

Portfolio Volume 1: Major Research Project

Ethical Competence: An Analysis of Decision-Making in Clinical Psychology.

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### Abstract

This research aimed to develop understanding of ethical competence in clinical psychology by exploring responses to hypothetical ethical dilemmas presented in vignettes, developed for the present research. It investigated what psychologists considered to be appropriate justifications for ethical decisions; and how the ethical decision-making process occurred.

A mixed-methods Delphi survey was employed using qualitative justifications for quantitative scores, in an iterative process. Ethical competence in clinical psychology is arguably socially constructed, largely within the discipline. Ethical decision-making was therefore assessed by exploring responses and consensuses to ethical dilemmas, from an opportunistic sample of experienced clinical psychologists, working in the UK (n = 31).

Quantitative analyses indicated that the vignettes developed for this research were rated as realistic (72-79%) and relevant (75-85%) to UK clinical practice. Thematic analysis identified five themes within ethical decision-making: *assessing*, *formulating*, *responding*, *influencing factors*, and *guiding principles*. A model describing this process of ethical decision-making is presented; the first of its kind in clinical psychology to be empirically derived.

Future research should assess whether this is seen by the wider profession as a competent way of making ethical decisions. It is argued that this research has important implications for clinical psychology, including for ethical instruction (as the vignettes and model can be used for research or teaching), and for those using clinical psychology services.

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## 1. Introduction

This research presents an analysis of ethical decision-making in clinical psychology, with the aim of developing a model of ethical competence in the profession. This is assessed through responses given to ethical dilemmas presented in vignettes. This arguably has highly relevant implications for supporting those entering the profession to develop ethical competence, continuing professional development for qualified clinical psychologists, and it is hoped that ultimately those using psychological services will benefit from increased competence within the profession.

This chapter will first provide a literature review of theoretical models of ethical competence, with a focus on applied psychology, followed then by a systematic review of empirical research related to ethical decision-making amongst professionals delivering talking therapies. Key terms and theories will be defined, as will the author's reflexive position. It will be outlined why ethical competence is important and concluded that the development of vignettes representing ethical dilemmas is indicated from the literature, as is the need to understand ethical decision-making in clinical psychology. This therefore provides the rationale for the present research.

### 1.1. Background

#### 1.1.1. Definitions.

**1.1.1.1. Clinical psychology.** Within the UK, the British Psychological Society (BPS) suggests that clinical psychology aims to reduce distress and improve well-being for people

across the lifespan with a range of psychological or physical difficulties, by drawing on different assessment and intervention methods (BPS, 2019a). This may involve working directly, indirectly or through consultation, with individuals, families, groups, or professionals. In the UK, the majority of clinical psychologists work for the National Health Service (NHS), many are employed in other statutory services or private organisations (BPS, 2019a), and others may work in the third sector. The title 'Clinical Psychologist' is protected, requiring registration with the Health and Care Professions Council (HCPC) after completion of an accredited Doctoral degree and ongoing CPD (Continuing Professional Development) to maintain registration (BPS, 2019a).

**1.1.1.2. Ethical, moral, and competence.** Collins Dictionary (2019a) defines *ethical* in British English as: "in accordance with principles of conduct that are considered correct, especially those of a given profession or group." *Moral* is defined as: "concerned with or relating to human behaviour, especially the distinction between good and bad or right and wrong behaviour" (Collins Dictionary 2019b). As can be seen, the terms are highly similar and often used interchangeably. The term *moral judgment* is used in the literature and considered to relate more to an individual's appraisal (for example, an individual may make a moral judgment about what is an appropriate course of action; this is the aspect of ethical decision-making that is explored presently). Lind (2016) defines moral competence as: "*the ability to solve problems and conflicts on the basis of universal moral principles through thinking and discussion...*" (p. 45) and highlights the importance of the process. A model of ethical competence in clinical psychology would therefore aim to describe the ethical

decision-making process of responding to professional ethical dilemmas and arriving at an outcome which is generally viewed by the profession as proficient. For clarity in the present research, *ethical* is used as far as possible to highlight the emphasis on social and specifically, professional consensus (for example, an ethical code of conduct, or a vignette which is agreed on as representing an ethical dilemma).

**1.1.2. Epistemological position.** From a stance of moral pluralism (that there may be more than one acceptable course of action but some which are unacceptable (Ethics unwrapped, 2019), it is argued that ethical competence in clinical psychology is socially constructed, and to an extent this is done within the profession (Handelsman Gottlieb & Knapp, 2005). Social constructionism posits that rather than existing objectively, our realities are co-created socially, through discourses between people, and influenced by cultural and historical contexts (Andrews, 2012; Young & Collin, 2004). This construction in clinical psychology occurs within the substantial historical context of the development of ethical principles from medicine and philosophy, which have been influential on the ethics of psychology and other health professions (Callan & Callan, 2005), but are nevertheless seen as distinct (Hadjistavropoulos, Malloy, Sharpe, & Fuchs-Lacelle, 2003).

However, the mode of enquiry of the present research takes a critical realist stance to investigating those created and shared meanings of ethical competence, existing within the present context. Critical realism (Archer, 1998) suggests that there are layers of meaning,

including empirically observable phenomena, which can provide information about underlying processes, but that a level of interpretation exists between the two.

**1.1.3. Self-reflexive position.** Growing up in a household with evangelical religious influences developed my interest in 'right' and 'wrong' from an early age. Challenges during my formative years left me with an implicit impression of the importance of being 'good'. On this basis, I have perhaps always been searching for answers on what is 'right', and how to be 'good'. It is perhaps unsurprising then that I have chosen to work in forensic settings. Given the binaries of the criminal justice system (i.e. guilty or not), a clear delineation between 'right' and 'wrong' is often assumed in these settings, at least initially. However, the more familiar I became with these settings, the more nuanced my position became, recognising that people are not their actions. In my first placement on training, I was shocked to experience an emotive ethical dilemma with a client. After much questioning, searching ethical guidelines, and talking to peers and supervisors, it seemed there were numerous perspectives on what constituted an appropriate response. Although there are clearly defined unethical behaviours (for example in The BPS Code of Ethics and Conduct, 2009), it appeared to me that understanding the process of deciding how to respond was also important. This experience is summarised appropriately by this quote from Kidder: "*As we practice resolving dilemmas we find ethics to be less a goal than a pathway, less a destination than a trip, less an inoculation than a process*" (as cited in Menzel, 2009, p. 225).

This has described the development of my interest in understanding ethical decision-making in clinical psychology. This research does not intend to provide answers to the specific ethical dilemmas that I had been looking for, rather it is hoped that it will support those confused by how to make professional ethical decisions, especially those in the early stages of learning.

### **1.2. Why is it important to research ethical competence in clinical psychology?**

In the UK, clinical psychologists are required to work within the HCPC Standards of Conduct, Performance and Ethics (2016) and Standards of Proficiency for Practitioner Psychologists (2015). Guidance is also available in the BPS Code of Ethics and Conduct (2018), focusing on the four principles of: *respect, competence, responsibility* and *integrity*, that members are expected to uphold. An earlier version of this guidance offers a system for approaching ethical decisions based on theoretical frameworks (BPS, 2009, p.7). These codes were developed through reviewing existing codes and guidance, and reflection on what is expected ethically by the Society and in relation to other professions (BPS, 2018). Even at the first formal level of education in psychology in the UK, secondary school syllabuses are required to “*enable students to: develop an understanding of the relationship between psychology and personal, moral, social and cultural issues, and develop an understanding of ethical issues in psychology*” (Department for Education, 2015, p. 3).

Given the codes and independent regulation, one might assume that clinical psychology is an ethical profession, within which effective ethical decision-making is integral. However, in



2018 alone, HCPC Conduct and Competence Committee panel hearings resulted in 3 practitioner psychologists being removed from the register, 7 having conditions placed on their practice and 5 being suspended for ethical breaches (HCPC, 2019a). This shows that a small proportion of psychologists do make serious ethical transgressions, despite guidelines. In a survey of USA psychologists by Pope, Tabachnick and Keith-Spiegel (1987), 2.9% of participants reported “engaging in erotic activity” with a client, 8.1% reported discussing “a client (by name) with friends”, and 5.9% reported practicing under the influence of alcohol (p.999). However, 95.0%, 94.5% and 89.5% of those surveyed believed these behaviours are never ethical, respectively. Although, it is notable that a recent replication of this research suggests ethical practice may have become more conservative (Schwartz-Mette & Shen-Miller, 2018).

Kish-Gephart, Harrison and Treviño (2010) completed a meta-analysis looking at unethical decisions in professional contexts and found that this may not just be down to individual “bad apples,” that there is also the context of the ethical dilemma (which may be “bad cases”) and the organisational context (which may be “bad barrels”) which influence ethical decisions. The implications of this are serious for service users, communities and the profession. It is therefore important that all is done to minimise these occurrences, starting with a thorough understanding of ethical decision-making, enabling effective instruction. Leaving serious infractions aside, recognising and responding appropriately to ethical dilemmas are arguably part of the day to day practice of clinical psychology. Pope, Tabachnick and Keith-Spiegel (1987) concluded that: “*The integrity of psychology is*

*contingent to a great degree on the extent to which we – both as a discipline or profession and as individuals – can regulate our behavior. Our ability to engage in effective and ethical regulation, in turn, is contingent on our willingness to study our own behavior and our beliefs about that behavior.”* (p. 1004). Taken together, this highlights the importance of considering how ethical decisions are made, and how this ability develops. These are addressed presently.

### **1.3. Literature review**

A number of models of ethical competence have been proposed in the literature and are now reviewed. These are drawn from different theoretical backgrounds including biomedical ethics, theories from different branches of applied psychology, feminist theory, hermeneutics, and cognitive developmental theories. This will culminate in a review of empirical evidence for Rest’s (1984) cognitive developmental model of ethical competence. One specific aspect of this model; making an ethical decision (which he termed *moral judgment*), will be taken forward for investigation in the present research.

**1.3.1.1. Biomedical ethical decision-making models.** Within medicine, there has been much more written about ethical decision-making than within clinical psychology. A commonly accepted theoretical framework is that of Beauchamp and Childress (1979, 2009), who highlight four core principles for making ethical decisions in healthcare settings. These are: *autonomy* (a patient’s right to choose); *beneficence* (acting in the patient’s best interest); *non-maleficence* (avoidance of harm to patients) and; *justice* (promotion of

fairness and equality between patients). This model was empirically evaluated by Page (2012), who found evidence for the prioritisation of non-maleficence but that the principles did not adequately explain decision-making in practice. The author concluded that there is a need for an explanatory behavioural model, taking into account contextual factors.

This model was adapted for use in counselling psychology by Kitchener (1984) with a fifth principle added, fidelity (loyalty and following through on commitments within therapy).

Whilst it is recognised that this model has been well documented in theoretical literature, a literature review suggests that there has been limited influence in clinical practice (Urofsky, Engels & Engebretson, 2008).

**1.3.1.2. A clinical psychology model for ethical decision-making.** This broad process is echoed by the theoretical framework of Knapp and VandeCreek (2012) for clinical psychology. Drawing on the American Psychological Association (APA) Ethical principles of Psychologists and Code of Conduct (2010), they outline a five-step model consisting of identifying the dilemma, generating solutions including through consultation with colleagues, evaluating solutions by reviewing pros and cons, trying the best potential solution (that which is believed to be the optimal balance between conflicting moral principles), and evaluating the outcome of the option tried. They suggest that this is a linear process also involving reflection on the psychological factors likely to be impacting the decision-maker's process. It is argued that this model relies on a prescriptive process which minimises the influence of non-rational factors, such as context, emotions, and heuristics

(Rogerson, Gottlieb, Handelsman, Knapp & Younggren, 2011). A significant limitation of this model is that it has not been compared empirically with clinical practice (Thomas, 2010).

**1.3.1.3. Feminist models of ethical decision-making.** Based on feminist theory.

Hill, Glaser and Harden (1995), proposed a model of ethical decision-making in counselling psychology. This involved recognising the value of the therapist's emotional responses, the therapeutic relationship context, and the client's perspective. This model suggested a rational-evaluative process (for example drawing on ethical codes) alongside an emotional-intuitive process (the therapist examining their own values, how a proposed response would feel to them, and how this might be received by others).

Another model of ethical decision-making drawing on feminist theory is known as the ethics of care (Gilligan, 1982). Based on care being a universal human experience, this theory prioritises the importance of considering how to respond to an individual, rather than principles of fairness that might be argued to be more ethical at a larger group level, but may foster indifference (Held, 2006). In comparison to more rationalist approaches, this theory attends to emotions such as empathy, and social relationships, as useful means of guiding ethical decision-making, rather than universal or abstract principles (Held, 2006). Gilligan (1982) postulated a gender difference in ethical decision-making, with women tending to prioritise compassion and universal principles, and abstract principles, such as justice, being seen as more masculine traits. Under controlled experimental conditions, Clopton and Sorrell (1993) found no gender differences in ethical decision-making and

suggested that where differences are found this may be a function of contextual factors, such as life stage. Critiques of this approach include the notion that this may reinforce oppressive gender stereotypes (Bartky, 1990), and foster a culture of self-sacrifice which does not critically consider who cares for whom, and what the associated costs of being the carer are (Puka, 1990).

**1.3.1.4. Hermeneutic perspectives on ethical decision-making.** Drawing on the APA Ethics Code (1992), Betan (1997) argued that reductionist models of ethical decision-making (such as Rest, 1984, described later) put forward a false distinction between rational and intuitive approaches. Instead, it is argued that existing theoretical models of ethical decision-making can be strengthened by acknowledging dialectic qualities of interactions between people; that they are subjective yet also universal experiences. Universality comes from shared subjective experiences and are interpreted within a cultural context. Therefore, Betan (1997) suggested, ethical principles should be interpreted within the contexts of both cultural and personal values. Employing social constructivist approaches, Cottone (2001) proposed a theoretical, interactional model of ethical decision-making whereby decisions are compelled socially, through processes of negotiations, developing consensus, and arbitration, rather than an individual cognitive process.

**1.3.1.5. Moral foundations theory (MFT).** MFT is a pluralistic model of ethical decision-making (Graham et al., 2013) compared to models which focus more on singular concepts such as care (Gilligan, 1982) or justice (Kohlberg 1973; see below). Drawing on

evolutionary theory and recognising the influences of cultural development (Haidt & Joseph, 2004), MFT posits that individuals prioritise one or more of five moral foundations, as deemed to most appropriately address a specific ethical challenge (Graham et al., 2013). Two of the five foundations are termed *individualising* due to focusing on individuals (Zhang, Hook & Johnson (2016). These comprise *Harm / Care* (prioritising the prevention of harm and the promotion of care towards another) and *Fairness / Reciprocity* (prioritising the fair treatment of an individual). The final three of the five foundations are termed *binding* due to focusing on social groups (Zhang, Hook & Johnson, 2016). These comprise *In-group / Loyalty* (prioritising obligations to the close social group and promoting group interests), *Authority / Respect* (prioritising authority and tradition) and *Purity / Sanctity* (prioritising chastity and decency). Graham et al., (2013) argue that there may be additional foundations that have not yet been uncovered, however this is still being researched. The model of five moral foundations aims to be descriptive and has been tested empirically and statistically, showing strong discriminant validity for the foundations as separate (Graham et al., 2013).

**1.3.1.6. Rest's four component model of ethical decision-making.** When considering how ethical decisions are made, Rest (1983) proposed an interactive, non-linear four-component model. While it is not specific to any profession or discipline, this model is advocated in the BPS *Guidance on teaching and assessment of ethical competence in psychology education* due to being “psychologically-informed” and accessible (BPS, 2015, p.3). It will be further elaborated on here with consideration of supporting empirical evidence. This model consists of recognising that a situation poses an ethical dilemma

(*Moral or Ethical Sensitivity*), making and justifying a decision about which of a number of courses of action to choose (referred to often in the literature as *Moral Judgment*), having reasons to prioritise acting in an ethical way at the expense of other pressures or motivations (*Moral Motivation*), and being able to persist with the decided course of ethical action despite barriers (*Moral Character*). See Table 1 for summary.

Table 1

*Representation of the relationship between theoretical models of ethical decision-making*

<p>Rest (1983) <b>Four component Model of Morality.</b> Interactive, non-linear, all components need to occur for moral behaviour, each involves cognitive and affective processes.</p>	<p>Kohlberg (1973) <b>Model of moral judgment.</b> Developmental model of increasing sophistication based on justification rather than outcome.</p>	<p>Rest (1986) <b>Moral Schemas.</b> Adaptation of Kohlberg stages, grouped, increasing sophistication, measured by DIT-2.</p>	<p>Bebeau and Thoma (1999) <b>Intermediate Concepts.</b> Profession specific, measured by ICM, validated against DIT-2, target area for understanding</p>	<p><b>Codes of Conduct.</b> Profession-specific.</p>															
<p>Increasingly profession-specific, decreasingly abstract →</p>																			
<p><b>Moral Sensitivity:</b> Recognising that a situation poses an ethical dilemma.</p>																			
<p><b>Moral Judgment:</b> Making a decision about which of a number of courses of action is most justifiable.</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Increasingly complex and sophisticated ↓</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center; vertical-align: middle;">Pre-conventional</td> <td style="border-bottom: 1px solid black;">Obedience &amp; punishment orientation</td> <td rowspan="2" style="vertical-align: middle;"> <p><b>Personal Interests:</b> Takes into account losses or gains of the individual</p> </td> </tr> <tr> <td></td> <td>Self-interest orientation</td> </tr> <tr> <td style="text-align: center; vertical-align: middle;">Conventional</td> <td style="border-bottom: 1px solid black;">Interpersonal accord &amp; conformity</td> <td rowspan="2" style="vertical-align: middle;"> <p><b>Maintaining Norms:</b> Emphasises law, rules and authority in upholding social norms</p> </td> </tr> <tr> <td></td> <td>Authority &amp; social-order maintaining orientation</td> </tr> <tr> <td style="text-align: center; vertical-align: middle;">Post-conventional</td> <td style="border-bottom: 1px solid black;">Social contract orientation</td> <td rowspan="2" style="vertical-align: middle;"> <p><b>Post-Conventional:</b> Focus on benefit for society overall, including, but not blindly,</p> </td> </tr> <tr> <td></td> <td>Universal ethical principles</td> </tr> </table>	Pre-conventional	Obedience & punishment orientation	<p><b>Personal Interests:</b> Takes into account losses or gains of the individual</p>		Self-interest orientation	Conventional	Interpersonal accord & conformity	<p><b>Maintaining Norms:</b> Emphasises law, rules and authority in upholding social norms</p>		Authority & social-order maintaining orientation	Post-conventional	Social contract orientation	<p><b>Post-Conventional:</b> Focus on benefit for society overall, including, but not blindly,</p>		Universal ethical principles	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Increasingly complex and sophisticated ↓</p>	<p>Intermediate level of reasoning, more specific than abstract schemas, more generalisable than codes of conduct.</p> <p>E.g. Professional autonomy, competence, informed consent, confidentiality, veracity, allocation or rationing of scarce resources.</p> <p>E.g. BPS Code of Conduct (2018), Practice Guidelines (2017). HCPC Standards of conduct performance and ethics (2016), Standards of proficiency (2015). Concrete, specific to professional groups, prescriptive and/or prohibitive.</p>
Pre-conventional	Obedience & punishment orientation	<p><b>Personal Interests:</b> Takes into account losses or gains of the individual</p>																	
	Self-interest orientation																		
Conventional	Interpersonal accord & conformity	<p><b>Maintaining Norms:</b> Emphasises law, rules and authority in upholding social norms</p>																	
	Authority & social-order maintaining orientation																		
Post-conventional	Social contract orientation	<p><b>Post-Conventional:</b> Focus on benefit for society overall, including, but not blindly,</p>																	
	Universal ethical principles																		



	following social norms.
<b>Moral Motivation:</b> Reasons to prioritise acting in an ethical way.	
<b>Moral Character:</b> Acting in a moral way, avoids distraction or derailment, maintaining courage to continue with ethical actions.	

**1.3.2. Models of ethical decision-making: the moral judgment component.** For the purposes of the present research, ethical decision-making refers to the moral judgment component of this model. As the present research focuses on this aspect of ethical decision-making only, further research into this area will now be outlined.

**1.3.2.1. Six stage model of moral judgment.** Considering only the moral judgment component of ethical decision-making, Kohlberg (1973) proposed a theory of moral development, outlining six stages of increasing sophistication of ethical decision making, grouped into three levels, also summarised in Table 1. Individuals would be classified as being in a specific stage based on the factors that they consider when making an ethical decision, or how they justify their decisions, rather than any judgments being made about whether a decision is right or wrong in itself. For example, in Heinz's dilemma (involving a man stealing a drug for his terminally ill wife; Kohlberg, 1981) an individual may state that Heinz should not steal because it is illegal, meaning he would be classified as being in the fourth developmental stage (the *authority and social-order maintaining orientation*),

whereas if an individual states that Heinz should not steal the medication because other people with equally valid lives may be in need of it too, this individual would be classified as being at the highest, sixth stage (*the universal ethical principles*), despite their judgment about what Heinz should do being the same.

**1.3.2.2. Three schema model of moral judgment.** Following this, Rest (1986) reviewed Kohlberg's model and proposed instead that individuals use one of three schemas (*the personal interests schema*, *the maintaining norms schema*, and *the post-conventional reasoning schema*), also summarised in Table 1. Like Kohlberg, this model is cognitive-developmental, suggesting that increasing sophistication of ethical decision-making is more cognitively complex (Thoma & Dong, 2014), correlates with increasing levels of education (Rest, Cooper, Coder, Masanz & Anderson, 1974), and indeed, is shown to correlate with increased grey matter volume (Prehn et al., 2015). Unlike Kohlberg's model emphasising discrete stages, schemas are conceptualised as more fluid, and movement between them is more gradual and can be context-dependent (Thoma & Dong, 2014).

This model was proposed following the development of the Defining Issues Test (DIT; Rest, Cooper, Coder, Masanz & Anderson, 1974; and the subsequently updated DIT-2; Rest, Narvaez, Thoma, & Bebeau, 1999). The DIT-2 is a questionnaire developed to assess which schemas are being activated in response to moral dilemmas in five social problems, such as Heinz's dilemma. The DIT-2 provides quantitative information about the level of sophistication of schemas being used, based on an individual's ratings and rankings of 12

statements relevant to each problem described. The DIT-2 has been shown to be reliable and valid, and empirical evidence supports the existence of three clusters rather than Kohlberg's six (Thoma & Dong, 2014). External validity has been shown as more sophisticated ethical decision-making schemas relate to pro-social behaviour (Rest, 1986) and desirable professional behaviours (Rest & Narvaez, 1994). Notably however, the DIT-2 focuses on personal ethical dilemmas, rather than being related to professional ethical dilemmas.

**1.3.2.3. Intermediate concepts within moral judgment.** Following this, Bebeau and Thoma (1999) put forward that at the abstract level, these schemas are activated when making ethical decisions, and at the more concrete, profession-specific level, professional guidance or codes of conduct are used. They felt however, that neither schemas nor codes adequately explain with sufficient detail *how* ethical decisions are made in professional contexts. This poses a difficulty for how ethical decision-making can be usefully taught in professional training. They therefore proposed a level in between these two, those factors which are taught on professional ethics training, which they termed *intermediate concepts*, also summarised in Table 1. With their focus being within the healthcare professions, they outlined that intermediate concepts are factors such as professional autonomy, candour and competence, confidentiality, informed consent, 'best interests' decisions, and the allocation of limited resources. They suggested that their research did not support a hierarchy of ethical sophistication amongst these concepts (that no single concept is

regarded as a more important principle to prioritise), as within the previous models described.

This model was proposed following the development of the Intermediate Concepts Measure (ICM; Bebeau & Thoma, 1999), which was designed to assess learning following teaching in ethics modules of dentistry training in the USA. Broadly, this can be described as a measure for assessing the development of moral judgment in professional contexts. This measure consists of five ethically challenging clinical vignettes representing intermediate concepts expected to be acquired by end of dental training. It was developed using a technique based on the Delphi method (for a review see Hsu & Sandford, 2007) by presenting vignettes to a group of academic and/or currently practising dentists and asking them to respond to the dilemmas, indicating what should be done and why. Although they report it was not their aim to determine a model for how these decisions were made, they found that participants' justifications could be classified into the Personal Interests schema, the Maintaining Norms schema (in terms of referring to dental codes of practice), and as using Intermediate Concepts, or employing normative philosophies, such as utilitarianism. Participants were then invited to rate and rank the collective answers as to which were better and worse decisions and justifications in response to the vignettes. To achieve a consensus, these responses were given to a new group of dentists who were again asked to rate and rank the options and discuss their answers together. Finally, the vignettes were given to teachers of dental ethics around the country who were asked to respond as to whether the consensus reached was appropriate, neutral, or inappropriate. There was high level of agreement

about good and bad and bad courses of action, although only a moderate level of agreement about better or worse justifications for these actions.

The ICM was shown to have good construct validity, and using this measure, increased use of intermediate concepts in moral judgment was shown to progress developmentally through dental training (Bebeau & Thoma, 1999). The ICM was given to first year arts students, first year dental students and final year dental students. This final year group were shown to have moral judgment scores that were increasingly closer to the expert-agreed consensus, based on both their decisions and justifications. This was not accounted for by students' overall academic performance, and although there was a significant correlation with their DIT-2 score (which is thought to measure ethical decision-making in social rather than professional contexts; Rest, Narvaez, Thoma, & Bebeau, 1999), it did not fully account for the variance in scores. This suggests that the ICM measures the unique contribution of dental ethics instruction. As such, it suggests that professional ethical training can be effective, and measures such as the ICM can be used as a valid standard, agreed upon by qualified practitioners, from which teaching can be guided and performance can be measured against (Bebeau & Thoma, 1999). As this measure was developed for the specific profession of dentistry, the authors suggest that the next stage is that this method is adapted and extended to other clinical disciplines. They suggest reviewing which concepts are currently taught, which concepts are thought amongst the profession to be essential, what kind of dilemmas are realistic, and what consensuses about appropriate responses and

justifications can be agreed upon by qualified practitioners. A literature review suggests that no such equivalent measure has been developed in the field of clinical psychology to date.

**1.3.3. How to reason when there are competing ethical principles.** A limitation of a number of these models of ethical decision-making may occur when there are competing ethical principles at stake in a dilemma. For example, in “The “standard” Jehovah’s Witness Case” (Gardiner, 2003, p. 298), a doctor must balance the principles of *beneficence* (giving a patient a life-saving blood transfusion) and *autonomy* (the patient’s choice to decline the procedure for religious reasons). Based on the biomedical ethical decision-making model, Beauchamp and Walters (1994) provided a five-part, prescriptive method for reasoning through ethical dilemmas in healthcare professions, when ethical principles, such as *beneficence* and *autonomy*, come into conflict with each other. This involves seeking out objective information, establishing clarity in terms of definitions, employment of an appropriate ethical code, and a process of weighing up the principles in conflict by considering examples and counter-examples, before analysing the merits of the arguments.

Another model identified for healthcare workers is Seedhouse’s (2008) ethical grid. This comprises four categorised layers; the external conditions relevant to the ethical decision (such as the law), the wider consequences of the decision (such as whether there will be an increase in societal good), key principles (such as fidelity and harm reduction) and in the middle of the grid, are the central conditions, which prioritise autonomy. In this model, autonomy is considered in two main ways; in terms of healthcare workers *creating*

autonomy for individuals (for example, by the provision of information etc.) and *respecting* their autonomy (for example, by accepting an informed decision). Autonomy is a central condition in the ethical grid as it is considered to originate from an intrinsic human quality of having the ability to be autonomous (albeit to different extents across developmental stages), and not just an abstract ethical principle. Seedhouse (2008) argues that best decisions come from analysis of at least some of each of the four layers. Therefore, this model would suggest that where ethical principles compete, the multi-faceted concept of autonomy ought to be prioritised, but with consideration of other principles and the wider context and consequences.

Turning to philosophical ethics, there have been numerous other normative theories about how to reason when there are competing ethical principles. Utilitarianism (a consequentialist theory) would posit that conflicting principles can be weighed by considering which principle, if followed, would achieve the greatest happiness for the greatest number of people, in terms of the outcome of the decision (Bentham, 1823). Conversely, deontological ethics would suggest that a principle should be prioritised in accordance with universal ethical obligations, known as categorical imperatives, in a rational rather than emotive manner, without consideration of the expected outcome (Thompson, 2010). Virtue ethics focuses on the decision-maker as having the capacity for emotion to interact with reasoning, and that a virtuous character can be developed through habit, suggesting that emotional experiences should be attended to when making ethical decisions (Gardiner, 2003). This theory would suggest that where there are competing ethical

principles, the decision-maker should reflect on their emotional responses, when considering virtues (such as *compassion, courage and justice*) pertinent to each dilemma, to inform their decision. Casuistry is an approach which considers the application of rules generated from one dilemma to another by considering the specific dilemma context (Thompson, 2010). Where ethical principles conflict with one another in an ethical dilemma, a casuist decision-maker would be encouraged to understand the dilemma in detail and then consider how precedents had been approached (Richardson, 2018).

Taken together, these different philosophical approaches to ethical decision-making suggest there is much debate about how to reason when faced with competing ethical principles in a dilemma. Moral psychology developed conceptually alongside these broad philosophical frameworks (Jackson & Smith, 2005), and this has, in turn, informed the development of ethical codes of practice (BPS, 2009). However, the emerging, interdisciplinary field of experimental philosophy, which tests some of these philosophical approaches using psychological research methods, has begun to converge with moral psychology (Knobe, Buckwalter, Nichols, Robbins, Sarkissian, & Sommers, 2012). Therefore, the present research focuses upon contemporary psychological guidelines (BPS, 2009, 2018), whilst acknowledging the current and historical context.

**1.3.4. The development of ethical competence.** The BPS outlines the importance of: *“developing our ability to teach students about ethics and ethical action, and to assess their levels of understanding, offers a way to counter misconduct and manage changing ethical*



*landscapes.*" (BPS, 2015, p.2.). Ellis-Caird and Wainwright (in prep.) suggest that clinical psychologists are assumed to be ethical professionals and this competence is thought to further develop through the process of training (which may include time spent in relevant unqualified roles) but note that there has been little research undertaken to warrant this claim. This is unlike the field of dentistry for example which, as described above, uses formal measurement tools such as the ICM, to guide training programmes and evaluate students' development in ethical competence. Further, if ethical competence does develop through clinical psychology training, it would be important to understand the process by which this occurs, in order to facilitate ethical instruction.

One way that ethical competence is argued to develop during clinical psychology training is through an acculturative process (Handelsman Gottlieb & Knapp, 2005). Taken from literature around migration and the integration of cultural identities (Berry, 2005), it is argued that professional ethical principles are a shared culture which may converge with personal ethical principles over time. The relationship between personal ethical principles and ethical decision-making is supported by the work of Patrick, Bodine, Gibbs and Basinger (2018), who found that adolescents' self-perceived ethical identity predicted pro-social behaviour. In the acculturation model, low identification with both personal and professional principles leads to *marginalisation*, where an individual may be at the greatest risk of ethical violations due to having few principles with which to guide behaviour. Low identification with personal principles and high identification with professional principles leads to *assimilation*, whereby the personal is subsumed by the professional. The risk of this

context is that rules may be blindly accepted with no personal convictions as to why. High identification with personal principles and low identification with professional principles leads to *separation*, whereby an individual prioritises their own values, may feel these are sufficient for their work and does not need to add professional values. However, in this context, personal values may not always lead to ethical behaviour in professional contexts, for example where values clash. Where identification with both personal and professional ethics is high, this is described as *integration*. This is described as the most successful strategy, as it facilitates psychological adaptation, and retains important aspects of both cultures, giving a richer understanding and potentially leading to more ethically competent decisions.

**1.3.5. Ethical competence in Trainee Clinical Psychologists.** To evaluate this hypothesis and examine the development of ethical competence amongst trainee clinical psychologists, Ellis-Caird and Wainwright (in prep.) undertook a pilot mixed-methods study. Using a sample from two UK training courses, trainee participants were asked to complete an online version of the DIT-2, complete qualitative reflections on the process of doing so, and provide demographic information including data about their stage of training. Trainees' scores, on an index measuring propensity to rate highly statements consistent with the Post-Conventional Schema, were found to be comparable with the norms on the DIT-2 for those in doctorate-level education (Bebeau & Thoma, 2003). However, comparing across the different stages of training, the authors found that there was no significant difference in DIT-2 scores between first and final year trainees, and in fact, observed a trend towards less

sophisticated schemas. Qualitative information led the authors to hypothesise that this may be explained by trainees becoming less idealistic throughout training, or to have more of an understanding of structures and policies in the workplace, which may lead them to rely more heavily on maintaining norms schemas. Qualitative information also suggested that participants felt they could not or would not always act on their moral judgment (even if this may be viewed by the profession as appropriate), for example due to service restrictions (which may suggest difficulties with the moral motivation component), or employment obligations (which may suggest difficulties with the moral character component).

Another cross-sectional study related to ethical competence within Trainee Clinical Psychologists examined the integration of personal and professional ethics (Jenkin, 2018; Jenkin, Ellis-Caird & Winter, in prep.). In a comparative design between first and final year trainees across 17 UK clinical psychology programmes, participants (n = 39) were asked to complete the DIT-2 and repertory grids to explore differences in their construing of personal and professional ethical dilemmas. First year trainees (n = 19) were found to rely more on personal ethical constructs, whereas final year trainees (n = 20) drew on more professional ethical principles. Final year trainees also showed a greater degree of integration between their personal and professional ethical principles, which arguably lends support to the acculturation model (Handelsman Gottlieb & Knapp, 2005). Like the previous study, the majority of trainees utilised post-conventional reasoning schema, although a small number of trainees were found to use less sophisticated schema, including those in their final year. Overall, final year trainees demonstrated a deterioration in the sophistication of their

ethical decision-making, which the authors hypothesise may have been due to a greater reliance on maintaining norms to manage training demands.

Considering this literature on the development of ethical competence amongst trainee clinical psychologists, one interpretation of these studies may be that training in ethics in clinical psychology is at present insufficient or ineffectual, or that the DIT-2 is an ineffectual way of assessing the learning brought about by this training.

#### **1.4. Systematic literature review**

Having reviewed theoretical models of ethical decision-making related to applied psychology, it was subsequently felt appropriate to systematically review empirical research in the same area. Literature reviews completed between November 2017 and May 2019 revealed no comprehensive empirically derived or tested models of ethical decision-making in clinical psychology, and very few when broadened out to related disciplines. This was highlighted by Cottone and Claus (2000, p. 281) in relation to counselling: *“Aside from the few empirical studies presented in this review article, surprisingly little research has been done on ethical decision making or models of decision making in counseling. There is much work in the ethics area that must be accomplished.”* This has been assessed more recently amongst the literature concerning clinical psychologists: *“few studies have empirically examined the decision making process...”* (Ferencz-Kaddari, Shifman & Koslowsky, 2016). This appears to contrast with other disciplines such as business for example, where there

were 84 empirical articles published on ethical decision-making between 2004-2011 (see Craft 2013, for a review). This supports the rationale for undertaking the present research.

However, to establish current empirical understanding of ethical decision-making and indicate gaps in the literature relevant to the present research, this search was extended to include other professionals delivering talking therapies (defined as: clinical psychologists, counselling psychologists, applied psychologists, counsellors and psychotherapists), and to explore factors affecting ethical decision-making as well as models of ethical decision-making. The following question was therefore the focus of the systematic review: *What does empirical research suggest about how professionals who deliver talking therapies make ethical decisions related to their work?*

A systematic review of the literature related to this question was completed between April and May 2019 using the method outlined by Siddaway, Wood and Hedges (2019). However, due to the scope of the research it was not possible to have two independent reviewers, as is recognised best practice (Siddaway, Wood & Hedges, 2019). This review was carried out using the following databases: PubMed, Scopus and PsycARTICLES. Table 2 shows the search terms used.

Table 2

*Literature search terms used in systematic review*


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“Ethical decision*” OR “ethical decision-making” OR “ethical judgment” OR “ethical judgement” OR “moral decision*” OR “moral decision-making” OR “moral judgment” OR “moral judgement” OR ethic* OR moral*
AND
“clinical psychology” OR “clinical psychologist” OR “counselling psycholog*” OR “counseling psycholog*” OR psycholog* OR counsel* OR psychotherap*

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Table 3 highlights the inclusion and exclusion criteria set for research included in the present systematic review. Due to the limited number of publications on the topic, an earliest publication date was not specified, and a country of origin was not set (although all must be published in full in English). It is recognised that these criteria may have brought some limitations, which will be discussed later in this section.

Table 3

*Inclusion and exclusion criteria for research included within systematic review*

<u>Inclusion criteria</u>	<u>Exclusion criteria</u>
Participants must be qualified: Clinical psychologists or Counselling psychologists or Applied psychologists or Counsellors (of varying kinds) or Psychotherapists (of varying kinds).	Disciplines other than those mentioned in the inclusion criteria or Trainees or Research / academic psychologists without applied psychology background or where applied background is unclear.
Process of ethical decision-making or factors affecting ethical decision-making in professional contexts.	Focus on topics other than how ethical decisions are made or what influences ethical decision-making. Descriptive of ethical decisions made or beliefs about ethical decisions but without reference as to how or why. Other types of decision-making (e.g. clinical but not specifically ethical decision-making, or personal ethical decision-making).
An original research article, empirically derived or tested data and published in a peer-reviewed journal.	Theoretical articles or reflective articles with no empirical component.
Qualitative, quantitative or mixed methods.	
Published in any year.	
Full text available in English, location of study can be worldwide.	Full text available only in another language than English.

In total, 957 articles were identified, of these 33 were duplicates, giving an initial pool of 924 unique articles for consideration in the present systematic review. From this, 819 articles were screened out from their title and 105 abstracts were read. After reading the abstracts, 50 articles were screened out due to not being empirical research, 29 articles were screened out due to not fitting with the participant inclusion criteria, 11 articles were screened out due to not fitting with the ethical decision-making criteria and 15 articles were taken forwards for full text review. Five further articles were identified through other means such as from a review paper (Cottone & Claus, 2000, p. 281), reference lists and articles already known to the researcher. Full text reviews were completed on these 20 articles; three were screened out due to not fitting with the participant inclusion criteria (Kimmel, 1991; Mannheim et al., 2002; Newfield, Newfield, Sperry & Smith, 2000) two were screened out due to not fitting with the ethical decision-making criteria (Bernard, Murphy & Little, 1987; Malone, 2012), one was screened out as only the abstract was available in English (Lin, Chang & Wang, 2009) and one was screened out due to not being empirical research (Gottlieb & Younggren, 2009). Therefore, 13 of these articles were included in the final review. This process is summarised in Figure 1.



