort when a difficult ethical situation arose but meant experienced CPs felt more confident about harnessing their emotional response appropriately to facilitate ethical sensitivity and contribute to ethical practice. Experienced participants had developed a greater ability to tolerate the discomfort they experienced which gave them time to think through the situation, rather than rushing to a decision. Those who were earlier in their career explained their hope and expectation that they would get better at tolerating this unpleasant feeling (of discomfort). They believed this would help them to be informed by their emotional reaction and to be able to attend to it reflectively, rather than it having a restrictive impact on their ability to think.

You know so, we could sit on it for longer, it's not like you have to make an instant decision, umm, yeah I can stew a bit longer now. (P.2)

I guess what I will probably learn over time…is a way to sort of limit the impact that those emotions have on my decision making in the sense that… where there is a lot of visible

distress in the room, lots of tears and stuff, that can be quite motivating and I guess what I will likely learn over the time is to try and reduce the impact that that has on my decision making. (P.8)

3. Third stage of ethical sensitivity: Impact of context on assessment of situation

Following the psychological process in which the initial feeling of discomfort becomes conscious, there was an external process in which the CP turned their attention outward to their context. The context seemed to impact strongly on whether the potential ethical issue was attended to or not.

But as I've said I do think emotions are important, picking things up, um I think you …you've got to go through a thinking process on top of that, because of all the pragmatics of what's possible to be done. (P.7)

The particular service context had a strong impact on the participants' level of ethical sensitivity i.e. whether they had the freedom of thought to be able to attend to their discomfort. Both 'service demands and resources' seemed relevant to whether the participants were fully able to understand the potential ethical issue and could hinder or facilitate their ethical sensitivity. The participants spoke repeatedly and strongly of the impact of poor service provision on their ability to work ethically and gave examples of 'services under pressure'. These included difficulties with staff retention and concerns about team morale being low, which all increased the pressure felt by participants when trying think about the impact of a situation on others.

…so I was prioritising morale for the team, of psychologists, versus an individual client need, …I'm very aware that actually at that moment cancelling a meeting … would have quite an effect on morale … so feeling at capacity, umm partly concerned for people

and … that inner discomfort… So you feel pressured into a decision that's about, it's something important at a difficult time. (P.3)

Participants from all healthcare sectors (NHS, private providers or those in independent private practice) described the negative impact on their practice of funding restrictions for healthcare services. They spoke of gaps in services and people having to "fight" (P.2) for the support that they need.

…actually it is because there isn't a service that meets this person's need… (P.2)

The impact of a shortage of resources in services reduced the ability for CPs to work in line with their values about what they believe is important, particularly for the vulnerable people that CPs work with. For example participants stated that they can feel they are not supported to offer as lengthy interventions as they believe clients often need; the issue of balancing client need with lengthy waiting lists was discussed several times. Participants also described problems arising due to inadequate rooms to see people in. The participants linked these difficulties with being in a "time of shortage" (P.3) financially.

Resources are really scarce and … the waiting lists were up to three years which was just ridiculous so I had to do a lot of work to kind of get them down (P.12)

These problems, related to inadequate funding, were described by participants as impairing ethical sensitivity because if there was no way to improve matters and they perceived their ethics to be habitually compromised (discussed further in relation to the category 'thinking restricted' below) participants found it "uncomfortable to be stuck anywhere. To be caught in a system and [to be] critical of it" (P.7)

It's difficult. It's getting worse. It is difficult, I'm less happy in the NHS…We can't see them for all that they need. That is for sure. But I'm concerned that we don't quite do enough for them really. (P.10)

Many of those interviewed described busy work environments, in which demand outstripped supply. The participants were less able to attend to feelings of discomfort aroused by any one ethical problem as they were constantly confronted with this feeling.

…if I am honest there was that oh, I didn't really want to deal with this, almost a heavy feeling of this is something. It is time consuming, and I want to deal with it well… I was dealing with loads of different things and I was thinking oh, I don't have time to deal with this as well as everything else. (P.4)

When participants were worried they may lose their job they found it harder to consider their own beliefs regarding what constitutes ethical behaviour if they perceived the organisation to have different priorities. This anxiety, driven by organisational pressures, impeded the process of ethical sensitivity.

And especially if you're anxious about the fact that you might lose your job …it's a big threat that we're all under. So I think it's harder to think about your own ethics if they're different from that in the organisation if you think that your own job's at risk. (P.12)

Alternatively, if the team was cohesive and functioned well, the team was available to support decision-making. This meant participants were more likely to feel able to attend to a feeling of discomfort, in the knowledge that they could obtain support to fully understand the issue and decide what to do about it. The contribution of their team to decision-making was valued by the participants in this study because they felt reassured by having reached a decision in consultation with others, rather than alone.

I feel umm if it has been considered by lots of individuals with different experiences and lots of different professional backgrounds and we come to it then it will be a wiser decision, I trust it more, I trust the decision more. (P.2)

When the context facilitates thinking

When the contextual factors together provided 'thinking space' this enabled participants to move forwards in attending to the ethical issue, which restored their sense of coherence with their values and their professional role.

The clarity of thought facilitated by a supportive context enabled participants to 'step back to think' and decide whether the situation was urgent and required an immediate response or whether they could take longer to reach a decision.

…having space to go to think about, breathing space to think about things is really useful. (P.8)

In addition to the importance of having space to think, participants frequently spoke about the process of 'talking to facilitate own thinking'. This turning outward to others seemed to be part of the process of identifying what the ethical issue is, what its possible impact is and what options there are for action. Talking with others supported the participants to identify the cause of their discomfort and understand this response. Therefore talking with others can be understood to facilitate ethical sensitivity.

Yes I think that's the value of, in any situation…if you have any sort of beginning gut level question about what you're doing or what's going on, however slight, I think it's worth talking to other people about it because… They will have a response that will make you see what you're beginning to see much more clearly… (P.7)

The outcome of being able to attend to the situation causing discomfort, in order to understand their emotional response and to be able to embark on a process of ethical decision-making was a sense of 'coherence with values being restored'. The participants described being able to attend to ethical challenges appropriately, so that their work was informed by and consistent with their personal and professional values. This facilitation of ethical sensitivity, which enabled engagement in ethical decision-making was vital for the CPs interviewed to feel that they are working ethically.

...you do the best you can with all the principles that you have and better at, to live with those decisions… (P.3)

When the context restricts thinking

When the service context for the CPs interviewed was one of the service demand outweighing the resources, the team context was not supportive or was experiencing overwhelming organisational pressure, so that 'thinking is restricted', this hindered ethical sensitivity. In restrictive contexts, the CPs interviewed perceived 'limits to their responsibility and control' which impeded their further consideration of the impact of the situation on others and possible ways to respond to the identified issue.

And I do think that you need new people … new eyes to stop bad stuff happening and to you know, make good stuff happen. And to shake systems up a little bit but if the system's unshakeable or it just destroys you in the process, actually when it comes down to it, when you've done what you can do, it's a job. (P.11)

This shutting off of thinking served a protective function, in some instances, to prevent the CP becoming overwhelmed by their discomfort in the situation because they

could attempt to move forward in the belief that it was the wider system and not them that is to blame.

You could argue that in fact you have to do that [stop thinking about it] because the trouble with this way of thinking about, in my experience, when you're thinking what should I do or what could I do, what are the possibilities, is that it can be very burdensome. (P.7)

However, this strategy was not always possible or effective and when the contextual factors restricted thinking and CPs' ethical sensitivity was compromised, a sense of 'ongoing emotional burden' was experienced. The CP was trapped with an uncomfortable and sometimes distressing felt response to a situation but was unable to do what they believe was required of them professionally, which resulted in a lack of coherence between one's values and practice and their sense of personal integrity was damaged.

I think that if you're going to work in a team in which there's not a lot of real thinking or openness to multiple perspectives or much respect for communication, you're going to get tainted by that kind of thing (P.11)

Yes it's resolved enough but it's not, it doesn't feel, it never will feel comfortable. (P.12)

Participants often spoke about this sustained clash between one's values and what their work setting allowed them to do having been intolerable long-term. For the twelve CPs interviewed: two participants had left the NHS altogether which they attributed to being unable to work in a way that they believed was ethical; two participants had reduced their NHS work to take on independent work, which they also discussed as linked with various intolerable pressures on them which they believed negatively impacted on their work; two participants had changed jobs within the NHS and specifically cited their compromised ethics

as being key to these decisions; and one participant discussed the helpfulness of working part time as they believed it helped them to maintain a work-life balance and to think more clearly. Therefore at least six participants had attempted to 'escape the intolerable burden' (a sub-category of the 'ongoing emotional burden' category) they experienced by leaving posts in teams or services that restricted thinking. Several participants discussed that their newer roles provided them with greater ability to work in line with their values, including to be able to identify and understand ethical issues when they arise, rather than to be constantly overwhelmed by multiple ethical problems.

...you decide you don't want to work there anymore which I think a lot of psychologists do, walk away; we go somewhere else. (P.7)

Discussion

This project aimed to understand the process of ethical sensitivity, as engaged in by CPs. The findings will be discussed in relation to the research questions. The contributions that existing theory and previous research can make to understanding the results, particularly in relation to the impact on participants of ethical sensitivity being facilitated or hindered will be explored. Following this, the clinical implications of the findings will be outlined. The limitations of the present study will be noted and areas for future research identified.

1. How do CPs first identify an ethical issue?

The presented theory illustrates that discomfort, described as "a kind of uncomfortableness" (P1), is key to how those interviewed identify ethical issues. Participants described an intuitive sense that something was not right, which developed into a conscious understanding that the situation jarred with their values. The role of emotions has previously been noted in a critique of ethical decision-making literature (Rogerson et al., 2011). The

model presented here provides an empirically-developed account of the role of CPs' emotions in identifying ethical issues.

Experience of cognitive dissonance

The discomfort experienced by participants, which once attended to enables a cognitive understanding to be developed that their values or beliefs are compromised by either their own or others' actions, can be linked with the concept of cognitive dissonance (Festinger, 1957 cited in Cooper, 2007).

Festinger (1957 cited in Cooper, 2007) posited that discomfort arises when a person's belief or behaviour conflicts with a previously held belief. The CPs interviewed in this study also experienced discomfort when a situation, which they may or may not be the actor in, jarred with their values. Festinger suggested that beliefs important to the person usually result in stronger dissonance and that results in a stronger motivation to resolve these feelings. This illustrates why several participants decided to leave work situations that were incompatible with their moral values. It can be understood that for the participants here, it was not so much a question of how they notice ethical issues but more about how do they manage the constant influx of discomfort caused by a risk to their ability to practice ethically, when this drives them to want to resolve this sense of conflict.

2. What process occurs when CPs notice a potential ethical issue?

Alongside discomfort and a developing conscious realisation of an ethical problem participants assessed whether they were able to engage in ethical decision-making in their particular context.

Impact of context providing thinking space

If the context provided space to think about the potential issue, the CP was able to fully consider the potential ethical issue they had experienced discomfort about. Participants explained that being able to follow this process of ethical sensitivity restored their sense of coherence between their values and their work which protected their integrity.

Integrity

Participants cited the importance of maintaining integrity in relation to how they understood their role as CPs and working in accordance with their values, for example, considering clients' needs and best interests. What previous theory and research has identified about the concept of integrity will now be considered.

A sense of integrity has been argued in philosophy to be valued by most people as it links with a display of loyalty which is valued, in this case loyalty towards oneself (Scherkoske, 2010). The assertion that "persons of integrity have an unbreakable allegiance to certain 'bottom line' principles" (Scherkoske, 2010, p.336) fits well with participants' descriptions of basic principles that must be adhered to. A sense of integrity is deeply linked with one's sense of self; "it is the moral self that is essential to our identity, more than personality traits, memory or desires" (Lapsley, 2015, p. 165). Therefore, it is understandable that threats to personal integrity were found to cause distress to participants.

Impact of context restricting thinking

The results indicate that a CP's service context can also reduce ethical sensitivity, preventing consideration about issues of ethical concern. In these contexts, unethical practice may be more likely (Rest, 1994).

The finding of the importance of context is supported by a recent review of professional misconduct cases in healthcare, which utilised a bad apple, bad barrel metaphor and specified that bad barrels (unsupportive organisations) can be corrupting due to the context normalising misconduct or depleting through an accumulative reduction of individuals' resources (Searle, Rice, McConnell & Dawson, 2017). Participants here described experiences that related to both of these organisational problems.

The influence of corrupting organisations can be understood in terms of social norms and social categorisation (Hogg & Terry, 2000). These processes, related to identification with particular groups, have been found to impact negatively on moral awareness (Moore & Gino, 2013).

Moral distress

In contexts that restricted thinking participants described an ongoing emotional burden from being unable to attend to and identify the cause of their discomfort. This was so distressing if unresolved that several participants cited it as a key motivator to leave previous jobs and seek a more supportive context.

The emotional burden participants described can be linked with the concept of moral distress (Morley, Ives, Bradbury-Jones & Irvine, 2017). Moral distress is the psychological distress elicited by being prevented from acting ethically, either due to situational constraints or when the person is uncertain about the correct course of action (Morley et al., 2017). The grounded theory developed in the present study indicates moral distress may also be experienced when CPs are prevented from thinking fully about an ethical issue they have started to notice. In this instance, identifying ethical issues (and later engaging in ethical decision-making) may be seen as an extension of ethical behaviour.

The findings on the long-term effects of emotional burden are consistent with previous findings on moral distress, that it is associated with poor job retention and reduced wellbeing for healthcare professionals (Lamiani, Borghi & Argentero, 2015).

Role of professional codes

Participants described conscious efforts to ensure their personal beliefs did not detract from acting on their professional values, which indicates those interviewed sought to uphold the values and behaviour outlined in professional ethics codes (BPS, 2009; HCPC, 2015). Participants discussed an underlying awareness of professional codes but did not mention utilising any tools to support identification of ethical issues or ethical decision-making. This suggests the decision-making models available as tools to support practice are not useful for these CPs. It seems that the CPs felt able to make complex ethical decisions, when the context enabled them to. Part of a supportive context is the availability of consultation and support from others in decision-making. Suggesting decision-making tools would be more useful in supervision or consultation situations.

Additionally, participants described more confidence and trust in decisions reached with a team as opposed to decisions made alone, which is consistent with previous findings on shared ethical decision-making (Park, 2012). Again, seeking supervision or advice from others is encouraged within professional codes of conduct (BPS, 2009).

Links with ethical decision-making theory

Rest's (1994) theory on the four components necessary for ethical behaviour includes moral sensitivity as identifying an issue and understanding the impact on others. The model presented here develops the concept of ethical sensitivity to explain how the process is experienced by CPs. This also builds on other theoretical literature on ethical sensitivity

which does not explain how ethical issues are identified (Betan, 1997; Cottone, 2001; Park, 2012).

Cross and Wood (2015) claimed it is imperative to separate one's emotional response to a situation from an evaluation of it to maintain professional practice. This seems somewhat at-odds with the findings here that CPs' emotional response to an event is the very thing that highlights to them there is a situation about which a decision needs to be made. Therefore whilst further consideration of one's emotional response is necessary to understand the reasons for it, rather than a decision being based solely on emotional response, it seems misleading to suggest it is necessary to separate one's feelings from events in order to consider the options impartially (Cross & Wood, 2015).

Limitations

Limitations of this study include that participants were drawn from one area of the country (South East England) and were mainly White British.

As the developed theory reflects participants' accounts of how they notice ethical issues and notes the importance of the context in affecting their thinking, it does not fully address how ethical problems may not be identified by CPs.

Despite efforts made to ensure an open-minded stance in data collection and analysis, it is possible that the researcher's beliefs about the importance of emotions in recognising ethical problems may have affected the developed theory.

Clinical implications

The pressures for services resulting in demands outstripping resources which in turn contributes to intolerable discomfort for CPs, which may result in them walking away from

public healthcare services altogether, is an important finding at this time of austerity-focused economic policy (Karanikolos et al., 2013). It is concerning because it may indicate service contexts are frequently causing CPs significant discomfort and may be preventing them from resolving this by preventing them from properly considering the issues.

To ensure CPs are not left turning away from their ethical sensitivity in order to reduce their discomfort services must ensure that professionals' concerns about how the service functions are listened to, even when they cannot be acted upon immediately. Services also need to foster a culture of ethical awareness and responsibility, so the prevailing norms and social processes encourage, rather than discourage ethical sensitivity.

Further implications for services of CPs experiencing ongoing emotional burden include that highly-trained professionals may leave their roles if they are not supported to think about ethical issues in a way that is consistent with their values. Services should strive to provide opportunities for CPs to have time and space for reflective practice, to talk with others and to be given enough autonomy so they can take some action themselves to resolve difficult ethical situations.

The results imply that emotional burden may be detrimental to CPs' mental wellbeing. CPs should be supported to understand their experiences of discomfort, the link with their values base and also taught how to recognise difficulties resulting from the wider organisational context. Attention should be paid to how CPs can protect their wellbeing so as to not feel overburdened by situations they have little control over.

Supervisors should be made aware of ethical decision-making tools during supervision training. Services could also provide opportunities for CPs to obtain ethics consultation in drop-in ethics clinics, to have these important conversations. This would likely also benefit service users and organisations by promoting ethical practice.

Future research

How CPs moderate their ethical sensitivity so as to not become overwhelmed by their emotional response could be further explored in future. It is important to understand how CPs can look after their mental wellbeing to support them to maintain clinical practice in the NHS.

It is notable that a large body of literature provides advice about making ethical decisions or maintaining ethical practice, alongside tools to use but participants here at no point mentioned using these. Further investigation as to why this is may help to provide information and resources in a useful format.

Conclusion

This research has highlighted that the CPs interviewed demonstrated high levels of ethical sensitivity; participants frequently experienced discomfort, rooted in a gut instinct that something in the situation was not right and a perception that important values were being compromised. Therefore it was not so much a case of finding that "…ethical lapses result from our lack of consciousness or neglect" (Walsh, 2015, p. 69) as was anticipated, but rather that the context the CP finds themselves within is key to whether they attend to their feelings of discomfort to understand the cause, which enables the process of ethical sensitivity.

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Section C: Appendices

Appendix A. Burns and Kho (2015). Quality appraisal guide for surveys

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Appendix B. Canterbury Christ Church University ethics approval

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Appendix C. NHS Trust 1 R&D Project Approval and Registration Confirmation

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Appendix D. Study information sheet

12th September 2017
Version 4

Information about the research

Clinical psychologists' moral sensitivity in clinical practice: how they identify ethical issues and when they choose to examine them further

Hello. My name is Catherine Chiffey and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish.
(Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study).

What is the purpose of the study?
The purpose of this project is to explore how clinical psychologists identify ethical issues at work. As healthcare professionals, clinical psychologists are expected to comply with professional standards and ethical guidelines including from the Health and Care Professions Council. In addition, the public expect a high level of ethical behaviour from public services. In order to behave ethically, it is necessary to make decisions about ethical issues that arise. There are a number of tools available to support professionals to make complex ethical decisions. However, it is unclear how the decision to think about ethical issues is reached. The identification of potential dilemmas has been described as moral sensitivity. Research has to date explored how other healthcare professionals identify and think about ethical issues but this has not been investigated in relation to clinical psychologists.

Why have I been invited?
You have been invited to participate as you are a practicing clinical psychologist and as part of your role you are likely to have encountered ethical issues. It is your personal experience of these moral dilemmas that are the focus of this research. We are hoping to gather a range of experiences and so are approaching psychologists working in different types of services and with varying amounts of post-qualification experience.

Do I have to take part?
It is up to you to decide whether to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the appraisal of your work performance or your employment in any way.

What will happen to me if I take part?
You would be contacted by me to arrange a suitable time and place to complete an extended interview. The interview would be conducted by me and would take place face to face (not on the telephone). It is likely that the interview would last around 1-2 hours. It might be necessary to hold the interview over more than one date. The meeting would take place in a venue that is convenient for you to access and you would not be expected to travel far from your place of work or home address. If it is not possible for me to meet you in person, the interview may be arranged to take place via a video call (e.g. using Skype). It is anticipated that all the study interviews will be held from June 2015 – December 2017. The data analysis and write up of the study is expected to be completed by April 2018.

The interview will be audio recorded and transcribed. The audio data will be stored until April 2018 or until project completion (if longer) and the anonymised transcript data will be stored for 10 years by Canterbury Christ Church University and in my possession to comply with research requirements. Paper consent forms will be stored in the Salomons research office in a sealed for five years. After five years they will be shredded without viewing. They will only be checked if a problem arises after the research and it is necessary to verify that informed consent was obtained.

Information that might identify participants will not be reported in either the study report or any publication that may result from this project.

Expenses and payments
If you choose to travel to a mutually agreed location for the interview, you can be reimbursed for your travel expenses for up to £10. There will not be any payment for participation in this study.

What will I have to do?
To take part in this study you will need to contact me to express an interest. Depending upon the numbers of people volunteering to take part, you may be asked to complete a short questionnaire to help us to decide who to interview as we are trying to gather a range of types of experience. You will be contacted to arrange an interview at a time and place convenient for you. You would then need to be willing to discuss with me your experiences of encountering ethical issues and making decisions about them. This would include discussion of your personal values and how they impact on your work.

What are the possible disadvantages and risks of taking part?
Sometimes ethical issues that clinical psychologists deal with are distressing in nature. You will not be asked specifically about distressing experiences, however in discussing ethical issues it might be that you find this stressful or uncomfortable.

What are the possible benefits of taking part?
Discussing your personal experiences of ethical issues may be an interesting reflective process to engage in. Whilst it is not certain that you would benefit in this way by taking part, your contribution to the study would help to inform ways to support clinical psychologists to comply with ethical and professional standards.

What if there is a problem?
If you are concerned about the way you have been dealt with during the study or any distress that you may experience as a result of taking part will be addressed. Detailed information is given on this in Part 2 of this information sheet.

Will my taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.
If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Canterbury Christ Church University

12th September 2017
Version 4

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?
If you decide to withdraw from the study after you have been interviewed, it is unlikely that the data you would have provided could be removed from the analysis. This is because grounded theory method, which will be used, requires data analysis to commence after the first interview. Therefore, if you withdraw from the study, we would like to use the data collected up to your withdrawal, however you would not be asked to provide any further information at a later date.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions. You can leave a message for me by phoning 01227 92 7070. Please leave my name (Catherine Chiffey) with the message as this is a shared message facility. If you remain unhappy and wish to complain formally, you can do this by contacting the Salomons Centre for Applied Psychology. Contact details can be obtained from www.canterbury.ac.uk.

Will my taking part in this study be kept confidential?
Your confidentiality will be safeguarded during and after the study. The following details what will happen with information collected from you.

- Your interview data will be collected using an audio-recorder. It will be transferred to a password protected encrypted memory stick following the interview
- Paper consent forms will be stored in the Salomons research office in a sealed for five years. After five years they will be shredded without viewing.
- The data will be used only for this study and analysis of the data will commence immediately after data collection
- The audio data will be transcribed by either the researcher or a professional external transcriber
- The external transcriber will be asked to sign a confidentiality agreement to ensure that they protect your data and your confidentiality
- When the interview is transcribed identifiable data will be removed from the transcription to ensure anonymity of participants
- The research supervisors may have access to a selection of the audio data during the process of data analysis and will have access to the anonymised transcriptions
- The audio data will be retained until the end of the study and the anonymised transcripts will be stored for 10 years. After this time has elapsed the data will be disposed of securely.
- The demographic data collected will be presented in the written report in a way that individual participants cannot be identified.