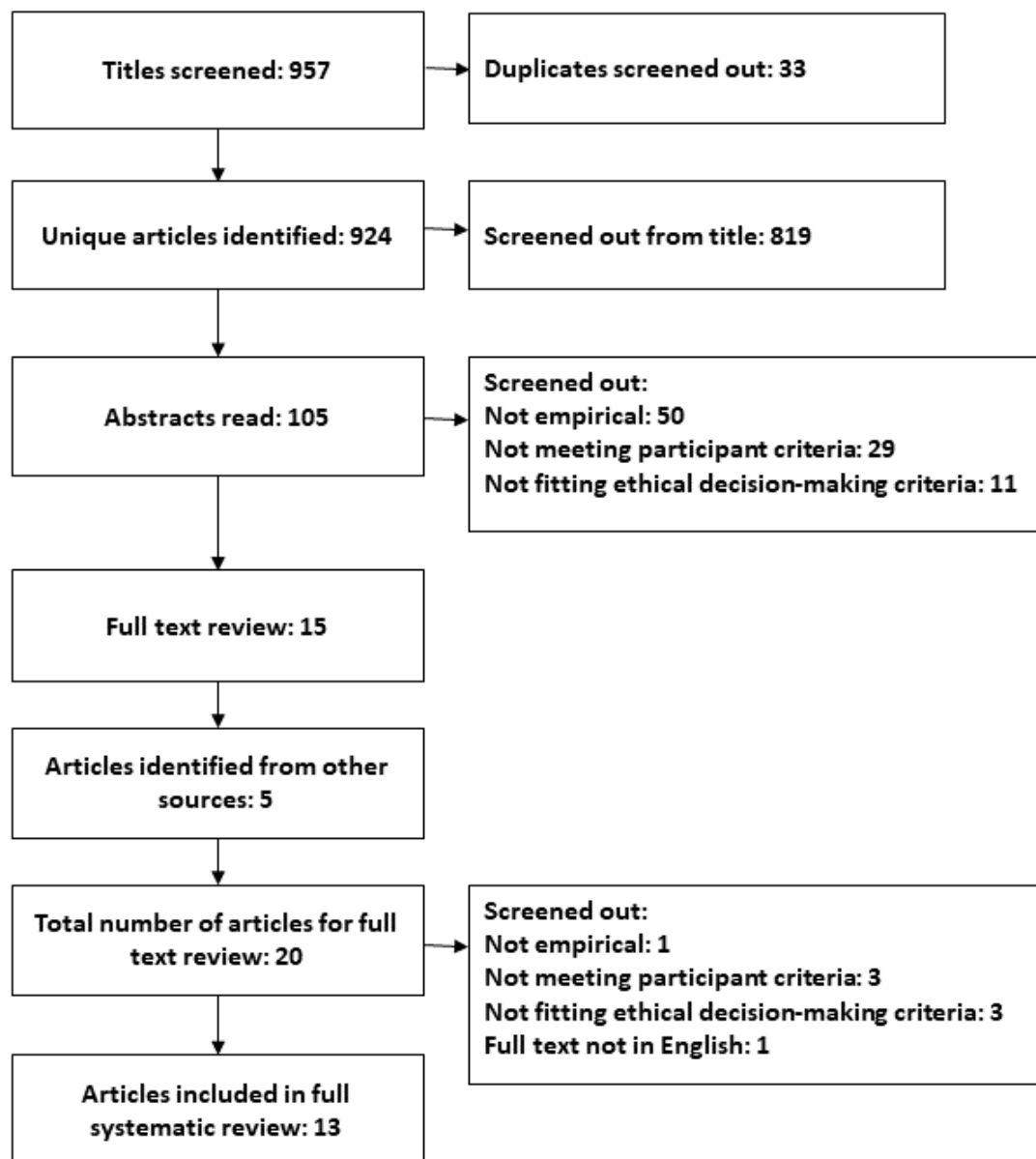


Figure 1. Flow chart to show the systematic review process.

Descriptive summaries of the articles are outlined in Table 4. Of the 13 articles, 10 employed survey methodology. Of these, 8 employed quantitative methods solely, and two employed mixed methods (Brown & Transgrud, 2008; Tymchuk et al., 1982). Whilst it is recognised that there are specific quality assessment tools for mixed-methods research (such as Pluye,

Gagnon, Griffiths & Johnson-Lafleur, 2009), both of these studies presented very little information about the qualitative aspect of their research, and results were reported quantitatively in the main. This is a limitation of these articles and will be discussed later in this section. In the interests of enabling comparison of quality between articles, these 10 articles were all appraised using Burns and Kho (2015) quality assessment criteria. This is summarised in Table 5. This was chosen as it provides a framework for assessing the quality of seven areas of design and reporting of research which uses survey methodology.

Empirical research (Burns & Kho, 2015) suggests that these seven areas are important for high quality surveys. A limitation of these criteria, relevant to the present research, is that the ethics of the research is not assessed. The authors acknowledge this but suggest that consent is implied through return of questionnaire (Burns & Kho, 2015). However, a quality assessment criterion related to whether ethical implications of the research have been considered would improve the rigor of this tool.

The remaining three articles employed qualitative analyses of semi-structured interviews. These were appraised using Tracy's (2010) quality criteria, presented in Table 6. This quality assessment tool was chosen as it assesses quality across eight areas of qualitative research methodology and outcomes, and can be flexibly applied to different types of qualitative research (Tracy, 2010). A limitation of this tool is that procedural standards are less well explored than they are in quantitative quality assessment criteria (for example whether a research question is stated), such as in the criteria by Burns and Kho (2015). However, a

strength, pertinent to the present research, is the focus on how different types of ethics have been approached.

Table 4

*Summaries of articles included in systematic review*

<u>Author, (date), title, location</u>	<u>Summary</u>	<u>Participants</u>	<u>Methodology</u>	<u>Results / Implications</u>
Ferencz-Kaddari, M., Shifman, A., & Koslowsky, M. (2016). Modeling Psychologists' Ethical Intention: Application of an Expanded Theory of Planned Behavior. Israel	Investigation of whether an adapted theoretical model explained professional ethical decision-making in two groups of psychologists, each completing one of two vignettes (dual relationships and payments).	395 clinical psychologists (no information about level of qualification but can be done at Masters level in Israel).	Quantitative survey. One of two professional ethical dilemmas and statements to rate relating to decision, attitudes, subjective norms, perceived behavioural control and professional commitment to client).	Process of professional ethical decision-making supports Theory of Planned Behaviour model impact psychologists' intentions. Attitude (appraisal of a behaviour as likely to yield +ve/-ve results) most significant. Decision-maker factor: Higher professional commitment to client increased intention to treat, so added to model. Dilemma factor: Differences between vignettes i.e. effect of vignette context on what is drawn upon.
Haas, L. J., Malouf, J. L., & Mayerson, N. H. (1988). Personal and professional characteristics as factors in psychologists' ethical decision making. USA	Investigation of choices, reasons and personal characteristics impacting ethical decision-making responses to vignettes (confidentiality, informed consent, loyalty, exploitation, whistle blowing).	294 practising psychologist members of American Psychological Association (APA) Division 29 (Psychotherapy) (90% PhD).	Quantitative survey. 10 professional ethical dilemma vignettes over 5 topics. 2 action options (yes/no), 8 reason options (categorised as codes, or personal standards/ideals).	More likely to take direct action for reasons relate to codes. Clinical setting did not affect responses. Hours of formal ethics training did not affect responses. Decision-maker factors: Gender – male more likely to act to ensure sexual exploitation reported. Female more strongly deny accepting accounting services in lieu of payment. Self-reported theoretical orientation impacted in

one vignette – all orientations except systems would agree to keep secret in couples' therapy. Years of experience – more experience less likely to report, more likely to act indirectly.

Hinkeldey, N. S., & Spokane, A. R. (1985). Effects of pressure and legal guideline clarity on counselor decision making in legal and ethical conflict situations. USA	Investigation of how pressure and explicitly stated legal guidelines affects professional ethical decision- making in vignettes (duty to warn, criminal liability, release of info, duty to report).	72 members of American Mental Health Counselors Association (94% Masters level or above).	Quantitative survey. 4 ethical vignettes (2 levels of pressure – high/low, 2 levels of legal clarity – clear/unclear) and asked to rate each of 5 choice responses.	Dilemma factors: High pressure (? immediate risk) reduces quality of ethical decision-making style: use of hypervigilance (high arousal, seeking quick solution) and unconflicted change (new course of action with minimal risk assessment) strategies (links to theoretical model). Legal guideline clarity had less of an impact and affected by vignette context.
McGuire, J., Nieri, D., Abbott, D., Sheridan, K., & Fisher, R. (1995). Do Tarasoff principles apply in AIDS-related psychotherapy? Ethical decision making and the role of therapist homophobia and perceived client dangerousness. USA	Investigation of relationship between homophobic beliefs in psychologists, perceived level of client risk and breaches of confidentiality when working with clients with HIV.	625 psychologists residing in Florida and licensed and through Florida Psychological Association.	Quantitative survey. 6 scenarios to rate in terms of breaching confidentiality (3 x client types, 2 x levels of risk). Questionnaire about homophobic attitudes.	Decision-maker factor: Personal biases (homophobia). Dilemma factor: (perceived level of risk) impact professional ethical decision-making (breach of confidentiality when working with clients with HIV).

Rae, W. A., & Worchel, F. F. (1991). Ethical beliefs and behaviors of pediatric psychologists: A survey. USA	Investigation of paediatric psychologists' beliefs about and compliance with APA ethical guidelines.	169 psychologist members of society of pediatric psychology and APA (89% PhD).	Quantitative survey. Asked to rate 101 behaviours in terms of occurrence in own practice and belief about ethicality (behaviours then categorised into the 8 APA ethical principles).	Dilemma factors: Minimal value gift more likely to be accepted. Age of client (child, adolescent, or parent) impacted decisions related to responsibility, client welfare, breaking confidentiality, assessment techniques. Perceived severity of presenting problem impacted decision to break confidentiality. Decision-maker factors: Female paediatric psychologists and those who graduated from APA approved courses showed tendency to endorse extreme view in items which reached consensus ( $\geq 80\%$ agreement) by the sample.
Buckloh, L. M., & Roberts, M. C. (2001). Managed mental health care: Attitudes and ethical beliefs of child and pediatric psychologists. USA	Investigation of relationship between child and paediatric psychologists' beliefs about managed care model (MC), personal characteristics, and ethical decision-making in MC context.	252 child and pediatric psychologist members of APA Division 12; Section 1 (Clinical Child Psychology) and Section 5 (Society of Pediatric Psychology) (94% PhD).	Quantitative survey. 3 vignettes ethical dilemmas related to managed mental health care payment model (confidentiality, restriction of services, misdiagnosis).	Differences between what they felt they should do, would do, and what they actually did. Autonomy valued more highly than fidelity. Most common reasons for decisions were beneficence and autonomy. Dilemma factor: MC context somewhat negatively impacted decision-making. Decision-maker factors: No difference between gender, ethnicity, years of experience, average length of treatment offered. Working privately more negative attitudes to MC.

<p>Luke, M., Gilbride, D., &amp; Goodrich, K. M. (2017). School counselors' approach to ethical decision making. USA</p>	<p>Investigation of how school counsellors made ethical decisions in response to a vignette incorporating cultural, religious worldview &amp; factors.</p>	<p>897 school counselor members of American School Counselor Association (80% Masters level).</p>	<p>Quantitative survey. 1 vignette with a focus on cultural, religious worldview &amp; factors (school counsellor personal/ religious beliefs differing from client's parent's lifestyle) and rating different responses and sources of information.</p>	<p>Supports Intercultural Model of Ethical Decision Making (IMED). Decision-maker factors: School counsellor's beliefs could impact ethical decision-making. Low levels of ethical sensitivity. Focus on legalistic and bureaucratic responses.</p>
<p>Tarvydas, V. M., Leahy, M. J., Saunders, J. L., &amp; Fong, C. (2001). Beliefs about the ethics of practice among CRC: A national survey. USA</p>	<p>Investigating rehabilitation counsellors' beliefs about whether specific behaviours are ethical, and beliefs about quality of sources of support for ethical decision-making. Confidence ratings of ethical decisions and decision-maker factors also investigated.</p>	<p>658 rehabilitation counselors certified by Commission on Rehabilitation Counselor Certification (CRCC) (84% Masters level).</p>	<p>Quantitative survey. Ethics of practice questionnaire rate ethicality of 104 actions across 7 categories (avoiding harm, demonstrating competence, avoiding exploitation, showing respect, maintaining confidentiality, informed consent, social equity and justice).</p>	<p>14 behaviours endorsed as ethical (<math>\geq 90\%</math> rated ethical). 23 behaviours endorsed as unethical (<math>\leq 10\%</math> rated ethical). 17 behaviours rated as controversial (endorsement rate 40-60%). National codes of ethics rated most effective source of support, more than research or laws. Dilemma factors: Difficulty (<math>&lt; 7/10</math> confidence rating) of dilemma affects decision made. Decision-maker factors: Years of experience influenced controversial items (<math>&gt; 3</math> years of work more confident in rating item about contingency fee).</p>

Brown, C., & Trangsrud, H. B. (2008). Factors associated with acceptance and decline of client gift giving. USA	Investigation of psychologists' ethical decision-making in scenarios where given gifts by clients, and what factors influence their decisions.	40 APA licensed psychologists (PhD in counselling or clinical psychology & practising clinically).	Mixed methods survey. 4 vignettes differing in factors related to gift giving by clients. Quantitative (decision and rate level of influenced from specific factors) and qualitative responses (explanation of decision). Qualitative transformed into analysed and reported quantitative results.	Dilemma factors: Inexpensive gifts, gifts informed by cultural contexts and gifts at end of therapy all more likely to be accepted. Less likely to accept gifts mid-therapy, or if appearing of coercive (perceived client intention) or of sentimental value to client. Decision-maker factors: Two participants reported personal ethical codes guided their decision-making.
Tymchuk, A. J., et al., (1982). Ethical decision making and psychologists' attitudes toward training in ethics. USA	Investigation of consistency in clinical psychologists' ethical decisions in a variety of clinical and research vignettes and into consistency in what decisions were based upon.	113 members of APA Division of Clinical Psychology.	Mixed methods survey. 12 clinical and research vignettes given and asked to rate a specific course of action, indicate relevant justifications from list and state what decision based on.	Dilemma factors: Strongest agreement about vignettes based around confidentiality, sexual boundaries and risk – related to context and availability of guidelines. Interests of clients most frequently cited justification. Financial concern of psychologist least cited. Decision-maker factors: Strong agreement about a decision also has strong agreement about how decision made. Hypothesis increased familiarity with these visible, topical issues.



Levitt, D. H., Farry, T. J., & Mazzarella, J. R. (2015). Counselor ethical reasoning: Decision-making practice versus theory. USA	Investigation of counselor ethical decision-making process in practice compared to theoretical models.	6 counselors with >5 years professional work experience (2 school, 2 mental health, 2 private, all graduate level education). Email via New Jersey state counselling association.	Qualitative Phenomenological. Semi-structured interviews. Heard vignette (boundary issue), asked to think aloud as to response.	Ethical codes provide guidance but not the whole process of ethical decision-making. Four themes guide counsellor's ethical decision-making: Personal values Client's best interests Transparency in decision-making Perceptions of formal training and practice.
Gonyea, J. L., Wright, D. W., & Earl-Kulkosky, T. (2014). Navigating dual relationships in rural communities. USA	Investigation of family therapists' management of dual relationships in rural communities and perceived impact of shared characteristics on likelihood of entering dual relationship(s).	15 Clinical and Associate members of AAMFT (American Association for Marriage and Family therapy) (Master's degree and practising clinically).	Qualitative grounded theory. 6 phone interviews and 9 recruited from conference did a written survey.	Overall theme of using professional judgment to manage dual relationships. Sub themes of level of benefit or detriment to client, the context of the dilemma and the nature of the dual relationship. Supervision was not identified as a strategy for this. Existing models not used in their entirety.
Frankel, Z. E., Holland, J. M., & Currier, J. M. (2012). Encounters with boundary challenges: A preliminary model of experienced psychotherapists' working strategies. USA	Investigation of how boundaries are maintained and what is taken into account in these ethically challenging situations.	5 clinical psychologists (doctoral level) "well reputed" and ≥8 years post qualification experience, range of theoretical backgrounds.	Qualitative grounded theory. Semi-structured interview. Talk about experience of clinical situation(s) where there were boundary challenges with client and how they responded.	Overall theme of preserving therapeutic relationship so clients can self-care. Sub themes of focus on clients' needs (acknowledge power, identify obstacles, recognise ethical limits), protecting therapist to be effective (protect psychotherapist resources, safeguard therapeutic perspective), protecting therapeutic relationship (understand client difficulties, maintain therapeutic space).

Table 5

*Assessment of methodological criteria of articles employing survey methodology, using Burns & Kho (2015) quality appraisal tool (p.199)*

<u>Author, (date), title</u>	<u>Was a clear research question posed?</u>	<u>Was the target population defined, and was the sample representative of the population?</u>	<u>Was a systematic approach used to develop the questionnaire?</u>	<u>Was the questionnaire tested?</u>	<u>Were questionnaires administered in a manner than limited both response and nonresponse bias?</u>	<u>Was the response rate reported, and were strategies used to optimize the response rate?</u>	<u>Were the results clearly and transparently reported?</u>
Ferencz-Kaddari, M., Shifman, A., & Koslowsky, M. (2016). Modeling Psychologists' Ethical Intention: Application of an Expanded Theory of Planned Behavior.	Focus of research (not posed as question) and hypotheses clearly stated.	Target population defined. Sample demographics given and reported to be similar to population, based on Israeli Health Ministry data. Convenience, non-random sample.	Scenarios initially generated from literature reviews, professionals with ethics background evaluated responses. Scenarios reduced to two through pilot where individual questions pre-tested.	Validity through development of responses and reduction of scenarios through extensive pilot. Two parallel questionnaires in final format not piloted. Validity and reliability of questionnaire items	Recruitment online and at conferences but questionnaire collection method (or differences) not reported. Completed anonymously. Groups broadly matched but justification for separation	Low to moderate response rate (37%), clearly stated. Non-responders not followed up, due to anonymity. Relatively large sample size.	Addresses research areas. Methods for handling missing data not reported. Results reported briefly. Interpretation aligns with results. Two implications briefly discussed. English translation of full questionnaire available from author.

				(Cronbach's alpha).	unclear. No details regarding cover letter, pre- notification or incentive(s).		
Haas, L. J., Malouf, J. L., & Mayerson, N. H. (1988). Personal and professional characteristics as factors in psychologists' ethical decision making.	Focus of research clearly stated (not posed as questions)	Target population defined. Sample demographics given and reported to be similar to population, based on APA personnel survey. Inconsistent reporting about gender split (70 female: 30 male in table, opposite in text). Random sample.	Brief information only about vignette generation (from database of examples). Reduction reported but no information about how. No information about questions being pre-tested.	No information about questionnaire being piloted or tests of validity or reliability. Validity of results increased through using more conservative p value ( $\geq 0.25$ ).	Questionnaire sent in post (appropriate, and particularly for time period). System to facilitate anonymity. Additional details regarding cover letter included, no information about pre- notification or incentive(s).	Moderate response rate of useable questionnaire s (59%), clearly stated. Non- responders followed up. Choice of sample size given a justification.	Addresses research areas. Methods for handling missing data not reported. Succinct summary of results. Interpretation generally aligns with results but some down-played. One implication discussed. All vignettes available. Copies of full questionnaire were available from author.
Hinkeldey, N. S., & Spokane, A. R. (1985). Effects of	Research question not explicitly	Target population defined. Sample demographics given but no detail	Brief information only about vignette generation (from literature and case	Three aspects of validity tested in pilot study, evaluated and	Questionnaire sent in post (appropriate, and particularly	Moderate response rate of useable questionnaire	Results related to hypotheses reported but not explicitly stated in relation to hypotheses.

pressure and legal guideline clarity on counselor decision making in legal and ethical conflict situations.	stated but hypotheses are.	as to how representative this may be of population. Systematic random sampling from an external randomly generated list.	examples). Generation of options based on previously published theoretical literature. Allocation of participants to survey formats detailed. Individual questions initially pre-tested with students.	reported and minor amendments made. No pilot of full or final version, or piloting with qualified sample.	for time period). Brief information about prenotification given. No details of cover letter or incentive(s) given.	s (60.5%), clearly stated. No information about incomplete questionnaire s. One follow-up completed.	Analytical methods clear. Not all results reported, further details were available from author. Methods for handling missing data not reported. Summary demographic information reported. Interpretation aligns with data, one implication stated. 1 of 4 vignettes provided, full questionnaire not available.
McGuire, J., Nieri, D., Abbott, D., Sheridan, K., & Fisher, R. (1995). Do Tarasoff principles apply in AIDS-related psychotherapy ? Ethical decision	Research question and hypotheses clearly stated.	Target population defined. Sample was 92.3% of population, unclear why not all. Sample reported as representative in terms of geographical spread, but	Confidentiality Rating Questionnaire adapted from previously published research but unclear what adaptations were or rationales. Attitude Questionnaire (AQ) from three previously published studies, adaptations and	Instruments tested individually in other research but no evidence of piloting or assessing the validity or reliability of this combination of instruments (in a random order)	Questionnaire sent in post (appropriate for time period). Administration technique appropriate for content of questionnaire (may be more likely to be biased if face to	Low response rate (36%), clearly stated. No detail on whether non-responders followed up. Returned questionnaire s categorised as useable	Results related to research question and hypotheses clearly and transparently reported, analytical methods clear. Methods for handling missing data not reported. Demographic information reported. Interpretation aligns with data, implications and recommendations stated.

making and the role of therapist homophobia and perceived client dangerousness.	unclear in terms of gender.	rationales for this given. AQ items randomly combined but not detailed.	or with this population specifically.	face). Additional details regarding cover letter included, no information about pre-notification or incentive(s).	(625) or not (18).	Questionnaire in this form not provided.
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Rae, W. A., & Worchel, F. F. (1991). Ethical beliefs and behaviors of pediatric psychologists: A survey.	No research question or hypotheses stated. Research aims: systematic exploratory study.	Target population defined. Sample demographics given but no detail as to how representative this may be of population. Random sample.	Items were generated based on previously published measure, no detail as to how or pre-testing. Information about question order.	Instrument questionnaire is based on tested elsewhere in literature but no evidence of piloting this study. Included a duplicate item to check reliability showed inconsistency and variability. No evidence of further checks of validity or reliability.	Questionnaire sent in post (appropriate for time period and content of questionnaire). Additional details regarding cover letter included and impact of incentive or not, no information about pre-notification.	Moderate response rate of useable questionnaires (56.3%), clearly stated. No evidence non-responders followed up.	Results presented in conjunction with discussion and in 7 page-long table, could not be linked to research question. Demographic information presented. Analytical methods clear. No succinct summary of results. Interpretation based on assumption that self-reported behaviour is accurately appraised and reported. Implications discussed. All ethical items to be rated in questionnaire reported.
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Buckloh, L. M., & Roberts, M. C. (2001). Managed mental health care: Attitudes and ethical beliefs of child and pediatric psychologists.	Research questions clearly stated.	Target population defined. Sample reported to be consistent with demographic characteristics of other relevant surveys, all areas of country. Random selection.	Unclear how vignettes generated. Choices for vignettes generated through qualitative pilot, categorised by two independent raters and theory. Questionnaire format described. Attitudes Towards Managed Care questionnaire adapted from previous research but unclear how or why.	Attitudes Towards Managed Care questionnaire tested elsewhere in literature but no evidence of pilot in this study. Inter-rater reliability given (acceptable level). Credibility assessed by participants (83-97.6%). Entire questionnaire in final format not pilot tested.	Questionnaire sent in post (appropriate for content). Additional details regarding cover letter included, system to maintain anonymity included. States no pre-notification or incentive(s) given.	Low response rate (31.5%), clearly stated. No information about non-responders being followed up but possible unable due to anonymity procedures.	Results clearly and transparently reported in relation to research questions as well as succinct summary. Methods for handling missing data not reported. Demographic data reported. Analytic methods clear but no justifications for choices. Interpretations follow from results. Implications discussed. All vignettes and all ethical items to be rated in questionnaire reported. Full questionnaire unavailable.
Luke, M., Gilbride, D., & Goodrich, K. M. (2017). School counselors' approach to	Research aims clearly stated (not posed as	Target population defined, whole population contacted. Sample reported to be consistent with	Vignette developed from literature and analyses to ensure consistency with previously published vignettes.	IMED questionnaire tested elsewhere in literature, inter-rater reliability	Online questionnaire (appropriate for time period and content). Additional	Low response rate (7%), clearly stated. Questionnaires categorised	Results related to research aims transparently reported. Analytical methods clear but choices not justified. Methods for handling

ethical decision making.	questions or hypotheses).	demographic characteristics of population.	Consultation of vignettes with someone with expertise in ethics and clinical supervision. Intercultural model of ethical decision-making (IMED) scoring tool based on previous research, no information about specific changes and rationales.	reported. No pilot of questionnaire in final format for this study. Assessment of Dunning-Kruger Effect in participants responses to look at reliability of self-reports.	details regarding covering email and link to survey included. No report of incentive(s). Indicates part of bigger study and further information on data collection available elsewhere.	as completed (897) or partial and not included (566).	missing data not reported. Demographic information reported. In general, interpretations align with data but other interpretations not covered. Implications and recommendations stated. Questionnaire in this form not provided.
Tarvydas, V. M., Leahy, M. J., Saunders, J. L., & Fong, C. (2001). Beliefs about the ethics of practice among CRC: A national survey.	Research questions clearly stated.	Target population defined. Justification given for sample size. Demographic information reported in detail but no comment on how representative this was. Random sample. Sample	Ethics of Practice Questionnaire (EPQ) adapted from previous research. Adaptations made from literature, rationales defined, verified by "expert panel" but no details about who this was composed of.	Ethics of Practice Questionnaire (EPQ) tested elsewhere in literature and specific additions consulted on. No report of pilot of full version. No reports of measures for	Questionnaire sent in post (appropriate for content), not anonymous. Additional details regarding cover letter included. States participation is voluntary. Participants	Moderate response rate (41%), clearly stated. No follow up completed.	Results in relation to research questions and additional finding stated. Succinct summary of results also given. Methods for handling missing data not reported. Analytical methods clear but choice not justified. Interpretation aligns with data, relevant

heterogeneous in level of ethics training.

validity and reliability.

offered continuing education credits for participation. No details of pre-notification.

implications discussed. All items of Ethics of Practice Questionnaire included but not full format and responses.

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Brown, C., & Trangsrud, H. B. (2008). Factors associated with acceptance and decline of client gift giving.	Research questions clearly stated.	Target population defined. Demographic information reported and stated to be representative (although largely White). Stratified random sampling (by geographical location).	Vignettes developed by authors and consultation with psychologists to assess clarity and research intent. No evidence of pilot study for final questionnaire or pre-testing of individual questions. Brief information about format.	No report of pilot of questionnaire. Validity of constant comparison method for analysing qualitative data (two raters independently sorted responses into categories. Three further raters reviewed categories.	Questionnaire administration information sparse. Sent in post (less appropriate for time period), not clear whether anonymous. No details regarding cover letter, incentive(s), or pre-notification.	Low response rate (27%), clearly stated. No follow up reported. 40 surveys completed, no data about partially completed.	Results in relation to research questions and summary of results given. Very sparse information given on qualitative method. Analysis of quantitative data more transparent but no rationales given for choices. Methods for handling missing data not reported. Interpretation aligns with data, implications discussed. All vignettes included but not questionnaire and responses in full.
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Tymchuk, A. J., et al., (1982). Ethical decision making and psychologists' attitudes toward training in ethics.	Research objectives clearly stated (not defined as questions) .	Target population defined. Some demographics described but some key ones missing (gender) and no information about representativeness. Systematic random sample.	Generation of vignettes from APA standards. Response types detailed but no rationale. Dilemmas reported to be "typical" to clinical psychologists' work, but not measured. Vignettes piloted with psychologists to review clarity and then adjusted. No evidence of pre-testing of questions. Brief description of format.	No evidence of pilot study for full questionnaire. Adjustment of language following consultation but no reports of validity or reliability.	Questionnaire administration information sparse. Sent in post (appropriate for time period and content), not clear whether anonymous. No details regarding cover letter, incentive(s), or pre-notification.	Low response rate (23%), clearly stated. No follow up reported.	Results relevant to research aims reported and succinct summary. Missing data reported. Limited demographic information reported. Very sparse information given on qualitative questions, unclear if these were formally analysed. Quantitative data analyses more transparent but mixing of number and letter systems difficult to review easily. Interpretation of the results aligned with data and implications stated. All vignettes included but not questionnaire or responses in full.
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Table 6

*Assessment of methodological criteria of articles employing qualitative methodology, using the Eight “Big-Tent” Criteria for Excellent*

*Qualitative Research (Tracy, 2010)*

<u>Author, (date), title</u>	<u>Worthy topic</u>	<u>Rich Rigour</u>	<u>Sincerity</u>	<u>Credibility</u>	<u>Resonance</u>	<u>Significant contribution</u>	<u>Ethical</u>	<u>Meaningful coherence</u>
Levitt, D. H., Farry, T. J., & Mazzarella, J. R. (2015). Counselor ethical reasoning: Decision-making practice versus theory.	Worthy topic, has received little attention in the literature to date. Suggests that models from ethical instruction are not how ethical decision- making occurs in practice.	Links to literature, appropriate theories. Appropriate for time. Aimed to describe depth of experience, and applicability not generalisability. Sample small but appropriate given the goals. Interviewing practices appropriate	Process of analysis quite succinct. Individual coding and then as a group. Readers encouraged to apply findings themselves. Acknowledged aimed for larger, more diverse sample. Acknowledge self-reflexive	Purposeful sampling of experienced participants to allow for reflection on experience. Use of triangulation in interviewing (e.g. prompting, summarising) and analysis (member checking, group review	Results and interpretation linked clearly and systematically throughout article. Encourages consideration of applicability (i.e. to other counsellors’ own practice) not generalisability of results. In principle, this could be	Theoretical and practical significance. Existing models are prescriptive whereas this is aims to be descriptive, capturing how participants approach ethical decisions in practice. Somewhat less heuristic significance as model can almost be seen	Limited account of procedural ethics (no report of ethical approval or informed consent etc.). Unclear how difficulties with situational ethics would have been managed. Relational ethics	Design, data collection and analysis fit coherently together and within existing literature. Appropriate implications follow from this. Article appears to achieve its aims (model of how ethical decision- making happens in

(semi-structured telephone interviews, audio recorded and transcribed). Report saturation was achieved.

factors. Report controls in place to minimise biases in design and interpretation but recognise some may remain.

of transcripts, group coding). Detailed quotes align with interpretation of data.

applied to other cognate disciplines such as clinical psychology. Noticed how findings feel transferable and naturalistic generalisations to the present research.

to stand alone. Methodological significance already established.

described through member checking of results and triangulation within data collection. Research presented in a way that reader's interpretation is likely to be consistent with findings, chose topic with meaningful implications.

practice and how this compares to theoretical models).

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Gonyea, J. L., Wright, D. W., & Earl-Kulkosky, T. (2014). Navigating dual	Worthy topic, supports decision-making where inevitable	Links to appropriate theories and guidelines. Appropriate for	Notes recorded immediately after data collection.	Purposive sampling. Investigator triangulation as interviews	Lack of transferability in terms of use of supervision in my clinical	Theoretically and practically significant. Extends knowledge,	Procedural ethics describes written and verbal	In general, achieves what it purports to be about however, UK
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relationships in rural communities.	ethical dilemmas exist. Results related to not seeking supervision are counter-intuitive.	time. Reasonable sample size, adequate to support claims. Appropriate data collection procedures, although unclear if phone interviews had more cues than surveys.	Details on self-reflexivity limited. Transparency about methods by availability of interview questions. Additional recruitment method reported as indicated by data but could be due to low initial response rate (not addressed).	carried out by several researchers. Credibility audits completed internally and externally. Information about participant demographics allows reader to assess transferability. Quotes support interpretation but are only few. No report of member checking.	psychology experience. Naturalistic generalisations to the present research and other ethical decisions (not just dual relationships or rural communities).	elucidates practices related to dual relationships in small community contexts and highlights practical implications. Generates ongoing research in terms of other contexts or types of dilemmas. Methodological significance already established.	consent as appropriate (no report of ethical approval). Unclear how difficulties with situational ethics would have been managed. Relational ethics in terms of responding to earlier participants' suggestions for more reflective time than phone call. Research presented so interpretation likely to be	context may differ in terms of definition of rural communities. Connects with a limited proportion of theoretical literature on ethical decision-making. Design, data collection and analysis fit coherently together, although impact of multiple data collection methods not explored. Appropriate
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							consistent with findings, no report of member checking.	implications follow results.
Frankel, Z. E., Holland, J. M., & Currier, J. M. (2012). Encounters with boundary challenges: A preliminary model of experienced psychotherapists' working strategies.	Worthy topic, extends current understanding of ethical considerations in ongoing ethically challenging situations. Although model is quite complex, results are reasonably intuitive.	Sample smaller than ideal due to different orientations but appropriate given the goals and report saturation. Enables depth rather than breadth of experience. Other recruitment methods may have increased participants. Appropriate data collection procedures, although	Self-reflexivity of researcher / interviewer's theoretical orientation clearly stated and reactions to findings discussed. Methods transparent and likely to be replicable. Recognition of limits in terms of causal claims with this methodology and limitations in	Purposeful, maximum variation sampling of experienced and well reputed participants from different theoretical backgrounds. Unclear how reputable was assessed. Interview schedule developed with experienced external consultant.	Deliberate sampling from different theoretical backgrounds to increase generalisability. Resonates less well with present research as no specific decision to be made, more an ongoing management of ethically difficult situation. Findings transferable to	Knowledge within this ethically challenging scenario extended, however limited extension to process of ethical decision-making. Practical implications less clear but generates more research in same area (heuristic significance, could be considered as a pilot or working model). Some	Limited information on procedural ethics. Method not likely to have caused harm, so outcomes justifiable, unclear how difficulties would have been managed. Relational ethics approached through member checking of results and	Research achieves what it purports to be about although generalisability may be limited. Connects with literature on boundaries but less so with decision-making. Methods, analysis and implication fit coherently together.

<p>unclear if reflective diary was kept.</p>	<p>terms of small sample size.</p>	<p>Detailed quotes support analysis. Triangulation within interviews and member checking. supports credibility.</p>	<p>other disciplines but perhaps less so to other ethical challenges. Aesthetic merit: results and interpretation linked throughout.</p>	<p>practical significance, could be utilised as a framework for approaching difficult ethical situation of this type.</p>	<p>triangulation within data collection. Exiting ethics through member checking, unclear how objections would have been managed.</p>
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#### **1.4.1. What does empirical research suggest about how professionals who deliver talking therapies make ethical decisions related to their work?**

Considering information from the systematic review as a whole, two models were found to explain aspects of professional ethical decision-making, and two types of factors were found to influence professional ethical decision-making; decision-maker factors, and dilemma factors. These are outlined in Tables 5 and 6 and will be explored in turn. Following this, general themes in terms of methodological strengths and weaknesses will be described (also described in more detail in Tables 5 and 6 and throughout the findings from the systematic review), as well as the identified gaps in the literature. This will support the rationale for the present research topic and method.

**1.4.1.1. Empirically tested models of ethical decision-making.** Two quantitative studies tested theoretical models of aspects of ethical decision-making amongst professionals delivering talking therapies (Ferencz-Kaddari, Shifman & Koslowsky, 2016; Luke, Gilbride & Goodrich, 2017) which will be reviewed presently. Using qualitative methods, Levitt, Farry and Mazarella (2015) put forward themes to explain aspects of ethical decision-making, which is reviewed in the next section.

Ferencz-Kaddari, Shifman and Koslowsky (2016) surveyed 395 clinical psychologists in Israel, asking them to respond to one of two vignettes relating to either dual relationships or financial matters. They assessed ethical intention (an ethical decision-made, which can be hypothetical, rather than a completed action) in comparison with the Theory of Planned Behaviour (Ajzen, 1985, as cited in Ferencz-Kaddari, Shifman & Koslowsky, 2016). This model puts forward that the

decision-makers' attitudes (such as a positive evaluation of a course of action), subjective norms (such as social pressure), and the decision-maker's perceived control of their ability to implement a particular behaviour impact ethical intention.

In their study, Ferencz-Kaddari, Shifman and Koslowsky (2016) added professional ethical commitment toward the client into the model and found this explained more variance than without it. They suggest that decision-makers' attitudes, followed by professional ethical commitment, predicted ethical intention most significantly, which is thought to then drive behaviour in response to the ethical challenges. A strength of this study is that this model was tested across two different vignette contexts, however the quality could be improved by each participant answering more than one dilemma. Although their results outline that the type of vignette impacted ethical intentions, the model does not encompass contextual factors related to the dilemma, or the interaction between the dilemma and the decision-maker, which may impact professional ethical decision-making. The quality of this research could also be improved through adding a qualitative aspect. Its quantitative nature means that participants had to rate only the influence of predetermined factors and if other factors had influenced their decision-making, this would not have been picked up.

Further, this study (Ferencz-Kaddari, Shifman & Koslowsky, 2016) may be less applicable to the UK context due to Israel having elements of both individualistic and collectivist cultures (Hofstede Insights, 2019) which may influence attitudes; a different political context (as political beliefs are considered to impact ethical decision-making; Graham, Haidt & Nosek, 2008); and clinical psychologist qualifications not necessarily being equivalent (State of Israel Ministry of Health,



2019; as the level of experience and training route may have an impact on ethical decision-making, as discussed later in this section).

The second article which tested a theoretical ethical decision-making model was by Luke, Gilbride and Goodrich (2017) who compared 897 USA school counsellors' decision-making to the Intercultural Model of Ethical Decision Making (IMED; Luke, Goodrich & Gilbride, 2013, as cited in Luke, Gilbride & Goodrich, 2017) using a cross-sectional survey. This is a seven-step framework to guide school counsellors in ethical dilemmas involving cultural, religious or worldview factors. Although this discipline does not practice in a health setting and the role may be considered quite different to that of clinical psychology, it was still felt to be relevant to the present research in terms of how clinicians manage their own biases. A methodological difficulty with this research is that only one vignette was used, with multiple complexities around the protagonists' cultures, religious beliefs and worldviews. Although this intersectionality has ecological validity, it is unclear which factors, or what proportion of each impacted school counsellors' ethical decision-making. The authors report low levels of ethical sensitivity in their sample (10% of participants identified that an ethical dilemma was the presenting issue), which itself had a low response rate (7% of those the survey was sent to). This research is also limited insofar as it aims to explain ethical decision-making in one context specifically, which may not apply to other types of ethical decisions.

Taken together, these models can be considered to explain aspects of ethical decision-making, but they do not seem to be all encompassing, and there are limits as to how generalisable they are to the UK clinical psychology context. Furthermore, both articles test models which have been

theoretically developed, rather than using inductive methods to inform the development of a model. The present research aims to address these limitations.