All information which is collected about you during the course of the research will be kept confidential unless you disclose to me unethical practice that you have engaged in or witnessed at work or if I am concerned for an individual's safety or wellbeing. In this situation I would be professionally obliged to discuss this with the project supervisors. It may then be necessary to report the details to the relevant regulatory organisation (the HCPC). I might need to seek further information or clarification about this from advisory bodies such as the British Psychological Society. If I have concerns and need to discuss them with persons outside of the research group (i.e. other than with my supervisors) I would endeavour to

discuss my concerns with you first using the contact details that you provide to me. If I am concerned for an individual's safety or wellbeing I would be professionally obliged to act and may need to discuss this with your employing organisation.

If you would like to see a copy of your interview transcript to check the accuracy of the data held about you, please discuss this with me.

What will happen to the results of the research study?
The results will be written up for submission to Canterbury Christ Church University. A shorter report will be written for submission to a research journal. You will not be identified in any report of this project. We would like to use anonymised quotes in both the reports. Any quotes will be selected carefully so individual participants cannot be identified from them. You will be given the opportunity to choose to receive a report of the study results.

Who is organising and funding the research?
The research is being organised by me and the research supervisors. It is being authorised and funded by Canterbury Christ Church University.

Who has reviewed the study?
As you will be aware, all research is reviewed by a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by The Salomons Centre Research Ethics Committee. If you have been recruited via your employing NHS trust this research has been registered and recruitment has been authorised by your trust research and development department.

Further information and contact details
If you would like information about research or ethics please see the British Psychological Society website (www.bps.org.uk).

If you would like information about professional standards of proficiency please see the HCPC website (www.hcpc-uk.org).

To discuss any questions or concerns about the study with me, you can leave a message for me on a 24-hour voicemail phone line at 01227 92 7070 and I will return your call. Please say that the message is for me (Catherine Chiffey) and leave a contact number so that I can get back to you.

Appendix E. Study consent form

Centre Number:
Study Number:
Participant Identification Number for this study:

CONSENT FORM

Title of Project: Clinical psychologists' moral sensitivity in clinical practice: how they identify ethical issues and when they choose to examine them further

Name of Researcher: Catherine Chiffey

Please initial box

1. I confirm that I have read and understand the information sheet dated 12th September 2017 (version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my employment or legal rights being affected.	☐
3. I understand that my interview will be audio recorded and fully transcribed by the researcher or an external transcriber.	☐
4. I understand that relevant sections of my audio recorded interview and the transcript may be looked at by the supervisors Dr Fergal Jones and Dr Helen Caird in addition to the researcher Catherine Chiffey. I give permission for these individuals to have access to my data.	☐
5. I agree that anonymous quotes from my interview may be used in the submitted report to Canterbury Christ Church University and published reports of the study findings.	☐
6. I agree to take part in the above study.	☐

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent _____ Date_____

Signature _____

Appendix F. Participant recruitment advert

Version 2

Canterbury Christ Church University

Would you like to be interviewed for research into **clinical psychologists' identification of ethical issues**?

Clinical psychologists' moral sensitivity in clinical practice: how they identify ethical issues and when they choose to examine them further

The purpose of this project is to explore how clinical psychologists identify ethical issues at work. Clinical psychologists make decisions about how to respond in ethically challenging situations. Before these decisions can be made individuals need to identify potential ethical challenges as they arise, which has been described as moral sensitivity. This research is exploring the factors involved in the process of noticing and thinking about ethical issues.

If you are currently working as a clinical psychologist and would like to contribute up to 2 hours of your time to participate please contact us!

You can register your interest by emailing the researcher Catherine Chiffey Trainee Clinical Psychologist, at **c.chiffey414@canterbury.ac.uk,** you will then be emailed the full information sheet and consent form before being asked whether you would like to participate in an interview.

This project is part of the researchers Doctorate in Clinical Psychology at the Salomons Centre for Applied Psychology, Canterbury Christ Church University. Interview locations will be arranged with each participant. If it is not possible for the researcher to travel to your location interviews can be conducted online.

Thank you for taking the time to consider taking part!

Appendix G. Ethics panel approval email of amendment to recruitment procedures

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Appendix H. NHS Trust 2 R&D Project Approval and Registration Confirmation

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Appendix I. Demographics form

Interview identification code: .....

Demographic Information

Please complete as much of this form as you would like to.

Number of years since qualification: .....

Type of service currently working in (e.g. inpatient or community; CAMHS, older adult):

.....
.....

Current role (banding or seniority within a team):
.....

Composition of team (please circle):

lone psychologist within a multidisciplinary team or within a team of psychologists

Areas of specialism or models primarily worked with:
.....

Age 25-34 35- 44 45-54 55-64 65-74 Prefer not to disclose

Gender .....

Ethnicity (please circle or state below)

Asian or Asian British:	Indian	Arab	Black or Black British:	Caribbean	Mixed:	White and Black Caribbean	White:	British
	Pakistani			African		White and Black African		Irish
	Bangladeshi			Any other Black background		White and Asian		Gypsy and Irish Traveller
	Chinese					Any other Mixed background		Any other White background

Any other ethnic group.....

Prefer not to disclose

Religion

Agnostic	Atheist	Baha'I	Catholic	Chinese (Taoist)
Hindu	Buddist	Christian	Humanist	Japanese (Shinto)
Jewish	Muslim	Pagan	Rastafarian	Sikh

Spiritualist

Other

Prefer not to disclose

Disability

Yes No Prefer not to disclose

Sexual orientation

Gay Lesbian Bisexual Heterosexual Prefer not to disclose

Appendix J. Interview guides

Interview guide 1

1. What do you understand to be the role of ethics in your work?

Prompts: What informs your understanding of ethics?

What factors are important to you?

- Prof guidelines
- Prof values
- Personal values
- Gut feel
- Colleagues
- Other?

2. How do your personal values have an impact on you at work?

3. What personal values are important to you?

Prompts: Why is that important?

When did this first become important to you?

Has this changed over time? i.e. pre-post qualification / in the years since qualification?

4. Can you tell me about a difficult ethical decision that you have had to make at work in the past 6 months?

5. How did this issue first become apparent to you?

Prompts: What did you first notice?
Why do you think you noticed this? Would others have noticed this?
What alerted you to the ethical component?
Is this typical of how you notice ethical decision? If not, how is it not?

6. How did you decide to act?

Prompt: Was this difficult?
Did anything hold you back/ deter you?

7. Are there other factors about noticing this ethical issue that are important which you haven't yet discussed?

Interview guide amended after five interviews

1. What does "ethics" mean to you?

2. What informs your personal ethics?

- What has informed the development of your values, moral beliefs and own ethics?

- Are your personal ethical beliefs static or are they continuing to develop? What contributes to their development?

3. What ethical considerations guide your work?

4. When you encounter a tricky situation at work, what first draws your attention to it?

5. What factors do you consider in order to decide if a tricky situation requires special attention?

6. At work, do you ever think in terms of something having ethical connotations?

- At work, do you ever think that something needs to be considered in terms of related ethical codes or guidelines?

7. Do you have an example of a tricky situation or ethical challenge from work that you could tell me about? Could you explain how you first encountered it? How did you notice it?

8. Do you think that ethical considerations can be separated from other considerations such as clinical factors (like best practice), legal factors, or service and Trust priorities?

Interview guide 3

1. What do you understand to be the role of ethics in your work?

2. Can you think of a situation you found to be an ethical challenge? (A situation you found genuinely difficult). How did you first notice it?

- What made you first realise you needed to think about it more?

3. If you do not think you have encountered a situation that you have found an ethical challenge recently, why do you think this is? Would this always have been the case or has your experience of ethical challenges changed over time?

4. What role do you think your emotions have in noticing ethical issues? Do you think they facilitate or hinder your noticing?

5. Do you encounter difficult situations at work, that require your decision-making, that you don't consider to be ethical in nature?

Appendix K. Abridged research diary

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Appendix L. Example coding of an interview

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Appendix M. Development of categories

1. Focused coding; starting to group into flexible categories

Code Family: *That kind of uncomfortableness is an alert
Created: 2017-12-30 09:09:06 (Super)
Codes (19): [A sense of wanting to resolve the discomfort] [Concern for others prompted noticing of issue] [Does that feel fair?] [Emotional response as an alert] [Feeling alerting to a problem] [First notice something individually; within oneself] [I always start with how do I feel; using feelings to evaluate situation] [Its a bodily feeling; gut reaction] [Jarring with beliefs and values] [Jarring with expectations] [Not knowing what to do next prompts identification of issue to be considered] [Others distress as alert] [Personal experiences contribute to gut reaction] [Pivotal role of others' emotions & perceptions in noticing issues] [Taboo topics, others shock in issues defined as ethical] [That feeling of going against my values] [That kind of uncomfortableness] [There's an emotional component to it] [Worry as catalyst for particular thoughts about situations' ethicality]
Quotation(s): 207

Code Family: A decision is required
Created: 2017-09-16 09:52:45 (Super)
Codes (3): [Pragmatic need to make a decision] [Team pushing for consensus] [Time pressures meaning a decision was necessary]
Quotation(s): 5

Code Family: A sense of fundamental, basic principles
Created: 2018-01-07 08:02:02 (Super)
Codes (29): [Belief in the importance of familiarity for clients] [Client experience different to psychologist's] [Clients have to be prepared to take risks in therapy] [Colleagues fear of client being harmed due to teams actions] [Considering best interests] [Considering clients needs] [Considering role of the person in the situation] [Considering who the client is] [Empowering clients and carers] [Enabling clients to make informed choices] [Encouraging clients to talk about their own ethics, values & beliefs] [Feel comfortable when client informed and views voiced] [Focus being on the client in session] [Guided by fairness and meaning for client] [Importance of strong relationship with client to get through any mistakes] [Interventions can be both helpful and unhelpful for different people] [Keeping the client at the centre] [Not wanting information compiled to support clients being used against them] [Noticing client's lack of control] [Person centred working] [Prioritising clients' needs] [Protecting clients rights] [Respecting clients choice] [Risk of accusations not being believed] [Taking a personal slant and advocating for client] [The importance of individualised care, not institutionalised care] [Thinking about each clients individual perspective] [Understanding of client informing response] [Unethical to provide assessments without further interventions or support]
Quotation(s): 171

Code Family: A sense of fundamental, basic principles to be adhered to
Created: 2017-09-16 10:52:47 (Super)
Codes (4): [A sense of fundamental, basic principles to be adhered to] [Ethics permeates all decisions] [Those are fundamental principl..] [Where is the line for it all]
Quotation(s): 13

Code Family: Awareness of professional responsibilities and rights
Created: 2017-09-10 08:19:35 (Super)
Codes (12): [Awareness of professional responsibility] [Basic tasks to ensure ethical practice] [Clients and carers seeking support] [Consideration of personal and professional boundaries] [Ensuring clients safety] [Having a clear rationale for work with clients] [Having to look into cases of false allegations] [Knowing your rights as a professional] [Limits to psychologists responsibility and control] [Needed to look after myself] [Own moral code is important because the work can be intrusive] [The type of issue can signal what needs to be considered if are clear frameworks for decision making (e.g. capacity)]
Quotation(s): 97

Code Family: Awareness that situation is not static; need to think flexibly
Created: 2017-09-10 20:14:25 (Super)
Codes (2): [Identifying a significant point at which dangerous situations might arise] [Situations can change]

Quotation(s): 8

Code Family: Certain events trigger thought about professional and ethical responsibilities
Created: 2017-09-10 13:06:46 (Super)
Codes (17): [Accidentally making a disclosure about oneself] [Certain events make you realise there's an ethical issue] [Clients not attending or dropping out as raising ethical issues regarding how to help] [Clients pushing boundaries] [Disinhibition as heralding ethical challenges] [Identifying a range of issues] [Identifying a significant point at which dangerous situations might arise] [Information obtained earlier 'got me thinking that way'] [Issues identified by others as ethical] [Not knowing what to do next prompts identification of issue to be considered] [Noticing a hidden agenda] [Noticing gaps in needs met as alert] [People being impacted indicating ethical issue] [Realising it would require more thought] [Realising that client de-railing session] [Safeguarding referrals as common ethical issues] [Topic of issue signalling ethical territory]
Quotation(s): 62

Code Family: Considering multiple perspectives
Created: 2017-08-24 10:36:46 (Super)
Codes (8): [Considering multiple perspectives] [Considering the team's needs] [Cultural differences in communication] [Making decisions as a team is important] [Others perceptions affecting whether situation is viewed as problematic] [Presence of multiple viewpoints in ethical challenges] [Trying to ensure plan appropriate for most involved] [What others know or perceive about a situation]
Quotation(s): 50

Code Family: Deciding there's no issue to resolve
Created: 2017-09-16 11:45:01 (Super)
Codes (2): [Problem perceived to have resolved] [Recognising when clients are receiving appropriate support]
Quotation(s): 3

Code Family: Deep recognition of another's feelings and perspective
Created: 2017-09-10 11:54:43 (Super)
Codes (17): [Appreciating peoples fragility] [Carers tired by role] [Clients sense of self diminished] [Coming to therapy at a crossroads or with regrets] [Complexity of different peoples involvement and emotional responses] [Considering clients feelings] [Deep recognition of another's feelings and perspective] [Difficulty of clients trying to share own personal views] [Disclosing some personal information is difficult for some people to "admit to"] [Identifying with the client] [Impact on caring for people with a history of making false allegations] [Importance of feeling able to still do] [Own experiences facilitating empathy and understanding] [Putting self in anothers shoes] [Recognising shared humanity of clients and psychologists] [Validating the clients/carers perspective] [Wishful thinking about things having been better]
Quotation(s): 74

Code Family: Different factors to be identified and considered
Created: 2017-09-10 20:27:40 (Super)
Codes (7): [Communication break down identified as a factor] [Ethical component of decisions made is "one of those streams" of different factors] [Interacting mental health and abilities issues] [Naming ethical components] [Need to identify the core components of the issue] [Tailoring response in light of understanding of each individuals needs] [There's an emotional component to it]
Quotation(s): 26

Code Family: Driven by sense of duty and values which maintains personal integrity
Created: 2017-09-09 16:58:33 (Super)
Codes (23): [Change is possible] [Coherence between personal beliefs and values with professional expectations] [Doing the right thing despite cost] [Driven by personal values] [Driven to act by personal values] [Driven to act by sense of duty and values to maintain personal integrity] [Ethical practice to help ensure individuals are valued] [Faith and beliefs inform morals, ethics and principles] [Family experiences having influenced career choices] [Guiding value of promoting quality of life] [Holding hope for the client as a value] [Holding on to own beliefs in the background] [Hoping not to offend people when discussing things] [I guess you have your own mora..] [I might fight for people's rig..] [Increasing awareness of own values] [Individuals own moral code informing their work] [Moral imperative to act when not happy to leave something] [Motivated by

value to care for others] [Motivated to attend to ethical considerations] [Role of psychologist to guide people to a positive future] [Role of psychologists passion in driving work choices] [Valuing people as guiding decisions]
Quotation(s): 183

Code Family: Emotional burden of noticing ethical problems
Created: 2017-09-09 17:14:10 (Super)
Codes (7): [Difficult for your offers of help to be unwanted] [Difficulties of relying on carers to take action] [Emotional burden of being confronted by ethical problems] [Emotions evoked by being unable to do what you know you should] [Fear of having missed something] [Keeping work in perspective] [Pressure to record all work and cover oneself "in case something horrible happens"]
Quotation(s): 38

Code Family: Enabling client's understanding
Created: 2017-09-07 19:43:53 (Super)
Codes (4): [Enabling clients understanding] [Helping clients have a sense of understanding their experiences] [Importance of client understanding what is being offered] [Importance of communicating understanding to client]
Quotation(s): 9

Code Family: Enabling others to develop alternative understanding
Created: 2017-09-10 13:16:01 (Super)
Codes (3): [Enabling others to adopt different viewpoint] [Providing a different perspective] [Psychologist role as breaking things to others in a manageable way]
Quotation(s): 26

Code Family: Encountering a range of ethical issues
Created: 2017-09-16 09:22:51 (Super)
Codes (1): [Ethical issues arise in all areas of work]
Quotation(s): 9

Code Family: Ensuring others supported
Created: 2017-09-16 09:08:37 (Super)
Codes (4): [Ensuring others supported] [Making sure care staff receive supervision to deal with challenging behaviour] [Offering support] [Shortage in services leaving people without support]
Quotation(s): 52

Code Family: Ethical challenges hard to define
Created: 2017-09-10 11:46:23 (Super)
Codes (10): ["tricky situations"] [Difficult to recall discussion of ethical challenge] [Difficulty naming ethical issue] [Ethical challenges hard to define] [Ethics as oblique] [Ethics is a massively broad-br..] [Guessing what the main ethical issue was] [I guess again] [The role of ethics in ones work is a "complicated question"] [Wrong and right and all the grey bits in the middle]
Quotation(s): 49

Code Family: Ethical dilemmas weighty and difficult to navigate
Created: 2017-09-10 20:17:41 (Super)
Codes (5): [Ethical dilemmas may be recognised by their weightiness] [Ethical issues as hard work to navigate] [Ethics and morality perceived as potential warzones] [Some things seem like bigger decisions at the time that they do when looking back] [Wading into ethical territory]
Quotation(s): 17

Code Family: Expectations clashing
Created: 2017-09-09 20:52:35 (Super)

Codes (10): [Differences in personal ethics and morals as a flashpoint between people] [Different perspectives in MDT prompting discussion] [Ethical dilemma occuring due to difference with others] [Ethics and morality perceived as potential warzones] [Historical work impacting carer expectations of psychologists behaviour] [Jarring with expectations] [Particularly difficult to work with clients who have radically different values] [Service restrictions clashing with personal ethics] [The challenge of clients trying to change oneself (the psychologist)] [Working with people with very different perspectives is challenging]
Quotation(s): 33

Code Family: Exploring and seeking to understand
Created: 2017-09-07 19:42:20 (Super)
Codes (7): ["get to the crux of [the problem]"] [Evaluating others' rationale] [Exploring the situation with clients] [Reading between the lines] [Talking to family when client cannot provide information] [Understanding informed by person's history] [When these issues come up it is helpful to have a discussion]
Quotation(s): 37

Code Family: Facilitating communication
Created: 2017-09-09 16:47:01 (Super)
Codes (7): [Communicating with others] [Expressing own emotional response] [Facilitating communication] [Facilitating communication, empathy and understanding] [Holding uncomfortable conversations] [Role of psychologist in making recommendations to others] [Thinking and talking about issues]
Quotation(s): 47

Code Family: Familiarity with issues can prompt noticing and aide decision making
Created: 2017-09-10 08:18:30 (Super)
Codes (2): [Frequency of issue prompts recognition] [Lots of ethical issues in challenging behaviour work]
Quotation(s): 8

Code Family: Helpfulness of diversity when discussing issues
Created: 2017-09-10 21:06:05 (Super)
Codes (6): [Making decisions as a team is important] [Seeking diverse opinions to support decision making] [Sought advice from a range of sources] [Team debating appropriateness of situation] [Teamwork enabling missed things to be noticed] [Value of diversity within own team]
Quotation(s): 40

Code Family: Helpfulness of team decision making
Created: 2017-09-16 09:58:41 (Super)
Codes (6): [Helpfulness of team decision making] [Importance of believing own team is good] [Making decisions as a team is important] [Much more experience of team decision making post-qualification] [Trust and safety in team decision making] [Unclear where ethics discussed and if by individuals or teams]
Quotation(s): 29

Code Family: Hidden truths
Created: 2017-09-05 21:17:45 (Super)
Codes (11): [A persons experience is concealed from others' understanding] [Information being concealed causing upset] [Making your best guess] [Not possible to know] [Not taking things at face value as gain more experience] [Others concealing things from clients] [Peoples abilities or intentions unknown by us] [Peoples experiences are concealed and unknown] [Psychologists desire to leave some things unknown] [Secrets staying secrets to avoid upset] [Seeking to identify the truth]
Quotation(s): 29

Code Family: Identifying level of ethical issue; individual, family, group, societal
Created: 2017-09-09 16:50:24 (Super)
Codes (5): [Considering ethics for individuals versus society] [Identifying level of ethical issue] [Noticing ethical issues at societal level] [Noticing systemic problems] [Noticing unfair systems and services]

Quotation(s): 19

Code Family: Impact of wider context
Created: 2017-09-16 09:49:35 (Super)
Codes (10): [Considering the team's needs] [Impact of pressure on teams can be subtle but adds up over time] [Impact of wider context on changing practice over time] [Knowing how to use the system to obtain support] [Power influencing whose ethics inform practice] [Risks being different in private practice] [Role of ethics in guiding own practice and wider service delivery] [Specific to the ward environment] [Time pressures] [Working privately enables work to be in line with personal values]
Quotation(s): 22

Code Family: Increasing ability to sit with discomfort
Created: 2017-09-09 16:53:25 (Super)
Codes (3): [Better now at living with decisions made] [I can stew a bit longer now.] [Increasing ability to sit with discomfort]
Quotation(s): 16

Code Family: Learning from experience; personal and professional
Created: 2017-09-05 21:26:02 (Super)
Codes (6): [Acquire framework for working ethically during training] [Learning from experience (own and others')] [Learning from experience; personal and professional] [Life experiences influence ongoing value development] [Managing the impact of personal life events on work] [Unfamiliarity with work topic or service]
Quotation(s): 68

Code Family: Motivated to do the best one can
Created: 2017-09-07 19:37:02 (Super)
Codes (2): [Motivated to try to find the best outcome] [You do the best you can at the time]
Quotation(s): 11

Code Family: Not knowing what to do next prompts thinking
Created: 2017-09-28 15:28:16 (Super)
Codes (2): [Not knowing what to do next prompts identification of issue to be considered] [Noticing areas of stuckness]
Quotation(s): 14

Code Family: Openness facilitates noticing
Created: 2018-01-03 20:25:55 (Super)
Codes (1): [Openness facilitates noticing and discussing beliefs and ethics]
Quotation(s): 12

Code Family: Others not respecting clients
Created: 2017-09-14 20:05:29 (Super)
Codes (3): [Others not informing clients of referrals is problematic] [Others trying to make clients go through "unecessary" assessments] [Peoples views being imposed on particular populations]
Quotation(s): 5

Code Family: Prioritising clients needs and motivated by clients best interests
Created: 2017-09-07 19:39:40 (Super)
Codes (29): [Belief in the importance of familiarity for clients] [Client experience different to psychologist's] [Clients have to be prepared to take risks in therapy] [Colleagues fear of client being harmed due to teams actions] [Considering best interests] [Considering clients needs] [Considering role of the person in the situation] [Considering who the client is] [Empowering clients and carers] [Enabling clients to make informed choices] [Encouraging clients to talk about their own ethics, values & beliefs] [Feel comfortable when client informed and views voiced] [Focus being on the client in session] [Guided by fairness and meaning for client] [Importance of strong relationship with client to get through any mistakes] [Interventions can be both helpful and unhelpful for different people] [Keeping the client at the centre] [Not wanting information compiled to

support clients being used against them] [Noticing client's lack of control] [Person centred working] [Prioritising clients' needs] [Protecting clients rights] [Respecting clients choice] [Risk of accusations not being believed] [Taking a personal slant and advocating for client] [The importance of individualised care, not institutionalised care] [Thinking about each clients individual perspective] [Understanding of client informing response] [Unethical to provide assessments without further interventions or support]
Quotation(s): 171