**1.4.1.2. Decision-maker factors: An overview.** A large number of different factors relating to the professional delivering talking therapies were identified as impacting ethical decisions. Several of these factors were only found by one article and as such are not reviewed in detail here. These include the decision-maker's theoretical orientation (Haas, Malouf & Mayerson, 1988), high levels of commitment to the client (Ferencz-Kaddari, Shifman & Koslowsky, 2016), personal biases (McGuire, Nieri, Abbott, Sheridan & Fisher, 1995), high level of commitment to transparency (Levitt, Farry & Mazzarella, 2015), practitioners' professional judgment (Gonyea, Wright & Earl-Kulkosky, 2014) and perception of clients' motivations (Brown & Transgrud, 2008).

**1.4.1.2a. Agreement within decision-maker factors: Clients' best interests.** Within the decision-maker factors, there was agreement that client's best interests are taken into account when making ethical decisions and that professionals may also draw on their own personal ethical systems. Considering the USA managed mental healthcare payment model, Buckloh and Roberts (2001) found that the principles of autonomy and beneficence were most highly prioritised in ethical dilemmas across a survey of 252 child and paediatric psychologists. Strengths of this research include the use of three dilemmas to explore the one context (looking at aspects of confidentiality, service restriction, and misdiagnoses) and the high credibility rating given by participants (83-97.6%). One limitation of this research is the focus on the payment system, which is not so applicable outside of the USA. A further limitation is that there is limited clarity to how the vignettes were generated, whereas other studies have based their vignettes on existing

literature (Ferencz-Kaddari, Shifman & Koslowsky, 2016), through consultation (Brown & Transgrud, 2008) or case material for example (Hinkeldey & Spokane, 1985). That decision-makers draw on what they believe to be in the client's best interests was also found by Tymchuk et al., (1982), Levitt, Farry and Mazzarella (2015), and Gonyea, Wright and Earl-Kulkosky (2014). The latter two of these studies add weight to this argument as they were qualitative in nature, particularly Gonyea, Wright and Earl-Kulkosky (2014) who asked 15 family therapists to consider their own practice in a grounded theory study, meaning participants generated these ideas in the main. Similarly, Frankel, Holland and Currier (2012 p.101) undertook a grounded theory study with five clinical psychologists which identified a key theme of "*maintaining a therapeutic relationship to facilitate client self care*", which could be argued approaches a similar dimension to taking account of the client's best interests. Strengths of this research include triangulation within interviews and member checking. Tymchuk et al., (1982) undertook what appeared to be mixed-methods research, however there was such sparse information on the qualitative aspect of this research that it was felt better to evaluate it using the survey quality assessment criteria. A strength of this study however is that the findings were generated from 12 different vignettes, rather than those with fewer (such as Luke, Gilbride & Goodrich, 2017; Ferencz-Kaddari, Shifman & Koslowsky, 2016) who asked each participant to consider one vignette only). Overall, this suggests that those delivering talking therapies are likely to consider clients' best interests when making ethical decisions.

**1.4.1.2b. Agreement within decision-maker factors: Personal ethics.** The other factor which was more consistently agreed upon within the identified literature as impacting professional ethical decision-making was personal ethics. Levitt, Farry and Mazzarella (2015)

undertook a phenomenological study with five counsellors using a vignette representing a boundary issue and asking them to describe how they would reason through this dilemma. One potential difficulty with this method is that it suggests a thinking process will necessarily be found. Where a decision may involve a limited process and be more automatic (Kahneman, 2011), prompting by the researcher may lead participants to retrospectively apply a process through slower thinking (Kahneman, 2011). Nevertheless, Charters (2003) argues that this is a robust method, with reliability being improved through triangulation. Levitt, Farry and Mazzarella (2015) addressed this through summarising during data collection, member checking, group coding and group review of transcripts during data analysis. This conclusion is supported somewhat by drawing on the research of Brown and Transgrud (2008) who employed a mixed methods survey to assess the factors impacting 40 psychologists' acceptance of gifts from clients. Within their research, two psychologists indicated that they would decline gifts from clients as they felt this contravened their personal ethical codes. Limitations with this research include insufficient information about the qualitative aspects to enable fair evaluation the most appropriate criteria, as with the other mixed methods research in this review (Tymchuk et al., 1982). This study also had a relatively small number of participants and a low response rate (27%) and only looked at one type of ethical decision (gift acceptance). However, a strength of this approach is that four varied dilemmas were used, enabling a comparison of the influence of different contexts (described in dilemma factors). Overall, this suggests that those delivering talking therapies are likely to be influenced by their own ethical systems (as separate from professional ethical systems), when making ethical decisions.

**1.4.1.2c. Debate about decision-maker factors: Gender.** Within decision-maker factors, there was limited agreement about the influence of gender upon ethical decisions. Two studies (Haas, Malouf & Mayerson, 1988; Rae & Worchel, 1991) found that gender did have an impact, whereas one did not (Buckloh & Roberts, 2001). Haas, Malouf and Mayerson (1988) presented 294 psychologists practising psychotherapy with 10 vignettes based around 5 different topics in the USA. They found small gender differences in two of their vignettes. Male psychologists in their study were more likely to act to ensure sexual exploitation was reported, whereas females were more likely to inform the client of their rights. In another dilemma, whilst both male and female participants were likely to decline accepting services in lieu of payment, this was demonstrated more strongly for female participants. Unfortunately, these findings are difficult to interpret due to inconsistent reporting within the article about their participant demographics. It is therefore difficult to consider whether this sample was representative of the population from which it was drawn. Considering paediatric psychologists only, Rae and Worchel (1991) asked 169 participants to rate a list of behaviours in terms of whether they had done it and how ethical they perceived it to be (such as “lying to a child”, or “breaking confidentiality if client is suicidal”). In their study, female psychologists tended to endorse more extreme positions (i.e. “unquestionably ethical”, “unquestionably unethical”). A limitation of this research is the exploratory rather than experimental nature of the study and the length of the questionnaire (101 items, not presented in a randomised order). A strength of this study is that there was an approximately even gender split (45% male) in their participants, although there is some evidence to suggest that males were therefore overrepresented in the sample compared to the target population of the time (APA, 1997). Conversely, Buckloh and Roberts, (2001) who also had an approximately even gender split in their participants (47.4% male) found no differences between males and females in their

attitudes towards managed care. Overall this suggests that gender may have an influence on ethical decision-making however, there may be numerous reasons for this.

***1.4.1.2d. Debate about decision-maker factors: Professionals' work settings.***

Another area of disagreement in the identified literature was whether participants' work settings impacted their ethical decision-making. Buckloh and Roberts, (2001) found that psychologists working privately held more negative attitudes towards the managed care model than those working in hospitals. Haas, Malouf and Mayerson (1988) found that the clinical setting participants were working in did not affect the ethical decisions made. Buckloh and Roberts (2001) hypothesise that clinical setting may be particularly relevant to managed care contexts due to the differential financial impact. Overall, this suggests that participants' work settings may have an impact on ethical decision-making amongst those who deliver talking therapies, where this is salient.

***1.4.1.2e. Debate about decision-maker factors: Experience.***

Another difference in results about factors influencing ethical decision-making was found with regards to years of experience. Haas, Malouf and Mayerson (1988) found in two of their 10 vignettes that more experience was correlated with less reporting and more indirect action. Tarvydas et al., (2001) surveyed 658 rehabilitation counsellors, asking them to rate how ethical they felt 104 behaviours were and how confident they were in their rating. Of the behaviours that were rated as controversial by the group, those with three or more years of experience were more confident in their ratings of these items, for example related to responding to a request for a contingency fee (payment only in the event of a pre-agreed favourable therapeutic outcome). A

strength of this research is that the questionnaire used (the EPQ; Ethics of Practice Questionnaire) had been validated in previous research and the additional rehabilitation specific questions were tested with a panel with expertise. As with the methodology from Rae and Worchel (1991), a limitation of this research is the length of the questionnaire (104 items, also presented in a static order). Similar to years of experience, Tymchuk et al., (1982) hypothesised that vignettes which had the strongest consensus about the appropriate course of action were more widely discussed, so participants may be more familiar with ethical decision-making in these areas (such as sexual behaviour, confidentiality and risk). Conversely however, Buckloh and Roberts (2001) found no effect of years of experience on ethical decision-making in relation to managed care.

Perhaps indirectly related to years of experience, there was disagreement in the literature about whether the level and type of ethics training participants had had influenced their ethical decision-making. Haas, Malouf and Mayerson (1988) found that the hours of formal ethics training (defined as graduate coursework and continuing education) undertaken did not have an impact on ethical decisions or reasons. This links to the work of Ellis-Caird and Wainwright (in prep.) who suggested that sophistication of ethical decision-making may not improve for trainee clinical psychologists over the course of training. This may be explained by the finding from Levitt, Farry and Mazzarella (2015) that counselling participants felt a disconnect between training in ethics and practice. However, Rae and Worchel (1991) did find a difference between type of ethical instruction. In their study, psychologists who had trained at courses approved by the APA (American Psychological Association) tended to endorse more extreme positions (i.e. “unquestionably ethical”, “unquestionably unethical”) than those who had trained elsewhere.

Taken together, the conclusion remains tentative about whether years of experience or type and duration of ethical instruction have an impact on ethical decision-making.

**1.4.1.3. Dilemma factors: An overview.** There were a number of factors related to the dilemma itself which were found to influence ethical decision-making, these consisted of the vignette context (Ferencz-Kaddari, Shifman & Koslowsky, 2016; Buckloh & Roberts, 2001; Tarvydas et al., 2001; Tymchuk et al., 1982) client factors (such as the client's age; Rae & Worchel, 1991), perceived severity of presenting problem (Rae & Worchel, 1991; McGuire, Nieri, Abbott, Sheridan & Fisher, 1995) and cultural or religious factors (Brown & Transgrud, 2008; Luke, Gilbride & Goodrich, 2017). Other dilemma factors such as the value of a gift (in dilemmas about accepting or declining gifts; Rae & Worchel, 1991; Brown & Transgrud, 2008), and the perceived level of pressure (Hinkeldey & Spokane, 1985) are also reported to have an influence on ethical decision-making.

**1.4.1.3a. Dilemma factors: Vignette context.** The specifics of the vignette were found to have an impact on the ethical decisions made. For example, Ferencz-Kaddari, Shifman and Koslowsky (2016) compared two types of ethical decisions (related to dual relationships and money) made by different groups of participants and found that there were differences in the factors participants took account of. Although they concluded that decision-maker factors (such as attitudes) play a large role in ethical decision-making, these contexts necessarily influence the decision-maker differently. Buckloh and Roberts (2001) reported that the managed care context negatively impacted decision-making, for example some participants reported they would misdiagnose clients in order to work within the system. However, the effect of this type of context could be empirically assessed through comparison with vignettes in a non-managed care context.



Tarvydas et al., (2001) reported that where rehabilitation counsellors rated ethical decisions as difficult (indicated by a confidence rating of less than 7 out of 10), there was less consensus between participants about whether a behaviour was considered ethical or not. As outlined with familiarity under decision-maker factors, Tymchuk et al., (1982) reported that topical, widely discussed issues had greater consensus. This could be about familiarity, or perhaps something about these dilemmas, such as the availability of guidelines (on sexual behaviour, breaching confidentiality, or risk issues). This led the authors to call for more research into how the nature of the dilemma impacts decision-making processes.

**1.4.1.3b. Dilemma factors: Gift value.** Considering the context of gift giving only, Brown and Transgrud (2008) found that the perceived value of a gift from a client impacted the likelihood of it being accepted; with less expensive gifts being more readily accepted. Rae and Worchel (1991) also observed this finding and furthermore found that this interacted with the client's age, whereby paediatric psychologists were more likely to accept a low value gift from a child than they were a high value gift from an adult. Rae and Worchel (1991) hypothesised that this may be influenced by the psychologist's theoretical orientation and that other dilemmas have clearer guidelines.

**1.4.1.3c. Dilemma factors: Cultural implications.** Two studies suggested that cultural factors may have an impact on ethical decision-making. As described earlier in this section (Luke, Gilbride & Goodrich, 2017) research suggested that the culture of a school (such a procedural pressure), and differences in religious beliefs or worldviews between school counsellors and clients or families may mean ethical decisions are more process oriented rather than values

based. Similarly, Brown and Transgrud (2008) found that if gift giving by clients was perceived by psychologists to be borne out of cultural significance to the client then they were more likely to accept the gift.

**1.4.1.3d. Dilemma factors: Pressure.** Hinkeldey and Spokane (1985) found in their survey of 72 mental health counsellors that increased pressure in a vignette reduced the quality of the decision-making style which participants drew upon. Pressure led participants to be more likely to be hypervigilant and seek quick solutions or to seek novel courses of action with limited regard for the risks. It is not clear what the authors mean by the high- and low-pressure conditions of their vignettes as only one was provided as an example. However, this is inferred to be scenarios where there are more immediate risks. Strengths of this study include the achievement of a moderate response rate and a follow up procedure which increased the initial return rate. These findings are supported by the research of McGuire, Nieri, Abbott, Sheridan and Fisher (1995) who, through a questionnaire of psychologists in Florida, USA, found that where clients' behaviours were considered higher risk, this impacted the decision to breach confidentiality, when working with clients with HIV. This study also found that a decision-maker factor (endorsement of homophobic attitudes) had a similar effect. It is worthy of note that all participants were from one state and this research is bound to a different time-context than the present. There were some limitations to this research, namely that questionnaires were adapted from previous research, but it is unclear what the adaptations were, making it difficult to replicate. It is a strength that another questionnaire employed by these authors combined items from three previously published studies in a random order, however the methodological quality of this research is limited by the lack of detail about how this was done and the validity and reliability of this new scale. That being

said, Rae and Worchel (1991) had similar findings to support the role of higher stakes as impacting ethical decision-making, such as the perceived severity of the client's presenting problem.

Overall, this suggests that factors related to the ethical dilemma, such as those related to the client, or facets of the dilemma itself, have an impact on the ethical decision-making of professionals delivering talking therapies. This is in comparison with decision-maker factors, where there is some disagreement in the results about whether specific characteristics influence ethical decision-making. Methodological strengths and difficulties have been highlighted throughout this section with regards to specific studies. At this point however, commonalities between the studies will be addressed.

**1.4.2. Areas of methodological strength in the research.** Bar one article, which described an exploratory study (Rae & Worchel, 1991), all the research shows methodological quality through the research questions, hypotheses or general area of research being clearly defined. This enabled the results to relate back to these clearly, which, on the whole, were presented clearly and with sufficient data to allow the reader to generate their own conclusions. In general, the interpretations made by researchers about their results aligned with the findings. Similarly, all studies clearly identified their target population and provided detail on their participant demographics, this increases the replicability of this research. The qualitative articles can all be considered worthy topics, and all of the articles extend the literature on professional ethical decision-making in various ways, subsequently highlighting the need for further research areas. The present research aims to follow these strengths by presenting clear research questions

related to extending current understanding of ethical decision-making, transparent results linking back to these aims and offering appropriate implications.

**1.4.3. Areas of mixed methodological strengths and difficulties in the research.** Across the different articles there was variation in the level of validity and reliability measures that had been put in place. For example, credibility is demonstrated in the qualitative studies by the inclusion of member checking (Levitt, Farry & Mazzaella, 2015; Frankel, Holland & Currier, 2012) and triangulation (Levitt, Farry & Mazzaella, 2015; Frankel, Holland & Currier, 2012; Gonyea, Wright & Earl-Kulkosky, 2014). However, in the quantitative survey by Rae and Worchel (1991) only one check was done on reliability through the duplication of one question, which was found to be unreliable. This therefore limits the conclusions and implications that can be drawn from this piece of research, and it is considered in the light of other articles. In contrast to this however, Ferencz-Kaddari, Shifman and Koslowsky (2016) demonstrate quality in their research through the development of their responses to vignettes via an extensive pilot. They also report acceptable levels of reliability (Cronbach's alpha ratings between 0.64-0.95) of the instrument employed in their study. The present research aims to draw on the strengths relating to reliability.

As outlined in Section 1.4.1.2a, there is variability in the quality of how the vignettes are generated, such as having limited information or by drawing on literature (Ferencz-Kaddari, Shifman & Koslowsky, 2016), consultation (Brown & Transgrud, 2008) case material (Hinkeldey & Spokane, 1985) or a combination of different methods (Luke, Gilbride & Goodrich, 2017). The present research aims to address this by using a robust method of vignette development, grounded in theoretical guidelines and drawing on appropriate consultants.

**1.4.4. Areas of methodological difficulties in the research.** Across all the research identified, some common themes of methodological difficulties were noted using the quality assessment tool (Burns & Kho, 2015; Table 5). Only one of the articles (Tymchuk et al., 1982) provided information on how missing or incomplete data was handled for the purposes of data analysis, which means the reader cannot assess validity of statistical conclusions. In a similar vein, no articles presented their questionnaires in full for the reader to assess, and many articles only gave an example vignette rather than providing all of them for review. All surveys had a low to moderate response rate from the original sample of participants approached and on the whole, non-responders were not followed up. It will therefore be important that these areas are addressed as far as possible in writing up the present research.

Most studies employed hypothetical ethical dilemmas in the form of vignettes, rather than asking participants about their experience of ethical decision-making, and some research suggests that these may rely on different neural mechanisms (FeldmanHall et al., 2012). Two qualitative studies (Frankel, Holland & Currier, 2012; Levitt, Farry & Mazarella, 2015) did investigate participants' experiences of ethical decision-making in practice. However, neither of these studies reported on how situational ethics (ethical issues arising from the specific context of the research; for example, if participants had disclosed illegal practices or practices which may be deemed ethically uncomfortable) were, or would have been, managed. This feels especially important given the research topic being related to ethical decisions, and this lack of precedent raises concern. As per the findings from research with trainee clinical psychologists (Ellis-Caird & Wainwright, in prep; Jenkin, 2018; Jenkin, Ellis-Caird & Winter, in prep) and rehabilitation counsellors (Tarvydas et al.,

2001) the development of a structured tool using vignettes to support the instruction in ethical competence is indicated: *“In future, it would be important to construct an instrument that utilizes scenarios so that a context for the ethical behaviours being rated is provided.”* (Tarvydas et al., 2001, p. 16). Hypothetical vignettes are therefore developed for use in the present research. This has the advantage of being comparable with existing literature, whilst it is recognised that there are limitations to this approach.

**1.4.5. Gaps identified from the systematic review.** Drawing this research together, some key gaps are highlighted in relation to the topic and the method. No studies speak to the UK context specifically, and all but one study (Ferencz-Kaddari, Shifman & Koslowsky, 2016) was based in the USA. There are obvious differences between the healthcare systems in these countries, with the UK clinical psychologists mainly working in the NHS (BPS, 2019a), and indeed one of the articles focuses exclusively on the USA mental healthcare payment model (Buckloh & Roberts, 2001). Cultural differences are also relevant between research carried out in the USA and the UK context. For example, a study investigating ethical decision-making in rural communities (Gonyea, Wright & Earl-Kulkosky, 2014) included participants who supported a population of more than 100,000 people, which is less likely to be considered rural in the UK.

Despite there being many commonalities between professions delivering talking therapies, there are also important differences in their approach, client groups, settings and levels of training, all of which may have an impact on their ethical decision-making. This indicates a role for the present research to focus on one professional group alone, namely clinical psychologists, and only those practicing in the UK context.

Similar to the context of the country that the study is based in, the time context is also considered to be important. It is put forward that ethical dilemmas and beliefs change over time (Schwartz-Mette & Shen-Miller, 2018) as does the makeup of the workforce. Many of the identified articles are a number of decades old now and it remains to be seen whether the findings are still relevant today. This suggests a role for providing an up to date analysis of ethical decision-making in the present research.

As outlined in Table 4, many of the studies in the present research utilise only one vignette. Some use several vignettes representing different aspects of one type of dilemma. Whilst this depth enables thorough assessment of those factors in particular, it is difficult to know to what extent the findings apply to other aspects of ethical decision-making. Having few vignettes limits the generalisability of the process of ethical decision-making, which would have important implications for ethical instruction. This supports the rationale for having a number of different vignettes covering a diverse range of ethical dilemmas in the present research.

In this systematic review, articles utilising qualitative and quantitative methods of enquiry were found. The quantitative research limited participants to commenting only on items already selected by the researcher, whereas the qualitative research had limited generalisability. This provides a rationale for employing a mixed-methods approach which supports the empirical derivation of a model of ethical decision-making as well as the ability to quantify influencing factors.

### 1.5. Summary, rationale and aims

In summary, there is a limited but growing body of research into ethical decision-making in clinical psychology. Given this is a regular and important part of clinical psychologists' work, it may be that training in this area needs review or that more appropriate tools need to be developed for measuring the changes taking place following ethical instruction. This provides a rationale for the development of vignettes featuring ethical dilemmas in UK clinical psychology practice. The eventual aim of developing vignettes would be to create a tool to assess ethical competence in clinical psychology, perhaps similar to the Intermediate Concepts Measure (ICM; Bebeau & Thoma, 1999). However, this is beyond the scope of the present research, as to do this, there first needs to be an agreement about what appropriate learning outcomes should be, to a more in-depth level than simply following BPS (2018) or HCPC (2016) Codes of Conduct.

The articles systematically appraised here suggest that there are a number of decision-maker factors and dilemma factors which impact ethical decision-making amongst professionals who deliver talking therapies. However, there is more disagreement about which personal or professional characteristics of decision-makers may play a role. A literature review revealed one theoretical model of ethical decision-making in clinical psychology specifically (Knapp & VandeCreek, 2012) and one empirically tested model (Ferencz-Kaddari, Shifman & Koslowsky, 2016) which has limited generalisability to the UK context. These limitations suggest the need for the development of an empirically derived model of ethical decision-making in clinical psychology, bringing together the interplay between the ethical decision-making process and the influence of the particulars of the dilemma and factors related to the decision-maker. This is summarised in this quote: *"If studies suggest that counsellors follow a consistent process, development of a*



*practitioner's ethical decision-making model may be useful to both further research and practice."*

(Levitt, Farry & Mazzarella, 2015, p.97).

**1.5.1. Aims.** The above identified gaps and conclusions highlight the need for the present study to focus exclusively on how clinical psychologists in the current, UK context make ethical-decisions, by exploring their responses to a range of ethical dilemmas, in a mixed methods study. The aim of the present research then, is to investigate how this participant group makes ethical decisions in response to professional ethical dilemmas, developed within the present research. This will have important clinical and educational implications for the practice and instruction of ethical competence in the profession. It is hoped that by describing the process employed by these participants, this can go towards developing a model of ethical competence in the profession. This may be done for example by undertaking further research and consultation about whether this is an ethically competent model, to be promoted within the profession, or whether it needs to be adjusted. This research will include gaining an understanding of whether the developed dilemmas are considered to be realistic and relevant to the profession; what courses of action are considered appropriate in response to said dilemmas and how these courses of action are justified.

**1.5.2. Research questions.** It is put forward that ethical decision-making in clinical psychology is a culture, constructed to some extent by those in discipline (Handelsman, Gottlieb & Knapp, 2005). This therefore points to practising clinical psychologists as being the most appropriate participant group and consensus reached by these participants as being the best way

of gaining knowledge in the subject matter. As such, the following research questions were identified:

1. What ethical dilemmas (as represented by vignettes) are agreed upon by practising clinical psychologists as realistic and relevant to the profession in the UK?
2. What ethical decisions are made by practising clinical psychologists in response to (the above identified) ethical dilemmas?
3. What do practising clinical psychologists agree are appropriate justifications for their ethical decisions made in response to ethical dilemmas in clinical psychology?
4. How do practising clinical psychologists make ethical decisions in response to ethical dilemmas?

## 2. Method

This chapter will describe the method used to address the research questions identified above. A review of the method in the context of quality criteria is given in the discussion chapter. This section will include a description of the research design, participant characteristics and recruitment, a discussion of the ethical issues relevant to this project, and how the method was adapted through consultation. A description of the measures used and why these were chosen is given, and information about the procedure for participants and the processes of data collection and analyses are described. Finally, reflections on my own position in relation to the method are described.

### 2.1 Design

**2.1.1. The Delphi method.** The study employed a mixed methods design, drawing on Delphi methodology. Due to the critical realist stance of the present research, it was felt that gathering the opinions of those working in clinical psychology was the best way of answering the research questions posed in the present research. Hsu and Sandford (2007) summarise the Delphi method as a well-suited means of exploring consensus through questionnaires. The Delphi method involves multiple iterations of questions (guided by the responses given at each stage) to the same participant group, providing them with controlled feedback at each stage about the other participants' answers, with the aim of exploring whether consensus can be reached.

**2.1.1.1. Strengths of the Delphi method.** Iqbal and Pison-Young (2009) argue that a strength of the Delphi method is that it enables the exploration of a range of opinions on a topic where limited empirical knowledge exists about a subject area, whilst also exploring whether

agreement can be reached within a professional group. This method is thought to be useful in healthcare research where there is less influence of dominant voices than there may be in face-to-face committees, for example (Powell, 2003). The Delphi method was also deemed to be particularly appropriate as it enabled communication within a group made up of individuals from a wide range of areas of the UK, working in a wide variety of settings which may not have been possible with other methods (Fish & Osbourn, 1992). A key benefit to this method is that participants have the opportunity to share answers within a group yet for their anonymity to be preserved. With ethics being a personal and emotive subject, it is likely that the anonymity provided by this method enabled participants to disclose more honest, and potentially more controversial opinions, which might otherwise be more moderated by group processes (de Meyrick, 2003).

**2.1.1.2. Limitations of the Delphi method.** Iqbal and Pison-Young (2009) review limitations of the Delphi method when applied to psychological research. These include a high level of participant commitment as the research requires participation across multiple iterations and high attrition rates can impact the validity of any consensus reached. Another limitation is that findings of the research may lack generalisability, as another participant group may come to a different consensus (Iqbal & Pison-Young, 2009). This is noted to fit with the epistemological stance of the research, acknowledging the influence of time and the cultural context, and it is recognised that this research is aiming to support the development towards a model of ethical competence, rather than providing a definitive answer. For this reason, recruitment to the participant group was carefully selected to be representative of the profession at large. The way in which these limitations were addressed in the present research is described further in Section 2.3. A further

limitation of the method is that there appears to be a lack of agreed methodological standards within the Delphi procedure, analysis and interpretation (Iqbal & Pison-Young, 2009). For this reason, within the present research, decisions taken at each stage needed to be justifiable by drawing on existing literature, and further guidance was sought from a number of review papers on the method (Iqbal & Pison-Young, 2009; Powell, 2003; Hsu & Sandford, 2007).

## **2.2. Consultation in research development**

The research team had relevant personal and professional experience which was drawn upon and reflected on throughout the research. External consultation was sought from practitioner psychologists and those in training to improve the accessibility of data collection tools for participants and the quality of the research outcomes. A clinical psychologist who had been a participant in an unrelated Delphi study was consulted on the design of the project. Following this conversation, the importance of keeping open communication with participants was stressed and this ethos was taken forward for recruitment and data collection. It was also suggested that the research be shortened due to the likely timescales needed for data collection and analysis between iterations, hence the research being the length presented here. Two further clinical psychologists were consulted on vignette context which began with ideas around ethical dilemmas from their practice. These conversations included discussions about altering the contents to ensure anonymity, adding in policy details and agreeing that the dilemma appeared realistic. Another practitioner psychologist with experience of qualitative methods and military psychology was consulted about details of the Marco vignette (Box 2) following which, details were amended to improve accuracy and clarity. This consultant also reviewed themes from iteration three and the emerging model. Throughout the research, the principal researcher met

with a number of other trainees using thematic analysis for workshops on the method, using anonymised material. This enabled practice in generating codes, themes and sub-themes to appropriately represent data. Following consultation with trainee clinical psychologists, the wording of the questions related to the vignettes was altered (see section 2.6.).

### **2.3. Participants**

**2.3.1. Expertise.** As the Delphi method is generally described to be drawing upon the opinions of a group of “experts” in any given field (Hsu & Sandford, 2007, p. 1), consideration was given as to what this would mean for the present research. Hsu and Sandford (2007) suggest that participants be “highly trained and competent within the specialised area of knowledge related to the target issue” (p.3) and may be senior decision-makers who will use the research outcomes. It was initially considered whether participants should therefore be Clinical Psychologists who have practiced for a number of years or who had specialist interest or training in ethics for example. However, Linstone and Turoff (2002) highlighted that diversity in a participant group produces more credible outcomes, enabling different perspectives to be expressed. It was therefore recognised that, as a product of working in the profession, this necessarily confers a level of expertise in ethical decision-making in clinical psychology to all clinical psychologists, however long they have worked in the profession, by having to work in an ethical way and regularly respond to ethical dilemmas in practice. The inclusion criteria were therefore limited only to HCPC registered Clinical Psychologists, working in the UK, and having been qualified for any length of time.

**2.3.2. Recruitment.** Both opportunistic and purposive sampling strategies were used to recruit participants to the present research. Initially, the research team made contact with professional colleagues and ex-colleagues known to them, to see whether they would be interested in learning more about the research and/or whether they would be willing to share an advertisement for the study through their own professional networks (see Appendix A). Adverts were also placed in the UK based Clinical Psychology Facebook Group, a closed Facebook group open to only clinical psychologists and trainees, and on Twitter (see Appendix B for example advert). Once review of the participant employment context and client group participants were working with was completed, further potential participants were contacted by email. This was done on a purposive basis following a Google search for services not represented in the sample which were either advertised as having, or appeared likely to have, clinical psychologists working in them.

Overall, it is a strength of the study that participants were actively recruited with consideration of a mix of genders, a range of years post-qualification, and those working in a variety of settings, and with a variety of client groups. This is described in Section 2.3.5. As outlined below, the participant group appears to represent a somewhat WEIRD (Western, Educated, Industrialized, Rich, and Democratic) sample (Henrich, Heine & Norenzayan, 2010). Nevertheless, limited diversity in the sample may be representative of the profession of clinical psychology at large (Bullen & Hacker-Hughes, 2016), suggesting that the recruitment strategy gave rise generalisable data.

**2.3.3. Participant numbers.** It is noted that there is limited agreement and “wide variation” in participant group sizes (Powell, 2003, p. 378) within the Delphi methodology. Literature suggests that a “minimally sufficient” number is required to gain a representative pool, and this may be between 10-20 participants (Hsu & Sandford, 2007, p.3). Within psychological research, Iqbal and Pison-Young (2009) suggest that between 10-50 participants is appropriate and optimal. For these reasons, the present research aimed to recruit 20 and finish with at least 15 participants at the end of the research. 31 participants consented to and took part in the first iteration of the study. A further three potential participants expressed an interest in taking part so were assigned an ID number and sent a link to the survey and consent form. However, they decided not to participate in the research, citing personal and workload reasons as incompatible with the data collection timescales. As these individuals did not access the survey and did not give formal consent to take part, they were not considered as part of the participant group. 28 of the original participant group (n = 31) took part in the second iteration, and 25 of these participants took part in the third iteration. This is an overall retention rate of 80.65% at the end of the research, which is above Sumsion’s (1998) reported ideal of 70% for Delphi methodology (as cited in Iqbal & Pison-Young, 2009, p. 599). Participants who did not undertake iteration two were not invited to complete iteration three, due to the nature of the task (described under procedure) and the assumption of their consent to continue having been withdrawn, due to no replies to follow-up correspondence.

**2.3.4. Participant demographic information.** This information about participants was collected in the first iteration of the research. Participants reported being between 1-34 years post-qualification ( $\bar{x}$  = 11.10 years, SD = 10.15).



**2.3.4.1. Gender identity.** In terms of gender identity, 16 participants identified as female and 9 as male, 2 participants did not respond, and 4 participants responded suggesting they had interpreted the question as related to their sexuality. This is summarised in Figure 2. 18.5% of registered practitioner psychologists are recorded as male (HCPC, 2019b), compared to 29.03% in this sample, so it may be that there is a slight over-representation of men.

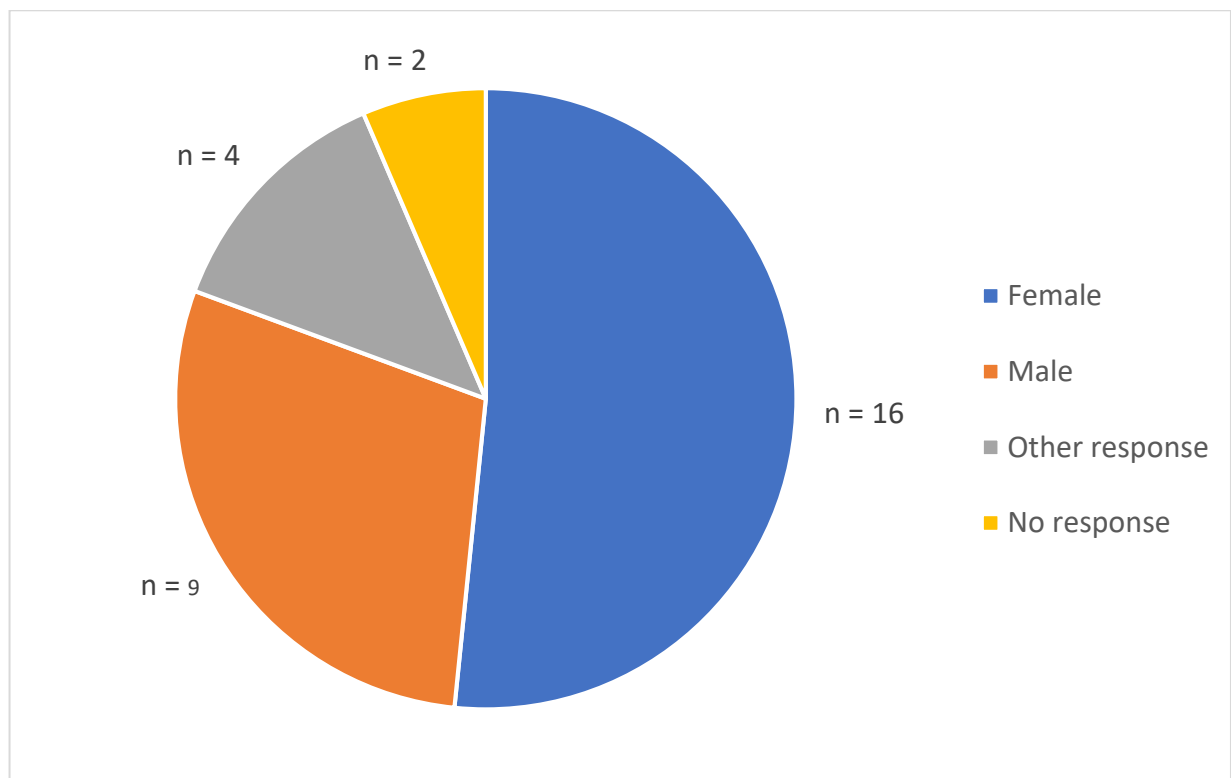


Figure 2. Pie chart to show participant gender identity demographics.

**2.3.4.2. Faith, spiritual or religious beliefs.** Research suggests that religious beliefs can interact with ethical decision-making systems (Graham et al., 2013); others have argued that it is crucial aspect of understanding professional ethical decision-making (Ananthram & Chan, 2016). For this reason, participants were asked about their faith, spiritual or religious beliefs. The majority of participants identified as atheist, agnostic, or not religious, with only 4 participants

identifying as belonging to major world religions. Of a sample of 246 Clinical Psychologists in the south east of England, Smiley (2001) reported that 61.8% described themselves as non-religious, which is somewhat lower than the present research. However, the numbers of people reporting to be non-religious has increased in the UK general population in recent years (Bullivant, 2017). Delaney, Miller and Bisonó (2013) identified that psychologists tend to have lower levels of religion and spirituality than the general population, although this is based on studies from the USA.

**2.3.4.3. Political orientation.** Research suggests that political beliefs can influence ethical decision-making (Graham, Haidt & Nosek, 2008); and they have been shown to be significantly correlated (Kenhove, Vermeir, & Verniers, 2001), therefore participants were asked about their political orientation. Two participants identified with conservative positions (one of whom said this was only sometimes), one as anarchistic, with the majority identifying as broadly within the left of the political spectrum and/or taking liberal positions. Five participants did not give a response or stated they were not sure. This is in line with available literature on psychologists' political beliefs; Inbar and Lammers (2012) report a lack of political diversity amongst US psychologists, a liberal bias, and only 6% of their sample identifying as conservative. The generalisability of this is limited due to it being undertaken with academic psychologists and not in a UK context.

### **2.3.5. Participant employment information.**

**2.3.5.1. Employment context and client group.** Participants worked across different client groups and in different contexts (shown in Table 7), broadly covering all areas represented by the

clinically-focused faculties of the BPS Division of Clinical Psychology (DCP; BPS, 2019b). There is greater representation of those working in adult mental health. Those areas listed under “other” were more specialist services such as within the legal system, autism services, educational and residential settings, and services for looked after children.

Table 7

*Participants responses to the question: Which client group(s) and service type(s) best describes your current work?*

	Adults	People with intellectual disabilities	Children, Young People and families	Older Adults
Mental health setting	11	7	6	5
Physical health setting	4	2	1	2

Neuropsychology setting	4	0	1	3
Forensic setting	5	3	2	2
Other	4	4	5	1

*Note. Number of responses is greater than the number of participants (n = 31), as some participants worked in more than one setting or with more than one client group.*

**2.3.5.2. Employment sector.** Participants were recruited to represent those working for the different employment sectors that might employ psychologists in the UK. The majority of participants worked for the NHS for some or all of their employment, which is in line with the profession nationally (BPS, 2019a; n = 21). Some worked in the private sector only (n = 5), some in a local authority only (n = 2), one participant worked in an educational setting only. Of those who worked in more than one employment sector, this consisted of NHS combined with the private sector (n = 3), the private sector combined with the third sector (n = 2), and a combination of NHS, the private sector and the third sector (n = 3).

**2.3.5.3. Service delivery setting.** Participants worked in a variety of service delivery settings, representing where Clinical Psychologists work in the UK. Most participants worked in the community only (n = 17), whereas less worked in inpatient settings only (n = 3), and some worked across both settings (n = 6). Others described themselves as working in other settings (n = 4), such as within the legal system. One participant did not respond to this question.

**2.3.5.4. Theoretical orientation.** Most participants described themselves as drawing on a number of different theoretical orientations in their clinical practice, with the most common being Systemic, Cognitive-Behavioural, Psychodynamic and Third Wave approaches. Only two participants described themselves as having only one main theoretical orientation in their clinical practice (one each of CBT and Psychoanalysis). This suggests there is a representative mix of different models practiced within the profession.

**2.3.5.5. Geographical area of employment.** In terms of the geographical areas of employment of participants, this was spread relatively evenly across different areas of UK, as shown in Figure 3. Although some areas of the country are not represented (North East England, Northern Ireland, Wales), a strength of the present research is that there is no obvious bias to specific areas.



Figure 3. Infographic to represent participants geographical area of employment.

## 2.4. Ethical considerations

**2.4.1. Ethical approval.** Ethical approval was sought from the University of Hertfordshire Health, Science, Engineering and Technology ECDA (Ethics Committee with Delegated Authority) (Appendix C) and received on 21<sup>st</sup> June 2018 (see Appendix D). Two amendment applications were submitted to and approved by the same committee on 4<sup>th</sup> July 2018 and 15<sup>th</sup> August 2018 (see Appendices E-H). This research did not require NHS Research Ethics (REC) approval in any areas of

the UK, as participants were not being recruited as service users of the NHS. This was confirmed through the NHS Health Research Authority (HRA) online decision tool (HRA, 2019).

**2.4.2. Ethical issues for the present research.** One key ethical issue to consider related to this research was around preserving participants' anonymity, both within the participant panel and more widely. During the second and third iteration, where feedback was provided to participants, no information was made available about who the other participants were or who gave which answers, in accordance with Delphi methodology (Hsu & Sandford, 2007). In the third iteration, participants received feedback on only their own score and aggregate quantitative information about the group's scores, through a personalised survey.

The terms of service (Qualtrics, 2019) for the intended survey platform, Qualtrics, were not written in plain English and suggested that the platform collects and retains ownership of some data. Legal advice was sought on this from the University of Hertfordshire's Data Protection Officer (see Appendix I) who confirmed that this would not be problematic as long as participants were made aware of this (I. Hanahoe, personal communication, July 26<sup>th</sup>, 2018). Participants were therefore advised of this when they were sent a link to complete surveys via Qualtrics (see Appendix J). It was agreed that each participant's anonymity could be further protected by being given a unique ID number to identify themselves within the survey platform, rather than using personal details. The cypher document including participants' names, contact details and corresponding ID numbers was held only by the principal researcher in a password-protected document, on a password-protected online storage system. All data was stored on a password-protected online storage system and any data reported was fully anonymised.

Another potential ethical concern was around exposing participants to potentially distressing clinical material. Care was taken to highlight to participants that the vignettes were hypothetical and were considered no more distressing than what participants might reasonably be expected to encounter in their normal professional practice.

A final ethical concern identified was the possibility that participants could have disclosed a behaviour which would not be condoned within professional guidelines or a concern may have been raised about illegal activities. To mitigate this, participants were asked not to comment on real life examples of their practice (see Appendix K for participant information sheet). Prior to the research commencing, it was agreed that if this was to occur, it would be discussed within the research team as to the best course of action. It was recognised that in extreme cases information may need to be reported to relevant authorities. It was intended that this would be discussed with the participant beforehand as far as possible, and this was outlined to participants at the consent stage (see Appendix L). Whilst no such issues were identified in the course of the research, one participant emailed the principal researcher to raise this as a concern about implications for their own practice, if their responses had been perceived to be unethical. Feedback outlining the above, and that the threshold for disclosure would be extremely high, needing to be indicative of clear evidence that people were being put at risk, was believed to reassure to the participant.

## **2.5. Dissemination**

Results of the first two iterations of the research were disseminated at the DCP Annual Conference (Grace, Wainwright & Ellis-Caird, 2019), followed by discussion with the audience



about whether ethical competence is something that can be taught. From this, a question was added into the third iteration to ask participants to consider to what extent they felt the vignettes would be helpful for teaching and why. Results of the research were also disseminated at the University of Hertfordshire School of Life and Medical Sciences Annual Research Conference (Grace, 2019; see Appendix M for example slides from these presentations) and shared with participants electronically (see Appendix N).

## 2.6. Measures

**2.6.1. Vignettes.** The literature review revealed no appropriate evidence-based vignettes representing ethical dilemmas relating to UK clinical psychology practice. Material was reviewed from a variety of sources including ethics modules of three UK clinical psychology training courses and other measures that have been developed for research into ethical competence and ethical decision-making (the DIT-2; Rest, Narvaez, Thoma, & Bebeau, 1999; the ICM; Bebeau & Thoma, 1999; the relational ethics scale; Hargrave, Jennings & Anderson, 1991; and the multi-dimensional ethics scale; Kujala & Pietiläinen, 2007). Therefore, in line with these other measures of ethical competence (the DIT-2; Rest, Narvaez, Thoma, & Bebeau, 1999, and the ICM; Bebeau & Thoma, 1999), vignettes were devised by the research team for the present research to represent professional ethical dilemmas, based on the ethical principles of *respect*, *competence*, *responsibility* and *integrity* outlined in the BPS Code of Ethics and Conduct (2009, 2018).

**2.6.1.1. Vignette construction.** Each ethical principle was taken in turn and then an initial idea for a dilemma was devised through extensive discussion and review amongst the research team about dilemmas personally faced in practice, discussions had with colleagues during or prior to the research and discussions with consultants to the project during the research. Across all the

vignettes, it was felt important to include a range of clinical settings (community, inpatient, NHS, 3<sup>rd</sup> sector) and client groups (adult, older adult, people with intellectual disabilities, children, young people and families). This information was outlined in the opening sentences, before a description of one of a range of different presenting problems in the vignettes was described (including individual mental and physical health difficulties, structural and systemic difficulties, and leadership challenges). These ranges were designed to complement the diversity amongst the participant group, so that most participants would likely have dilemmas in which they were more and less experienced in thinking about ethical issues. The vignettes then culminated in a forced-choice question to highlight to participants the decision needing to be made, i.e. *Would you, as a clinical psychologist do x (yes or no)?* The rationale for this wording is described in section 2.6.1.3.

Knapp, Gottlieb and Handelsman (2015) outline that an ethical scenario can be considered to be a *dilemma* when ethical principles appear to conflict, for example with another ethical principle, a law or policy, or when professional codes offer insufficient direction. That is to say, an ethical dilemma has no clear solution. Four vignettes were designed to elicit dilemmas around one each of the ethical principles from the BPS Code of Ethics and Conduct (2009, 2018). As per the other measures of ethical competence (Rest, Narvaez, Thoma, & Bebeau, 1999; Bebeau & Thoma, 1999), five vignettes were used, with the fifth one being designed to cover multiple principles, in case one of the other vignettes was rated as not realistic or relevant (although, this turned out not to be the case, see results). Further, five vignettes aimed to meet the balance of representing the variety of challenges faced in practice whilst not being excessively long and potentially disengaging for participants. For similar reasons, the vignettes were 200-250 words, to give enough but not excessive detail. The vignettes are shown in Boxes 1-5 below.

**Box 1**

*Maria Vignette (dilemma based on BPS ethical principle of responsibility; BPS, 2018).*

You are a clinical psychologist in an NHS community team for adults with intellectual disabilities. Maria is a 24-year-old female who has been receiving support from the service since she was aged 18, and worked with you on her difficulties with low mood. She lives with her boyfriend of 4 years, Chris, who also uses intellectual disabilities services. They are expecting their first child and you do not have concerns about Maria's ability to parent.

Your impression is that Maria has a mild level of cognitive impairment, and although you suspect that she may not meet the criteria for a diagnosis of an intellectual disability, this has not been formally assessed. You have relayed this information to Social Services. However, child protection procedures have been initiated, the reason given being that Maria has an intellectual disability. You are told that if evidence can be provided that she does not have an intellectual disability, then no further child protection action will be taken.

Your team is strictly commissioned only to provide support to people who meet the criteria for a diagnosis of an intellectual disability. If Maria was assessed and found not to have an intellectual disability, she would need to be discharged from your service.

Would you, as a clinical psychologist, undertake a neuropsychological testing to assess whether Maria has an intellectual disability?

## Box 2

*Marco Vignette (dilemma based on BPS ethical principle of competence; BPS, 2018).*

You are the sole clinical psychologist in a clinical health service in a rural setting in the UK. This supports people with psychological needs related to physical health difficulties, rather than mental health. You begin seeing Marco, age 45, who was recently medically discharged from the armed forces. After an assessment, you agree to work together for 10 sessions to support him to manage his diabetes.

After 2 sessions, you realise that he is experiencing post-traumatic stress symptoms (PTSD) related to his experiences serving in Afghanistan. You discuss this with your local community mental health team (CMHT) who decline to accept a referral for Marco, as he does not meet their threshold. You have never worked with PTSD before, although you were taught about it when you were training, 5 years ago. You are not aware that your supervisor has any experience working with PTSD either. Although you attend a CPD day and make efforts to read about PTSD, you do not feel confident treating Marco.

You cannot locate any other services (such as veteran's organisations) that operate in this rural setting, nor does he have the means to finance private therapy. Marco expresses a wish to continue working with you.

Would you, as a clinical psychologist, treat Marco's PTSD?

## Box 3

*Norman Vignette (dilemma based on BPS ethical principle of respect; BPS, 2018).*

You are a clinical psychologist in a medium secure unit for older people. You are working with Norman, aged 88, who has been detained under Section 2 of the Mental Health Act (1983) for up to 28 days, for assessment.

Norman was initially brought to the unit by police after threatening a neighbour and causing damage to their property, with reports indicating he appeared "confused" and "paranoid". He has historical convictions under the Misuse of Drugs Act (1971) and police reports highlight recent complaints of loud music being played late at night.

Norman lives alone but you are able to speak with his niece by phone. She explained that she does not know Norman well, describing him as "a very private person". He has not previously been known to mental health services. Since being on the ward, he has been disorientated to time and place on several days. In one of your meetings, he expresses distress that his neighbour was trying to poison him and explains that he will do "whatever it takes" to protect himself.

Norman consistently reports having been a famous musician in 1960s. He gives details of a UK tour and outlines several violent incidents which he and other band members were involved in. You discuss this at the ward round, but none of the team recognises the name of the band. Someone suggests you undertake an internet search.

Would you, as a clinical psychologist, undertake an internet search of Norman?

## Box 4

*Alissa's dad Vignette (dilemma based on BPS ethical principle of integrity; BPS, 2018).*

You are a clinical psychologist in a city-centre CAMHS and are seeing Alissa, aged 11, for support with OCD symptoms. These started after her mum passed away 18 months ago and Alissa and her dad had to move into a one bedroom flat. She is anxious that she will be hurt and spends several hours a day checking windows, doors and switches.

You arrange to meet with Alissa's dad to review strategies to support Alissa at home and get a better understanding of his resources to do this. During this meeting, Alissa's dad explains that he is finding things difficult financially so is now working 25 hours a week cash in hand. He says he knows he probably shouldn't be doing this, as it contravenes the rules of one of the benefits he receives. You are aware that Alissa's dad has received appropriate support to apply for all the benefits for which they are eligible, and that he accesses food vouchers.

Your Trust's policy is that any and all suspicions of fraud (within or outside of the NHS) should be reported to the appropriate body. The policy document includes a link to a government website providing details of how to report suspected fraudulent benefit claims.

Would you, as a clinical psychologist, report the information Alissa's dad has given you about his benefits to the relevant authorities?

## Box 5

*Commissioning Vignette (dilemma based on multiple BPS ethical principles; BPS, 2018).*

You are a clinical psychologist working for a small charity supporting under 21s who have experienced psychological trauma. The organisation relies on ongoing commissioning to continue running, and employs five part-time clinicians, at a cost of £80,000 per year. Each year, the service sees approximately 80 children, young people and their families, for an average of 12 sessions of individual therapy. This works out to a cost of £1000 per client.

Your service has approximately a 5-month waiting list. Local commissioners have offered an additional £70,000 to allocate to a provider in your area for trauma-focused interventions. This has been offered to your charity in the first instance, but they have asked you to see 120 more clients per year. At the current level of service provision, you estimate you would need a further £120,000 to meet this request. The length of the interventions have not been stipulated, nor has the need for these interventions to be one-to-one.

However, there is a very limited and conflicting evidence base about the efficacy of group-based or other service delivery models for treating trauma in children and young people. NICE clinical guidelines [CG26] (2005) suggest that trauma-focused psychological interventions "should normally be provided on an individual outpatient basis".

Would you, as a clinical psychologist, take the additional £70,000?

**2.6.1.2. Limitations to vignettes.** It is recognised that important ethical dilemmas may have been missed through the choices of vignettes which were used in the present research, for example related to liberation psychology and social justice, amongst others. The vignettes designed for the present research were not intended to be an exhaustive list of challenges faced by clinical psychologists in practice today, and it is acknowledged that different types of ethical decisions may be approached in different ways. It is also likely that the content development was influenced by the WEIRD (Western, Educated, Industrialized, Rich, and Democratic; Henrich, Heine & Norenzayan, 2010) nature of the research team. Nevertheless, it is put forward that the vignettes developed for the present research are a starting point for further studies. One way in which these limitations were approached was by asking participants to comment on whether they

felt any dilemmas were missing, and to give examples. These results are summarised in Section 3.6.

**2.6.1.3. Vignette testing.** Four trainee clinical psychologists were asked to answer one of two versions of pilot questions about one of the vignettes (see Appendix O), in order to ensure that the question wording elicited the type of answers the research aimed to investigate. From this, it was decided that the first question in response to the dilemma would be a forced choice (*yes, no*, or the option to leave *blank*) in order to encourage participants to avoid a problem-solving approach in favour of discussing their ethical decision-making (Bebeau, 2014; i.e. *Would you, as a clinical psychologist do x?* Rather than *What would you, as a clinical psychologist, do?* Appendix P). It was also decided that a second qualitative, free-text response question would be asked to try to elicit further information about the justifications. The range of responses given suggested that this was a true dilemma, that people make their decisions based on different factors and that there was no clear answer about the optimal course of action. This suggested that the vignette was a valid means of approaching the research question.

At different stages of the research, a debate between question wording of 'would' and 'should' was discussed within the research team (i.e. *Should you do x?* or *Would you do x?*). On the one hand, it was felt important to gain consensus about what was felt to be an ideal model of ethical competence within the profession (*should*), from which to develop teaching and potentially measurement tools (as with the DIT-2; Rest, Narvaez, Thoma, & Bebeau, 1999, and the ICM; Bebeau & Thoma, 1999). However, on the other hand, it was felt that this information would not



be very meaningful if it was quite divorced from how participants are approaching ethical dilemmas in their clinical practice (*would*). In their study using vignettes, Buckloh and Roberts (2001) found differences between what child and paediatric psychologists reported they should do, would do, and what they said they did. Smith, McGuire, Abbott and Blau (1991) identified that mental health professionals may not always implement an ethical ideal they have identified, for example due to personal value systems and pragmatic considerations. It was also felt that if there was a difference between what participants felt they should and would do, then this would be important to understand.

Therefore, for this research, participants were asked what they *would* do, with the aim of developing an empirically derived model of how ethical dilemmas are approached in practice, by this participant group. Follow up research would then take this further towards a model of ethical competence by evaluating whether the identified process is felt to be ethically competent (see discussion). In iteration two, participants were given the opportunity to comment qualitatively on whether there would be a difference between these circumstances.

**2.6.2. The Moral Foundations Questionnaire (MFQ-30).** The MFQ (Graham, Haidt & Nosek, 2008) was administered to participants at the end of the first iteration (see Appendix Q). This is a 32 item self-report questionnaire in which participants are asked to indicate the extent to which they see specific considerations as relevant, and their level of agreement with statements which map on to each of their five domains of ethical decision-making (Graham, Haidt & Nosek, 2008). It has been shown to have construct validity and reliability (Zhang, Hook & Johnson,

2016). It was felt that it would be useful to gain an understanding of what participants consciously identify as the moral frameworks they draw upon and how this might compare to frameworks they appear to draw upon when answering dilemmas. Scores can range from 0-30 in each domain.

In the present research, 28 out of the 30 participants who completed the questionnaire achieved their highest two scores on the foundations of *Harm / Care* and *Fairness / Reciprocity*.

Quantitative data on this is reported in the results section. Research suggests that this pattern fits those identifying as liberal in terms of their politics, and that people identifying as conservative generally show the opposite pattern (Graham, Haidt & Nosek, 2008). The other two participants identified strongly with these domains also, but additionally achieved high scores within the foundation of *Authority / Respect*, one of whom had described their political affiliation as more conservative.

**2.6.3. Rating scales.** Within the quantitative aspect of this research, two types of rating scales were devised. Questions asking participants to rate items on 7-point scales and on 101-point scales. Krosnick and Presser (2010) identified that there is wide variation in the number of points used on a Likert scale in research and as such, there is no recognised standard. Their literature review suggests that reliability increases with up to 7 points on a scale but with larger-sized scales there are minimal gains. They also suggest that moderate length scales provide the optimum effect size for validity.

For this reason, 7-point scales were chosen for most quantitative questions, and these made up the main body of iterations two and three. For example, participants were asked to review a list of justifications for an ethical decision (generated by the group) and rate how likely they would be to take this justification into account when making the decision in their own practice (see Appendices R and S for summary questions from iterations two and three). Participants were asked to use a scale from 1 (I definitely would not take this justification into account) to 7 (I definitely would take this justification into account), with 4 indicating a more neutral position (I might or might not take this justification into account). Evidence suggests that dichotomous scales and qualitative descriptors increase clarity, which positively impacts validity and reliability ratings (Krosnick & Presser, 2010)).

In iteration one, the list of different justifications for ethical decisions generated by the group data was substantial (between 30-37 per vignette). It is acknowledged that this is a cognitively demanding list, therefore, for iteration two, where participants were asked to rate all of these items, they were presented in a random order within a vignette, per participant. This was to minimise serial order effects (Krosnick & Presser, 2010), such as participant fatigue and motivation across the group data. This minimised the influence of satisficing (responding according to an acceptability threshold rather than optimally), which may be impacted by primacy and recency effects (Krosnick & Presser, 2010).

Other quantitative questions employed 101-point scales. Participants were asked to rate items between 0 (not at all) and 100 (fully) using a sliding scale. These were questions around the extent

to which participants felt the dilemmas were realistic and relevant, the extent to which they felt taking part in the research had influenced their thinking or practice in relation to ethical competence, and the extent to which they felt the vignettes would be helpful in the context of teaching ethical competence. 101-point scales have been shown to have greater discriminating power (ability to detect a more fine-grained difference in responses), and participants feel it allows them to better express their feelings (Preston & Colman, 2000). One limitation of this is that some studies have shown a decrease in test-retest reliability with scales of this length. However, the effect sizes for this and for validity are still described as high (Preston & Colman, 2000). Participants have also reported that longer scales were more time-consuming and more difficult to use than shorter ones (Preston & Colman, 2000). Krosnick and Presser, (2010) assert that they may require greater cognitive effort. Therefore, fewer 101-point scale questions were asked in the present research. Where they were asked, the greater discriminatory power was considered worth these potential costs.

## **2.7. Procedure**

This research comprised three iterations; each consisting of the design, data collection and data analysis of a survey. A summary of this process is outlined in Figure 4. Surveys took participants approximately 30 minutes (this is felt to be a reasonable time commitment within the Delphi methodology (Iqbal & Pison-Young, 2009), and were open for approximately one month. Surveys opened with an introduction to the format of that survey and ended with a debrief sheet (Appendix T). Informed consent was sought at the start of survey one, covering up to four iterations of research (Appendix L) however, participants had the opportunity to review this and

the information sheet (see Appendix K) with each subsequent survey. Participants had the opportunity to exit the survey and return to complete it at a later time, but due to limitations within the Qualtrics software participants could not go back within a survey to review or adjust previously submitted answers due to the randomisation process. Partially completed surveys were automatically submitted after one week of inactivity. Non-responders were followed up, as recommended within the Delphi methodology to maintain the required response rates (Iqbal & Pipon-Young, 2009).

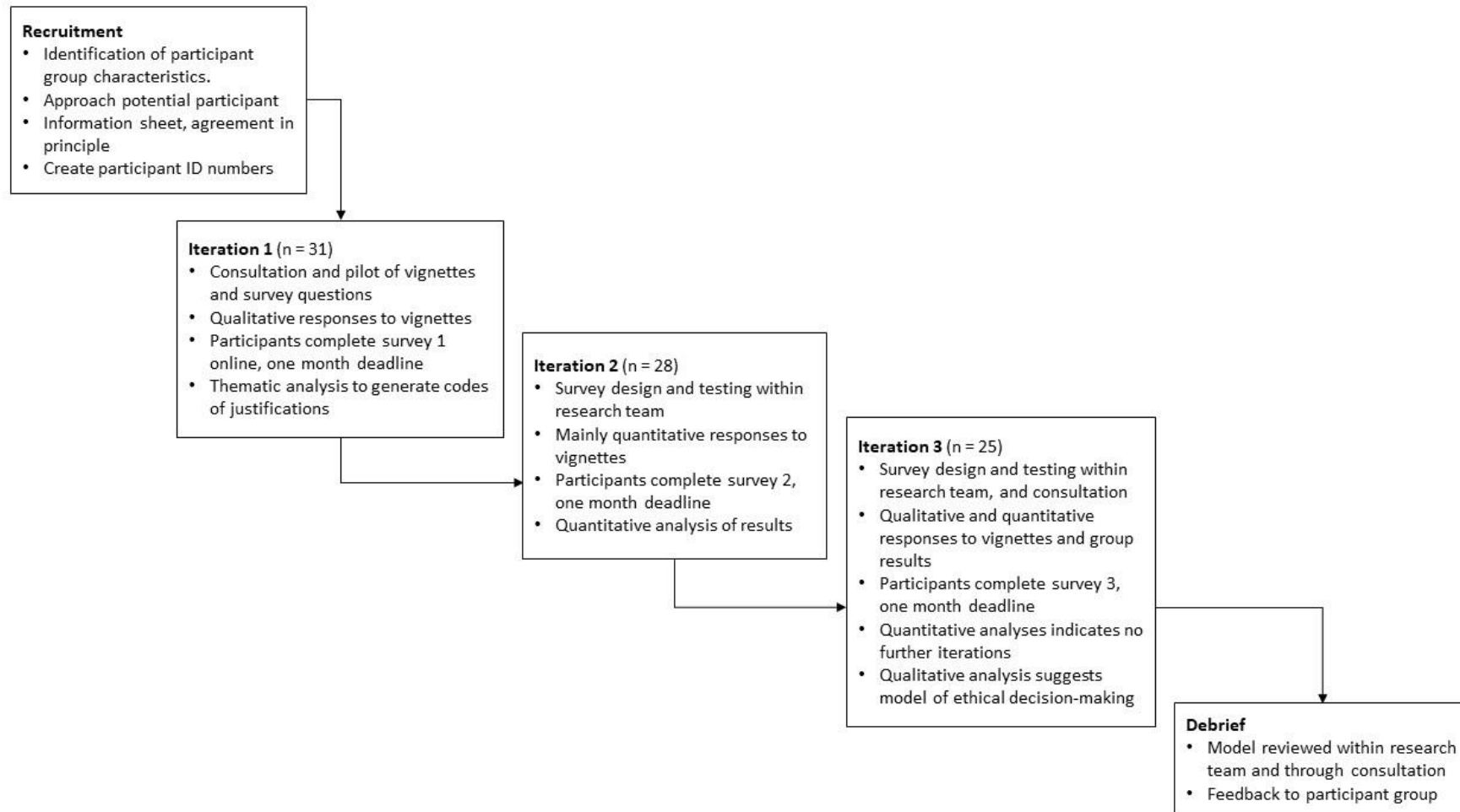


Figure 4. Flow chart to show the iterative procedure employed in the present research.

**2.7.1. Iteration one.** Survey one including the vignettes was designed and tested over a number of months prior to data collection as described in section 2.2. Potential participants were approached by members of the research team with information about the study. Once agreement in principle was in place from a sufficient number of participants, participant ID numbers were generated, and participants were sent an email link to survey one. Participants were first asked professional demographic questions (Appendix P) to cue their ethical identity as clinical psychologists, rather than personal ethical principles. Participants were then presented with the five vignettes and associated questions about how they would respond and why. These were mainly free-text qualitative response questions, in line with recommended practice within the Delphi method for the first iteration to gather ideas (Hsu & Sandford, 2007; Iqbal & Pison-Young, 2009; Appendix P). The MFQ-30 was then administered (Graham, Haidt & Nosek, 2008) before more personal demographic questions were asked (Appendix P). Results from this round were analysed per vignette over approximately a one-month period, to generate a list of the different justifications which were identified in the data (see below). This formed the basis for iteration two.

**2.7.2. Iteration two.** Surveys two and three were designed and tested within the research team over the course of approximately one month. Had the results of iteration one suggested that some vignettes were not realistic or relevant they may have been omitted from subsequent iterations, however this was not the case. Survey two was sent to all participants who had taken part in iteration one. Participants were presented with the same vignettes and the list of justifications which emerged from iteration one. Questions in this survey mainly involved

quantitative responses (Appendix R). Participants were asked to rate each justification as to how likely they would be to take it into account when making the ethical decision, as a clinical psychologist. Ethical rather than practical thinking was emphasised. Participants were then asked to rank-order the justifications which they would be most and least likely to take into account. Results from this round were analysed over approximately a one-month period to generate a hierarchy in the justifications within a vignette, by calculating the group's average score for each justification (see below). This formed the basis for iteration three.

**2.7.3. Iteration three.** Only participants who took part in both survey one and two were sent a link to survey three, this was personalised for each participant (Appendix S). Participants were reminded of the vignettes and presented with quantitative feedback on the collective responses from iteration two (in line with Delphi methodology; Iqbal & Pison-Young, 2009) to the five highest and five lowest rated justifications within each vignette. Participants were reminded of the scores they had given for these items in iteration two (recommended within the Delphi methodology; Iqbal & Pison-Young, 2009) and asked to score the items again, considering this information. Participants were reminded that the aim of the research was to explore whether there was consensus on these issues but were permitted to give the same score again. Participants were asked to rate the extent to which they felt drawing on these justifications in this order would lead to an ethically competent decision and ethically competent behaviour, and to comment qualitatively on justifications they felt would not be ethically competent. Participants were presented with a summary of the highest rated justifications across all the vignettes and asked to comment on similarities and differences between them. Finally, participants were asked



to rate the extent to which they felt that taking part had impacted their thinking and practice in relation to ethical competence, the extent to which they felt the vignettes would be helpful in ethical instruction, and comment on why they gave these ratings.

Although there is no theoretical limitation on the number of iterations needed to reach consensus (Powell, 2003), typically three to four are sufficient and maintain high response rates (Hsu & Sandford, 2007; Fish & Osbourn, 1992). Where relevant, quantitative results were analysed to assess whether a statistically significant change had occurred between participant responses in this iteration and previous ones. As this was not the case, this suggested that scores were stable. Therefore, another iteration would not likely bring about further change so would not be warranted (Hsu & Sandford, 2007). Qualitative results from iteration three were analysed with data from all vignettes combined. After analyses were complete and the model reviewed and revised within the research team and with a consultant, written feedback was sent to all participants and consultants (Appendix N). This is best practice within Delphi methodology (Iqbal & Pison-Young, 2009) as it ensures participants feel ownership of outcomes and have the opportunity to comment.

## **2.8. Data collection and analysis**

Data was collected using Qualtrics, a secure online survey platform, which holds a variety of question format types and is compatible with numerous internet browsers and devices (Qualtrics, 2019). Qualtrics is licenced to the University of Hertfordshire School of Life and Medical Sciences. Links to the surveys were sent out via email (Appendix J). Being an online platform, this meant

participants could complete the survey at their own convenience. Needing access to a computer and email address was not felt to be a barrier to the participant group who were all necessarily, in employment.

**2.8.1. Data analysis.** Data was imported from Qualtrics into Excel for Microsoft Office 365 ProPlus. Data analysis methods are described here and results of both the qualitative and quantitative analyses are described in the following chapter.

**2.8.1.1. Quantitative analyses.** Descriptive statistics were generated using Microsoft Excel, and statistical tests of difference were carried out using IBM SPSS Statistics Version 25. As commonly reported within Delphi methodology (Hsu & Sandford, 2007; Iqbal & Pison-Young, 2009), measures of dispersion and measures of central tendency were calculated, as appropriate. Likert scales are generally considered to be ordinal data and therefore the median is considered a more appropriate measure of central tendency (Gavin, 2008). However, the mean was also calculated as this proved to have greater discriminating power (enabling a hierarchical list to be established between items with the same median). As these were longer scales (7- or 101-points), and all points on the scales were assigned numerical values, this is arguably interval data. Therefore calculating the mean is valid and meaningful (Norman, 2010).

There are a number of ways of defining when consensus has been reached within the Delphi method including setting a criterion level (Powell, 2003). For example, when 70% of the participant group agree on an item's score (Hsu & Sandford, 2007). However, the present research

was not aiming to gain consensus on the inclusion of specific items, or of particular numerical values. Statistical significance testing was therefore used as a reliable means of assessing stability in participant's responses between iterations (Hsu & Sandford, 2007). Where  $p > 0.05$ , this indicates that participants have not adjusted their responses to a statistically significant level. This suggests that an agreement has been reached, as far as it is going to be.

**2.8.1.2. Qualitative analyses.** Qualitative data was imported into NVivo 11 Pro for Windows and analysed using thematic analysis (Braun & Clarke, 2006). The six-phase process for use in psychological research described by Braun and Clarke (2006) was employed. This involved familiarisation with and coding of the raw qualitative data, searching, reviewing and defining themes, and disseminating the findings (Braun & Clarke, 2006). Thematic analysis was felt to be the most appropriate method of analysis for this research due to this study being about the construction of what it means to be ethically competent. It was also felt to be useful for its theoretical flexibility (Braun & Clarke, 2006), meaning it could be employed differently across different iterations of the study as necessary.

For iteration one, to ensure a robust method was employed (as recommended within Delphi methodology; Iqbal & Pison-Young, 2009), first stage thematic analysis of responses to qualitative questions was completed to generate initial codes, but these were not further analysed into themes and sub-themes. This was with the aim of drawing together duplicate responses whilst retaining diversity, to create a useable list of justification statements for participants in iteration two. This was done with the minimum of interpretation, in an inductive manner, to facilitate the

list being participant-generated as far as possible. This was to enhance the validity and reliability of the research (Iqbal & Pison-Young, 2009). Data was analysed from all participants together, by vignette. This fits well with the social constructionist understanding of ethical competence, and the critical realist approach of the research, aiming to interpret shared ideas within the data set. A sample of codes were discussed and quality-checked within the research team.

For iteration three, thematic analysis (Braun & Clarke, 2006) of qualitative responses was completed in full using NVivo (Appendix U) as well as coloured pens and post-it notes at the later stages to explore relationships between themes. Again, this was intended to be inductive (reviewing the developing content), rather than deductive (attempting to fit data into existing models), as far as possible. After initial coding, codes which seemed to speak to similar concepts were grouped, for example where participants spoke of laws, policies and guidelines. Equally, where codes appeared to have similar underlying concepts yet offering differing perspectives, these were also grouped. For example, data that suggested familiarity with the dilemma context was helpful was grouped with data that suggested not having experienced a particular dilemma context made it more challenging to respond to (Appendix V).

Of course, knowledge of existing models and literature undoubtedly influenced the thinking when undertaking analyses. To reflect on and mitigate these influences as far as possible, a reflective diary was kept during the process (Appendix W) and consideration was always brought back to what was grounded in the data. The final themes, sub-themes and developing models were discussed within the research team and with one of the research consultants.

**2.8.1.2a. Self-reflexive position.** During qualitative data analysis, I sometimes felt myself aligning with particular participants and also being quite surprised by my reaction to other responses. As I analysed the data per vignette in iteration one, I almost looked forward to reading certain participants' responses in subsequent vignettes or iterations, who had previously seemed to share my ethical stance. Conversely, I found myself quite shocked and, at times, somewhat judgmental towards some of the responses, where they appeared to contrast with my own values of transparency and working collaboratively with colleagues. This felt important to acknowledge, and subsequent reflections have left me appreciative of the honesty of participants as I deem it important to understand barriers to ethical competence, whilst also acknowledging the value of diversity in ethical thinking and moral pluralism. It is perhaps unsurprising that responses to ethical dilemmas should elicit strong responses as in practice, this can have significant implications. It is this, after all, that prompts the need for research into ethical decision-making.

These emotional responses led me to reflect on how these allegiances might have played out in an unhelpful way through a focus group for example, through dominant opinions or social pressure to conform (Hsu & Sandford, 2007) and the strength of this method having an anonymous participant group. This started me questioning further the influence of social processes on ethical decision-making and the implications of this for practice, such as those described in *The Lucifer Effect; Understanding How Good People Turn Evil* (Zimbardo, 2007).

### 3. Analysis

This chapter will outline the results and analyses in response to the four research questions identified in the introduction, across the three iterations of the method. The first three research questions were analysed using both qualitative (thematic analysis) and quantitative analyses (descriptive statistics and measures of difference, as appropriate). The final research question was approached qualitatively, using thematic analysis. Key themes and sub-themes generated are described, with example quotes. From this, a model of how this participant group made ethical decisions is put forward. Additional findings are presented and reflections on my own position in relation to the analyses are explored. To protect participant identity when using quotes to illustrate themes, random letters have been assigned to participants.

#### **3.1. Research question one. What ethical dilemmas (as represented by vignettes) are agreed upon by practising clinical psychologists as realistic and relevant to the profession in the UK?**

**3.1.1. Quantitative analyses.** Overall, all the ethical dilemmas presented in the vignettes developed for this research were described as realistic and relevant by participants. Participants were asked to rate the extent to which they felt the dilemmas were realistic to the current practice of clinical psychology in the UK on a 101-point scale (0 = not at all, 100 = fully) and using the same scale and question for how relevant they felt the dilemmas were. In iteration three, participants were shown the group descriptive statistics from iteration one and reminded of their own score. They were asked to decide whether they wished to adjust their responses or not, whilst keeping in mind the research aim to explore consensus. *Realistic* results for each vignette are summarised in Table 8 and *relevant* results are summarised in Table 9. To summarise, this

participant group deemed the vignettes developed for the present research to pose ethical dilemmas which are both realistic (between 72-79%) and relevant (between 75-85%) to the current practice of clinical psychology in the UK.

Table 8

*Participant ratings of how realistic the vignettes were in iterations one and three*

<u>Vignette name</u>	<u>Iteration 1</u>					<u>Iteration 3</u>					<u>Wilcoxon S-R p value</u>
	<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	<u>n</u>	<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	<u>n</u>	
Maria	73.77	24.76	80	94	31	76.12	19.88	80	90	25	0.952 (n.s.)
Marco	74.87	24.65	76	91	31	71.75	22.01	75	83	24	0.130 (n.s.)
Norman	78.45	20.84	81	88	31	79.26	17.47	80	80	23	0.935 (n.s.)
Alissa's dad	75.71	26.26	82	99	31	76.50	16.98	80	80	24	0.255 (n.s.)
Commissioning	79.00	18.63	81	70	31	77.63	13.59	80	60	24	0.570 (n.s.)

*Note. n.s. indicates not significant at  $p \leq 0.05$ . Wilcoxon Signed-Rank (S-R) to test difference in distributions between iterations one and three.*



Table 9

*Participant ratings of how relevant the vignettes were in iterations one and three*

<u>Vignette name</u>	<u>Iteration 1</u>					<u>Iteration 3</u>					<u>Wilcoxon S-R p value</u>
	<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	<u>n</u>	<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	<u>n</u>	
Maria	79.77	19.90	82	70	31	79.60	17.41	82	70	25	0.831 (n.s.)
Marco	85.23	16.06	89	69	30	84.63	9.98	85	40	24	0.465 (n.s.)
Norman	81.48	16.99	81	68	31	82.61	12.00	81	40	23	0.872 (n.s.)
Alissa's dad	73.81	26.63	83	98	31	75.00	18.04	80	79	24	0.715 (n.s.)
Commissioning	84.81	14.75	91	51	31	85.33	9.46	85	40	24	0.903 (n.s.)

*Note. n.s. indicates not significant at  $p \leq 0.05$ . Wilcoxon Signed-Rank (S-R) to test difference in distributions between iterations one and three.*

Shapiro-Wilk tests were applied to assess normality, due to the sample size being less than 50 (Shapiro & Francia, 1972). As this data did not meet parametric assumptions of normality and homogeneity of variance (assessed using Levene's test) non-parametric tests were applied (Miles & Banyard, 2007; Appendix EE). Wilcoxon Signed-Rank (Wilcoxon S-R) tests were used, with average values within a question replacing incomplete responses in survey three (shown to be a statistically valid approach; Twisk & De Vente, 2002). This was preferable to only using data for which there were complete pairs (up to  $n = 25$  who took part in all iterations) because the data was somewhat self-referential. If the mean of  $n = 25$  from iteration one was statistically tested against the mean from iteration three, these values would be different to the information about the mean that the group received as their 'exposure' condition (as this was based on  $n = 31$ ). Had participants who completed iteration three been exposed to the mean value that came from their data only in iteration one, this value would have been slightly different, and may have impacted their responses differently<sup>1</sup>. It would not have been possible to predict which participants would not complete all iterations (unless they had formally withdrawn) and this circumstance would only have been avoidable if the attrition rate was 0%. This is one of the reasons why maintaining a high response rate is important within the Delphi methodology however, rates were deemed satisfactory within the present research (Iqbal & Pison-Young, 2009).

There was a substantial range in both realistic and relevant responses, although this tended to converge in iteration three, more noticeably for relevant ratings. Wilcoxon S-R tests indicated

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<sup>1</sup> Analyses were also completed using the 25 pairs only and a similar pattern of results was observed, however the method presented here was felt to better represent the data.

that there were no-significant differences between the mean scores for *realistic* ( $p > 0.05$ ; Table 8) nor for mean *relevant* ratings, between iteration one and three ( $p > 0.05$ ; Table 9). This suggests consensus had been reached and further iterations would not yield different results.

**3.1.2. Qualitative analyses.** All qualitative data in iteration three was analysed together using thematic analysis (Braun & Clarke, 2006) including, but not limited to, questions around general feedback on the research. This identified themes around the process of ethical decision-making (described in research question four), and three key general themes around the present research (outlined under additional findings). One of these themes, *recognising strengths in the present research* comprised sub-themes of how realistic and relevant the vignettes were, and it was therefore felt most appropriate to report these findings here.

**3.1.2.1. Realistic.** When exploring qualitative data, there appeared to be diversity in the perceptions of how realistic participants felt the vignettes were, with a similar number of participants suggesting this was a strength or a limitation of the present research. Some data suggests that the dilemmas were perceived to be realistic, as summarised by this quote from participant DEF: *"I think this case is realistic and relevant because I used to work in an LD [Learning Disabilities] service where similar issues were frequently presented..."*. Whereas a similar amount of data suggested disagreement with this position, as represented by this quote from participant WXY: *"I did not feel that these dilemmas regularly come up for psychologists in day to day practice, and I am confused as to why my colleagues felt that they were so realistic. It may have been helpful to ask clinicians to give better examples of clinical dilemmas they face day to day."*

Data suggests that participants' perception of how realistic the dilemmas were may be related to the level of exposure they have had to similar dilemmas in their own practice. This can account for higher scores, as summarised by quotes from participant DEF (above) and this one from participant ABC: *"I note I have rated this as more plausible than the average rating. However, I've met a few Normans."* Equally, this may also account for lower scores, where extensive experience with a scenario may lead participants to no longer see a dilemma, as summarised by a quote from participant WXY: *"The scenario is highly unrealistic, I would imagine it almost impossible for a clinical psychologist to practice for five years without encountering anyone with a trauma history of some description."*

**3.1.2.2. Relevant.** Qualitative data for how relevant the vignettes were perceived to be suggested that this was a strength of the research. One participant expressed ambivalence about one vignette: *"I'm not sure that I consider this a particularly pressing ethical dilemma"* (Participant EFG). This may or may not be considered in the light of ethical sensitivity (Rest, 1983). However, all other data within this theme suggested that this was considered a strength of the research, as summarised by this quote from participant ABC: *"It seems to me that they are ecologically valid and that they do assist in bringing out the difficulty of balancing complicated issues."* This mirrors the quantitative results which showed a trend towards *relevant* ratings being higher than *realistic* ratings.