Code Family: Putting effort into thinking
Created: 2017-09-07 19:49:23 (Super)
Codes (2): ["...puzzled over it a lot..." to understand ethical situations] [Thinking through ethical challenges takes effort]
Quotation(s): 4

Code Family: Seeking information from diverse sources to inform decision-making
Created: 2017-09-16 08:38:25 (Super)
Codes (4): [Charity published information as source of information to inform responses to behavioural challenges] [Knowing where to obtain information to guide decision making] [Seeking information from diverse sources] [Took issue to a meeting to ask colleagues' advice]
Quotation(s): 5

Code Family: Seeking meaningful change
Created: 2017-09-16 09:07:43 (Super)
Codes (3): [Others changing their behaviour when confronted with problem] [Seeking meaningful change] [Seeking to stop others behaving in certain ways]
Quotation(s): 11

Code Family: Sense of self as a professional
Created: 2017-09-10 12:14:59 (Super)
Codes (17): [Being able to take independent viewpoint] [Belief in psychologists ability to make people better] [Change how act on own values as gain experience] [Considering own position within ones team] [Easier when feel have had more input to decision] [Experienced lots of ethical challenges] [Growing sense of professional self] [I have never been sexually att..] [More of a sense of working within a team once qualified] [Not necessary to define self as religious] [Positioning self clearly when working independently] [Realising that other people may not have all the answers] [Self awareness developing through experience] [Sense of self as a professional] [Situating self in relation to length of experience] [Taking up a particular position] [Thinking about how the service constructs understanding of peoples difficulties]
Quotation(s): 76

Code Family: Societal context
Created: 2017-09-01 14:01:18 (Super)
Codes (9): [Attitudes in society changing slowly] [Does not think about wider societal ethical issues in day to day practice] [Ethics and morals of society must inform practice] [Impact of societal norms on people's lives unknown] [Impact of time people live in on how open they are to discussing personal information] [More recently things are being talked about more] [Problematic discourse in society] [Shortage in services leaving people without support] [Thinking about the impact of the time people live in as impacting views and attitudes]
Quotation(s): 59

Code Family: Some people more interested in ethics
Created: 2017-09-14 20:21:40 (Super)
Codes (3): [Ethics as happening to the other] [Some people more interested in ethics than others] [Wider issues neglected by others]
Quotation(s): 7

Code Family: Stepping back to think
Created: 2017-08-24 10:38:50 (Super)

Codes (17): [Considering wider impact of decisions] [Creating a safe space for clients] [Ethics committee was a small panel open to anyone to bring a case] [Evaluating situational factors] [Flag up need for external support] [Giving oneself permission to not make a decision immediately] [Have I done enough] [Having a dilemma to make a decision about can be intellectually stimulating] [I think I am quite open minded..] [Open mindedness important] [Providing a thinking space as a supervisor] [Psychologist seeking support] [Questionning stance] [Role of the psychologist in understanding "big picture"] [Stepping back to think] [Supporting clients to think] [Thinking space]
Quotation(s): 141

Code Family: Taking account of peoples' beliefs
Created: 2017-09-01 10:39:43 (Super)
Codes (1): [Respect for others]
Quotation(s): 7

Code Family: Talking to facilitate own thinking
Created: 2017-09-10 08:41:41 (Super)
Codes (6): [Seek out people who share an interest in the same issues, to talk with them about them] [Talk to family about ethical issues in general] [Talking to facilitate own thinking] [Talking to others can help oneself think about ethical issues] [Thinking and talking about issues] [When these issues come up it is helpful to have a discussion]
Quotation(s): 27

Code Family: That kind of uncomfortableness
Created: 2017-09-01 17:18:20 (Super)
Codes (19): [A sense of wanting to resolve the discomfort] [Concern for others prompted noticing of issue] [Does that feel fair?] [Emotional response as an alert] [Feeling alerting to a problem] [First notice something individually; within oneself] [I always start with how do I feel; using feelings to evaluate situation] [Its a bodily feeling; gut reaction] [Jarring with beliefs and values] [Jarring with expectations] [Not knowing what to do next prompts identification of issue to be considered] [Others distress as alert] [Personal experiences contribute to gut reaction] [Pivotal role of others' emotions & perceptions in noticing issues] [Taboo topics, others shock in issues defined as ethical] [That feeling of going against my values] [That kind of uncomfortableness] [There's an emotional component to it] [Worry as catalyst for particular thoughts about situations' ethicality]
Quotation(s): 207

Code Family: Thinking flexibly and thoroughly
Created: 2017-09-09 16:45:31 (Super)
Codes (7): [Ability to think flexibly] [Having the ability to think] [Holding multiple possibilities in mind] [Holding things in mind] [Prioritising is essential] [Thinking flexibly and thoroughly] [Thinking systematically]
Quotation(s): 53

Code Family: Understanding emotional response
Created: 2017-09-01 13:35:52 (Super)
Codes (4): [Endeavouring to understand others] [I always start with how do I feel; using feelings to evaluate situation] [Making sense of own feelings and actions] [Understanding emotional response]
Quotation(s): 81

Code Family: Using both emotional and rational information to make tricky decisions
Created: 2017-09-28 21:50:21 (Super)
Codes (1): [Using emotional and rational information to make tricky decisions]
Quotation(s): 3

Code Family: Viewing situations differently compared with others
Created: 2017-09-10 08:10:06 (Super)
Codes (8): [Belief that others thought differently about the situation] [Clients' needs not being considered] [Cultural background affecting behaviour and interactions with others] [Ethics not prioritised by others] [Issues not identified by others] [Others not

giving issues as much weight] [People generally recognise dilemmas but give them different weight] [we will be biased in different..]
Quotation(s): 19

Code Family: Weighing things up and seeking a balance
Created: 2017-09-05 21:31:22 (Super)
Codes (9): [Balancing peoples different needs] [Balancing the clients rights with professional responsibility] [Complexity of ethical issues] [How do you weigh those things ..] [Priorities change when you are part time] [Recent organisational structure changes have helped in balancing different ethical considerations] [Weighing things up and seeking balance] [Weighing up competing factors] [Wondering how to prioritise things]
Quotation(s): 44

Code Family: When thinking is restricted
Created: 2017-09-09 16:49:08 (Super)
Codes (15): [Biases impacting decision making] [Challenges to thinking ethically] [Defining some clients as most difficult] [Equating own experience with that of clients] [Ethical issues arising when people lose ability to think] [Forced into making a decision on the spot] [Growing awareness of situation as went along] [Hard for others to stop and think] [Having to get on with practical tasks can prevent further thought about a situation] [Judgement being clouded by other needs and wants] [Lack of professional autonomy] [Reacted without thinking] [Service priorities impacting practice] [Trying to work out where judgement may be clouded (impaired) by own experiences] [When thinking is restricted]
Quotation(s): 67

2. Continued development of categories; searching for core categories

Code Family: *That kind of uncomfortableness is an alert

Intuitive component:

Gut feeling

Emotional response as an alert

Anxiety

Emotional response:

Deep recognition of another's feelings and perspective

Code Family: Emotional burden of noticing ethical problems

Cognitive component:

Observed event clashes with values

Certain events trigger thought about professional and ethical responsibilities

Jars with beliefs and values (inc. others not respecting clients)

Jars with expectations of ethical work practices (viewing situations differently compared with others)

Naming ethical components

Worry as catalyst for thinking about ethicality

Realisation becoming conscious

Code Family: Ethical challenges hard to define – renamed as 'process of defining ethical challenges'

Surprise, sudden reaction – also memo 'surprise'

Gradual realisation of unease

Code Family: Impact of wider context
Economic

Time of shortage

Service

Helpfulness of team decision-making

Personal

A sense of fundamental basic principles to be adhered to (core category)

Code Family: Driven by sense of duty and values which maintains personal integrity
Learning from experience

Growing sense of self as professional

Increasing ability to sit with discomfort

Psychologists desire to leave some things unknown – part of being driven by sense of duty to maintain personal integrity

Considering multiple perspectives (inc. helpfulness of diversity when discussing issues; openness facilitates noticing)

Prioritising clients' needs and motivated by clients best interests (inc. seeking meaningful change)

Ethics permeates all decisions

Awareness of professional responsibilities and rights

When thinking is restricted (core category?)

Forced to make a decision on the spot (inc. a decision is required)

Believe action to resolve issue is not possible in the context.

Limit to psychologists responsibility and control

Code Family: When thinking is restricted
A decision is required
Ongoing emotional burden

May leave context perceived as unethical

May decide not in their control

Seek coherence between personal values and role expectations

Ethical dilemmas weighty and difficult to navigate

Code Family: Thinking space

Stepping back to think
Putting effort into thinking
Thinking flexibly and thoroughly
Awareness that situation is not static; need to think flexibly
Exploring and seeking to understand

Talking to facilitate own thinking (inc. helpfulness of team decision making)

Psychologist seeking support

Seeking information from diverse sources to inform decision-making
Using both emotional and rational information to make tricky decisions
Weighing things up and seeking a balance

Coherence with values restored

Coherence between personal beliefs and professional expectations

3. Final categories and sub-categories

Table 10. Table of categories and sub-categories with illustrative quotes

Core Category	Categories	Sub-categories	Example quotes
Discomfort	Discomfort *(Felt response and intuition that something is wrong)*		*That kind of uncomfortableness* *…it is the gut reaction, it's your gut, you know, does that feel comfortable or is it err, what feeling does that produce in you.* *I always kind of start with what, how do I feel about it.* *There's something that's not quite right and then you worry about it and then maybe you do get that discomfort. That sense of like you know, this isn't, I don't feel comfortable with this or what should I do and then yeah and then you're worrying about what you should do and then yeah, worry I think is that first sense that somethings, you need to think about this.* *I think it's a lot about gut reaction* *I just felt, just kind of like, a feeling of I want to get out of here. If that is a feeling. Frustration, yeah.* *…not a fully-fledged emotion that one can feel…when seeing somebody you're, quite often it will be a little bit after as I'm writing notes or something. I might have some discomfort, a feeling of discomfort or a feeling of that something doesn't feel quite right here.*
	Fundamental basic principles *(including personal values and professional responsibilities)*		*Those are fundamental principles that other people come back to and I am aware that a lot of those things that I see as fundamental principles come from different faiths.* *Things to do with sort of compassion and empathy and sensitivity I think are core in terms of thinking about how you work with someone, how you make decisions when it gets tricky as well.* *I think with rights come responsibilities so I have a responsibility because of the rights that I have, to promote the same for other people.*
	A sense of fundamental basic principles to be adhered to	Driven by sense of duty to maintain personal integrity	*Even though you know that if anything went wrong no one would point the finger at you. Everyone would say, yes you did everything you could. On paper. But they didn't know what, that you have this feeling, that tells you you're not, so you can either ignore that or for your own integrity be true to - and it is really unpleasant if you don't respond to what you think is the right thing to do and are proved right. It's a horrible feeling because you feel like you've done something wrong in a quite personal way.*
Conscious realisation of ethical problem	Conscious realisation of ethical problem	Clash with own values	*I think that is at the heart of the anxiety that I've been speaking about and that we've been talking about and also that kind of, yeah, the discomfort of realising, I'm acting in a way that doesn't necessarily fit with my ethical guidelines.* *It just jarred I suppose with my expectations and my understanding of what gives people good quality of life.*