Taken together, results from qualitative and quantitative analyses suggest that the vignettes used in the present research were considered to pose ethical dilemmas which are both realistic and relevant to the current practice of UK clinical psychology. Prior experience may have an impact on how realistic the dilemma is seen to be.

### **3.2. Research question two. What ethical decisions are made by practising clinical psychologists in response to (the above identified) ethical dilemmas?**

**3.2.1. Quantitative analyses.** In response to the dilemmas posed in the vignettes (Boxes 1-5), participants were asked to answer *yes* or *no* to questions beginning with: *Would you, as a clinical psychologist....* (Table 10). The main aim of these questions was to encourage thinking about professional ethical decision-making, from which to generate the justifications to be analysed in research questions three and four. In line with Kohlberg's (1973) theory of development of ethical decision-making, the ethical decision itself (the *yes* or *no* response to the dilemma) is seen as less important in the present research, than the factors that are considered when making the decision.

Table 10

*Participant ethical decisions in response to vignettes in iterations one and two*

<u>Vignette name</u>	<u>Iteration 1</u>				<u>Iteration 2</u>		
	<u>Yes</u>	<u>No</u>	<u>No response</u>	<u>Total</u>	<u>Yes</u>	<u>No</u>	<u>Total</u>
<i>Would you, as a clinical psychologist...</i>	<u>n</u>	<u>n</u>	<u>n</u>	<u>n</u>	<u>n</u>	<u>n</u>	<u>n</u>
Maria <i>...undertake neuropsychological testing to assess whether Maria has an intellectual disability?</i>	15	14	2	31	14	14	28
Marco <i>...treat Marco's PTSD?</i>	11	20	0	31	11	17	28
Norman <i>...undertake an internet search of Norman?</i>	23	8	0	31	24	4	28
Alissa's dad <i>...report the information Alissa's dad has given you about his benefits to the relevant authorities?</i>	6	25	0	31	6	21	27
Commissioning <i>...take the additional £70,000?</i>	13	17	1	31	12	16	28

As these questions were exploratory and aiming to tap into participants' cognitive processes rather than consensus building, participants did not receive feedback in iteration two about the responses given to these questions in iteration one. For context, participants were provided with a summary of these results in iteration three (Appendix S) but not asked to respond again. In iteration one, participants had the option to leave the question blank, whereas in iteration two this was a forced-choice, mandatory question, which suggests they are not directly comparable. For these reasons, statistical measures of difference (and hence of consensus) were not completed on these questions. Despite not undertaking the analyses, visually there appears to be minimal change between iteration one and two. Tentatively, this may suggest that once a clinical psychologist makes a professional ethical decision, this may be fairly static.

For three vignettes (*Maria; Marco; Commissioning*), both negative and affirmative ethical decisions appear to be permissible within the participant group. The *Norman* vignette appears biased towards participants saying they would undertake an internet search of a client. The vignette about Alissa's dad appears biased towards participants saying they would not report a client's family member for suspected benefit fraud. Results described in response to research question three and the discussion aim to elucidate these findings.

Overall, ethical decisions made by practising clinical psychologists in response to these ethical dilemmas appear to be diverse. There appears to be limited agreement about more and less competent ethical decisions (although this was not assessed through consensus building), and

theoretical models suggest this is of lesser importance (Kohlberg, 1973). Although there is a bias in ethical decisions in two vignettes, there are still participants representing alternative positions.

**3.2.2. Qualitative analyses.** In iteration three, qualitative data (including general feedback on the research) was analysed using thematic analysis (Braun & Clarke, 2006). This generated themes around the process of ethical decision-making (described in research question four), and themes related to the present research (outlined under additional findings). Within this, the theme *recognising strengths in the present research* comprised sub-themes of *coverage of a wide range of dilemmas* and *seeing the vignettes as posing real dilemmas*. It was therefore felt most appropriate to report these findings here.

**3.2.2.1. Coverage of a wide range of dilemmas.** Using thematic analysis, the theme of a *wide range of dilemmas* having been covered in the present research was identified. This is exemplified by quotes from participant OPQ and JKL, respectively: *“the vignettes tapped into diverse clinical and operational issues”* and *“Good range of settings and service user characteristics”*. Participants suggested additional dilemmas that they felt would be helpful to explore (as described under additional findings within the theme *coming across difficulties in the present research*). However, that this was identified as a strength supports the validity of consideration that was given to develop vignettes which represented a variety of settings and challenges faced by UK clinical psychologists.



**3.2.2.2. Seeing the vignettes as posing real dilemmas.** Thematic analysis generated a theme within feedback on the present research that the vignettes posed dilemmas, summarised by quotes from participants VWX and HIJ, respectively: “...*the study presented some very real dilemmas...*” and “*these tricky situations*”. The description of the vignettes as posing dilemmas is considered a strength of the method as it suggests that there is no obviously appropriate ethical decision (Knapp, Gottlieb & Handelsman, 2015), meaning they are a valid means of addressing the research questions.

Although there was some variation between vignettes, results from qualitative and quantitative analyses suggest that the vignettes used in the present research were seen as representative of true dilemmas, as there was a range of ethical decisions made within the participant group.

Participants suggested that the vignettes represented a wide range of ethical dilemmas, lending further support to their use in ethical instruction or further research.

### **3.3. Research question three. What do practising clinical psychologists agree are appropriate justifications for their ethical decisions made in response to ethical dilemmas in clinical psychology?**

Using first stage inductive thematic analysis (Braun & Clarke, 2003) within qualitative responses to each vignette, codes from iteration one were derived. These were not further analysed into themes and sub-themes at this stage, as it was felt it would be beneficial to give the participant group ownership of the process of refinement, and the opportunity to prioritise nuances in the data collectively, through subsequent iterations. This generated between 30-37 different codes

per vignette, each summarising a different justification given (Appendices X-BB). As noted in the introduction, Kohlberg (1973) suggests that the ethical decision (*yes* or *no*) is less salient than the justifications drawn upon. This stance was applied to the present research and therefore codes for iteration two aimed to be neutral about whether the justification had been used in support of or against the decision in the dilemma, where possible. This was not always possible, due to all data within some codes supporting one ethical decision only, or a code representing a response given by only one participant. To demonstrate these processes, examples are given below. These codes have been chosen as they have subsequent relevance in the present research. These examples draw on different vignettes to illustrate these points, but codes are not necessarily exclusive to one vignette.

### **3.3.1. Example codes from iteration one.**

**3.3.1.1. *The law.*** Within the Maria vignette for example, a number of participants identified different legislation or legal obligations as a justification for their ethical decision. This was the case for both those stating they would undertake the neuropsychological testing and those stating they would not. This is exemplified by quotes from participants ABC and GHJ, respectively: *“If the testing was asked for by a court and in that context then I would.”* and *“If it was only based on this diagnosis I would be raising that this is discrimination”*. These items were therefore coded together as *“The decision to undertake neuropsychological testing or not was based on...” “...the law(s)”*.

**3.3.1.2. Avoidance of harm.** Within the commissioning vignette the code *“The decision to take the additional £70,000 or not was based on...”* *“...avoidance of harm”* was generated through both affirmative and opposing ethical decisions. For example, participant IJK stated: *“If you didn't take the funding boost - you may be doing harm to those who would benefit from your input.”* in support of taking the money, whereas participant RST drew on a similar justification about avoiding harm, as a reason not to take the money, outlined by this quote: *“Risks of iatrogenic harm in providing inappropriate intervention”*.

**3.3.1.3. Best interests.** Across several vignettes, codes focusing on *clients' best interests* were identified. Within the Norman vignette, this justification was used to make ethical decisions both for and against undertaking an internet search of him. This is summarised by this quote from participant DEF: *“it seems to be in the clients best interest to search the internet”*, as well as this quote to the contrary *“[No, because] I would try and focus on what is helpful at this time.”* from participant EFG. Therefore, the code of *“The decision to undertake an internet search of Norman or not was based on...”* *“...Norman's best interests”* was generated, to be taken forward to iteration two.

Interestingly, within the Alissa's dad vignette, only one participant (RST) in iteration one suggested they would draw on the *client's best interests* as a justification for their ethical decision. This is shown within this quote: *“my consideration would be the wellbeing of my patient, would Alissa benefit from my actions in reporting her father or would I make the situation worse?”*. The code *“The decision to report the information Alissa's dad gave about his benefits to the relevant authorities or not was based on...”* *“...Alissa's best interests”* was therefore generated for this piece of data, in

line with similarly named codes in other vignettes. Despite only being derived from one piece of data, this justification consistently received one of the highest scores from the group in this vignette (and others), as will be outlined subsequently.

**3.3.2. Justification ratings.** Codes representing all justifications from iteration one were fed back to participants in iteration two (Appendices X-BB). Participants were asked to rate each one as to how likely they would be to draw upon that justification when making the ethical decision. From this, a hierarchy of justifications was generated (Appendices X-BB). Approximately the highest and lowest rated five justifications were presented back to participants to rescore in iteration three, as presented in Tables 11-15. Rather than asking participants to rescore all 30-37 justifications per vignette and consider those lists as a whole, this number of items was chosen due to cognitive numerical limits on participants' working memory (Miller, 1956). In three vignettes, six justifications were used instead of five, where the cut-off of five items would have excluded an item with the same mean score. In these cases, the hierarchy was determined by the smaller standard deviation. See Tables 11, 14, 15 (Maria<sub>5</sub>  $\bar{x}$  = 5.89, SD = 1.07; Maria<sub>6</sub>  $\bar{x}$  = 5.89, SD = 1.42), (Alissa's dad<sub>32</sub>  $\bar{x}$  = 4.00, SD = 1.73; Alissa's dad<sub>33</sub>  $\bar{x}$  = 4.00, SD = 2.04), (Commissioning<sub>4</sub>  $\bar{x}$  = 5.71, SD = 0.98; Commissioning<sub>5</sub>  $\bar{x}$  = 5.71, SD = 1.05; Commissioning<sub>6</sub>  $\bar{x}$  = 5.71, SD = 1.12).

Table 11

*Rating of ethical decision justification code for the Maria vignette iteration two and three*

		<u>Iteration 2</u>				<u>Iteration 3</u>				
<u>The decision to undertake neuropsychological testing or not was based on...</u>		<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	<u>Wilcoxon S-R p value</u>
1	...Maria's best interests.	6.43	0.96	7	4	6.52	0.92	7	4	0.238 (n.s.)
2	...seeing the capacity to parent as separate from whether Maria has an intellectual disability.	6.14	1.38	7	5	6.52	0.77	7	3	0.090 (n.s.)
3	...the child's best interests.	6.07	1.21	6	5	6.20	0.96	6	3	0.209 (n.s.)
4	...whether I felt Maria had capacity to give informed consent to undertake neuropsychological testing.	6.04	1.14	6	4	6.16	0.80	6	2	0.259 (n.s.)
5	...the extent to which I felt it was clinically justified.	5.89	1.07	6	4	5.88	0.88	6	3	0.495 (n.s.)
6	...avoiding doing emotional harm to Maria.	5.89	1.42	6	5	6.04	1.21	6	5	0.314 (n.s.)

7 - 28	(See Appendix X)									
29	...avoiding doing financial harm to Maria.	3.82	1.72	4	6	3.60	1.55	4	6	0.095 (n.s.)
30	...the extent to which I believe the intellectual disability service resources should go to someone else if Maria does not meet the criteria for accessing the service.	3.57	1.69	4	6	3.72	1.37	4	6	0.464 (n.s.)
31	...having been asked to.	3.43	1.71	3	6	3.04	1.48	3	5	0.111 (n.s.)
32	...how it may reflect on the service.	2.68	1.28	3	4	2.48	1.04	3	4	0.194 (n.s.)

*Note. n.s. indicates not significant at  $p \leq 0.05$ . Wilcoxon Signed-Rank (S-R) to test difference in distributions between iterations one and three.*

*Mean (M) scores can range from: 1 = I definitely would not take this justification into account, 4 = I might or might not take this justification into account, 7 = I definitely would not take this justification into account.*

Table 12

*Rating of ethical decision justification code for the Marco vignette iteration two and three*

		<u>Iteration 2</u>				<u>Iteration 3</u>				
<u><i>The decision to treat Marco's PTSD or not was based on....</i></u>		<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	<u>Wilcoxon S-R p value</u>
1	...getting adequate supervision.	6.32	0.86	7	3	6.38	0.82	7	3	0.498 (n.s.)
2	...avoiding doing more harm than good.	6.25	1.21	7	4	6.33	1.05	7	4	0.490 (n.s.)
3	...the extent to which I see this is outside my competence.	6.18	1.19	7	4	6.25	1.11	7	4	0.200 (n.s.)
4	...Marco's needs.	6.04	0.79	6	2	6.08	0.83	6	3	0.305 (n.s.)
5	...consideration of how risk would or would not be managed if Marco's difficulties escalate.	5.93	1.18	6	5	6.17	0.70	6	2	0.073 (n.s.)
6 - 25	See Appendix Y									
26	...the impact on the service.	4.07	1.63	4	6	4.08	1.21	4	4	0.545 (n.s.)
27	...economic, political and systemic pressures.	3.78	1.37	4	6	3.71	1.20	4	5	0.566 (n.s.)
28	...resources needing to go to someone else, if Marco does not meet	3.68	1.61	4	6	3.96	1.55	4	6	0.206 (n.s.)

	the criteria for accessing the service.									
29	...the potential emotional impact on me.	3.57	1.26	4	5	3.42	0.88	4	4	0.248 (n.s.)
30	...disagreeing that treatment is an accurate description for what clinical psychologists do.	3.36	2.11	3	6	3.29	1.78	3	6	0.776 (n.s.)

*Note. n.s. indicates not significant at  $p \leq 0.05$ . Wilcoxon Signed-Rank (S-R) to test difference in distributions between iterations one and three.*

*Mean (M) scores can range from: 1 = I definitely would not take this justification into account, 4 = I might or might not take this justification into account, 7 = I definitely would not take this justification into account.*



Table 13

*Rating of ethical decision justification code for the Norman vignette iteration two and three*

		<u>Iteration 2</u>				<u>Iteration 3</u>				<u>Wilcoxon S-R p value</u>
<u>The decision to undertake an internet search of Norman or not was based on...</u>		<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	
1	...Norman's best interests.	6.46	0.84	7	3	6.56	0.79	7	3	0.089 (n.s.)
2	...avoiding harm for Norman.	6.43	0.79	7	3	6.52	0.73	7	2	0.089 (n.s.)
3	...possible implications for Norman's treatment and care.	6.14	1.30	7	5	6.41	0.91	7	3	0.107 (n.s.)
4	...the extent to which I would see this as useful in assessing risk.	6.07	1.21	6	5	6.26	0.69	6	2	0.450 (n.s.)
5	...the extent to which I see this as useful for intervention purposes.	6.04	1.37	6.5	5	6.21	0.85	6	3	0.524 (n.s.)
6 - 30	See Appendix Z									
31	...the extent to which I believe this should be expected in the modern age.	3.86	1.82	4	6	3.65	1.37	4	5	0.257 (n.s.)

32	...seeing this as no different to discussing details with the team.	3.82	1.94	4	6	3.70	1.96	4	6	0.340 (n.s.)
33	...seeing this as a distraction from working with Norman.	3.61	2.02	4	6	3.57	1.47	3	6	0.916 (n.s.)
34	...the level of effort involved for me.	2.61	1.75	2	5	2.35	1.40	2	5	0.402 (n.s.)
35	...personal curiosity.	2.04	1.43	1	5	1.82	1.03	2	4	0.100 (n.s.)

*Note. n.s. indicates not significant at  $p \leq 0.05$ . Wilcoxon Signed-Rank (S-R) to test difference in distributions between iterations one and three.*

*Mean (M) scores can range from: 1 = I definitely would not take this justification into account, 4 = I might or might not take this justification into account, 7 = I definitely would not take this justification into account.*

Table 14

*Rating of ethical decision justification code for the Alissa's dad vignette iteration two and three*

		<u>Iteration 2</u>				<u>Iteration 3</u>				<u>Wilcoxon S-R p value</u>
		<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	
<i><u>The decision to report the information Alissa's dad gave about his benefits to the relevant authorities or not was based on...</u></i>										
1	...avoiding doing harm to Alissa and her dad.	6.33	1.07	7	4	6.61	0.50	7	1	0.106 (n.s.)
2	...avoiding doing harm to Alissa.	6.33	1.07	7	4	6.65	0.57	7	2	0.050*
3	...Alissa's best interests.	6.30	1.35	7	5	6.74	0.45	7	1	0.044*
4	...the potential impact on the therapeutic relationship.	5.85	1.20	6	5	6.00	1.04	6	3	0.248 (n.s.)
5	...being transparent with Alissa's dad.	5.85	1.32	6	5	5.83	0.93	6	3	0.521 (n.s.)
6 - 31	See Appendix AA									
32	...Trust policies.	4.00	1.73	4	6	3.83	1.50	4	6	0.297 (n.s.)
33	...my beliefs about the benefits system.	4.00	2.04	4	6	4.26	1.18	4	5	0.348 (n.s.)
34	...the extent to which I felt I could advocate for Alissa's dad.	3.93	1.75	4	6	3.91	1.56	4	6	See note Alissa's dad <sub>34</sub>

35	...it being my choice (or not) to work for an organisation with this policy.	3.48	1.67	4	6	3.26	1.29	3	6	0.310 (n.s.)
36	...the emotional impact on me.	3.30	1.71	3	6	2.87	1.46	3	6	0.036*
37	...what research says about different aspects of this dilemma.	3.26	1.51	4	5	3.22	1.41	3	5	0.822 (n.s.)

*Note. n.s. indicates not significant at  $p \leq 0.05$ , \*indicates significant at  $p \leq 0.05$ . Wilcoxon Signed-Rank (S-R) to test difference in distributions between iterations one and three.*

*Mean (M) scores can range from: 1 = I definitely would not take this justification into account, 4 = I might or might not take this justification into account, 7 = I definitely would not take this justification into account.*

*Alissa's dad<sub>34</sub>:  $t = 0.086$ ,  $df(26)$ ,  $p = 0.932$ , two-tailed (n.s.).*

Table 15

*Rating of ethical decision justification code for the Commissioning vignette iteration two and three*

		<u>Iteration 2</u>				<u>Iteration 3</u>				
<u>The decision to take the additional £70,000 or not was based on...</u>		<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	<u>M</u>	<u>SD</u>	<u>Median</u>	<u>Range</u>	<u>Wilcoxon S-R p value</u>
1	...avoidance of harm.	6.36	0.99	7	4	6.50	0.78	7	3	0.319 (n.s.)
2	consideration of whether the service could be more cost effective.	5.89	0.88	6	3	5.92	0.76	6	2	0.917 (n.s.)
3	having consulted colleagues.	5.82	1.28	6	5	5.64	0.95	6	4	0.137 (n.s.)
4	how well I feel the current service is working.	5.71	0.98	6	3	5.63	0.82	6	3	0.251 (n.s.)
5	consideration of different intervention options.	5.71	1.05	6	4	5.83	0.82	6	3	0.436 (n.s.)
6	research evidence.	5.71	1.12	6	5	5.50	1.06	6	5	0.082 (n.s.)
7 - 30	See Appendix BB									
31	a recognition of offering some service to clients as being better than not	4.79	1.52	5	4	4.67	1.37	5	5	0.646 (n.s.)

	being able to offer anything.									
32	anticipation of this being the best offer we would be likely to receive.	4.79	1.40	5	6	4.67	1.24	5	6	0.522 (n.s.)
33	the perspective of management.	4.61	1.52	5	6	4.50	1.14	5	4	0.377 (n.s.)
34	consideration of whether another provider (who may be in a better or worse position to provide a service than my own) may take the money if I do not.	4.54	1.60	5	6	4.42	1.02	4	5	0.503 (n.s.)
35	the extent to which I see decisions that commissioners make as outside of my responsibility.	3.57	1.50	4	5	3.54	1.41	4	5	0.676 (n.s.)

*Note. n.s. indicates not significant at  $p \leq 0.05$ . Wilcoxon Signed-Rank (S-R) to test difference in distributions between iterations one and three.*

*Mean (M) scores can range from: 1 = I definitely would not take this justification into account, 4 = I might or might not take this justification into account, 7 = I definitely would not take this justification into account.*

As Shapiro Wilk tests revealed this data did not meet parametric assumptions of normality (used as  $n < 50$ ; Shapiro & Francia, 1972) and homogeneity of variance (Levene's test), non-parametric tests were applied (Miles & Banyard, 2007; Appendices FF-JJ). One justification (Alissa's dad<sub>34</sub>) did meet parametric assumptions so a Paired Samples T-Test was used. For all other justifications, Wilcoxon S-R was used, with average values within a question replacing incomplete responses in iteration three (as described in 3.1.1; Twisk & De Vente, 2002). As shown in Tables 11-15, these analyses indicated no statistically significant differences between mean justification scores between iterations two and three, apart from two justifications in the Alissa's dad vignette which increased significantly (Alissa's dad<sub>2</sub> iteration two  $\bar{x} = 6.33$ , Alissa's dad<sub>2</sub> iteration three  $\bar{x} = 6.65$ ,  $p = 0.05$ ; Alissa's dad<sub>3</sub> iteration two  $\bar{x} = 6.30$ , Alissa's dad<sub>3</sub> iteration three  $\bar{x} = 6.74$ ,  $p = 0.04$ ) and one which decreased significantly (Alissa's dad<sub>36</sub> iteration two  $\bar{x} = 3.30$ , Alissa's dad<sub>36</sub> iteration three  $\bar{x} = 2.87$ ,  $p = 0.04$ ). This suggests that for almost all justifications, consensus had been reached, and further iterations would not yield different results.

There was a variety of ranges given for justification ratings in iteration two (e.g. Range Maria<sub>31</sub> = 6; Range Marco<sub>4</sub> = 2; Tables 11-15). Visually, there appears to be a trend towards convergence in iteration three with many of the ranges decreasing (e.g. Iteration two range Alissa's dad<sub>3</sub> = 5; Iteration three range Alissa's dad<sub>3</sub> = 1), despite the non-significant changes in mean scores. This in line with what can be expected in Delphi methodology (Powell, 2003).

**3.3.3. Justification rankings.** In iteration two, as well as being asked to rate the justification codes, participants were also asked to rank the top four justifications they would be

most likely to draw upon and the three justifications that they would be least likely to draw upon, in order. The highest ranked justifications were then calculated into composite group ranking scores by assigning four points to each participant's top ranked justification, three points to each participant's second ranked justification and so on, and zero points to all other justifications they had not selected to be one of their top four ranked justifications. Similarly, with the lowest three ranked justifications, three points were given to each participant's lowest ranked item, two to their second lowest ranked item, one to their third lowest. All other justifications participants had not selected to rank as one of their lowest three were given a score of zero. This created relative composite scores for the justifications ranked highest and lowest (Appendices X-BB). Although there were some differences between the ratings and rankings, largely these results followed a similar pattern with highly rated justifications also ranking highly (*client's best interests* and *avoidance of harm*). As the ratings data was felt to be more accessible for participants and the implications of rankings somewhat challenging to interpret effectively, the rankings were therefore not taken to further iterations of the research. A summary of the highest (Table 16) and lowest (Table 17) ranked justifications are shown and one key finding of interest is now described.



Table 16

*Summary of justifications ranked most highly in iteration 2 across vignettes, in order*

<u>The decision to X or not was based on...</u>					
	<u>Maria</u>	<u>Marco</u>	<u>Norman</u>	<u>Alissa's dad</u>	<u>Commissioning</u>
Highest group ranked justification	...the child's best interests. (n = 12)	...the extent to which I see this is outside my competence. (n = 13)	...the extent to which I would see this as useful in assessing risk. (n = 10)	...avoiding doing harm to Alissa and her dad. (n = 9)	...avoidance of harm. (n = 10)
Second highest group ranked justification	...having discussed with Maria what she felt to be the most appropriate course of action. (n = 12)	...avoiding doing more harm than good. (n = 13)	...the extent to which I see this as useful to inform the formulation. (n = 12)	...having weighed up the pros and cons of both courses of action. (n = 8)	...having discussed this further with the commissioner. (n = 8)
Third highest group ranked justification	...Maria's best interests. (n = 12)	...Marco's needs. (n = 7)	...Norman's best interests. (n = 8)	...Alissa's best interests. (n = 7)	...the extent to which I feel I would need to meet what I have agreed. (n = 8)
Fourth highest ranked justification	...seeing the capacity to parent as separate from whether Maria has an intellectual disability. (n = 12)	...getting adequate supervision. (n = 7)	...the extent to which I see this as useful for intervention purposes. (n = 9)	...avoiding doing harm to Alissa. (n = 7)	...a recognition of offering some service to clients as being better than not being able to offer anything. (n = 6)

*Note. (n = number of participants who ranked this justification as one of their top four, out of a maximum of 28 who took part in this iteration).*

Table 17

*Summary of lowest ranking justifications in iteration 2 across vignettes, in order*

<u>The decision to X or not was based on....</u>					
	<u>Maria</u>	<u>Marco</u>	<u>Norman</u>	<u>Alissa's dad</u>	<u>Commissioning</u>
Lowest group ranked justification	...how it may reflect on the service. (n = 16)	...disagreeing that treatment is an accurate description for what clinical psychologists do. (n = 13)	...personal curiosity. (n = 20)	...the emotional impact on me. (n = 7)	...the extent to which I see decisions that commissioners make as outside of my responsibility. (n = 15)
Second lowest group ranked justification	...having been asked to. (n = 9)	...the extent to which I see it as useful to consider PTSD as a distinct diagnostic entity. (n = 6)	...the level of effort involved for me. (n = 16)	...what research says about different aspects of this dilemma. (n = 7)	...NICE guidelines. (n = 6)
Third lowest group ranked justification	...the extent to which I believe the intellectual disability service resources should go to someone else if Maria does not meet the criteria for accessing the service. (n = 7)	...the potential emotional impact on me. (n = 6)	...seeing this as a distraction from working with Norman. (n = 8)	...it being my choice (or not) to work for an organisation with this policy. (n = 6)	...the perspective of management. (n = 7)

*Note. (n = number of participants who ranked this justification as one of their top four, out of a maximum of 28 who took part in this iteration).*

**3.3.3.1. The emotional impact the self.** The justifications “...the emotional impact on me” from the vignette about Alissa’s dad and “...the potential emotional impact on me” from the Marco vignette were ranked the lowest and third lowest respectively. Out of a maximum of 28 participants who took part in iteration two, 11 different participants ranked these items as one of the three justifications they would be least likely to draw upon. This equates to 39.29% of the group who said *the emotional impact on the self* would be one of the justifications they would be least likely to consider when making an ethical decision. Linking back to Gilligan’s (1982) theory of morality, the influence of gender identity was investigated as a possible influence on this result. This did not appear to be relevant, as 3 out of these 11 participants described themselves as male (27.27%; in line with the sample value of 29.03%).

This result is echoed in the ratings scores (Alissa’s dad<sub>36</sub> iteration two  $\bar{x}$  = 3.30, Alissa’s dad<sub>36</sub> iteration three  $\bar{x}$  = 2.87; Marco<sub>29</sub> iteration two  $\bar{x}$  = 3.57, Marco<sub>29</sub> iteration three  $\bar{x}$  = 3.42). Wilcoxon S-R tests indicated a statistically significant decrease between Alissa’s dad<sub>36</sub> in iteration two and three ( $p$  = 0.04). This suggests that on average, participants lowered their score for “...the emotional impact on me”, after seeing that the group had said in iteration two that they would be unlikely to draw upon this justification when making the ethical decision. Interestingly, justifications related to *the professional impact on the self* scored more highly in iteration two. For example, Marco<sub>21</sub> “...the potential impact on me professionally (such as having a heavy caseload, maintaining my registration and avoiding litigation)”  $\bar{x}$  = 4.71, SD = 1.78; Alissa’s dad<sub>20</sub>, “...the potential impact on my professional life”  $\bar{x}$  = 4.63, SD = 1.52). This will be further explored in the discussion, however the self-reflexive position is reported presently.

**3.3.3.1a. Self-reflexive position.** When preparing to present preliminary results at the DCP Annual Conference (Grace, Wainwright & Ellis-Caird, 2019), I noticed myself feeling quite invested in these low scores around *the emotional impact on the self*. It could have been hypothesised from the literature that justifications around *avoidance of harm* and *client's best interests* might score highly and this data lends empirical support to that. However, that the justifications around *the emotional impact on the self* were rated and ranked so low spoke to something which I have experienced intuitively throughout training, but which would have been difficult to parse as an a priori hypothesis. My experience is that self-care is a concept which is talked about as important within the profession and on training, but in practice is often prioritised less. Similar reflections on this are reported in the literature (Bettney, 2017). I have noticed both observable systemic barriers to this for myself and others (such as the demands of training, or busy caseloads) and I also recognise my internal cognitive barriers. The message I have interpreted, supported by data from 39% of this participant group, is that the impact of an ethical decision on oneself *emotionally* is of lesser importance than other justifications, when making an ethical decision. This is not necessarily a position I wish to endorse and will be further addressed in the discussion.

**3.3.4. Similarities between vignettes.** The highest and lowest rated justifications for each vignette are listed in order of the mean score generated from iteration two in Tables 11-15. Looking across the vignettes, there is some commonality in the highest rated justifications summarised in Table 18. The codes of *avoidance of harm* and *client's best interests* were consistently rated the highest. Participants were presented with a similar summary table and

asked to rate and comment on similarities and differences. However, on review of the responses it appears the wording of this question had been somewhat tautological, so results of this are not presented here. This could be mitigated in future by further piloting questionnaires. Participant BCD summarised these key similarities and hypothesised about differences: *“For the highest rated principles most agree that avoiding harm and the client's best interests are the over-riding principles. It is interesting that there is more disagreement when one looks at the 3rd highest rating, perhaps an indication that we have one or two clear ethical values that guide our decisions but far more individual difference when we move beyond that.”* [sic].

Within the Marco vignette, the code *getting adequate supervision* scored the highest however, it can be argued that the functions of supervision are to ensure that care is of high quality (CQC, 2013) and client safety is maintained (Milne, 2007). This was identified by participant LMN in this quote *“Looking at the table there is slight variation. e.g. Marco is supervision rather than doing no harm - although realistically this is related.”*.

Table 18

*Summary of highest rated justifications in iteration 2 across vignettes, in order*

<u>The decision to X or not was based on...</u>					
<u>Position</u>	<u>Maria</u>	<u>Marco</u>	<u>Norman</u>	<u>Alissa's dad</u>	<u>Commissioning</u>
1	...Maria's best interests. ( $\bar{x}$ = 6.43)	...getting adequate supervision. ( $\bar{x}$ = 6.32)	...Norman's best interests. ( $\bar{x}$ = 6.46)	...avoiding doing harm to Alissa and her dad. ( $\bar{x}$ = 6.33)	...avoidance of harm. ( $\bar{x}$ = 6.36)
2	...seeing the capacity to parent as separate from whether Maria has an intellectual disability. ( $\bar{x}$ = 6.14)	...avoiding doing more harm than good. ( $\bar{x}$ = 6.25)	...avoiding harm for Norman. ( $\bar{x}$ = 6.43)	...avoiding doing harm to Alissa. ( $\bar{x}$ = 6.33)	...consideration of whether the service could be more cost effective. ( $\bar{x}$ = 5.89)
3	...the child's best interests. ( $\bar{x}$ = 6.07)	...the extent to which I see this is outside my competence. ( $\bar{x}$ = 6.18)	...possible implications for Norman's treatment and care. ( $\bar{x}$ = 6.14)	...Alissa's best interests. ( $\bar{x}$ = 6.30)	...having consulted colleagues. ( $\bar{x}$ = 5.82)

*Note. Mean (M) scores can range from: 1 = I definitely would not take this justification into account, 4 = I might or might not take this justification into account, 7 = I definitely would not take this justification into account.*

**3.3.5. Differences between vignettes.** With regards to the Commissioning vignette it is interesting to note that all but one of the justifications were rated as above a four on the scale of 1-7 (1 = I definitely would not take this into account, 7 = I definitely would take this into account, 4 = I might or might not). The only justification rated below four was Commissioning<sub>35</sub> ("*...the extent to which I see decisions that commissioners make as outside my responsibility*"; Iteration two  $\bar{x}$  = 3.57, SD = 1.50). This is compared to the other vignettes where almost all of the lowest five rated

justifications received a mean score of less than four, suggesting participants would be less likely to draw upon these (Appendices X-BB). Further, the Commissioning vignette also received the lowest scores for the list of justifications as likely to lead to an ethically competent decision and behaviour(s), described subsequently. However, this vignette also received some of the highest ratings for how realistic and relevant it was (section 3.1.1) to the UK practice of clinical psychology. This suggests this vignette may differ from the others, which will be explored in the next chapter.

**3.3.5.1. Context as a mediator.** It was interesting to note that whilst similar or the same codes were generated as justifications in different vignettes, these often scored differently between vignettes. This suggests that there may be a mediating role of the dilemma context on the likelihood of a particular justification being drawn upon (or considered salient) when making an ethical decision. For example, in iteration one, codes related to *research evidence* were generated for all vignettes. In iteration three, these justifications received mean ratings between 3.26 (the lowest mean rated justification in the Alissa's dad vignette, Alissa's dad<sub>37</sub>, suggesting participants would be less likely to draw upon it) and 5.71 (Commissioning<sub>6</sub>, suggesting participants would be likely to draw upon it). This is further explored in section 3.4.

**3.3.6. Justifications for ethically competent decisions.** In iteration three, participants were asked to review the lists of highest and lowest rated justifications within each vignette. They were asked to rate the extent to which they felt that making an ethical decision in this way (i.e. being more likely to draw upon higher rated justifications and less likely to draw upon lower rated

ones, as shown in Tables 11-15) would be competent, and separately, would lead to ethically competent behaviour(s). This was rated on a 101-point scale (0 = not at all, 100 = fully).

Participants were also asked to explain their answers qualitatively. Quantitative results (Table 19), suggest that across the vignettes participants appeared to feel that decisions made in this way would be ethically competent (76– 82%) and would lead to ethically competent behaviour(s) (73-75%), although there was a substantial range in responses. This suggests broad agreement about more and less appropriate justifications in response to ethical dilemmas in clinical psychology.

Whilst these figures are considered high, it also suggests they are not believed to be ideally ethically competent by the group. Review of qualitative data suggests there may be some important factors missing for some participants, as outlined by these quotes from LMN and EFG, respectively: *“I chose 70% as i don't feel confident that I am taking into account all ethical aspects / issues and would seek further guidance on this”* and *“There is no reference to professional guidance or policy in the list - this might be important, as otherwise it is just a personal decision.”*.



Table 19

*Participant ratings from iteration three of the extent to which drawing on the list of justifications (in the order developed in iteration two) would lead to ethical competence*

<u>Vignette</u>	<u>Ethically competent decision</u>				<u>Ethically competent behaviour</u>			
	<u>M</u>	<u>SD</u>	<u>Range</u>	<u>n</u>	<u>M</u>	<u>SD</u>	<u>Range</u>	<u>n</u>
Maria	77.28	14.95	50	25	74.04	14.21	46	25
Marco	77.29	14.85	69	24	74.25	15.63	62	24
Norman	82.22	14.29	50	23	75.48	19.40	65	23
Alissa's dad	78.00	12.50	50	24	73.71	16.06	57	24
Commissioning	76.46	14.67	80	24	72.58	15.24	70	24

*Note. Scores range from 0 (not at all) to 100 (fully).*

**3.3.7. Summary of research question three.** Taken together, this suggests there is broad agreement about appropriate justifications for ethical decisions made within this participant group. Drawing on collectively generated lists of justifications, in order (being more likely to draw on highly rated justifications and less likely to draw on justifications with lower ratings), was considered more likely to generate ethically competent decisions and lead to ethically competent behaviours. Specifically, participants felt it was important to prioritise justifications around *client's best interests* and the *avoidance of harm*. It was noted that participants reported they would be less likely to consider *the emotional impact on the self* when making ethical decisions. There may

be a mediating role of the dilemma context, and other contextual factors, as to the likelihood of specific justifications being drawn upon.

### **3.4. Research question four. How do practising clinical psychologists make ethical decisions in response to ethical dilemmas?**

**3.4.1. Iteration one results.** In iteration one, first stage inductive thematic analysis was used (Braun & Clarke, 2003) to generate codes describing each of the different justifications given within a vignette. Although this was not further analysed into themes and sub-themes at this stage (to allow participants to prioritise nuances in the data; Section 3.3.), the data could be considered to fit broadly into *professional ethical considerations* and *more than professional ethical considerations*. This distinction was not fed back to participants in subsequent iterations, to minimise the possible influence of social expectations on the scoring.

To some extent, *professional ethical considerations* could fit into Codes of Conduct, Intermediate Concepts (Bebeau & Thoma, 1999), and Rest's (1986) Schema. As outlined in Section 3.3.4., there were common codes across vignettes (Appendices X-BB). Examples of how this data fits into these models are outlined in Table 20, using justifications from all vignettes. However, these models appeared insufficient in describing all the justifications given. The remaining justifications were deemed *more than professional ethical considerations* (Table 21). Some of these were professionally-related but also included a variety of practical, contextual considerations, as well as more personal considerations.

Table 20

*Categorisation of 'professional ethical considerations' drawn upon in iteration one and their relationship to existing theoretical models of ethical decision-making*

<u>The decision to X or not was based on....</u>		
<u>Schemas</u> <u>(Rest, 1986)</u>	<u>Intermediate concepts</u> <u>(Bebeau &amp; Thoma, 1999)</u>	<u>Professional Codes</u> <u>of Conduct</u>
<b>Personal interests:</b> "...the potential impact on my professional life." "...wanting to feel I've done everything I can."	"...Alissa's best interests." "...avoidance of harm." "...whether I felt Maria had capacity to give informed consent to undertake neuropsychological testing."	"...professional guidelines" "...NICE guidelines." "...research evidence."
<b>Maintaining norms:</b> "...workplace policies about internet searching." "...the law(s)." "...the perspective of management."	"...being able to be transparent with Marco." "...the extent to which I see this as useful to inform the formulation."	
<b>Post-conventional reasoning:</b> "...seeing the impact of disclosing as disproportionate to the act to be disclosed." "...how having an intellectual disability identity confirmed or refuted may impact Maria"	"...the extent to which I would see this as useful in assessing risk."	

Table 21

*Categorisation of 'more than professional ethical considerations' drawn upon in iteration one*

---

The decision to X or not was based on....

---

"...the level of effort involved for me."

"...consideration of whether I have any other options."

"...the number of sessions we have agreed being insufficient."

"...the extent to which I believe this should be expected in the modern age."

"...economic, political and systemic pressures."

"...the extent to which I believe the costings are realistic."

"...having an awareness of this policy."

"...personal curiosity."

"...my personal values."

---

These results from iteration one suggest that whilst existing models can provide a framework for understanding how clinical psychologists make ethical decisions, alone they are insufficient.

Therefore, in iteration three, a full inductive thematic analysis (Braun & Clarke, 2003) was carried out on the qualitative data. This generated five themes around the process of ethical decision-making (and three themes around the process of the present research described in Section 3.6.).

Towards the end of this analysis, this was compared deductively to existing models, and a new model is subsequently proposed.

**3.4.2. Iteration three results.** From analysis of iteration three, five themes were developed from the qualitative data, this seemed to suggest that participants saw ethical competence in the decision-making process, rather than in the ethical decision itself. A number of participants commented on this, as shown by these quotes from participants LMN and BCD, respectively: *"it's*

*a good framework*", *"it has been helpful to try and operationalise the decision making process."*. Although, a small minority of participants identified this as a possible barrier to ethical competence, as shown by this quote from participant GHI: *"...despite the group of participants seeming to take similar things into consideration, the group is split with regards to the decision that would be made. This suggests there is a lot of difference in the interpretation..."*. Following the self-reflexive position, this process will shortly be described in terms of the five themes developed (*assessing the problem, formulating the problem, responding to a reasoned judgment, influencing factors on the process, and drawing on guiding principles*), followed then by the proposal of a model to suggest how these themes may interact.

**3.4.2.1. Self-reflexive position.** In developing names for the following themes, I was struck by a quote from participant YZA: *"[The ethical decision is] Based on weighing up ethical justifications so in a way what the ethical justification doesn't matter. It's about the assessment, formulation and weighing up of the factors."* This developed my thinking into how ethical decision-making fits with other types of decision-making in clinical psychology and it could be the case that it is not considered different to the process of clinical decision-making. For example, as described by The Cycle of Professional Practice's Core Competencies of: *assessment, formulation, intervention / implementation, evaluation and communication*, as shown in Figure 5 (BPS, 2017). Initially, I was somewhat crestfallen that I may have inadvertently been investigating an already well described process. However, upon checking, this cycle only partially fits the present data, as described below. This cycle may also provide further fruitful avenues for future research for example whether additional parts need to be added to the model derived from the present data,

or it may speak to the development of ethical decision-making within the profession. These issues are discussed in the next chapter.

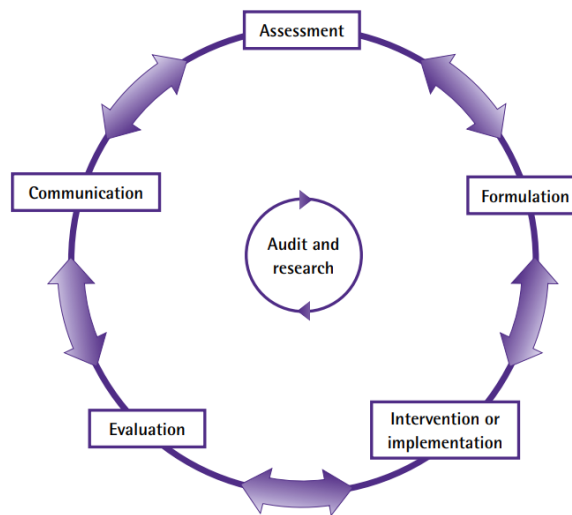


Figure 5. The Cycle of Professional Practice illustrating the five Core Competencies in applied psychology (adapted from BPS, 2017).

**3.4.2.2. Theme: Assessing the ethical problem.** The superordinate theme of *assessing the ethical problem* was developed. It aimed to capture how participants initially approached an ethical problem and what they saw as competent about drawing on the justifications generated by the group. This theme consisted of two distinct sub-themes; *assessing the problem thoughtfully* and *assessing the problem systematically*. To me, the data suggested similarities to the Core Competency of *assessment* (BPS, 2107).

**3.4.2.2a. Sub-theme: Assessing the problem thoughtfully.** This sub-theme was identified in response to participants commenting on the importance of considering salient issues in a

thoughtful manner. This also encompassed consideration of justifications considered to be important and relevant by participants. This is outlined by quotes from participants DEF and XYZ, respectively: *“I think it would not be ethically competent to simply rush into [an ethical decision], without careful consideration and having a well thought out rationale for the decision”*, *“I think these criteria reflect a range of rationales which seem to bear on the case and would be likely to produce a thoughtful and ethically competent response”*.

**3.4.2.2b. Sub-theme: Assessing the problem systematically.** This sub-theme described participants’ suggestions that a systematic approach to assessing an ethical problem was important for ethical competence. This sub-theme encompassed ideas of objectivity, transparency and accountability in the assessment process. This sub-theme is exemplified by a quote from participant VWX: *“This would offer a more systematic way to think about and consider a response to a situation that could also be justified if it was questioned later down the line.”* This sub-theme is seen as distinct from assessing thoughtfully, as outlined by participant YZA who cautioned against excessive credulity in a systematic approach: *“I would be concerned that this might lead to a reliance on a check list rather than fluid and thoughtful thinking.”*

**3.4.2.3. Theme: Formulating the ethical problem.** The superordinate theme of *formulating the ethical problem* was developed. This aimed to capture a process for participants of integrating and weighing up different justifications (which had been *thoughtfully* and *systematically assessed*) to indicate a response. This theme consisted of four sub-themes; *drawing on specific considerations, weighing up, developing a justifiable reasoned judgment* and *developing a*

*utilisable reasoned judgment*. In this way, this theme bears similarities to the Core Competency of *formulation* (BPS, 2017).

*3.4.2.3a. Sub-theme: Drawing on specific considerations.* The sub-theme of *drawing on specific considerations* was developed to represent specific justifications that, participants suggested, if considered would likely lead to ethical competence. This sub-theme also encompassed those justifications that were considered to reduce ethical competence if drawn upon. Towards the end of the analysis, it was felt that within this sub-theme, *specific considerations* could be categorised according to the ethical decision-making model (Rest, 1986) as outlined below.

It was considered important to take into account a *client's context* when formulating (e.g. "*You also need to consider the individual and how to respond to their needs and those around them...*" participant DEF) and *consequences for the client* of a particular formulation, such as the *avoidance of harm* (e.g. "*harm avoidance being in such a prominent position is reassuring*", participant ABC) and *clients' best interests* (e.g. "*Covers the essential issues - like best interest*", participant IJK). These consequences can be likened to the aspects of the biomedical ethical decision-making model; *non-maleficence* and *beneficence* Beauchamp and Childress' (1979, 2009).

Similarly, participants considered it important (although seemingly less so) to consider wider *systemic contexts* when formulating (e.g. "*...this decision is being heavily influenced by individual/interpersonal factors and less consideration is being given to systemic/resource*



*questions. While I believe the former carry more weight, the latter are also important...”,* participant HIJ) and *systemic consequences* of implementing a decision indicated from formulating (e.g. *“There does perhaps need to be more consideration of fairness in the public sector in making this decision”,* participant CDE). *Systemic consequences* can be likened to the *justice* principle within the biomedical ethical decision-making model (Beauchamp & Childress, 1979, 2009).

Another set of specific considerations it was considered important to pay heed to was *authorities*. These included reference to policies, laws and guidelines (e.g. *“to practice ethically within this society, you need to pay attention to policies and guidelines - specifically ones related to ethical decisions and decided upon by individuals who represent the organisations you work with and for (incl. BPS and NHS) and the law.”*, participant DEF). Research evidence (e.g. *“Consideration of the important issues: ...research evidence”,* participant RST) and supervision (*“I think the emphasis placed on competence and supervision is really important and helpful.”*, participant HIJ) were also deemed important specific considerations to draw upon when formulating. However, the limits of these authorities was acknowledged. It was suggested that ethical competence may involve going beyond these at times (e.g. *“based on narrow unreliable research evidence”,* participant STU; *“prefer to make my own mind up and not trust policy on this type of thing”,* participant IJK), However, this was debated (*“I wonder if giving less weight to Trust Policy in this situation could lead to other behaviours that contravene policy, and people taking decisions like this more into their own hands.”*, participant CDE). The suggestion that it is competent to draw on specific considerations around *authorities* when formulating an ethical problem, whilst recognising this

can sometimes be limited, can be considered to fit within the maintaining norms schema (Rest, 1986).

A final set of specific considerations reflected in the *drawing on specific considerations* sub-theme are those that were considered less ethically competent by the group, if solely drawn upon when formulating. These included personal (e.g. *"It seems that a lot of personal feeling and 'hero' behaviour is involved for some - this is not ethically competent."*, participant EFG), professional (e.g. *"Cv boosting. Boredom in role and want for new challenges."*, participant ZAB), political (e.g. *"Political pressures could lead to a less competent decision."*, participant ABC), and interpersonal considerations (e.g. *"the personal relationship they have with [the client]"*, participant MNO). The data suggests that drawing on these specific considerations alone when formulating was believed to decrease ethical competence, and this can be considered to fit within the personal interests schema (Rest, 1986).

*3.4.2.3b. Sub-theme: Weighing up.* Following *drawing on specific considerations* when formulating, the next sub-theme described was *weighing up*, within the theme of formulating. Participants spoke of considering a number of items and a process of balancing. This is exemplified by quotes from participants YZA and CDE, respectively: *"Agree that these are important factors to weigh up in relation to making ethical decs..."* [sic; decisions]. *"The considerations balance the client need against other sensible and relevant factors"*.

*3.4.2.3c. Sub-theme: Developing a justifiable reasoned judgment.* When formulating an ethical problem, it appeared that to do this competently, in the eyes of this participant group, the formulation must lead to an ethical decision that is justifiable. This was identified as another sub-theme encompassing *developing a reasoned judgment* that is defensible and professionally or clinically *justifiable*. This sub-theme is exemplified by quotes from participants HIJ and VWX, respectively: “*There is a more clear and direct clinical justification...*”, “*think about and consider a response to a situation that could also be justified if it was questioned later*”.

*3.4.2.3d. Sub-theme: Developing a utilisable reasoned judgment.* Like *developing a justifiable judgment*, it also appeared important to participants that the formulation led to a workable or useable ethical decision. This led to the identification of the *developing a utilisable reasoned judgment* sub-theme. Participants spoke of the ethical decision needing to be being pragmatic, flexible and achievable. This sub-theme is illustrated by quotes from participants CDE and HIJ, respectively: “*would lead to actions in the client's best interests with clinical utility*”, “*It seems realisable consideration of ethical factors for [the client's] care and treatment*”.

**3.4.2.4. Theme: Responding to a reasoned judgment.** The superordinate theme of *responding to a reasoned judgment* was developed to describe the part of the process of reacting to an ethical decision, once indicated from the formulation. This bears similarities to the Core Competency of *intervention / implementation* (BPS, 2017). This comprised two sub-themes; *comparing with colleagues* and *deciding vs. behaving*.

*3.4.2.4a. Sub-theme: Comparing with colleagues.* This sub-theme described the action of participants of comparing their reasoned judgment with those of others, once developed through *formulating*. It is recognised that the identification of this evaluative process may be influenced the methodology of the present research. However, *considering multiple perspectives* was also identified as a sub-theme within the *guiding principles* theme and barriers to this were identified within the *influencing factors on the process* theme. Within this sub-theme, similarity or difference with colleagues' ethical decisions did not necessarily sway participants' decisions, but the comparative process was felt to add weight to the competence of the decision. The data suggested that in response to comparison with colleagues, this could serve to validate the reasoned judgment (e.g. "*...similarity between my personal opinion and that of others in the study, suggesting there is a high degree of validity in taking into consideration those factors.*", participant GHI), to reconcile differences, by recognising subjectivity in the process (e.g. "*This has been a chance to explore some of those aspects of my decisions that might be different to others, in terms of values and beliefs.*", participant HIJ) or lead to alterations to the reasoned judgment (e.g. *I have adjusted my thinking on this issue considering how it might impact on [the client].*", participant WXY).

*3.4.2.4b. Sub-theme: Deciding vs. behaving.* This sub-theme was developed to indicate a split in the participant group, some who saw the process of developing a reasoned judgment, and then responding to it as different, and those who saw these as indistinguishable. A number of participants highlighted that a justifiable and reasoned judgment generated through *formulating* may be ethically competent, but this may not necessarily lead to ethically competent behaviour.

This is identified in this quote from participant RST: *“Behaviour may not lead on directly from an ethical decision”*. This is also supported by quantitative results (Section 3.3.6.), where the scores for the process leading to ethically competent behaviour trend towards being lower than the scores for the process leading to an ethically competent decision (Table 19).

From a self-reflexive position, what was most surprising to me about these responses was the number of participants who suggested they did not see a distinction between an ethically competent decision and ethically competent behaviour(s). Many participants gave the same score for both items within a vignette, and qualitative responses for behaviour(s) referred the researcher to the same rationale given above for ethically competent decision. This is exemplified by quotes from participants BCD and WXY, respectively: *“I’m not sure that I draw a distinction between an ethically competent decision and ethically competent behaviour. In my view one leads to another, i.e. if i have made an ethically competent decision then that guides my behaviour”*, *“Taking the decision is engaging in behaviour, is it not? I’m confused, this feels like you have asked the same question twice.”*. This may suggest that for some participants there is a belief that once a justifiable, reasoned judgment is made is made through the process of formulating, this equates to an ethically competent action being carried out. Literature (Rest, 1983) suggests that there are pitfalls to this approach and it also goes against my experience of decision-making more generally. For example, when working in forensic settings, people would often make (what I perceived to be) a genuine declaration of desistance from offending, only to be thwarted by factors they had been unable to predict. This sub-theme could also suggest a lack of understanding of the concepts, as outlined by quote from participant OPQ: *“The difference between an ethically competent decision*

*and an ethically competent behaviour is not clear to me*". As discussed in Section 4, this may indicate a role for ethical instruction to include exploration of a distinction between the two, and the potential implications of this.

**3.4.2.5. Theme: Influencing factors on the process.** The superordinate theme of influencing factors was developed to describe three sub themes which appeared to impact participants throughout the processes of *assessing, formulating and responding*. This comprised three sub-themes, *dilemma factors, decision-maker factors, and overlapping contextual factors* (between the dilemma and decision-maker).

*3.4.2.5a. Sub-theme: Dilemma factors.* The sub-theme of *dilemma factors* influencing the process of *assessing, formulating and responding* was developed to describe factors related to the ethical dilemma which participants suggested made it more or less challenging for them. Within this, participants felt that specific aspects of the dilemma influenced their approach (e.g. *"Each vignette felt different in terms of the reasons that were important/challenging to consider."*, participant MNO). Context as a mediator is also supported by quantitative results (Section 3.3.5.1.). The complexity of the dilemma (e.g. *"less room for a decision to be made to act in an unethical manner in this case - there appears to be more gray in this than in the other vignettes"*, participant HIJ), including the number of different justifications that could be taken into account (e.g. *"I'm not sure I can hold in mind all the responses and the group's reactions to them in order to give a thought-through answer..."*, participant ZAB), was also reported to influence the process of ethical decision-making.

*3.4.2.5b. Sub-theme: Decision-maker factors.* The sub-theme of *decision-maker factors* was generated to describe aspects related to participants which they felt made the process of ethical decision-making more, or less, challenging. Namely, this related to experience, such as familiarity with the service area described within the dilemma (e.g. *“For those vignettes that were more relevant to the areas I work in, I was able to consider these in more detail. For the areas I don’t work in, I was less familiar with the relative risks/importance of factors that would need to be considered.”*, participant VWX). Additionally, participants spoke to the importance of having experience or learning about ethics (e.g. *“The research has alerted me to my need to read and reflect more on ethics! I do think these vignettes when joined with some teaching about ethics would be invaluable”*, participant XYZ).

*3.4.2.5c. Overlapping contextual factors.* The final sub-theme identified within influencing factors on the process of *assessing, formulating and responding* to an ethical dilemma was the intersection between decision-maker factors and dilemma factors. This concept was developed to describe factors which it appeared to be difficult to attribute to either one or the other. One example of this was the level of trust in others (which may be considered a decision-maker factor but may be influenced by the context), which could either serve to facilitate (e.g. *“while I often don't want to report minor things to security/police/others - I have to trust they will use the information appropriately”*, participant DEF) or hinder (e.g. *“I dont really consider NHS trusts as ethical bodies - which is why I have my own insurance...”*, participant IJK) collaboration in ethical decision-making. The other overlapping factor highlighted was related to resources, such as time

constraints, workload pressures, or perceived support. This is demonstrated in this quote from participant LMN: *“I know my answers are being influenced by what I consider as being the beliefs held in the NHS as I experience them - namely I don't know many people who would see [a particular ethical decision] as a priority in a stressed working day.”*.

**3.4.2.6. Theme: Drawing on guiding principles.** The superordinate theme of *drawing on guiding principles* was developed to describe factors that seemed to underpin the whole process and guide ethical decision-making for participants. This comprised four sub-themes; *taking a reflective stance, taking a critical stance, considering a wide range of justifications, considering multiple perspectives*.

*3.4.2.6a. Sub-theme: Taking a reflective stance.* This sub-theme was developed to summarise data which spoke to participants' views that ethical competence could be improved by remaining reflective throughout the decision-making process. This is summarised by a quote from participant YZA: *“It's been helpful to take a metaposition in relation to practice... It is interesting to see how other colleagues have responded and the factors that they have used in their thinking too. This allows for reflection on my own assumptions inherent in my thinking.”*

*3.4.2.6b. Sub-theme: Taking a critical stance.* Like the reflective stance, this sub-theme was developed to summarise data which described taking a critical or questioning stance towards knowledge. This included participants questioning themselves (e.g. *“situations where implicit bias may be significantly at play but unacknowledged”*, participant PQR), what is 'known', such as



others' opinions or established norms (e.g. *"I would take issue with the idea that we are trained to treat diagnoses - an idea implicit in the dilemma here - which in the psychiatric domain don't stand up to any scientific or ethical scrutiny."*, participant IJK), and what they felt was still unknown (e.g. *"We also don't have all the facts and don't know all the information..."*, participant DEF).

*3.4.2.6c. Sub-theme: Considering a wide range of justifications.* This sub-theme was developed in response to many participants highlighting the ethical competence of drawing on multiple different justifications, as opposed to more singular thinking. This is outlined by these quotes from participants CDE and DEF, respectively: *"...pause to consider ethical considerations and be more mindful that there may be multiple considerations with different weightings."*, *"The Psychologist is considering a range of relevant factors."*

*3.4.2.6d. Sub-theme: Considering multiple perspectives.* This sub-theme was developed in response to many participants highlighting the ethical competence of considering multiple perspectives when making ethical decisions. In general, participants spoke of this enhancing competence, as exemplified in this quote from participant BCD: *"it is important to consider the views and opinions of others, to consult and listen to different perspectives when considering ethical issues."* Participants expressed interested in others' views and seemed to feel this could mitigate their own lack of familiarity, or biases and allow them to consider things they might otherwise have not. This is summarised in a quote from participant VWX: *"this would likely mean that a range of factors important to multiple clinical psychologists would have been considered. As*

*opposed to those that one individual feels are important, which could be biased by their own views and experiences."*

A small number of participants raised the collaborative process as a reason they had not scored the list of justifications more highly in iteration three. This is outlined by a quote from participant KLM, highlighting a limitation of the anonymous method: "*...I think it would be a frankly terrible way to make any decision, and not ethical at all. I know nothing about who else is responding, their reasons for doing so, etc.*". Participant WXY also expressed concern about consulting colleagues: "*...often I do not find them to have the most ethically robust decision making processes.*". This also supports the *influencing factor* sub-theme of *overlapping contextual factors*, suggesting there are decision-maker and dilemma factors which impact whether *considering multiple perspectives* is deemed ethically competent.

### **3.4.3. An empirically derived model of ethical decision-making in clinical psychology.**

Drawing together the five themes discussed above and in conjunction with existing literature, a model has been developed to explain how clinical psychologists make ethical decisions in response to professional ethical dilemmas. The model is shown in Figure 6 and a previous draft of the model (illustrating its development over time) is shown in Appendix CC. At the centre of the model are the three themes related to *assessing and formulating the ethical problem* and then *responding to a reasoned judgment*. As outlined above, formulating within the present research encompasses the schema model (Rest, 1983), aspects of the biomedical ethical decision-making model Beauchamp and Childress (1979, 2009) and prioritisation of the individual, which draws on

the ethics of care (Gilligan, 1982). This appears to be consistent with quantitative data from participant self-reports that suggests they prioritise needs of the individual over needs of the social group (MFQ-30, Graham, Haidt & Nosek, 2008). *Responding to a reasoned judgment* appears to overlap with the motivation and character aspects of Rest's (1983) four component model. However, these models on their own were insufficient to explain how ethical decisions were made in the present research. Therefore, additional theory about clinical decision-making from the BPS Core Competencies was brought in (BPS, 2017), but again this did not fully fit the data. Connections between this model and existing literature are discussed in Section 4.

Originally the model was more complex, with arrows to show sequential flow of decision-making as a process (Appendix CC). On reflection and discussion within the research team, it was not clear that the data fits a linear process, therefore the majority of arrows were removed. Consultation with an applied psychologist suggested removal of the sub-themes in the final presentation for visual clarity.

In Figure 6., *Assessing* (shown in green) and *formulating* (shown in purple) appeared to occur more closely, as represented by their proximity in the model. This appeared to be followed by *responding to a reasoned judgment* (shown in yellow) which comes from *formulating* (grey single headed arrow). *Adjusting thinking* was added to represent participants who described altering their reasoned judgment in response to comparing with colleagues (grey double-headed arrow). Tentatively, it is hypothesised that this could represent participants thinking through the impact of a specific reasoned judgment before reformulating or deciding further information is needed.

This process occurs within the context of *influencing factors on the process* (shown in blue) which includes the decision-maker context, dilemma context and overlapping contextual factors. The process is underpinned by *guiding principles* (shown in pink) which are drawn on throughout, and these drive the way in which *assessing, formulating, and responding* are carried out, and the way in which *influencing factors* are responded to. These themes were generated to describe the process of ethical decision-making in this group of clinical psychologists in the present research, following qualitative analysis. Figure 6. represents how these themes are perceived to interact.

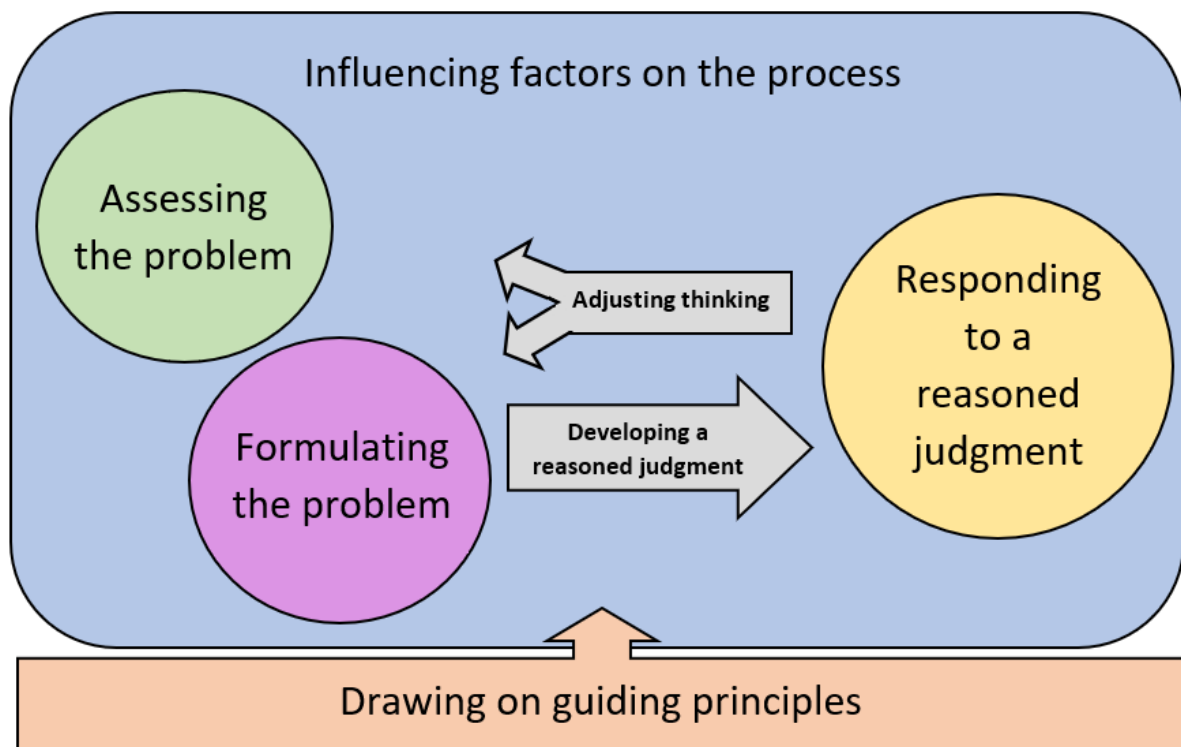


Figure 6. An empirically derived model of ethical decision-making in clinical psychology.

### 3.5. Additional quantitative findings of interest

**3.5.1. MFQ-30 (Graham, Haidt & Nosek, 2008).** In the MFQ-30 (Graham, Haidt & Nosek, 2008) from iteration one (outlined in the Section 2), participants self-reported that they value the *individualising* foundations of *Harm / Care* and *Fairness / Reciprocity* (focusing on individual needs; Zhang, Hook & Johnson, 2016) the most when making ethical decisions, with *Fairness / Reciprocity* trending towards being rated more highly (Table 22). A review of the highest scoring justifications from iteration two (Tables 11-15, 18), and qualitative data from iteration three indicates that justifications based around the *individualising* foundations are also prioritised in practice, and justifications related to the *binding* foundations (focusing on group needs and cohesion Zhang, Hook & Johnson, 2016) are drawn upon less. Participants' self-appraisal of the factors they consider when making ethical-decisions is consistent with the justifications they drew upon in the present research, suggesting this information is cognitively available to them. The lesser value placed on justifications represented by the *binding* foundations was noted as problematic by a minority of participants, as shown in these quotes from participants HIJ and PQR, respectively: "...I feel that focusing less on being able to perhaps help a greater number of clients diminishes the competence of the decision.", "...losing some points because it does not much factor in the need for equity with others... it is an individual human rights approach but not factoring in collective factors..".

Table 22

*Participant scores on MFQ-30 (Graham, Haidt & Nosek, 2008) completed in iteration one*

	<u>Moral Foundations</u>				
	<u>Harm / Care</u>	<u>Fairness / Reciprocity</u>	<u>In Group / Loyalty</u>	<u>Authority / Respect</u>	<u>Purity / Sanctity</u>
M USA Norm	20.2	20.5	16	16.5	12.6
M	20.7	21.33	7.93	9.3	4.57
SD	4.30	4.25	2.59	4.24	3.15
Range	16	20	16	21	11

*Note. M (Mean) scores can range from 0-30 on each foundation. n = 28.*

*M USA Norm: Mean politically moderate score from USA participants (Graham, Haidt & Nosek, 2008).*

This suggests that this participant group felt it is ethically competent to draw on specific considerations around *individual's contexts* and *consequences*. This can be considered to fit with the ethics of care (Gilligan, 1982). The *societal context* and *consequences* were also considered important (although less so than the individual), when formulating an ethical problem. This can be considered to fit within the post-conventional reasoning schema (Rest, 1986).

**3.5.2. Feedback on the research.** At the end of iteration three, participants were asked for qualitative and quantitative feedback on the research. Participants were asked to rate on a 101-point scale (0 = not at all, 100 = fully) the extent to which taking part in the research had impacted their *thinking* and *practise* in relation to ethical competence, and how useful they felt the

vignettes would be in the context of teaching ethical competence within the profession. This data was assessed using Shapiro-Wilk tests (used as  $n < 50$ ; Shapiro & Francia, 1972) which showed no significant differences from normally distributed data (*thinking*, S-W value = 0.93,  $df = 22$ ,  $p = 0.13$ ; *practise*, S-W value = 0.93,  $df = 22$ ,  $p = 0.11$ ; *teaching*, S-W value = 0.91,  $df = 22$ ,  $p = 0.52$ ). It was therefore suitable to review the means and standard deviations as measures of central tendency and dispersion for these questions. The median and range are also shown for transparency (Table 23). Two participants did not complete these questions and data from one participant was removed for these questions as they were significant outliers (more than two standard deviations away from the means), and this appeared to contradict their qualitative responses given elsewhere in the survey. Overall, participants rated these questions highly.

Table 23

*Participant ratings of the impact of the vignettes on their thinking and practice in relation to ethical competence and their usefulness for ethical instruction*

	<u>Impact on thinking about ethical competence</u>	<u>Impact, or likelihood of impact, on practise in relation to ethical competence</u>	<u>Helpfulness of vignettes for teaching ethical competence</u>
M	69.35	62.10	84.25
SD	17.12	19.51	14.01
Median	73.40	68.55	84.40
Range	65.80	70.00	50.00
n	22	22	22

*Note. M (Mean) scores range from 0 (not at all) to 100 (fully).*

Table 23 shows participants' ratings of the usefulness of the vignettes in the context of teaching ethical competence in the profession was rated the highest (84%), the impact on participant's thinking about ethical competence next (69%) and then the impact or likelihood of impact on their practice in relation to ethical competence (62%). These scores suggest that the participant group felt this research would be most helpful to inform ethical instruction in the profession but also, simply taking part in a research study had an effect on their thinking and practise. This is further evidence for the implications of this research and was summarised by participant IJK (iteration 3): "I think they would be a great teaching resource as ethics is so often talked about in a ham fisted way".



### 3.6. Additional qualitative findings of interest

All qualitative data in iteration three was analysed together using thematic analysis (Braun & Clarke, 2006) including, but not limited to questions around general feedback on the research. This identified themes around the process of ethical decision-making (Section 3.4.), and three key themes around the present research; *recognising strengths, coming across difficulties, and identifying other ethical dilemmas*. The theme *recognising strengths in the present research* encompassed four sub-themes related to how *realistic* and *relevant* the dilemmas were, *seeing the vignettes as posing real dilemmas*, and the *coverage of a wide range of dilemmas*. These speak more clearly to research questions one and two so are reported in those sections. The themes of *coming across difficulties in the present research* and *identifying other ethical dilemmas* are presented here.

**3.6.1. Theme: Coming across difficulties in the present research.** The theme *coming across difficulties* was generated through feedback from participants about the present research. This theme consisted of sub-themes around *feeling confused, finding the dilemmas challenging* and *responding to time constraints*.

**3.6.1.1. Sub-theme: Feeling confused.** A number of participants commented on the research being confusing. This is highlighted by quotes from participants OPQ and KLM, respectively: *“Sometimes, some of the options (particularly in this study) were not clear to me”* referring to the third iteration, and *“I think the study became a little confusing at points, and I*

*think it would have benefited from a slightly simpler structure and from significantly clearer instructions.”.*

*3.6.1.2. Sub-theme: Finding the dilemmas challenging.* The second sub-theme identified within *coming across difficulties in the present research* refers to participants seeing the ethical dilemmas as challenging or having difficulty responding (due to the nature of the topic, rather than due to procedural concerns as above). This is exemplified by quotes from participants GHI and IJK, respectively: *“It also highlighted the difficulties of making decisions like this, and that there is not always a clear answer.”* and *“It is a difficult question to consider.”* Whilst this was felt to fit within this theme, it also supports the research as having explored valid ethical challenges. It could be argued that investigating ethical decision-making using dilemmas which are not considered to be challenging may be of less interest and utility to understanding the process and support ethical instruction.

*3.6.1.2. Sub-theme: Responding to time constraints.* The final sub-theme identified in this theme was *responding to time constraints*. A number of participants described time resources as a limiting factor within their responses. This is summarised by quotes from participants FGH and VWX, respectively: *“It did take quite a long time and some of my answers are rushed.”* and *“I may have given fuller responses .... simply due to time constraints.”*. This is worth reflecting on and considering how this may have impacted the quality of the present research and how this may be mitigated in future (discussed in Section 4). However, it is also interesting to consider this in the wider context of clinical practice. Perhaps what is being alluded to is that ethical decision-making

is a time-consuming process, and a lack of sufficient time may be detrimental to ethical competence. Along with other data, this has been incorporated into the model within research question four under the theme of *influences on the process*. This is summarised by participant ZAB: “*unfortunately I do not have time to give as much thought to the questions or answers as I would like and which has hindered my responses to the questions... Interesting in itself, as ethical questions often need a little more thinking space than often afforded in the NHS in the current climate and thus a good highlight of the difficulties of ethical decision making*”.

For participants who completed iteration three in full and appeared to do so within one sitting (exact data unavailable from Qualtrics for those who completed over multiple sittings), the average length of time taken was 38 minutes (rounded to the nearest minute; SD = 14, Range = 53, n = 19). This was somewhat over the estimated guide time that participants were given of 30 minutes.

**3.6.2. Theme: Identifying other ethical dilemmas.** The concept of *identifying other ethical dilemmas* aimed to describe what participants felt had been missing from the present research, including specific types of dilemmas or different ethical-principles from which to draw upon. This theme consisted three sub-themes; *clients’ best interests’ conflicting with other ethical principles*, *navigating professional’s behaviour*, and *responding to systemic problems*.

**3.6.2.1. Sub-theme: Clients’ best interests conflicting with other ethical principles.** The most substantial sub-theme identified was initially termed client-related dilemmas. Many of these

examples were each identified by only one participant and described only briefly, such as complexities around end of life care, sex and relationships and unacknowledged biases. Issues of confidentiality, consent, and multiple stakeholder responsibilities were brought out more strongly. At first, I was surprised by the number of participants identifying confidentiality as an ethical dilemma not explored in the present research, as I felt this was covered in the vignettes based around integrity (reporting Alissa's dad to the relevant authorities) and respect (undertaking an internet search of Norman), at least to a degree. This was noted by participant JKL: *"I think there is an issue of seeking information without the client's consent. I don't think the fact that it's an internet-based search is important/relevant."* Confidentiality is also an area which has received more attention in the literature as outlined in the literature review (Haas, Malouf & Mayerson, 1988; Hinkeldey & Spokane, 1985; McGuire, Nieri, Abbott, Sheridan & Fisher, 1995; Rae & Worchel, 1991; Buckloh, & Roberts, 2001; Tarvydas, Leahy, Saunders & Fong, 2001; Tymchuk et al., 1982). However, this may be precisely because it is an area deemed to challenge those delivering talking therapies.

On review of the data, it appears that participants may find it difficult when what they see as in a client's best interests conflicting with another principle they deem important such as maintaining confidentiality (such as this quote from participant OPQ: *"breaking confidentiality vs. disclosure"*). This fits with the definition of a *dilemma* insofar as it is an ethical challenge where multiple principles collide (Knapp, Gottlieb & Handelsman, 2015). Similarly, it appeared difficult for participants to reconcile responsibilities to multiple stakeholders when clients' best interests are at stake. This thinking enabled the development of the sub-theme name and is summarised in

these quotes from participants CDE and BCD, respectively: *“Confidentiality and information sharing. Especially sharing formulations, e.g. with schools and parents so that they can have understanding and be supportive, but without transgressing confidentiality in a damaging way.”*, *“Working with families, the tension between what parents may want for the child and the pressure on the service to deliver this, with professional opinion about what is in the child's best interests.”*

3.6.2.2. *Sub-theme: Navigating professional's behaviour.* The second sub-theme identified was professional-related dilemmas. In the main, this related to navigating other's practice within and outside of work, and managing differences in opinion. This is exemplified by quotes from participants EFG, WXY and LMN, respectively: *“witnessing poor professional care from others in a team”*, *“Posting political opinions on social media”* and *“how we position ourselves in teams when we disagree with a dominant view, culture or intervention.”*

Linking back to the self-reflexive position identified in research question three, I felt optimistic that some participants, albeit a small minority, identified managing the impact of work (for oneself or staff) as an ethical dilemma to be further explored. This data was therefore coded within the sub-theme of navigating professional's behaviour, and is represented by a quote from participant PQR: *“taking on more responsibility or workload than is commensurate with own well being as a practitioner”*. It is important to keep in mind that other codes were represented more strongly within the data however, and this will be further explored in Section 4.

3.6.2.3. *Sub-theme: Responding to systemic problems.* The third sub-theme was termed *responding to systemic problems*. Data forming codes for this related to difficulties within services, such as managing limited resources or being aware of harm done by services. This is outlined by quotes from participants JKL and IJK, respectively: “*more examples of service 'rationing' would be helpful in the current context*” and “*iatrogenesis is still an under recognised issue and vital to ethics*”. Further, data forming codes within this sub-theme spoke to psychologists finding it challenging to respond to wider systemic problems such as the representation and engagement of the profession in society and ideas around social justice. This sub-theme encompassed ideas of balancing the needs of the individual with the common good, as highlighted by this quote from participant HIJ: “*arguments around best interest and most good for the most people. Psychology tend to, as a profession, focus on the individual and the therapeutic relationship, which can be at odds with some...moral philosophy ideas.*”

This suggests that future research or ethical instruction around *clients' best interests conflicting with other ethical principles, navigating professional behaviour (of self and others) and responding to systemic problems* would be welcomed, as will be outlined in Chapter 4. It is worthy of note that within the *strengths* theme, a sub-theme of *coverage of a wide range of dilemmas* was identified, and within the *difficulties* theme a sub-theme of *being constrained by time* was recognised.

#### 4. Discussion

This chapter will provide an overview of the analyses in relation to the research questions and additional findings, making links to the relevant literature. Implications of this will be outlined. Strengths (including the quality of the study) and limitations (including ideas for further research) will be described. Finally, closing concluding remarks will be made.

##### **4.1. Research question one. What ethical dilemmas (as represented by vignettes) are agreed upon by practising clinical psychologists as realistic and relevant to the profession in the UK?**

The ethical dilemmas presented the vignettes developed for this research (Boxes 1-5) were described as realistic (between 72-79% across different vignettes) and relevant (75-85%) to the practice of UK clinical psychology. Between participants, there was a range in scores within these ratings however, this appeared to converge in iteration three. This in line with what can typically be expected in Delphi research (Powell, 2003). There were no significant differences in the mean *realistic* and *relevant* ratings between iteration one and three, suggesting that these scores were not likely to change any further through additional iterations, and agreement had been reached as far as it was going to be.

Qualitative data for how relevant the vignettes were perceived to be suggested that this was considered a strength of the present research by this participant group. Qualitative analysis suggested the group was divided in terms of participants who thought the vignettes were highly realistic and those who thought they were less so. This is reflected in the range of quantitative scores. The data suggested that participants' ratings of how realistic the dilemmas were may be

related to their level of familiarity with a particular dilemma, on an optimal curve. Some participants reported scoring a vignette as *realistic* if they had come across it themselves in practice. Indeed, the vignettes were derived from clinical practice. Conversely, other participants reported giving lower *realistic* scores, if the scenario was very familiar to them. This could be interpreted by drawing on the concept of ethical sensitivity (recognising an ethical problem exists; Rest, 1983), suggesting that some participants no longer see an ethical dilemma, if this is very routine for them. This links to research by Kahneman (2011) on decision-making systems. System two is characterised by slow, conscious thinking, whereas system one is quicker, more automatic but more error-prone. Kahneman (2011) suggests that individuals may draw on system two for novel decisions, whereas increasing levels of relevant expertise may lead them instead to draw upon system one. For individuals with lots of experience, the judgment may feel so intuitive, that they may not have paused to identify a dilemma. Research suggests that ethical sensitivity (recognition of an ethical challenge) may mediate the relationship between the ethical judgment (deciding on a specific course of action) and the motivation to carry out the decided action (Morton, Worthley, Testerman & Mahoney, 2006). Klein, Calderwood and Clinton-Cirocco (2010) found that in high pressure situations, experienced US fire personnel responded to fire situations automatically, "*without deliberation by applying an "if x, then y" strategy*" (p.201). By being primed with situational cues, the task becomes one of identifying the type of situation, rather than making an ethical decision. This may have important implications for ethical decision-making in practice, perhaps suggesting a role for ongoing reflection and CPD in ethical competence amongst experienced clinical psychologists and those new entering the profession alike.