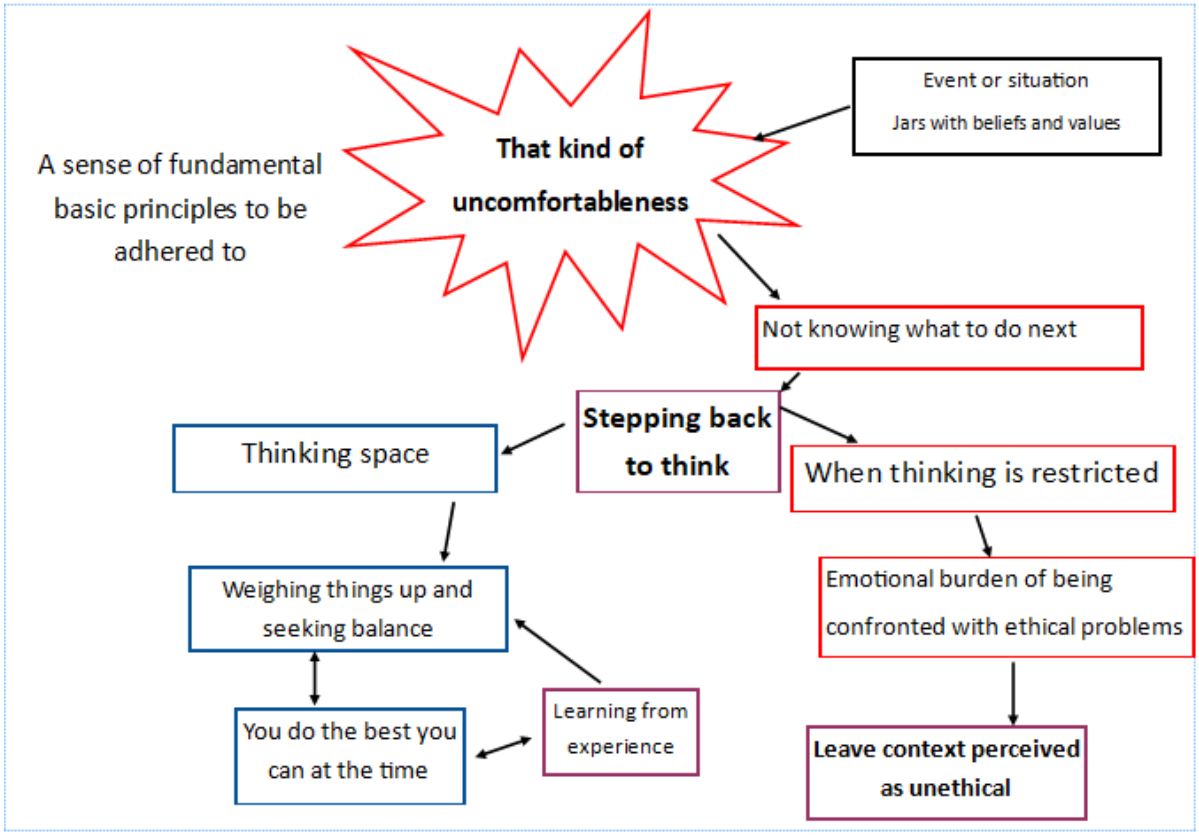
			But I think it's important to be able to take those things and actually then be able to kind of articulate exactly what it is that arouses those emotions because an emotion doesn't you know, you can't take an emotion to HR. *…it's very quick I am sure there is a thought, you know if you were to take that model, but very quick, just like any marked or strong reaction of surprise, a surprise, you know I just was surprised, so I think it was just, yeah it was quite sudden.*
	Conscious realisation of ethical problem	Openness to noticing	*The going beyond I think requires an openness to other things that might be giving you an, indicating to you that there are some other options to consider.* *So I think probably yeah, my own childhood, my own kind of adult life or my experiences. They have given me this sense of you know, that, what I'm comfortable with but then I always have to be aware that things might be different for other people and so I have to be aware of that and be open to that and question it and make sure that you know, I do question it, yeah.*
	Conscious realisation of ethical problem	Distraction preventing conscious realisation	*Because I've got kids and running the service, it's quite hard to stop and think and then sometimes at night I'll wake up and think, 'oh! I need to be thinking about that one a bit more'.* *I think in my earlier career I was saturated with anxiety about role stress and clinical sort of guilt and have I done enough, have I done it right? So I think a lot of that sort of intuition or nouse is sort of quite lost really, you know.*
Impact of context on assessment of situation	Service demands and resources	Time of shortage	*It's difficult. It's getting worse. It is difficult, I'm less happy in the NHS…We can't see them for all that they need. That is for sure. But I'm concerned that we don't quite do enough for them really.* *I've had some occasions recently where I've had to put myself in the position where I am promoting diagnosis where actually I think for an individual it's unhelpful but I think in order to get the service for that person made available I've had to promote it.* *…society feels individuals need more labels on them in order to be able to fight for them to get the resources that actually they need* (P.2) *…was just thinking actually, because, I think because the day-to-day running of my service is so in line, I hope, with what I like and if it's not I tweak it the biggest ethical dilemmas come I think in terms of connection with the outside world…. One dilemma I have, although I think I've got better at managing this recently, is referring onto CAMHS because I don't know quite whether they'll bounce back…*
	Service demands and resources	Services under pressure	*…if I am honest there was that oh, I didn't really want to deal with this, almost a heavy feeling of this is something. It is time consuming, and I want to deal with it well. I can't remember exactly but I think it came on a day where I was dealing with loads of different things and I was thinking oh, I don't have time to deal with this as well as everything else.* *And especially if you're anxious about the fact that you might lose your job and obviously in the current NHS climate that is quite a, you know, it's a big threat that we're all under. So I think it's harder to think about your own ethics if they're different from that in the organisation if you think that your own job's at risk.* *And then you know that those things will then impact on client care because morale impacts on, you know and it's subtle but over time they add up and if that's constantly happening…* *people leaving which then makes it even more stressful trying to manage what is left*

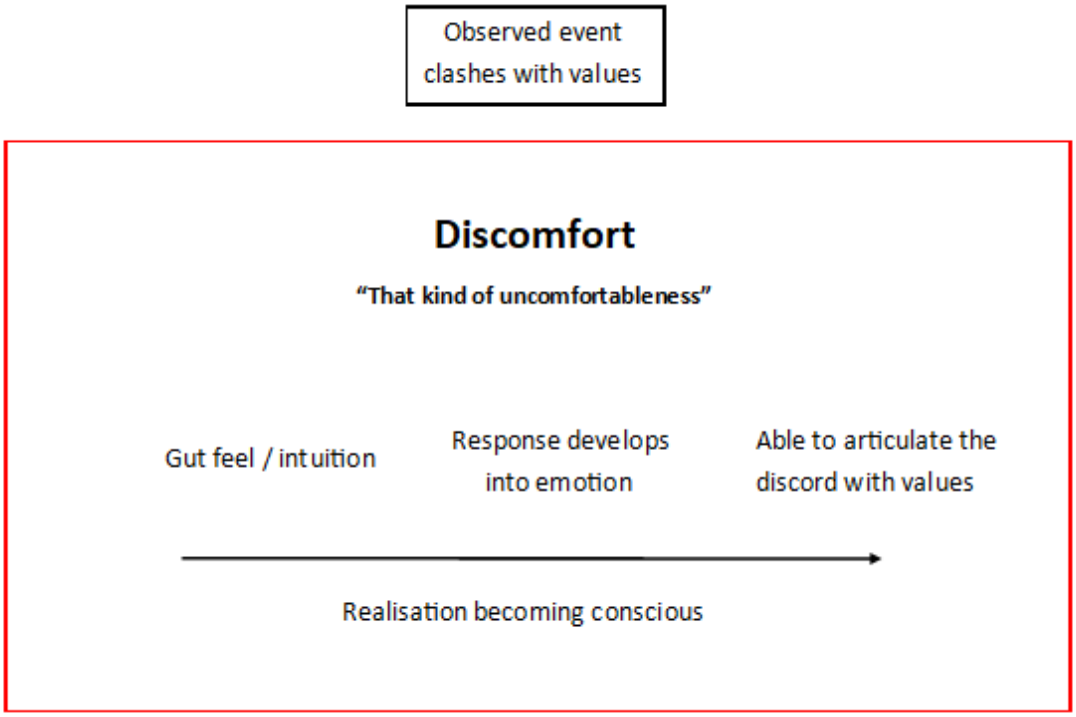
	Service demands and resources	Helpfulness of team decision-making	*I feel umm if it has been considered by lots of individuals with different experiences and lots of different professional backgrounds and we come to it then it will be a wiser decision, I trust it more, I trust the decision more* *I'm a member of a peer supervision group… So we have other people who are in independent practice so we share our ideas.*
	Thinking space	Stepping back to think	*Starting by just sort of reflecting, thinking it all through, keeping the anxiety parked but mindful of it.* *…it's still that stepping back from what's going on and almost like reading between the lines of what's going on.* *…having space to go to think about, breathing space to think about things is really useful.* *I personally prefer to take something away with me, think about how I'm going to respond and then respond in a way, that feels a bit more contained…*
	Thinking space	Talking to facilitate own thinking	*…but certainly seeking support and input from other psychologists and sort of mulling it over with them, I guess. Because it's not even necessarily about finding a solution, I think I know what I'm going to do. It's just having that conversation and sharing that with somebody, getting another perspective on it.* *I think it would be a sense of that feeling not quite right. I would do quite a lot of analysis of that myself and asking questions and also trying to problem-solve for myself within that but then I would be taking it elsewhere for further discussion.* *Yes I think that's the value of, in any situation the value of, if you have any sort of beginning gut level question about what you're doing or what's going on, however slight, I think it's worth talking to other people about it because erm sometimes that's just for clarity but sometimes I think genuinely people will see it through a kind of feeling response when you describe the situation. They will have a response that will make you see what you're beginning to see much more clearly…* *I had one case where [there was] an ethical situation and I spoke with my supervisor and I still wasn't happy with it so I spoke with the team and I had another response and I still wasn't sure about it so I spoke with my supervisor, you know still not sure, so I she said well where else can you take it? Where else can you discuss this? Why don't you go and discuss it with the family therapy service or why don't you do and discuss it with the ethics committee for the trust?*
	Thinking space	Increasing ability to sit with discomfort	*You know so, we could sit on it for longer, it's not like you have to make an instant decision, umm, yeah I can stew a bit longer now.* *I guess what I will probably learn over time, I'm not there at the minute, but I imagine in the future is a way to sort of limit the impact that those emotions have on my decision making in the sense that… where there is a lot of visible distress in the room, lots of tears and stuff, that can be quite motivating and I guess what I will likely learn over the time is to try and reduce the impact that that has on my decision making.* *It's easier if you can think 'well, I'll sort it out tomorrow' because usually you go through the options as you are going about other things.*

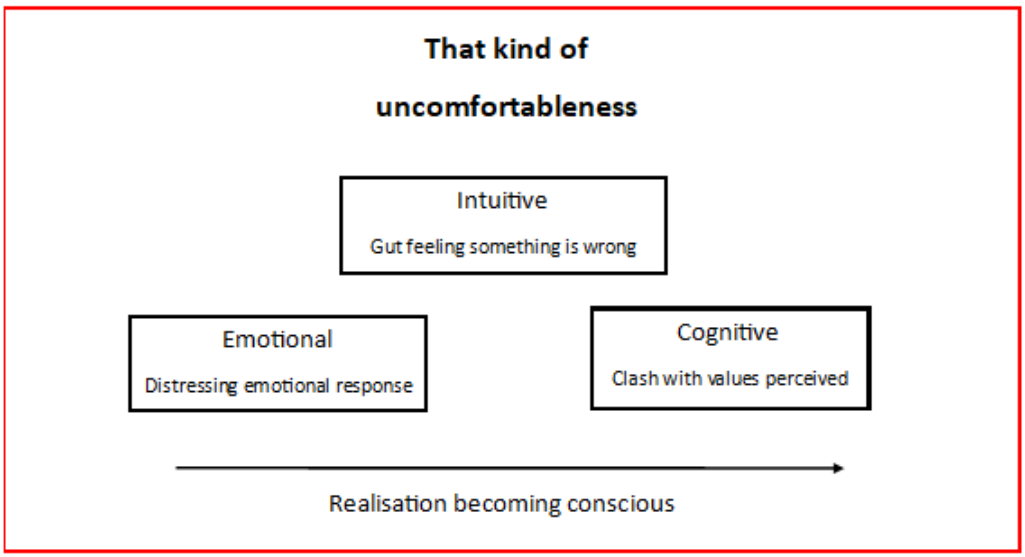
			I imagine if I've been in a team for five years it will be a lot easier to take that position of sort of that really kind of challenging all of the ethical stuff that comes up that feels a bit uncomfortable and encourage people to think about that and talk about it. And I think that will develop. *I think I probably had more anxiety than some people might have done, because I'm still newly qualified.* *I think having experience, for anybody, everyone's got, we've all got experience, for me at least the value of experience is a sort of greater relaxedness than I had when I was earlier in my career. I'm less anxious about my work than I used to be and it's to do with a kind of sense that should something come up here it will make itself known.*
	Coherence with values restored		*…you do the best you can with all the principles that you have and better at, to live with those decisions…* *Well, I think I probably am more of an action person than a sitting on it and hoping it will be alright. I like to kind of be quite…a bit more sure about that and to know that I've done all the right things.* *But when it's something else that is just like a more general clash with my identity, then there will be a bit of sitting with that and just trying to change things in more subtle ways. And feeling like if you are doing that then you are still having an influence. Even though it might be a slow one, it might just kind of seep out a little bit into the team. Then I think that's enough for now.*
	Thinking restricted	Limit to psychologists responsibility and control	*So not feeling that it's my responsibility to solve entirely I think that's the other thing.* *Is that ok? I don't know. But as you say I think it's when people come from such different cultures it's like questioning well what is the right thing, what is better or worse or good enough? And then thinking well actually maybe it's none of my business.* *And I do think that you need new people … new eyes to stop bad stuff happening and to you know, make good stuff happen. And to shake systems up a little bit but if the systems unshakeable or it just destroys you in the process, actually when it comes down to it, when you've done what you can do, it's a job.*
	Ongoing emotional burden		*Yes it's resolved enough but it's not, it doesn't feel, it never will feel comfortable.* *…you know the most stressful thing for any clinician, anybody in any job is where there's a massive discrepancy between what the organisation is wanting you to do and what you feel is the right thing from your own personal ethics.*
	Ongoing emotional burden	Escape intolerable burden	*Just the stress of it. There was one particular time where yeah, they just wanted reports and they wanted things done at very short notice and it was just too stressful. Err and yeah, that kind of you know, uncomfortable feeling, yeah you kind of get triggered by your own feeling and you think actually no. This isn't right for me…* *You could argue that in fact you have to do that [stop thinking about it] because the trouble with this way of thinking about, in my experience, when you're thinking what should I do or what could I do, what are the possibilities, is that it can be very burdensome.* *…you decide you don't want to work there anymore which I think a lot of psychologists do, we walk away; we go somewhere else.*

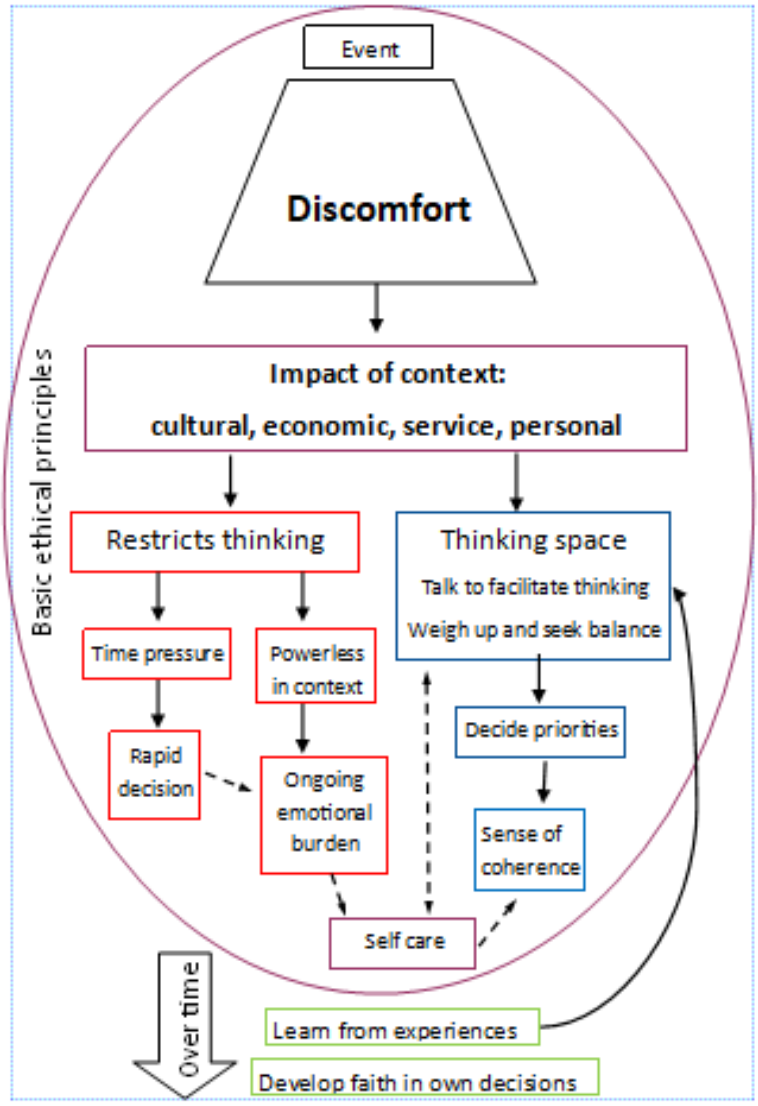
	Kind, generous, empathic, I think yeah just being a kind, good person. I think that is very important to me. Erm yeah, and if I'm put in a situation where maybe I feel that that's not valued or its maybe taken advantage of or something I won't alter to that, I'll just leave. *…for psychologists there's something about being the person who can step back from things and reflect on it and bring a more detached perspective that is both a strength but potentially is also, makes it uncomfortable to be stuck anywhere. To be caught in a system and you get critical of it or question.*

Appendix N. Development of theory using diagrams






That kind of
uncomfortableness
Intuitive
Gut feeling something is wrong
Emotional
Distressing emotional response
Cognitive
Clash with values perceived
Realisation becoming conscious


Event
Discomfort
Impact of context:
cultural, economic, service, personal
Basic ethical principles
Restricts thinking
Thinking space
Talk to facilitate thinking
Weigh up and seek balance
Time pressure
Powerless in context
Rapid decision
Ongoing emotional burden
Decide priorities
Sense of coherence
Self care
Over time
Learn from experiences
Develop faith in own decisions

Appendix O. Example memos

1. Memos about initial coding and ideas

MEMO: "I can stew a bit longer now"
Able to sit for longer with discomfort and gain more experience. Perhaps this facilitates noticing and allowing into consciousness that noticing of potential ethical problems - rather than feeling uncomfortable and seeking to resolve it immediately.
Suggests changing relationship to discomfort and seeking to resolve things, and therefore perhaps to noticing ethical issues.

MEMO: "Just this sense…"
Thinking about a gap in person's family role, sense of client being forgotten, feeling sad; empathy.
Thoughts as first thing that is mentioned in noticing a gap and potential problem for a client but also co-occuring with feelings in response to the observed situation and sense made of it. Role of feelings in categorising of situation as requiring further thought?

MEMO: …and it is one of those streams…
Ethical considerations when making decisions at work is one facet of the situation to be considered...along with clinical considerations, practicalities such as workload and what the service provides. Perhaps this is why some people say they do not come across ethical challenges - but they do come across clinical challenges...ethics are wrapped up as part of decisions to be made about things that arise at work. So perhaps this research should not be about how ethical issues are identified - because that suggests some issues are solely, and clearly, ethical in nature...perhaps it should be about - when faced with a decision to make at work, or a difficult decision to make at work, how do you notice it? Do you ever think in terms of it as being ethical in nature? Or is that only afterwards or when something is clearly at risk of breaking ethical guidelines or values that it might be named as ethical in nature?
Ethics is intimately woven through so much of a psychologists work that it is perhaps almost impossible to separate it out to consider it separately?

2. Memos about developing categories

MEMO: Anxiety driving thought processes
Anxiety and worrying thoughts seem to have driven the respondent to keep thinking about what to do when confronted with the situation. Similar to what came up in interview 6 about worry being the main thing the respondent noticed which flagged up the issue to be thought about in more detail.

Still unclear whether this anxious response / emotive response is unique to noticing ethical issues or if it occurs with other types of decisions that may not be categorised as ethical e.g. clinical decisions about how to respond to clients raising emotive topics etc?? This may also lead to heightened emotional responses for the CP but may not always involve thinking about ethics?! Or is it entirely impossible to separate them because ethics is woven through all work consideration e.g. responding respectfully and appropriately, and competently to emotive issues in therapy requires ethical behaviour? Respondent 6 seemed to be saying it is not possible to separate them because ethical considerations are woven through whole of life - personal and professional. Need to analyse that interview to check if that is coming through from it.

MEMO: Both emotional and other information
The participant explained the need to be able to think clearly about their own emotional response, in order to be able to convey to others what the issue is. The role of both emotional and what may be called more rational information has been discussed by other participants. The role of a CP also seems to often be to clearly convey some information of have difficult conversations, this could be seen as another area where the job role involves high levels of communication and also an ability to reflect on ones own reactions to understand them.

MEMO: Acting in accordance with policy and guidelines is not always enough (1 Quotation) (Super, 2018-
Some of the interviewees, including this one spoke about professional or service guidelines as sometimes not being sufficient to ensure ethical practice and that they can become something to hide behind; as a way to justify minimum standards. Which contrasts with the sense of being driven (strongly motivated) to act in a way which

maintains personal integrity, which may mean going beyond service procedures to really prioritise clients' needs and best interests.

MEMO: Different streams of ethical issues: ethical in nature but not personally challenging versus ethical dilemmas that are challenging for the individual
There is a theme coming out of the data that ethics permeates everything that we do. Both as people. And that CPs do professionally and personally. This is similar to the ideas in the article that suggests ethics permeate every decision from what to wear to work etc (decisions on the ethical rim). However in many of these instances participants have calmly given "textbook" responses that sound as though they are forming a dispassionate interview answer, or merely regurgitating the contents of ethical guidelines or training/teaching sessions on ethics. This is very different from when participants have spoken about feeling personally challenged by situations or dilemmas; there is an acute emotional response, a sense of stuckness about how to proceed and a need to engage in active decision making. Rather than an almost more passive recalling of known and understood things to do in that type of situation.

MEMO: Does anyone look at ethical guidelines?
My research is looking at how CPs notice (potential) ethical issues that require further thought about them to decide how to act. One question I had starting this was when CPs decide to utilise tools out there, such as ethical guidelines and decision-making tools, and whether the types of situations people notice and when they choose to use these tools vary. Participants have mentioned awareness of ethical guidelines but no one has mentioned looking at them since training. Is it that ethics guidelines only relate to well-known and understood ethics related topics, which don't trigger the type of noticing and individual decision making that has become the focus of this research? Is it that they can only deal with one type of issue/encounter/situation? For the more emotionally charged/personal value-driven /cognitive stuckness noticing and decision making something different is required? Would anyone in an "ethical crisis" ever turn to a written guideline or would their anxiety/emotions prevent them from doing this?