Similarly, after exploring the generalisability of the model of the process of ethical decision-making (Section 4.4) to the broader population of qualified clinical psychologists, further research would then consider how this compares with processes employed by those entering the profession (including those in training and working at the Assistant Psychologist level). The acculturation model (Handelsman, Gottlieb & Knapp, 2005) would lead to the hypothesis that there would be gradual convergence with professional ethical values throughout the training process, for which there is empirical support (Jenkin, 2018; Jenkin, Ellis-Caird & Winter, in prep.).

**4.2. Research question two. What ethical decisions are made by practising clinical psychologists in response to (the above identified) ethical dilemmas?**

Participants were asked to make an ethical decision (respond *yes* or *no*) when asked if they, as a clinical psychologist, would undertake a specific action outlined in the vignettes. This was to elicit decision-making processes (for research questions three and four), and the ethical decisions themselves were seen as less important than the process. This is in line with Kohlberg's (1973) theory of moral development. However, this threw up a number of interesting observations, namely that once made, participants did not appear to change their ethical decisions substantially, although this could not be analysed quantitatively. Hypotheses around this are necessarily speculative but may relate to reducing cognitive dissonance (Festinger, 1962) by altering the weight given to particular justifications, rather than altering the decision. This could be further explored if participants were given the opportunity to adjust their ethical decisions in light of group feedback, and further investigation of whether ethically competent action follows from the decision. However, the focus of the present research was to analyse the decision-making process.

Comparing across vignettes, there appears to be limited agreement about more and less competent ethical decisions for three of the five vignettes (Maria, Marco, and Commissioning). These vignettes therefore appear to be the strongest examples of ethical dilemmas. As suggested by Knapp, Gottlieb and Handelsman (2015), an ethically challenging scenario can be deemed a *dilemma* when there is no obvious solution. The proportion of *yes* and *no* responses appears to be similar. In two of the vignettes, participants appeared to favour one ethical decision over the other.

Within the vignette based on Alissa's dad, participants mainly stated that they *would not* report a client's family member for potentially fraudulently claiming benefits. In the vignette based on Norman, the majority of participants said they *would* undertake an internet search of a client. These results were considered in the light of ethical sensitivity (Rest, 1983) however, this was felt to be an unlikely explanation given the high scores for the vignettes as representing *realistic* and *relevant* dilemmas to the profession of UK clinical psychology. This then poses the question of whether these decisions are considered competent within the profession more widely, and whether sufficient training and reflective space has been given to ethical decision-making in the current socio-political and financial climates, and the digital age. This is outlined by a quote from participant JHK: *"It poses an interesting question about where we gather assessment information from in the modern age. I had not previously stopped to think about whether using the internet to find out about our service users was an issue. Interestingly, I don't think I would ever see it as ethical to look at someone's facebook profile as part of an information gathering approach and yet*

*I don't see it as problematic to search other internet-based resources that are in the public domain.”.*

Some research has been undertaken on the ethics of decision-making in the digital age, and recommendations produced for the USA clinical psychology context, consisting of maintaining professional behaviour (such as gaining informed consent and drawing on policies and codes of conduct) with situational flexibility (such as only doing so if essential and treating others how you would wish to be treated; Kaslow, Patterson, & Gottlieb, 2011). Fisher and Appelbaum (2017) suggest that there are situations where it is appropriate and useful to use clients' electronic footprints within psychiatry in the USA. In UK psychiatry however, Ashby et al., (2015) suggest that unanswered questions remain about the acceptability of searching for clients on the internet, urging healthcare regulatory bodies to provide further guidance on the topic. Although it could be argued that the principles remain the same regardless of the medium in which the ethical decision is made, the ever-changing nature of technology may mean that new types of dilemmas occur and guidelines in this area are in continual need of being updated (Kaslow, Patterson, & Gottlieb, 2011), for example with the case of driverless cars (McBride, 2016). This lends support towards developing a model of a *process* of decision-making which is agreed upon as ethically competent. This links to literature outlined in the systematic review about school counsellors, in cases where there are no clear ethical violations, the authors highlight their position: *“The ethical decision is making a decision through a clear and explicit process; it is not outcome based”* (Luke, Gilbride & Goodrich, 2017, p.5). Although it is put forward that ethical competence is socially constructed, and may change over time, the present research takes the position that there are some non-

negotiable principles, such as those set out in the Universal Declaration of Human Rights (United Nations, 1948).

Despite the higher level of agreement in the Norman and Alissa's dad vignettes, there are still participants advocating for the alternative ethical decisions. This may be further explored through a bigger sample. This discrepancy, in conjunction with qualitative data suggests that the vignettes developed for the present research pose ethical *dilemmas*, and their use in further research or training is warranted. This is summarised by a quote from participant OPQ (iteration 3): *"I think there is a severe lack of evidence based scenarios and consensus data to use when teaching; these are really excellent - I'd definitely use them!"*

#### **4.3. Research question three. What do practising clinical psychologists agree are appropriate justifications for their ethical decisions made in response to ethical dilemmas in clinical psychology?**

Overall there was broad agreement about appropriate justifications for ethical decisions made in this participant group. Across the vignettes, justifications around *clients' best interests* and *avoidance of harm* were rated amongst the highest and ranked highly. Often, these justifications were used to guide both *yes* and *no* ethical decisions within the same vignette. This suggests that the way in which the justification is interpreted or applied is important as the same justification may not lead to the same ethical decision. This supports the idea of ethical competence as a process (as described in Section 4.4.), involving drawing on these specific considerations

considered to be important within the profession, rather than only following particular principles unquestioningly.

It could be argued that the justifications of *avoidance of harm* and *clients' best interests* are broad, all-encompassing principles that are fundamental to healthcare professions, and reflective of the biomedical ethical principles of *non-maleficence* and *beneficence* (Beauchamp and Childress (1979, 2009), respectively. As a result, it could be suggested that it would be hard for participants not to prioritise these justifications, especially in relation to more specific justifications such as “...the number of sessions we have agreed being insufficient” or “...the impact of the extra work itself on Alissa and her dad”, which may be subsumed within the avoidance of harm or client’s best interests justifications. In response to this, it is put forward that justifications representing other key psychological principles such as “...the extent to which I see this as useful to inform the formulation”, “...the extent to which I see this as a breach of confidentiality” and “...the extent to which I feel I need Norman's consent” are not rated amongst the five highest justifications within their vignettes. Further, the ratings scores are not zero-sum; participants could have chosen to rate all justifications as a 7 (I definitely would take this into account) when making the ethical decision, but ceiling effects were not seen. However, the rankings scores were zero-sum, and although *client's best interests* and *avoidance of harm* ranked highly, they did not consistently rank the highest (see Table 16).

**4.3.1. Differences in justification ratings.** As outlined above, there was broad agreement about which justifications would be most likely to be drawn upon, across the vignettes. However,

the same or similarly-worded justifications received different scores in different vignettes. This suggests that something particular to the dilemma may impact the likelihood of any one justification being drawn upon, as the decision-maker is the same in each case. In a review of empirically explored factors affecting ethical decision-making in business ethics, Craft (2013) highlighted situational components (such as perceived fairness, organisational culture, and consequential severity) as having an important influence on ethical decisions and behaviour. This suggests there may be limited agreement about absolute standards of ethical competence in the profession, linking in to the stance of moral pluralism (Ethics unwrapped, 2019). This lends further support to the benefit of seeing ethical competence as a process and developing a model to guide practitioners around that, notwithstanding the aforementioned ethical imperatives (United Nations, 1948).

**4.3.2. Justifications for ethically competent decisions.** Overall, participants indicated that drawing upon justifications rated more highly by the group would lead to ethically competent decisions (76– 82%) and ethically competent behaviour(s) (73-75%). This suggests broad agreement about appropriate justifications in response to these professional ethical dilemmas. However, these figures do not suggest full agreement and some participants commented on the absence of additional or specific justifications. The present research used the 5-6 highest rated justifications (and the 4-6 lowest) to reduce the cognitive load for participants (Miller, 1956). Further research may explore higher rated justifications only, which would enable a slightly longer list to be used. This could also be addressed by consulting with a larger group of clinical psychologists as to missing justifications, or consulting those with more formal expertise in ethical

decision-making in clinical psychology (such as those teaching on UK DClinPsy ethics modules, or those who have published on professional ethical issues).

**4.3.3. Justifications within the Commissioning vignette.** Overall, the commissioning vignette was rated as *realistic* and *relevant* by the participant group. However, in contrast to other vignettes, participants rated all but one of the justifications as above four (4 = I might or might not take this justification into account). This suggests that almost all justifications may be considered. This vignette is different to the others in several ways; it is the only vignette which is service-focused and not related to a specific client. This vignette also draws on multiple ethical principles from the BPS Code of Ethics and Conduct (2018), rather than only one, as per the other vignettes. Given this, it is likely that this vignette was more familiar to more experienced clinical psychologists. Less experienced participants may have had less transferable knowledge from which to draw, so may have been less sure about which justifications would guide their decision-making. This is supported by qualitative data, as outlined by this quote from participant ZAB (iteration one): *“I would want all the facts/figures before I knew for sure and perhaps some more experience of running services first!”*. This is echoed in iteration three, where participant KLM commented that they felt this vignette may be less relevant to those in training: *“I’m not sure that the Commissioning vignette is very workable from a teaching perspective”*.

It may therefore be that this vignette is less relevant for ethical instruction for those entering the profession. The Clinical Psychology Leadership Development Framework (DCP, 2010, p.3) suggests that advising commissioners on safe clinical practice would only be expected at the Consultant

Clinical Psychologist level. However, it also highlights the need for those in training to develop awareness of political and organisational issues through liaison with commissioners (p.4). Given the current economic and political context in the UK, it may be that more becomes expected of Clinical Psychologists with less experience, and service level decision-making becomes increasingly common. This suggests the potential value of including such a vignette, particularly for CPD. It could be developed further for example, in consultation with those experienced in working with commissioners, to generate some justifications which may be rated as less likely to be drawn upon.

**4.3.4. Justifications within the Alissa's dad vignette.** Only justifications from one vignette (Alissa's dad) exhibited statistically significant changes in ratings between iteration two and three. A significant increase in score was seen for "*...avoiding doing harm to Alissa*" (Alissa's dad<sub>2</sub>  $\bar{x}$  iteration two = 6.33,  $\bar{x}$  iteration three = 6.65) and "*...Alissa's best interests*" (Alissa's dad<sub>3</sub>  $\bar{x}$  iteration two = 6.30,  $\bar{x}$  iteration three = 6.74). Interpretation of these findings is not conclusive; it may be due to an interaction with other vignettes as these items tended to be rated more highly in other vignettes iteration two (e.g.  $\bar{x}$  Norman<sub>2</sub> "*...avoiding harm for Norman*" = 6.43;  $\bar{x}$  Maria<sub>1</sub> "*...Maria's best interests*" = 6.43). This may have reinforced the need in the group for these justifications to be prioritised, although this was not consistent (e.g.  $\bar{x}$  Maria<sub>3</sub> "*...the child's best interests*" = 6.07, was rated lower than Alissa's dad<sub>3</sub> in iterations two and three). Additionally, the vignettes were presented in a random order per participant with the aim of reducing order effects, meaning some participants will have seen this vignette first.



This was one of the two vignettes where there was a majority view on a particular ethical decision (on the whole, participants said they would *not* report Alissa's dad for potentially fraudulently claiming benefits, despite knowing this was against Trust policy). It may be that to reduce cognitive dissonance (Festinger, 1962) related to ignoring Trust policy, participants felt the need to justify their decision more highly, or that they were drawing on post conventional-reasoning (Rest, 1986). Individuals drawing on this method of reasoning may feel that laws or rules are a product of a particular social context and may be insufficient, so may draw on ethical ideals such as justice; this would include going against rules perceived to be unjust (Kohlberg, 1973). It is notable that "*...Alissa's best interests*" was a justification generated by data from only one participant in iteration one. This may have meant that having this option in subsequent iterations gave participants the opportunity to reflect on and re-evaluate its importance.

A fourth iteration (akin to iteration three, with the hierarchy of justifications and descriptive statistics allowing participants to re-score these justifications in the light of the group scores from iteration three) would enable the exploration of whether consensus had been reached on the order of these justifications, and qualitative questions could follow up what participants felt had accounted for this change. However, as only these three justifications amongst all the vignettes demonstrated a statistically significant change, it was decided that a fourth iteration was unwarranted.

**4.3.5. The emotional impact on the self as a justification.** The mean score for one other justification was rated as significantly different between iterations two and three, with Alissa's

dad<sub>36</sub> (“...*the emotional impact on me*”) decreasing significantly. A similar justification was rated as being unlikely to be drawn upon when making an ethical decision in the Marco vignette (Marco<sub>29</sub> “...*the potential emotional impact on me*”), although the mean score for this did not change significantly between iterations. Across these vignettes, these justifications were ranked by 39% of participants as one of the three least likely justifications they would consider when making an ethical decision. However, these justifications were in the list in the first place because they were suggested by some (albeit a minority) of participants. These results might be interpreted as being less ethically sophisticated and fitting into the personal interest’s schema (Rest, 1986), so being perceived by the participant group to be less ethically competent. However, other justifications relating to personal interests such as the impact of the ethical decision on the decision-maker’s professional life scored more highly (Marco<sub>21</sub> “...*the potential impact on me professionally (such as having a heavy caseload, maintaining my registration and avoiding litigation)*”; Alissa’s dad<sub>20</sub> “...*the potential impact on my professional life*”; Appendices Y, AA).

This suggests that this participant group felt that the impact of an ethical decision on one’s professional life is more important than the impact on one’s emotional well-being; or something about the culture of the profession makes it more acceptable to voice one type of personal interest over another. It could be argued that the emotional impact on the self was not rated more highly due to participants not feeling that these dilemmas were emotive for them, and the context of these specific dilemmas was a mediator. This could be explored in further research by asking participants which justifications they would draw upon in ethical dilemmas they found

emotive or emotionally challenging, although the ethical issues around this would of course require further thinking.

Within the Alissa's dad vignette, in response to learning of a low group score for "*...the emotional impact on me*", on average, participants said they would be less likely to consider it themselves, when making an ethical decision. This supports a hypothesis of a (real or perceived) social pressure in the profession not to consider (or at least to report not considering) the emotional impact on the self when making an ethical decision. This can be situated within theories on conformity, shown to be prevalent within medical education (Newton, 2014) including at post-graduate level (Grendar, Beran & Oddone-Paolucci, 2018), and can lead individuals to act against their ethical beliefs (for a review see Beran, Kaba, Caird & McLaughlin, 2014). This research suggests that this can be exacerbated by hierarchical professional structures which may have important implications for ethical instruction in clinical psychology. It is difficult to comment on the relative influence of social pressure in the present research, due to the anonymity of the participant group. This could be explored experimentally in relation to ethical decision-making in clinical psychology, for example involving deception about the mean scores relating to the emotional impact on the self, as the independent variable. However, the ethical issues associated with this would also require significant thinking (Boynton, Portnoy & Johnson, 2013).

The definition given of clinical psychology in the introduction highlights the focus of the professional identity on caring for others (reducing distress and improving well-being; BPS, 2019a); for some this may imply that this is at the expense of the self. It would be important to

explore through wider consultation within the profession about whether prioritising the emotional impact on the self is considered ethically competent, and why. It is argued here that this is an aspect of self-care, which is an “ethical imperative” (Bettney, 2017, p. 371) for the profession. This is due to the protective quality of self-care for the personal and professional, which has been shown to be linked to lower rates of burnout in doctors (Zwack & Schweitzner, 2013). Indeed, the HCPC standards of proficiency for practitioner psychologists (2015, p. 8) outline the professional responsibility to “be able to maintain fitness to practice”, including importance of managing the emotional impact of the work and one’s own health.

However, the New Savoy Partnership / BPS Wellbeing Survey (2019) found that 23% of the psychological workforce surveyed think of leaving the NHS at least once per week (for various reasons, including burnout) and 40% had felt depressed at least some of the time in the past week. Although undoubtedly the reasons for this are multifaceted, it may be that not prioritising the emotional impact on the self when making ethical decisions is contributing to this. This is supported by research by Chiffey (2018); Chiffey, Jones and Ellis-Caird (in prep.); who found that unsustainable emotional burden from ethical issues led to clinical psychologists reducing their hours, leaving the NHS or changing jobs. From a utilitarian perspective (Bentham, 1823), an ethical decision could be considered as less competent if it means the clinical psychologist subsequently cannot help other clients. Consultation and action towards overcoming “personal, professional and systemic barriers to self-care” (Bettney, 2017, p. 369) could have significant implications for individual clinicians, those using services and the profession of clinical psychology.

#### **4.4. Research question four. How do practising clinical psychologists make ethical decisions in response to ethical dilemmas?**

**4.4.1. How these results fit with existing literature.** In iteration one, qualitative analysis identified that participants drew on *professional ethical considerations* and *more than professional ethical considerations* when making ethical decisions. At that stage, *professional ethical considerations* could be as seen fitting into codes of conduct, intermediate concepts (Bebeau & Thoma, 1999) and Rest's (1986) schema model (Table 20). *More than professional ethical considerations* could not be fully explained by existing models of ethical decision-making; drawing on pragmatism, personal and contextual considerations (Table 21). Some of these justifications could be seen as fitting into Rest's (1986) personal interests schema, whereas others could be considered non-rational processes (Rogerson, Gottlieb, Handelsman, Knapp & Younggren, 2011). Results from iteration one suggested that existing models can be used to explain some aspects of how ethical decisions are made in clinical psychology, but not fully.

Iteration two involved quantitative analysis to inform iteration three, which included qualitative and quantitative questions. Due to existing models being insufficient to explain all the data, a new model was developed to explain ethical decision-making in *this* group, following qualitative analysis in iteration three. It is important to be clear that at this stage, it is not intended to be a prescriptive or normative model but instead, a descriptive synthesis of how participants in the present research approached these ethical dilemmas. As this was a collective account, based on consensus, further research and consultation with the professional group could assess whether this is considered to be an ethically competent way of approaching ethical decision-making in

clinical psychology. If so, a normative model could be developed, which may be used to guide users in ethical decision-making and may specify which ethical principles should be considered. This model was developed as a process, informed by existing literature on ethical decision-making (as outlined in Section 1) and Core Competencies of the profession (BPS, 2017). This is shown in Figure 6 and comprises five themes; *assessing the ethical problem* (sub-themes: *thoughtfully* and *systematically*); *formulating the ethical problem* (sub-themes: *drawing on specific considerations*, *weighing up*, *developing a justifiable reasoned judgment* and *developing a utilisable reasoned judgment*); *responding to a reasoned judgment* (sub-themes: *comparing with colleagues* and *deciding vs. behaving*); *influencing factors on the process* (sub-themes: *dilemma factors*, *decision-maker factors*, and *overlapping contextual factors*); and *drawing on guiding principles* (sub-themes: *taking a reflective stance*, *taking a critical stance*, *considering a wide range of justifications*, *considering multiple perspectives*).

This model bears similarity to others in that ethical decision-making is considered a process, and aspects of the process overlap. For example, those of Beauchamp and Walters (1994) within healthcare professions (seeking objective information, establishing clarity, employing an ethical code, and weighing up), and Knapp and VandeCreek (2012) for clinical psychology (identifying the dilemma, generating solutions e.g. by consulting with colleagues, weighing up solutions, trying out an option and evaluating it). However, the present model differs from these insofar as these are prescriptive and have not been empirically evaluated. Whilst others have empirically tested existing theoretical models of ethical decision-making in clinical psychology (Ferencz-Kaddari, Shifman & Koslowsky, 2016) and counselling (Levitt, Farry & Mazzarella, 2015),

this is the first of its kind to be empirically derived, and for the UK context. It is suggested that the present participant group is largely representative of the profession, and these findings may be generalisable. Further research is needed to confirm that utilising this process is considered to be an indication of ethical competence within clinical psychology. This could be approached by using other groups of clinical psychologist participants and then consulting with the profession about whether changes are felt to be necessary to the model for example, greater prioritisation of self-care (as described in Section 4.3.5.) or the addition of an evaluative process (described in Section 4.4.1.5.).

The present model differs from some of literature on ethical decision-making in a number of ways. For example, existing models in clinical psychology appear to suggest a linear process (Knapp & VandeCreek, 2012; Ferencz-Kaddari, Shifman & Koslowsky, 2016). The present research considers also the social impact of decision-making within a peer group. Some decision-makers adjusted their thinking and reverted to *formulating* in response to comparing their *reasoned judgment* with others' in the profession. Whilst some of this may be related to the present methodology, decisions are not made in a social or professional vacuum. This could be argued to mimic social feedback in group decision-making processes, such as within clinical teams. Events such as those contained in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry ('The Francis Report'; Francis, 2013) highlight all too clearly the influence of professional and peer culture on ethical decisions. This speaks again to the importance of considering *the cases, the barrels and the apples* (Kish-Gephart, Harrison & Treviño, 2010) when exploring ethical decision-making. It is also hypothesised that participants may imagine the implications of particular courses of action in their

process of weighing up or deciding that further assessment is needed. In these ways, the process of ethical decision-making can be seen as dynamic and interactive.

**4.4.1.1. Drawing on specific considerations.** Within the formulation theme, the sub-theme of *drawing on specific considerations* was developed to describe particular justifications which participants named in iteration three as related to ethical competence. These can be understood in terms of Rest's (1986) schema model and using aspects of the biomedical ethical decision-making model (Beauchamp & Childress, 1979, 2009). Rest's (1986) post-conventional reasoning schema could be said to be present in justifications related to the context and consequences for individuals and society. Within this, prioritising the *avoidance of harm* and *clients' best interests* was consistently felt by the participant group to facilitate ethically competent decision-making. These can be likened to the principles of *non-maleficence* and *beneficence*, respectively (Beauchamp & Childress, 1979, 2009). Justifications related to the context and consequences for society were also seen as important (although to a lesser extent) and could be seen as using post-conventional reasoning schema (Rest's, 1986). This can be likened to the biomedical ethical principle of *justice* (Beauchamp & Childress, 1979, 2009).

Data from the MFQ (Graham, Haidt & Nosek, 2008) is also consistent with this. Participants self-reported that they value care towards individuals (the *individualising* foundations; Zhang, Hook & Johnson, 2016) over the needs of the social group (the *binding* foundations; Zhang, Hook & Johnson, 2016). The highest rated justifications of *avoidance of harm* and *client's best interests* fit



particularly well with the *Harm / Care* foundation. This suggests that participants were able to utilise metacognition to explore ethical decision-making, strengthening the present findings.

That context and consequences for individuals appeared to be valued more highly than those for society, when *formulating*, could be explained by drawing on the ethics of care model (Gilligan, 1982). This posits that responding to needs of individuals should be prioritised over groups. It could be argued that something about these vignettes led participants towards these lines of reasoning. As outlined under the theme of *influencing factors on the process*; dilemma factors were found influence the processes of *assessing, formulating and responding*. Whilst four of the five vignettes were centred around individual clients (one of which was related to a client indirectly; Alissa's dad), the Commissioning vignette concerned a local population. However, *avoidance of harm* was still the highest rated justification in the Commissioning vignette. Further, as there were between 30-37 different justifications generated per vignette in iteration one, including justifications related to societal contexts and consequences, this suggests that the vignettes did not steer the group to prioritising certain ethical principles. A minority of participants suggested that the context and consequences for society should be prioritised more highly when making ethical decisions. These issues could be further examined through the development of additional vignettes which do not focus on individual clients or families.

Rest's (1986) maintaining norms schema could be said to be present in justifications related to following BPS guidance, laws, policies, research evidence and NICE guidelines. Solely drawing on specific considerations around one's own personal, professional or interpersonal considerations

with the aim of personal gain or loss aversion can be considered to fit within the personal interests schema (Rest, 1986). These justifications were considered less ethically competent by the group.

**4.4.1.2. Deciding vs. behaving.** Within the *responding to a reasoned judgment* theme, the sub-theme of *deciding vs. behaving* was developed to describe responses which indicated a belief that an ethically competent decision equated to ethically competent behaviour(s), and those participants who reported they believed there was a difference between the two. Cognitive behavioural theories would suggest there is a distinction between thoughts and actions (Beck, 2011), as would the expanded Theory of Planned Behaviour for ethical decision-making in clinical psychology (discussed in Section 1.4.1.1.; Ferencz-Kaddari, Shifman & Koslowsky, 2016). This may also be considered in the light of moral motivation and moral character (Rest, 1983), where decision-makers experience barriers to acting in accordance with the ethical decision which they have deemed as ethically competent. There could be significant implications for clinical practice of assuming that behaviour leads on from a decision, for example related to the intention not to make an ethical transgression. This indicates a role for ethical instruction (for both qualified and unqualified clinical psychologists) to explore a distinction between an ethically competent decision and behaviour(s), the implications of this and any barriers.

**4.4.1.3. Comparing with colleagues.** Within the *responding to a reasoned judgment* theme, the second sub-theme of *comparing with colleagues* was developed to describe the process of evaluating a reasoned judgment against others'. It is recognised that this may be an

artefact of this methodology as participants were explicitly asked to review their responses in comparison to the group responses. However, many participants spoke of the benefit of collaborative decision-making (with colleagues and clients), and *considering multiple perspectives* was identified as a *guiding principle*. This fits with hermeneutic models which suggest that the process of ethical decision-making is social and interactional (even if others are not present; e.g. Cottone, 2001). The HCPC Standards of Proficiency for Practitioner Psychologists (2015) highlight the importance of “...seeking advice and support from... colleagues...” in clinical decision-making (p.5). Drawing on multiple perspectives is reported to improve clinical decision quality in medical critical care settings (Patel, Kaufman & Arocha, 2002) and in social work relating to child welfare (Crea, 2010), due to synergistic properties of groups. Although, there are also critiques of collaborative decision-making, suggesting that depending on context, it can either improve or reduce the quality of decisions (Kerr & Tindale, 2004). Similarly, a small number of participants expressed reservations about consulting with colleagues, particularly as they could not evaluate others’ experience or levels of expertise. This suggests there may be barriers to *drawing on multiple perspectives* when making ethical decisions. Exploration of this could have important implications for professional practice, not in the least because the credentials of individuals responsible for developing professional ethical guidance is not always available (e.g. HCPC, 2015; BPS, 2018). This could be explored in clinical psychology by asking participants on an individual basis about their experiences of collaborative decision-making.

**4.4.1.4. Influencing factors on the process.** Within the theme of *influencing factors on the process*, *dilemma factors* (such as familiarity and experience), *decision-maker factors* (such as

complexity of the dilemma, specific aspects of the dilemma) and overlapping contextual-factors (such as levels of trust in colleagues and availability of resources) were found to impact the ethical decision-making process. All articles from the systematic review (Section 1.4.) identified certain *decision-maker factors*, *dilemma factors* or both. Broadly, the present themes are consistent with this literature, such as client's best interests (Buckloh & Roberts, 2001), the decision-maker's level of experience (Tarvydas et al., 2001), and the vignette context (Ferencz-Kaddari, Shifman & Koslowsky, 2016; McGuire, Nieri, Abbott, Sheridan & Fisher, 1995). However, the present research did not aim to experimentally explore the influence of specific factors. Rather, themes in the present research were derived from qualitative analysis of free text responses and prompting may have revealed more factors. Together, this suggests that multifaceted contextual factors likely have an impact on ethical decision-making, but that the relative influence of particular factors could be explored in further research.

**4.4.1.5. Evaluating the impact of an implemented reasoned judgment.** The present model drew on the Core Competencies for applied psychology of *assessment*, formulation and *intervention/implementation*, illustrated in the Cycle of Professional Practice (Figure 5, BPS, 2017). An explicit evaluative component of the process was not identified in the present research (for example whether the outcome was in line with what was expected or not and how this might feedback for future similar decisions). This may be due to the use of hypothetical vignettes, and therefore a reasoned judgment was not in fact implemented, for the impact and outcome to be evaluated by participants. Sub-themes from the *guiding principles of taking a reflective stance* and *taking a critical stance* throughout the process may cover this to an extent, as well as the sub-

theme of *consulting with colleagues* from the *responding to a reasoned judgment* theme. The lack of an evaluative aspect was identified as missing from the model by participant LMN: “*I would want to include more about how the impact of the decision is being monitored and reviewed.*”. As this is a Core Competency in clinical work, it is hypothesised that this would be present, however this would need to be explored further. One way of doing this might be through qualitative interviews with clinical psychologists about how they have managed ethical dilemmas in clinical practice (not limited only to the decision-making phase), and then further asking them to comment on how their experiences fit with the present model.

**4.4.1.6. Ethical sensitivity.** If an evaluative process comes after the process of ethical decision-making described presently, this model is contingent on a recognition of an ethical dilemma beforehand. This can be described through one aspect of Rest’s (1983) model, *ethical sensitivity*; identifying an ethical problem and the ethical consequences of any ethical decisions made. A grounded theory of ethical sensitivity in clinical psychology was developed by Chiffey (2018); Chiffey, Jones and Ellis-Caird (in prep) using semi-structured interviews with twelve clinical psychologists. Their model suggests that clinical psychologists identify professional ethical dilemmas through feelings of discomfort which, if attended to, become consciously in conflict with their values. At that point, the decision to further assess the ethical dilemma is mediated by contextual factors related to the working environment. Overall, the data in the present research supports the hypothesis that participants had gone through this process of recognising an ethical problem to get to the assessment stage and beyond, as described by the present model. For example, the sub-theme of *seeing the vignettes as posing real dilemmas* within the theme of

*coming across difficulties in the present research*, and the relatively high scores for the vignettes as depicting *realistic* (Table 8) and *relevant* (Table 9) dilemmas to UK clinical practise.

It recognised that participants could have been cued in to seeing ethical dilemmas to some extent, due to the nature of the research. However, the qualitative data supports the existence of a process of decision-making in the present research and this must be prompted in some way. For two participants, qualitative responses may suggest ethical sensitivity was not triggered in some of the vignettes. For example, participant EFG: *"I'm not sure that I consider this a particularly pressing ethical dilemma."* That not all participants identified an ethical dilemma in every vignette suggests that participants responded from their own appraisal, their ethical sensitivity, rather than through being primed in the present research.

**4.4.2. How these results fit less well with existing literature.** As outlined above, elements of the biomedical ethical decision-making model (Beauchamp & Childress, 1979, 2009) are incorporated into the present model (*justice, beneficence and non-maleficence*). One aspect of this model was not clearly present in the current research; *autonomy*. This principle highlights the importance of recognising clients' own decision-making capacities and their right to choose interventions. To some extent this principle was cited in iteration one, for example, Maria<sub>9</sub>: *"...having discussed with Maria what she felt to be the most appropriate course of action"*; Marco<sub>16</sub>: *"...Marco's preference"* and Norman<sub>23</sub>: *"...what Norman thinks about me doing the search"*. However, these justifications were not rated relatively highly enough to be taken forward into iteration three (Appendices X-Z). This suggests that in this participant group, although ethical

decision-making may have been informed by the principle of autonomy, justifications relating to other principles (as outlined above) were more likely to be prioritised. A reflection on this is summarised by a quote from participant IJK in relation to ethical dilemmas in the profession not covered in the present research: "*Not properly informing clients about therapy etc. - clinical psychology does informed consent very badly*".

Kitchener (1984) extended the biomedical ethical decision-making model for use in counselling psychology by adding a fifth principle; *fidelity*. This principle emphasises the importance of prioritising the therapeutic relationship. Similarly, justifications seeming to draw on this principle were present in iteration one, for example Alissa's dad<sub>4</sub>: "*...the potential impact on the therapeutic relationship*"; Marco<sub>19</sub>: "*...Marco having already built a relationship with me*" and Norman<sub>18</sub>: "*...the possible benefits or detriment to the therapeutic relationship*". Although Alissa's dad<sub>4</sub> was rated highly, the other examples were not rated highly enough in iteration two to be taken into iteration three, nor did qualitative comments suggest that *fidelity* was highly prioritised in the present research.

This suggests a role for further exploration within the profession of the perceived importance of *client autonomy* and *fidelity* to the therapeutic relationship. It would also be important to consult with the profession more widely as to whether these principles are felt to support ethical competence. If so, it may be that there is room for increased focus on these principles within ethical instruction.

#### 4.5. Summary of additional findings

Participants noted that taking part in the research had impacted their thinking and, to a lesser extent, their practice in relation to ethical competence. The vignettes were rated as posing realistic and relevant ethical challenges to participants and perceived to be most useful for ethical instruction. It is hoped that the vignettes will be taken forward by members of the supervisory team for use as a resource connected to the review of the BPS Guidelines on Teaching and Assessment of Ethical Competence in Psychology Education (2015).

Thematic analysis (Braun & Clarke, 2006) was used to develop five themes on the process of ethical decision-making (Section 4.4.), as well as three themes about the process of the present research: *recognising strengths* (Sections 4.1.-4.2.), *coming across difficulties in the present research*, and *identifying other ethical dilemmas*.

**4.5.1. Coming across difficulties in the present research.** This theme relates to the present research, but it is also worth considering these challenges in the light of ethical thinking more generally. This theme consisted of sub-themes around *feeling confused*, *finding the dilemmas challenging* and *responding to time constraints*. The sub-theme of *feeling confused* suggests that procedurally, there was room for improvement within the third iteration, which may be addressed by increased consultation and piloting. However, other results including themes around *strengths* were identified. It is recognised that an exploratory-sequential mixed methods investigation of an abstract concept, such as ethical decision-making, is challenging to design and implement. That



the vignettes themselves were found to be ethically challenging is seen as a strength of the present research, as a means of eliciting ethical decision-making.

The sub-theme of *responding to time constraints* suggests that time resources may have impacted the length of qualitative responses given (and thus the amount of data for analysis) but are not thought to have altered the direction of participants answers. This is summarised in a quote from participant VWX: “[time constraints] ...made me give more concise answers! My overall opinion and ratings would not have been different.”. For future research, participants may feel less of a sense of the surveys being lengthy if this was assessed more rigorously beforehand, for example through further piloting, enabling more accurate estimates of survey length. Equally, it may be important to minimise survey length by using fewer vignettes or providing fewer justifications to be rated. This result also suggests that time constraints are relevant to how ethical decisions are made in practice. Chiffey (2018), Chiffey, Jones and Ellis-Caird (in prep.) found that restricted thinking space due to service pressures reduced the likelihood of clinical psychologists acting on an ethical problem. An implication of their research was for services to facilitate time for thinking about ethical issues.

**4.5.2. Identifying other ethical dilemmas.** This theme aimed to describe what participants felt could be added to the present research and consisted of three sub-themes; *clients’ best interests conflicting with other ethical principles*, *navigating professional’s behaviour*, and *responding to systemic problems*. With regards to the *client’s best interests* sub-theme, participants expressed that conflict with confidentiality posed an ethical challenge, which would

warrant further exploration. Another ethical challenge identified by the participant group was *professionals' behaviour*, including colleagues' practice within and outside of work. This tension between personal and professional behaviours is explored further by Pipes, Holstein and Aguirre (2005). The final sub-theme highlighted suggestions for additional dilemmas related to *responding to systemic problems*, including iatrogenic harm and balancing individuals' needs with needs of a group, such as in the case of limited resources. This suggests that future research or teaching could develop ethical thinking on these topics. Although the vignettes were designed to represent the BPS ethical principles (BPS, 2018), a limitation is that the vignettes are unlikely to comprehensively cover all types of dilemmas that could be encountered in clinical practice. However, participants also highlighted the range of dilemmas as a strength of the present research and the addition of further vignettes would need to be balanced with time constraints.

#### **4.6. Quality considerations**

It was considered important to critically appraise the present research against appropriate, recognised quality criteria. Due to the Delphi methodology employing mixed methods, it was felt that to use assessment tools based solely around quantitative (such as the McMaster Critical Review Form for Quantitative Studies; Law, Stewart, Pollock, Letts, Bosch & Westmorland, 1998) or qualitative methodologies (such as the Eight "Big-tent" Criteria; Tracy, 2010), would not provide an adequate assessment. It is recognised that there are quality assessment tools for mixed-methods research (such as Pluye, Gagnon, Griffiths & Johnson-Lafleur, 2009), however, as the Delphi method is a specific approach it was felt more robust to evaluate the present research against guidelines for this method. Chalmers and Armour (2019) outline that there is a lack of recognised guidelines available, and this is a known limitation of the Delphi method (Iqbal &

Pipon-Young, 2009). It appears that guidelines for electronic Delphi studies are being developed (Guerreiro, MacLure, Santos & Stewart, 2016) but not yet available. Hasson, Keeney and McKenna (2000) developed guidelines for appropriate reporting of Delphi studies, and building on this Jünger, Payne, Brine, Radbruch and Brearley (2017) developed CREDES (Guidance on Conducting and Reporting Delphi Studies) following a systematic review. Whilst this was based on literature around palliative care, the authors suggest CREDES can be used to evaluate research in other disciplines. Therefore, the present research was evaluated for methodological quality using points 1-7 of CREDES standards (Appendix CC) on the rationale, design and conduct of Delphi research, and the remaining points (8-16 on reporting Delphi research) were used to guide a robust write up of the method.

**4.6.1. Quality of the rationale.** The choice of this method in the present research is justified because it aimed to systematically explore views and consensus from those with expertise in ethical decision-making in clinical psychology. Further, the subject matter, ethical competence, is considered to be constructed.

**4.6.2. Quality of the planning and design.** The method was tailored to address the present research questions and deviations from recognised practises were justified and documented. The definition of what would constitute a consensus was agreed within the research team before completion of data collection following a recognised guideline (Hsu & Sandford, 2007).

**4.6.3. Quality of research conduct.** In line with CREDES guidelines, the vignettes and associated questions used from iteration one were piloted and based on consultation outside of the research team. Questions used in iterations two and three were mainly developed using the literature on Delphi methodologies (Hsu & Sandford, 2007; Iqbal & Pison-Young 2009) and within the research team. However, consultation informed the study design and content at various stages (Section 2.2.). Although some participants were known professionally to members of the research team, no conflicts of interest were identified. Once potential participants expressing an interest were able to make contact with the principal researcher, there was no disclosure to the supervisory team on who had answered what. The stance of critical realism in the present research recognises that consensus cannot be said to have identified the 'correct' answer and the importance of stability was recognised. The conduct of the research may have been improved somewhat according to CREDES criteria by further consultation and piloting of questions in later iterations.