MEMO: Feeling something is unjust or amoral leads to thinking
Feeling "gives you a chance" (prompts one) to think about your ethical values "reconstruct those thoughts" - indicates something that has already been built/prepared/the way has been paved for in terms of ones values, to weigh up different factors when making ethical decisions. "Confrontation" - called this noticing a feeling a "sort of confrontation", similar to other interviewees' ideas of it being sudden or a surprise and linked with strong feelings.
"It makes you reflect on that" - it makes you suggests you are almost forced to reflect, perhaps due to the strength of emotional reaction. However taking time to reflect on something is a voluntary act.
Feeling something is unjust - can be experienced as a confrontation (sudden; abrubt) - opportunity to "reconstruct" (cognitively) earlier-developed ethical frameworks/values - reflect on the situation and weigh up different factors

3. Memos about developing theory, including links between categories

MEMO: Concurrent emotional response and intellectual/cognitive stuckness about what to do next
Arising from the interviews to date (1-5) and that came up in interview 6 is the notion that emotional response alone is not enough to initiate noticing of ethical issues. This appears to need to co-occur with not knowing what to do next - so a sense of stuckness that goes beyond a felt response and is present at a more conscious, processing level of a person's awareness. They have had an acute emotional response (anxiety / shock / panic) that has reached a particular level to prompt them to realise (notice) that there is an issue that needs further thought. ARE THESE ALWAYS ETHICAL IN NATURE? Then once their attention has been drawn to it and they start to think about what to do next, then they realise they do not know what to do next. This requires further thought and consideration. And probably talking it through with someone else.
So emotional response is key to noticing but is not in itself enough to denote an ethical challenge or dilemma as emotions arise during the course of work of CPs as this is a key tool used in the work.

MEMO: That kind of uncomfortableness
Once noticed or had a feeling of uncomfortableness that has triggered further consideration of the situation, one respondent (P.5) described asking themselves questions to try to identify the specific cause of their discomfort. Suggests that they have an uncomfortable feeling and that this can be linked with unprocessed information as

they may not know what has made them uncomfortable. Sounds as though the feeling comes first and the cognitive/intellectual/rational understanding comes afterwards, after some thought.

MEMO: Interview 8 linking categories memo
Similarly to other participants regarding the role of ethics this participant believes that *ethics permeates all decisions,* they spoke about *prioritising clients' needs and best interests* as well as *enabling clients' understanding* and *facilitating communication; holding uncomfortable conversations* Which they believe develops from clinical experience (*learning from experience; personal and professional).* The interviewee works in a specialist service which they described as being a "very political area" because people fairly often strongly oppose the service or believe it should be run differently. They spoke about their decisions at work always involving *weighing things up and seeking balance*. Which they spoke about in terms of *prioritising clients' needs and best interests* but also later in the interview explained that they believe sometimes their *emotional response* may lead them to prioritise what the client is saying too much and not give as much consideration to other factors (*considering multiple perspectives*), which they hope they will be more about to do as they gain experience (*increasing ability to sit with discomfort)*. They also spoke about this being why *making decisions as a team is important*.
This interviewee spoke about the *emotional burden of being confronted by ethical problems,* including being unable to sleep before an appointment they anticipated would be very difficult. *Not knowing what to do next prompted their identification of the issues to be considered* and they sought support from more senior colleagues (*psychologist seeking support).* The interviewee also spoke about *people being impacted indicating an ethical issue* at that sometimes they are *forced into making a decision on the spot.*
In relation to noticing an issue they described that *there's an emotional component to it* and also a *deep recognition of another's feelings and perspective.* The *emotional burden of being confronted by ethical problems* can restrict thinking (see memo 'Feeling overwhelmed restricts thinking').

MEMO: It felt like too much
The interviewee (P.9) described quite intense dissatisfaction with practices within a service they previously worked in that they felt clashed with their beliefs about what is an ethical way to run a service. They were motivated to speak up and try to change things, however they believed they would be unable to do anything about such large organisational (national) practices and priorities. It felt like too much and this restricted their thinking in the situation. It also contributed to them finally leaving that service.

MEMO: Why do some CPs choose to leave?
Some CPs choose to leave NHS because feel and believe they cannot work ethically within that context. In fact this has been stated as the main motivator for them leaving and working privately for most (if not all) those working in private practice. They have spoken about having to work within a system, procedures, cultures that require them to act in ways that are not completely coherent with their values and personal morals/ethics. They are unable to go as far as they want to ethically and do what they believe they should. Psychologists, being equipped to take a step back and think about this, are perhaps particularly well placed to be able to identify, notice and articulate this particular pressure and motivation for leaving the NHS/public sector. As opposed to it being labelled as "burn-out" or not having the professional qualification to be able to set up a private practice or work privately. WHAT IS THE DIFFERENCE BETWEEN THOSE WHO DECIDE TO LEAVE THE NHS BECAUSE THEY CANNOT WORK AS THEY WANT TO AND THOSE WHO REMAIN IN THE NHS THROUGHOUT THEIR CAREERS? OR PERHAPS FOR A VERY LARGE PART OF THEIR CAREER?

MEMO: Weighing things up and seeking balance
Weighing things up and seeking balance has mainly been discussed in the interviews in relation to weighing up competing factors to make an ethical decision. However, it has also been discussed and is mentioned here (P.8) as part of obtaining a more general balance in their life. A few interviewees have spoken about the need to not always consider all ethical issues or keep thinking about the complexities of situations as it is exhausting. This interviewee is describing the need to sometimes put things to one side and choose not to think about them in order to have time off and do something different.

Appendix P Summary report of research for participants

'A kind of uncomfortableness': Clinical psychologists' ethical sensitivity in clinical practice

Summary Report of Research

April 2018

Dear Participant

Thank you for contributing your time and experiences to my research project. I have now completed the project and am writing with a short summary of the project. I also plan to submit the project for publication in The Journal of Mental Health Training, Education and Practice.

Aims and Approach

Whilst a literature review identified some research on Clinical Psychologists' ethical decision-making, this relied on surveys. Respondents were asked to make judgements on the ethicality of behaviours described in vignettes or state their engagement in listed behaviours. How Clinical Psychologists identify potential ethical issues during their work had not been explored. Additionally, the theoretical literature that described processes of ethical decision-making, offered varied understandings of ethical sensitivity (see Park, 2012). Many theories of ethical decision-making presumed individuals identify ethical issues but did not offer any explanation about how this happens.

The present study sought to understand the process of Clinical Psychologists' ethical sensitivity. Specifically:

1. How do Clinical Psychologists first identify an ethical issue?

2. What process occurs when Clinical Psychologists notice a potential ethical issue?

A qualitative methodological approach was taken, using a Grounded Theory method. This approach is well-suited to exploring areas about which relatively little is known. It also leads to the development of a theory, which is empirically developed, providing a useful contribution to the existing literature on ethical decision-making and more specifically, ethical sensitivity.

Participants

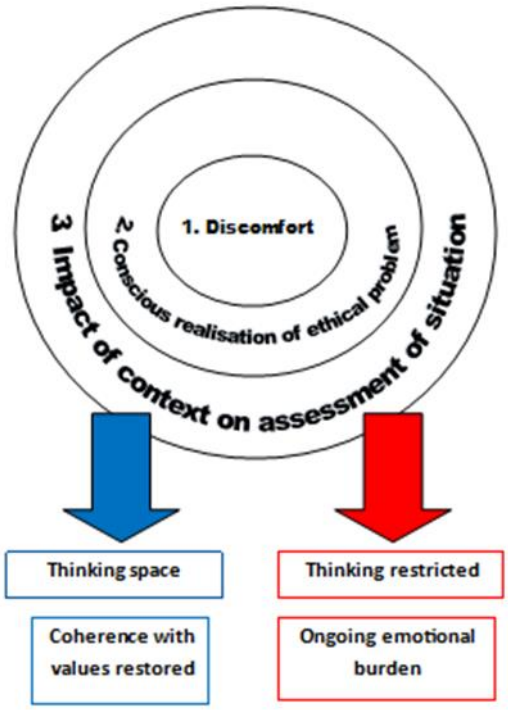
Twelve Clinical Psychologists participated in semi-structured interviews. Participants represented a range of different services, including NHS, private healthcare providers and independent private practice across a range of client groups. Participants had varied lengths of post-qualification experience.

Summary of Findings

The model developed to describe the process of ethical sensitivity in action for Clinical Psychologists is below.

It was identified that participants have identified ethical issues at work through feelings of discomfort. When this feeling was attended to, they developed a conscious realisation of an ethical problem, which was perceived to jar with their values. Participants' assessment of the situation, including the impact it may have on others and possible responses to it, was mediated by the context they found themselves in. The service context, specifically the balance of service demands to resources resulted in either thinking space or restricted thinking.

Figure 1. The process of ethical sensitivity in action



There were different outcomes for participants, which appeared to depend greatly on their context. Contexts that provided thinking space enabled participants to attend to their discomfort and understand its cause (a clash with their values). This process of ethical sensitivity being facilitated led to a restored sense of coherence with participants' values.

When the context restricted thinking this resulted in an ongoing emotional burden. Participants described this as unsustainable long-term and it had led several to changing jobs, reducing their hours or leaving the NHS altogether to work for private providers or in independent private practice.

It was concluded that the Clinical Psychologists interviewed demonstrated high levels of ethical sensitivity; participants frequently experienced discomfort, rooted in a gut instinct that something in the situation was not right and a perception that important values were being compromised. Therefore it was not so much a case of finding that "…ethical lapses result from our lack of consciousness or neglect" (Walsh, 2015, p. 69) as was anticipated. But rather that the context the Clinical Psychologist finds themselves within is key to whether they attend to their feelings of discomfort to understand the cause, which enables the process of ethical sensitivity.

Clinical Implications

- To ensure Clinical Psychologists' are not left turning away from their ethical sensitivity to reduce their discomfort, services must ensure that professionals' concerns about how the service functions are listened to, even when they cannot be acted upon immediately

- Services need to foster a culture of ethical awareness and responsibility, so the prevailing norms and social processes encourage, rather than discourage ethical sensitivity
- Highly-trained professionals may leave their roles if they are not supported to think about ethical issues in a way that is consistent with their values. Services should provide opportunities for Clinical Psychologists to have time and space for reflective practice
- Services could provide opportunities for CPs to obtain ethics consultation in drop-in ethics clinics.
- Services should give Clinical Psychologists enough autonomy so they can take some action themselves to resolve difficult ethical situations.
- Emotional burden may be detrimental to Clinical Psychologists' mental wellbeing. Clinical Psychologists should be supported to understand their experiences of discomfort, the link with their values base and also taught how to recognise difficulties resulting from the wider organisational context.
- Supervisors should be made aware of ethical decision-making tools during supervision training.

Areas for Future Research

- How CPs moderate their ethical sensitivity so as to not become overwhelmed by their emotional response could be further explored in future.
- Tools to support ethical decision-making and to maintain ethical practice are available. However, participants in this project at no point mentioned using these. Further investigation as to why this is may help to provide information and resources in a useful format.

If you have any questions please feel free to get in touch with me. Once again, thank you for taking part in my project.

Yours sincerely

Catherine Chiffey

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References referred to

Park, E. (2012). An integrated ethical decision-making model for nurses. Nursing Ethics, 19, 139-159.

Walsh, R.T.G. (2015). Introduction to ethics in psychology: Historical and philosophical grounding. Journal of Theoretical and Philosophical Psychology, 35, 69-77.

Appendix Q End of project letter to Salomons Ethics Panel and NHS R&D Departments

April 2018

Dear [insert contact name]

Re. Research project on Clinical Psychologists' ethical sensitivity completion notification

I am writing to inform you that this research project has now been completed. As intended interviews were completed with twelve Clinical Psychologists to investigate how they identify potential ethical issues during their work.

Please find enclosed a brief summary report prepared for feedback to the study participants. This outlines the main findings of the project, as well as clinical implications and areas for future research.

It is also intended that the project will be submitted for publication in The Journal of Mental Health Training, Education and Practice.

If you would like any further information, please let me know.

Yours sincerely

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Appendix R Journal of Mental Health Training, Education and Practice author guidelines

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