**4.6.4. Quality of reporting.** The present research aimed to demonstrate CREDES standards 8-16 (Appendix CC), through quality and detailed presentation in this write up, enabling the reader to evaluate the quality of reporting. To summarise, the purpose of the study was defined with an appropriate rationale for using the Delphi methodology (Section 1.5.). Participant selection, demographic information, criteria for expertise and retention rates were reported (Section 2.3.). The method was described comprehensively including the design, procedures and rationales for decisions made throughout the iterations (Sections 2.1-2.2, 2.6-2.8). Figure 4 shows a flow chart of the iterative process employed in the present research. Consensus was defined

through statistical stability in quantitative scores across iterations, and a lack of consensus would have been addressed through further iterations. Results are reported from each iteration within research questions, enabling the reader to see how consensus developed (Section 3). Limitations are discussed throughout the discussion and more specifically in Section 4.7. Similarly, implications are discussed throughout the discussion and more specifically in Section 4.8. It is argued that the conclusions are warranted and reflective of the present data (Section 4.10). Overall, the present research holds up well when compared to CREDES guidelines. This highlights the methodological quality of the present research, suggesting that the results and implications are valid and robust.

#### **4.7. Limitations of the research**

**4.7.1. Reliability of responses.** As participants were not anonymous to the principal researcher, it could be argued that participants might not have felt truly able to be candid about their decision-making processes, or propensity to draw on justifications which they felt may be perceived as less ethically competent. It may be that participants responded with how they felt they *should* rather than how they *would* in clinical practice, although participants were asked to comment on this distinction in iteration three (Appendix S). Social pressure was minimised in the present research as participants were anonymous to each other (Hsu & Sandford, 2007) and this is likely to be a limitation of much research looking at ethical practice. There was no reason to doubt the veracity of participants' claims. If this was felt to be an outstanding concern, this could be ameliorated through sending an anonymous link to a survey through large mailing lists however, this would necessarily be at the expense of an iterative process.

**4.7.2. Reliability of thematic analysis.** Another limitation is the fact that the thematic analyses were carried out by the principal researcher only. In iteration one, a sample of the codes were discussed and checked with the principal supervisor and in iteration three the themes and a sample of sub-themes were discussed with a secondary supervisor and applied psychologist consultant to the project. A reflective diary was kept during the analyses (Appendix W) for transparency in how codes and themes were derived. This was deemed to be sufficient within the scope and aims of the present research. Insofar as is accepted within a critical realist stance, the quality and generalisability of these results could be improved by using two researchers to code qualitative data independently and then a review of inter-rater reliability carried out (Campbell, Quincy, Osseman & Pederson, 2013). This could be completed using Cohen's Kappa (Cohen, 1960) to look at the percentage of agreement in codes and then reconciliation of differences through inter-rater discussion (Campbell, Quincy, Osseman & Pederson, 2013).

**4.7.3. Participant demographics.** Within the present research, participants were not asked about their cultural background and it is likely that participants' ethical decision-making processes were influenced by this. However, all were working in the UK and to some extent arguably have a shared culture of UK clinical psychology (Handelsman, Gottlieb & Knapp, 2005). It is possible that the individualistic focus of specific justifications drawn upon (outlined in research question three) relate to characteristics of the sample not representing those from more collectively-oriented cultures. This has been discussed within the nursing profession (Ludwick & Silva, 2000). However, the profession of clinical psychology more widely is suggested to be under representative of the populations it serves (Turpin & Coleman, 2010). The Delphi method advocates for inclusion of

diversity and minority view points (Iqbal & Pison-Young, 2009), so it may be pertinent to explore this further, whilst being careful to avoid tokenism. Further evaluation of the model could for example involve consultation with the DCP Minorities in Clinical Psychology Group, amongst others.

**4.7.4. Implicit assumptions of the present research.** It is recognised that there were a number of implicit assumptions within the present research, which may have impacted the results. For example, participants were asked to develop a hierarchy of the justifications they were more and less likely to draw upon when making ethical decisions. This of course assumes that some justifications are more and less likely to be taken into account, whereas it is possible that multiple considerations are taken into account equally, or that it is in fact the broader ethical principles (such as *non-maleficence*, *beneficence* etc.) which influence the process of weighing up justifications, and this may be different depending on the dilemma. It is important to note here that whilst the *ranking* questions (subsequently dropped from data collection and analysis) required participants to score justifications according to zero-sum criteria, participants were asked to *rate* all justifications, so could have given all justifications the same scores if they had wished. However, this was not the case (see Section 4.3.).

Another implicit assumption of the research is that, when asking participants to identify which justifications they draw upon when making ethical decisions, this information is cognitively available to them. It is possible that participants made the decisions intuitively, for example using system one (Kahneman, 2011), and then identified justifications in a post-hoc manner, in response

to being asked. However, results from the MFQ (Graham, Haidt & Nosek, 2008), taken by participants in iteration one, suggests that they self-report drawing on the moral foundations which focus on individuals, when asked in an abstract way (without a vignette or dilemma to influence intuitive responding). This is consistent with the justifications scoring most highly in response to the present vignettes (see also Section 3.5.1.). Within the critical realist framework of the present research, this suggests that overall, participants are able to comment on their cognitive processes when making ethical decisions.

As outlined in Section 2.6.1., clearly it is recognised that the choice of vignettes developed for this research are not representative of all types of dilemmas that occur in clinical psychology practice. Similarly, the choice of vignettes is likely to have influenced which ethical principles were utilised by participants. Some ethical principles may have been omitted from participants' decision-making, which may have otherwise been elicited by different vignettes. Therefore, the vignettes in this research are based on broad ethical principles the broad ethical principles of *responsibility*, *integrity*, *respect* and *competence*, as defined by the BPS Code of Ethics and Conduct (2009, 2018). Arguably, these principles subsume a number of other ethical principles, for example, *honesty* is covered within *integrity* and *client autonomy* is covered within *respect*. However, other ethical principles, originating from diverse philosophies and cultural or religious backgrounds, may be less likely to be elicited by the present choice of vignettes. Examples of this include; the moral foundation of *purity / sanctity* (Graham et al., 2013; outlined in section 1.3.1.5.), *Ubuntu* ethics (an African worldview focusing on the interconnectedness of the self to others, and the community; Ujomudike, 2016), and ethical principles originating from Eastern philosophies such as



*Confucianism* (valuing loyalty and deference to familial authority; Yao & Yao, 2000) or *Taoism* (an emphasis on harmony within the universe; Little, Eichman, Shipper, & Ebrey, 2000). On balance, basing the vignettes on the principles outlined in the BPS Code of Ethics and Conduct (2009, 2018) was felt to be appropriate for the scope of this research and the present UK clinical psychology context. However, it is recognised that clinical psychologists may practice in diverse ways and be influenced by different ethical principles to the ones outlined in the present research.

#### **4.8. Clinical implications**

Four main implications stand out from the present research; implications for those using services, for those developing their ethical competence (including trainees and CPD for qualified clinical psychologists), for those supervising individuals developing their ethical competence, and for teaching or guidance in ethical competence.

**4.8.1. Service users.** The implications for this research for those using services is considered the most important. As outlined in the introduction, a small proportion of clinical psychologists do make ethical transgressions which can have serious consequences for vulnerable individuals. Leaving aside the more extreme examples of misconduct, ethical decision-making is part of the everyday practice of the profession. By understanding how ethical decisions are made by clinical psychologists in practise and then consulting with the profession about how ethically competent this is seen as, it is aimed that this will lead to improved teaching, supervision and guidelines towards ethical competence (Section 4.10.). With these improvements, it is hoped that

this will lead to more ethically competent decision-making within the profession, which can only be beneficial for those using services.

**4.8.2. Individuals developing their ethical competence.** For those developing competence in ethical decision-making in clinical psychology (including those entering the profession and CPD for qualified clinical psychologists), implications of the present research suggest a role for developing skills in the Core Competencies (BPS, 2017) of *assessment, formulation* and *implementation* and reflection on how these skills can be applied to ethical dilemmas. Consultation with the wider profession and review of any key areas missing (such as an evaluative component, or an emphasis on self-care) will determine whether the way in which this participant group approached ethical decision-making can be deemed ethically competent. Self-care was not highly prioritised within the participant group when making ethical decisions. However, it is argued that self-care is an ethical position for clinical psychologists and those entering the profession to take, and individual and profession-wide reflection on this is encouraged.

**4.8.3. Supervisors of individuals developing their ethical competence.** Drawing on the self-reflexive origins of the project, and hypothesis that ethical competence develops over time for those entering the profession, there are felt to be important implications for those supervising them. Vasquez (1992) highlights supervisors' responsibilities to "enhance the ability of supervisees to provide ethical services." (p. 196). If this model is deemed to be ethically competent by the profession, this would suggest a role for supervisors to assist with the development of ethical competence through discussion of the Core Competencies (BPS, 2017) and their application to

ethical dilemmas. It may also be beneficial for supervisors to support supervisees to take a critical and reflective stance towards ethical dilemmas and to encourage them to draw on multiple perspectives and multiple justifications. Supervisors could be encouraged to scaffold the level of instruction to the supervisee's zone of proximal development (Vygotsky & Cole, 1978), and clinical psychology training courses could be encouraged to review assisting with the development of trainees' ethical competence during supervisor training.

**4.8.4. Teaching and guidance in ethical competence.** There may be important implications for those teaching or guiding those developing their ethical competence in two ways; use of the vignettes and model in teaching and in the development of guidelines for the profession.

Participants reported that the vignettes were realistic and relevant to UK clinical psychology and would be useful for teaching ethical competence. These could be used to base a discussion around the range of ethical decisions and justifications and reflection on multiple perspectives in ethics modules of training courses, as well as for CPD for qualified clinical psychologists. If consultation suggests that the decision-making process used by these participants is deemed to be ethically competent by the wider profession, then ethical instruction may benefit from discussion of applying the Core Competencies (BPS, 2017) to ethical decision-making, opportunities to learn and practice employing the *guiding principles*, and to reflect on factors influencing the process.

Examples of this could be formulating ethical problems (as opposed to clinical problems) as an academic exercise, according to particular therapeutic models. Similarly, reflective practice groups structured around a particular ethical dilemma could enable practitioners to discuss and identify

the key ethical principles at stake, helping them to reason about how to weigh up competing ethical principles, and allowing the opportunity to reflect on what aspects of the dilemma and of themselves may be influencing their thinking. One approach CPD or training courses could draw upon is values-based practice (see e.g. Fulford, Dickenson, & Murray, 2002). Values-based reasoning approaches could be used to reflect on the range and strength of different values present for practitioners when considering a particular dilemma.

Teaching and training in ethical competence in clinical psychology may be enhanced by considering approaches employed in the medical profession. Medical ethics are arguably more established than in clinical psychology, for example with the introduction of compulsory ethics teaching in UK medical training since 1980 (Crisp, 1985) and the Institute of Medical Ethics (IME) being established in 1984 (Kong & Vernon, 2013; which aims to “raise ethical standards in clinical practice... by promoting dialogue, teaching and research in medical ethics.”, p. 670). Within medicine, the development of ethical competence is supported through discussion and systematic reflection on a specific ethical problem, known as ethical case deliberation (Steinkamp & Gordijn, 2003). This approach can be used for training and development or with the aim of generating a reasoned judgement in a live case (Molewijk, Verkerk, Milius & Widdershoven, 2008). Ethical case deliberation may be done by local clinical ethics committees such as in hospitals (Steinkamp & Gordijn, 2003; Pedersen, Akre & Førde, 2009) or through national conferences involving panel discussions and presentations (Molewijk, Verkerk, Milius & Widdershoven, 2008).

More broadly the present research has implications for national policy. Amongst other research, it is intended that this empirically derived model will be taken forward by members of the supervisory team to support the upcoming review and development of the BPS Guidelines on Teaching and Assessment of Ethical Competence in Psychology Education (2015).

#### **4.9. Further research**

Suggestions for further research have been explored throughout the discussion where relevant, leaving two suggestions to be put forward now.

**4.9.1. Towards an evaluative tool of ethical competence.** Research with trainee clinical psychologists suggested that there was no change (Ellis-Caird & Wainwright, in prep) or a deterioration (Jenkin, 2018; Jenkin, Ellis-Caird & Winter, in prep.) in sophistication of ethical schemas utilised between the first and third year of training, as measured by the DIT-2 (Rest, Narvaez, Thoma, & Bebeau, 1999). This suggests that either ethical instruction in the profession may be inadequate or development of professional ethical competence is not measured by the DIT-2, with this measure focusing more on personal ethical decision-making. Therefore, one aim at the start of this research was to develop a psychometric test to assist in the teaching and development of ethical competence in clinical psychology. This would be similar to the Intermediate Concepts Measure (ICM; Bebeau & Thoma, 1999), which was designed to assess the impact of ethical instruction in dentistry in the USA, through changes in participant's responses to clinical vignettes. The present research lays the foundations for the development of this tool, the vignettes (Boxes 1-5) have been empirically tested and reported to be realistic and relevant to the

profession of UK clinical psychology, and a hierarchy of justifications for the present participant group have been generated (Appendices X-BB). The next steps are to validate the materials and evaluate the model through consultation with a larger participant group, before explore whether and how this process develops in those entering the profession.

Ethically, it will be important that this measure is used appropriately and that its development within this culture and context is kept in mind. It is recognised that there have been significant historical concerns with the oppressive use of standardised testing (see e.g. Bulhan, 2004) and this would, of course, be insupportable. It is put forward that this would be a tool to aid the assessment of ethical instruction in clinical psychology and utilised only in accordance with the Code of Good Practice Guidelines for Psychological Testing (BPS, 2016). Without the development of this tool it may be difficult to justify time and resources spent on these teaching sessions, and may have important consequences for service users, practitioners and the profession.

**4.9.2. Applicability to other professional groups.** During recruitment, a number of counselling psychologists approached the research team to express interest in participating. It was decided to only include clinical psychologists for the present research due to the differing training routes and emphasis on different values (Woolfe, Dryden & Strawbridge, 2003) which may mean the ethical decision-making processes differ. It is interesting that there appears to be more research into the topic in counselling psychology (e.g. Kitchener's, 1984, principles of ethical decision-making; Hill, Glaser & Harden's, 1995, feminist model and; Levitt, Farry & Mazzarella's, 2015, four themes). After exploring the generalisability of the results of the present research from

this sample to the wider population of clinical psychology, further research would then aim to elucidate similarities and differences to cognate disciplines such as counselling psychology and psychotherapies, as suggested in the systematic review.

#### **4.10. Summary and concluding remarks**

Vignettes representing ethical dilemmas in UK clinical psychology have been developed through consultation with members of the profession and empirically tested with this participant group of qualified clinical psychologists. These vignettes were reported to be realistic and relevant and to have impacted participants' thinking and practice in relation to ethical competence. In particular, participants felt the vignettes would be useful for ethical instruction. By analysing participants' responses to the ethical dilemmas presented in these vignettes, a model of the process of ethical decision-making in this participant group was developed. This is the first attempt at an empirically derived model of ethical decision-making in clinical psychology. Participants in the present research were recruited to be representative of the profession, however the next phase of the research will involve consulting more widely about whether this model is felt to be ethically competent, or whether other aspects need adding to the model. This research has key implications for ethical instruction and the development of ethical competence. This may have significant effects for clinical psychologists, those using their services and how the profession is viewed in society. It is hoped that this research will be taken forward to support the review and development of the BPS Guidelines on Teaching and Assessment of Ethical Competence in Psychology Education (2015).

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## Appendices

*Appendix A. Example first contact to potential participants sent via email among research team networks.*

**Please note that this email is directed at qualified Clinical Psychologists, working in the UK. Please feel free to forward this email and the attached participant information sheet to colleagues who may be interested.**

I am a Trainee Clinical Psychologist at the University of Hertfordshire Doctorate course, currently completing my research project looking at developing a model of ethical competence in clinical psychology.

For this phase of the research, I am aiming to recruit a small 'virtual' group of qualified Clinical Psychologists to take part in a short delphi study. I am trying to sample those working in a range of different organisational contexts, with a range of years post qualification, and working with different client groups.

It would involve answering questions about ethical dilemmas posed in vignettes, and then responding anonymously to how other (also anonymous) participants have answered. You would be asked to complete up to four online surveys (at approximately monthly intervals, lasting approximately 30 mins each), I am hoping to start within the next month. The aim of this would be to work towards an agreement about which are more, and less, appropriate justifications for ethical decisions.

For further details, please see the participant information sheet attached.

Thank you for taking the time to read this. If you this is something you would be willing to consider participating in, or would like to discuss this further, I can be contacted by email on: \*\*\*\*@herts.ac.uk.

Kind regards,

**Becky Grace**  
**Trainee Clinical Psychologist**

Appendix B. Example recruitment advert to potential participants posted via social media.



**Becky Grace** ▸ UK based Clinical Psychology Facebook Group



22 July 2018 · 📍

DClinPsy thesis participation request (qualified Clinical Psychologists):

I am currently undertaking an exciting delphi study to look at developing a model of ethical competence in clinical psychology.

It would involve answering questions about ethical dilemmas posed in vignettes, and then responding anonymously to how other (also anonymous) participants have answered. You would be asked to complete up to four online surveys (at approximately monthly intervals, lasting approximately 30 mins each).

If you think this is something you would consider participating in, or would like to discuss this further, please message me directly.

Thank you for taking the time to read this.



██████████ and 5 others

👍 Like

💬 Comment

*Appendix C. Application to the University of Hertfordshire Health, Science, Engineering and Technology ECDA for ethical approval for the present research.*

UNIVERSITY OF HERTFORDSHIRE

## **FORM EC1A: APPLICATION FOR ETHICS APPROVAL OF A STUDY INVOLVING HUMAN PARTICIPANTS (Individual or Group Applications)**

Please complete this form if you wish to undertake a study involving human participants.

Applicants are advised to refer to the Ethics Approval StudyNet Site and read the Guidance Notes (GN) before completing this form.

<http://www.studynet2.herts.ac.uk/ptl/common/ethics.nsf/Homepage?ReadForm>

Use of this form is mandatory [see UPR RE01, 'Studies Involving Human Participants', SS 7.1-7.3]

Approval must be sought **and granted** before any investigation involving human participants begins [UPR RE01, S 4.4 (iii)]

If you require any further guidance, please contact either [hsetecda@herts.ac.uk](mailto:hsetecda@herts.ac.uk) or [ssahecda@herts.ac.uk](mailto:ssahecda@herts.ac.uk)

Abbreviations: GN = Guidance Notes UPR = University Policies and Regulations

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## **THE STUDY**

Q1 Please give the title of the proposed study

Towards a model of ethical competence in Clinical Psychology

## **THE APPLICANT**

Q2 Name of applicant/(principal) investigator (person undertaking this study)

Becky Grace

Student registration number/Staff number

\*\*\*\*\*



Email address

\*\*\*\*@herts.ac.uk

Status:

Undergraduate (Foundation)

Undergraduate (BSc, BA)

Postgraduate (taught)

Postgraduate (research)

Staff

Other

If other, please provide details here:

[Click here to enter text.](#)

School/Department: School of Life and Medical Sciences

[Click here to enter text.](#)

If application is from a student NOT based at University of Hertfordshire, please give the name of the partner institution: [Click here to enter text.](#)

Name of Programme (eg BSc (Hons) Computer Science): Professional Doctorate in Clinical Psychology (DClinPsy)

Module name and module code: 8PSY0047-0000-Research DCLIN Y2

Name of Supervisor: Dr Helen Ellis-Caird    Supervisor's email: \*\*\*\*@herts.ac.uk

Name of Module Leader if applicant is undertaking a taught programme/module:

Dr Helen Ellis-Caird

Names and student/staff numbers for any additional investigators involved in this study

Is this study being conducted in collaboration with another university or institution and/or does it involve working with colleagues from another institution?

Yes

No

If yes, provide details here:

Dr Tony Wainwright (Clinical Psychologist, External Supervisor) \*\*\*\*@exeter.ac.uk

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## DETAILS OF THE PROPOSED STUDY

**Q3** Please give a short synopsis of your proposed study, stating its aims and highlighting where these aims relate to the use of human participants (See GN 2.2.3)

It is intended that this study will investigate how ethical dilemmas are approached in clinical psychology, by experienced, qualified clinical psychologists working in the UK.

There are a number of models of how people make moral judgements in non-professional contexts (e.g. Rest, 1986; Kohlberg, 1973). These have aimed to categorise, in terms of abstract schemas, how people make ethical decisions, with increasing levels of sophistication. In professional contexts, people use profession-specific codes of conduct to support ethical decision making in clinical practice (e.g. BPS, HCPC in Psychology). More recently, (Bebeau & Thoma, 1999) identified a level in between these two, which they named intermediate concepts. These include principles such as confidentiality, candour and competence which clinicians draw on support professional ethical decision making. This has been shown in the field of dentistry and is proposed to exist in other healthcare professions, but as yet there is has been no research identifying how clinical psychologists make ethical decisions. This is therefore the aim of the proposed project. This project sits within a broader, emerging field of research looking at ethical competence in clinical psychology, following on from the BPS ethical code (2009; 2018). One example of this is the work of another Trainee Clinical Psychologist at the University of Hertfordshire (Jenkin, in prep.) which found that current methods of evaluating the development of ethical competence throughout the process of training are insufficient, and suggests that a profession-specific understanding and means of measuring are indicated.

From a stance of moral pluralism (that there may more than one acceptable course of action but some which are unacceptable), this research cannot be conceptualised as seeking to uncover certain positivist knowledge rather, it is put forward that moral judgement in clinical psychology is a culture, constructed largely within the discipline itself. This therefore points to experienced clinical psychologists in the field as being the most appropriate participant group and consensus reached by these participants as being the best way of gaining knowledge in the subject matter. As such, the following research questions are identified.

1. What do clinical psychologists agree are appropriate justifications for moral judgements made in response to ethical dilemmas (as represented by vignettes) in clinical psychology?
2. How can the way that clinical psychologists make moral judgements in response to ethical dilemmas in clinical psychology be best explained?
  - a. by using schemas, intermediate concepts, and codes of conduct?
  - b. by using existing alternative theoretical model(s) of moral judgement (such as

e.g. the Ethics of Care; Gilligan, 2008)?  
 c. or by developing a new theoretical model?

Q4

Please give a brief explanation of the design of the study and the methods and procedures used. You should clearly state the nature of the involvement the human participants will have in your proposed study and the extent of their commitment. Ensure you provide sufficient detail for the Committee to, particularly in relation to the human participants. Refer to any Standard Operating Procedures SOPs under which you are operating here. (See GN 2.2.4).

The design of the study is based on the delphi method as a means of developing consensus through questionnaires.

For the initial online survey group - participants will receive approximately four, 200-word vignettes representing fictional ethical dilemmas designed to be realistic and representative of UK clinical psychology practice (see appendix for the first two of these). They will be asked questions about how they would respond (see appendix) and some demographic information. This method involves multiple iterations of questions to the same participant group, providing them with controlled (anonymised) feedback at each stage about the other participants' answers, and asked to rate all the answers in terms of the most appropriate courses of action and justifications in each of the vignettes. with the aim of reaching an agreed set of answers about what are more appropriate ways to responding to these dilemmas. It is expected that this participant group will need approximately 30 minutes to complete each survey and they will be sent links to approximately 3 iterations of the survey over the course of 3-4 months, although all participants (in all groups) will have the right to withdraw from the study without giving a reason at any time. All participants (in all groups) will have the right to request their data be removed from the study up to one week after each period of data collection. This is because subsequent iterations of the study (proposed to be 3-4 weeks apart) are derived from anonymised previous answers given by participants.

The second group, will consist of a new group of qualified clinical psychologists and will comprise a focus group discussion lasting approximately one hour with no more than 7 other participants. This will be facilitated by Becky Grace (Trainee Clinical Psychologist) at a bookable group room at the University of Hertfordshire. Prior to this meeting, they will be sent the same survey as per the first iteration sent to the online survey group (containing the vignettes, questions about how they would respond and some demographic information). They will be invited to discuss their answers, with the aim of reaching a consensus. They will also be provided with feedback on the agreement that was reached by the initial online survey group and asked to comment on these. The audio from the focus group will be recorded, transcribed, and analysed using thematic analysis. Thematic analysis will likely take place using NVivo software. All participant data including audio recording will be stored securely and confidentially at all times.

The third group will comprise qualified clinical psychologists who are working on DClinPsy courses in the UK. They will be sent the same survey as per the first iteration sent to the online survey group (containing the vignettes, questions about how they would respond and some demographic information). They will then be provided with the pooled feedback from consensuses reached by groups 1 and 2 and asked to comment on these. For this group the

involvement will be this one off survey.

Q5 Does the study involve the administration of substances?

Yes  No

PLEASE NOTE: If you have answered yes to this question you must ensure that the study would not be considered a clinical trial of an investigational medical product. To help you, please refer to the link below from the Medicines and Healthcare Products Regulatory Agency:  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/317952/Algothrim.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/317952/Algothrim.pdf)

To help you determine whether NHS REC approval is required, you may wish to consult the Health Research Authority (HRA) decision tool: <http://www.hra-decisiontools.org.uk/ethics/>

If your study is considered a clinical trial and it is decided that ethical approval will be sought from the HRA, please stop completing this form and use Form EC1D, 'NHS Protocol Registration Request'; you should also seek guidance from Research Sponsorship.

I confirm that I have referred to the Medicines and Healthcare Products Regulatory Agency information and confirm that that my study is not considered a clinical trial of a medicinal product.

Please type your name here: Becky Grace

Date: 01/05/2018

Q6.1 Please give the starting date for your recruitment and data collection: 02/06/2018 (once ethics approval received)

Q6.2 Please give the finishing date for you data collection: 01/06/2019  
 (For meaning of 'starting date' and 'finishing date', see GN

2.2.6)

Q7 Where will the study take place?

Online survey platform and focus group at University of Hertfordshire

Please refer to the Guidance Notes (GN 2.2.7) which set out clearly what permissions are required;

Please tick all the statements below which apply to this study

I confirm that I have obtained permission to access my intended group of participants and that the agreement is attached to this application

I confirm that I have obtained permission to carry out my study on University premises in areas outside the Schools and that the agreement is attached to this application

- I confirm that I have obtained permission to carry out my study at an off-campus location and that the agreement is attached to this application
- I have yet to obtain permission but I understand that this will be necessary before I commence my study and that the original copies of the permission letters must be verified by my supervisor before data collection commences
- This study involves working with minors/vulnerable participants. I/we have obtained permission from the organisation (including UH/UH Partner Institutions when appropriate) in which the study is to take place and which is responsible for the minors/vulnerable participants. The permission states the DBS requirements of the organisation for this study and confirms I/we have satisfied their DBS requirements where necessary.  
NB If your study involves minors/vulnerable participants, please refer to Q18 to ensure you **comply with the University's requirement regarding Disclosure and Barring Service clearance.**
- Permission is not required for my study as:  
[Click here to enter text.](#)

## HARMS, HAZARDS AND RISKS

- Q8.1 It might be appropriate to conduct a risk assessment (in respect of the hazards/risks affecting both the participants and/or investigators). Please use Risk Assessment Form EC5 if the answer to any of the questions below is 'yes'.

If you are required to complete and submit a School specific risk assessment in addition to Form EC5, please append it to your completed Form EC5.

### Will this study involve any of the following?

- |                                                                                                             |                                         |                                        |
|-------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------|
| Invasive Procedures/administration of any substance/s?                                                      | <input type="checkbox"/> YES            | <input checked="" type="checkbox"/> NO |
| Are there potential hazards to participant/investigator(s) NO from the proposed study? (Physical/Emotional) | <input checked="" type="checkbox"/> YES | <input type="checkbox"/>               |
| Will or could aftercare and/or support be needed by participants? NO                                        | <input checked="" type="checkbox"/> YES | <input type="checkbox"/>               |

IF 'YES' TO THE ABOVE PLEASE COMPLETE EC1 APPENDIX 1 AND INCLUDE IT WITH YOUR APPLICATION

- Q8.2 Is the study being conducted off-campus (i.e. not at UH/UH Partner?)  YES  NO

It might be appropriate to conduct a risk assessment of the proposed location for your study (in respect of the hazards/risks affecting both the participants and/or investigators) (this might be relevant for on-campus locations as well). Please use Form EC5 and, if required, a School-specific risk assessment (See GN 2.2.8 of the Guidance Notes).

If you do not consider it necessary to submit a risk assessment, please give your reasons:  
[Click here to enter text.](#)

## ABOUT YOUR PARTICIPANTS

- Q9 Please give a brief description of the kind of people you hope/intend to have as participants, for instance, a sample of the general population, University students, people affected by a particular medical condition, children within a given age group, employees of a particular firm, people who support a particular political party, and state whether there are any upper or lower age restrictions.

Qualified Clinical Psychologists, working in the UK, registered with HCPC (Healthcare professions council and qualified for at least two years. No upper / lower age restrictions. For final round, inclusion criteria will be as above but will also be those working on Clinical Psychology training courses on ethics modules.

- Q10 Please state here the maximum number of participants you hope will participate in your study. Please indicate the maximum numbers of participants for **each** method of data collection.

For initial group maximum of 60 Clinical Psychologists (aim to recruit 12-16).  
 For focus group maximum of 20 Clinical Psychologists (aim to recruit 5-8).  
 For final group maximum of 40 Clinical Psychologists (aim to recruit 12-16).

- Q11 By completing this form, you are indicating that you are reasonably sure that you will be successful in obtaining the number of participants which you hope/intend to recruit. Please outline here your recruitment (sampling) method and how you will advertise your study. (See GN 2.2.9).

The nature of the Delphi method (Powell, 2003), means that participants will not be a statistically representative sample. Representativeness will need to be assessed by the research team based on the participants' qualities. This will include consideration of striving for an approximately even gender mix, a range of ages or years post-qualification (ensuring a minimum as per the inclusion criteria), working in a variety of settings, and of representing a variety of theoretical orientations (for example as defined by the individual or the orientation of the course they trained at). Given this, the recruitment process will be variable. It will be helpful to identify specific individuals and consider where the supervisory team may have existing connections and how they may be best contacted to encourage participation. It is likely that the team will send individual emails to those with personal

connections and depending on the response this will be followed up with a phone call from myself (Becky Grace) and then an information sheet.

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## CONFIDENTIALITY AND CONSENT

(For guidance on issues relating to consent, see GN 2.2.10, GN 3.1 and UPR RE01, SS 2.3 and 2.4 and the Ethics Approval StudyNet Site FAQs)

**Q12** How will you obtain consent from the participants? Please explain the consent process for each method of data collection identified in Q4

- Informed consent using EC3 and EC6 (equivalent)
- Implied consent (e.g. via participant information at the start of the questionnaire/survey etc)
- Consent by proxy (for example, given by parent/guardian)

Use this space to describe how consent is to be obtained and recorded for each method of data collection. The information you give must be sufficient to enable the Committee to understand exactly what it is that prospective participants are being asked to agree to.

Consent to participate in the focus group will be obtained by signed consent form (see attached EC3 form). Consent to participate in the online surveys (groups one and three) will be obtained by ticking a box on an online form to indicate consent (see attached EC3 form). All consent forms will be stored securely. Participants will be provided with an information sheet (EC6 attached) so that they are fully informed of what they are being asked to consent to.

If you do not intend to obtain consent from participants please explain why it is considered unnecessary or impossible or otherwise inappropriate to seek consent.

[Click here to enter text.](#)

**Q13** If the participant is a minor (under 18 years of age) or is unable for any reason to give full consent on their own, state here whose consent will be obtained and how? (See especially GN 3.6 and 3.7)

[Click here to enter text.](#)

**Q14.1** Will anyone other than yourself and the participants be present with you when conducting this study? (See GN 2.2.10)

- YES  NO

If YES, please state the relationship between anyone else who is present other than the applicant and/or participants (eg health professional, parent/guardian of the participant).

[Click here to enter text.](#)

Q14.2 Will the proposed study be conducted in private?

YES

NO

If 'No', what steps will be taken to ensure confidentiality of the participants' information. (See GN 2.2.10):

[Click here to enter text.](#)

Q15 Are personal data of any sort (such as name, age, gender, occupation, contact details or images) to be obtained from or in respect of any participant? (See GN 2.2.11) (You will be required to adhere to the arrangements declared in this application concerning confidentiality of data and its storage. The Participant Information Sheet (Form EC6 or equivalent) must explain the arrangements clearly.)

YES

NO

If YES, give details of personal data to be gathered and indicate how it will be stored.

Name, age, gender, number of years since qualifying, client group they carry out their clinical work with (e.g. adults, older adults), setting working in (e.g. NHS, private etc.), theoretical orientation they identify with (e.g. psychodynamic, CBT), level of seniority in profession (e.g. consultant clinical psychologist, principle clinical psychologist). Please note that although content of participants' responses to vignettes will be disclosed to other participants, none of the above personal data will be disclosed to other participants. This will be available in aggregate form upon thesis submission/publication. Data will be pseudo-anonymised (linked with participant ID number). All data collected will be securely stored (password protected if in digital form, locked in secure drawer if hard copy).

Will you be making audio-visual recordings?

YES

NO

If YES, give details of the types recording to be made and indicate how they will be stored.

Audio recording of focus group discussion will be made using encrypted dictaphone. Recordings will be securely stored (encrypted and stored on password-secured laptop).

State what steps will be taken to prevent or regulate access to personal data/audio-visual recordings beyond the immediate investigative team, as indicated in the Participant Information Sheet.

Any and all electronic data collected will be stored in a secure, password-protected environment, until the end of the project, after which time it will be destroyed under secure conditions on passing of the thesis, and on publication. Any and all hard copies of data collected will be stored by the researchers in a secure environment until the end of the project and publication, after which time it will be destroyed under secure conditions.



Indicate what assurances will be given to participants about the security of, and access to, personal data/audio-visual recordings, as indicated in the Participant Information Sheet.

Once data is collected, it will be pseudo-anonymised, meaning names will be replaced with an identifying number. Any and all information recorded digitally will be encrypted and stored securely on password-protected computers at all times. Any hard copies (e.g. consent forms from focus group) will be securely stored in a locked drawer to ensure confidentiality

State as far as you are able to do so how long personal data/audio-visual recordings collected/made during the study will be retained and what arrangements have been made for its/their secure storage, as indicated in the Participant Information Sheet.

The survey responses and audio recording will be stored securely on a password-protected computer until the end of the project (once this has been passed and published) upon which originals will be deleted.

Will data be anonymised prior to storage?  YES  NO

Q16 Is it intended (or possible) that data might be used beyond the present study? (See GN 2.2.10)  YES  NO  
If YES, please indicate the kind of further use that is intended (or which may be possible).

It is hoped that a follow up project will enable the generation of a formal measure of ethical competence in clinical psychology. This will enable the tracking of development of moral justification skills over time, for example through the course of training in clinical psychology. This measure will be based on test-takers responses to vignettes (based on the ones used in the present study), and the response options in the test will be multiple choice based on the consensus answers reached in the present study. No personally identifiable data from the participants in this study would be used in the follow up project, only short responses to the vignettes which may be verbatim or may be only based on collective responses or superordinate themed responses generated through data analysis. The second project would look at developing norms for this test, using different participant groups, at different stages of professional training. A further application will be made to the committee before commencement of this follow up project.

If NO, will the data be kept for a set period and then destroyed under secure conditions?  YES  NO  
If NO, please explain why not:

[Click here to enter text.](#)

Q17 Consent Forms: what arrangements have been made for the storage of Consent Forms and for how long?

Paper consent forms will be stored in a locked environment and digital consent given will be stored on a password protected computer and a second password protected survey platform. These will be kept until the end of the project and publication, after this point they will be destroyed under secure conditions.

Q18 If the activity/activities involve work with children and/or vulnerable adults satisfactory

Disclosure and Barring Service (DBS) clearance may be required by investigators. You are required to check with the organisation (including UH/UH Partners where appropriate) responsible for the minors/vulnerable participants whether or not they require DBS clearance.

Any permission from the organisation confirming their approval for you to undertake the activities with the children/vulnerable group for which they are responsible should make specific reference to any DBS requirements they impose and their permission letter/email must be included with your application.

More information is available via the DBS website -

<https://www.gov.uk/government/organisations/disclosure-and-barring-service>

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## REWARDS

Q19.1 Are you receiving any financial or other reward connected with this study? (See GN 2.2.14 and UPR RE01, S 2.3)

YES

NO

If YES, give details here:

[Click here to enter text.](#)

Q19.2 Are participants going to receive any financial or other reward connected with the study? (Please note that the University does not allow participants to be given a financial inducement.) (See UPR RE01, S 2.3)

YES

NO

If YES, provide details here:

[Click here to enter text.](#)

Q19.3 Will anybody else (including any other members of the investigative team) receive any financial or other reward connected with this study?

YES

NO

If YES, provide details here:

[Click here to enter text.](#)

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## OTHER RELEVANT MATTERS

Q20 Enter here anything else you want to say in support of your application, or which you believe may assist the Committee in reaching its decision.

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Nothing to add.

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## DOCUMENTS TO BE ATTACHED

Please indicate below which documents are attached to this application:

- Permission to access groups of participants from student body
  
- Permission to use University premises beyond areas of School
- Schools Permission from off-campus location(s) to be used to conduct this study
- Risk Assessment(s) in respect of hazards/risks affecting participants/investigator(s)
- Copy of Consent Form (See Form EC3/EC4) Copy of Form EC6 (Participant Info Sheet)
- Copy of Form EC6 (Participant Info Sheet)
- A copy of the proposed questionnaire and/or interview schedule (if appropriate for this study). For unstructured methods, please provide details of the subject areas that will be covered and any boundaries that have been agreed with your Supervisor
  
- Any other relevant documents, such as a debrief, meeting report. Please provide details here:

[Click here to enter text.](#)

## DECLARATIONS

### 1 DECLARATION BY APPLICANT

- 1.1 I undertake, to the best of my ability, to abide by UPR RE01, 'Studies Involving the Use of Human Participants', in carrying out the study.
  
- 1.2 I undertake to explain the nature of the study and all possible risks to potential participants,
  
- 1.3 Data relating to participants will be handled with great care. No data relating to named or identifiable participants will be passed on to others without the written consent of the participants concerned, unless they have already consented to such sharing of data when they agreed to take part in the study.
  
- 1.4 All participants will be informed **(a)** that they are not obliged to take part in the study, and **(b)** that they may withdraw at any time without disadvantage or having to give a reason.

**(NOTE:** Where the participant is a minor or is otherwise unable, for any reason, to give full consent on their own, references here to participants being given an explanation or information, or being asked to give their consent, are to be understood as referring to the person giving consent on their behalf. (See Q 12; also GN Pt. 3, and especially 3.6 & 3.7))

Enter your name here: Becky Grace

Date 01/05/2018

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**2 GROUP APPLICATION**

(If you are making this application on behalf of a group of students/staff, please complete this section as well)

I confirm that I have agreement of the other members of the group to sign this declaration on their behalf

Enter your name here: [Click here to enter text.](#)

Date [Click here to enter a date.](#)

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**DECLARATION BY SUPERVISOR** (see GN 2.1.6)

I confirm that the proposed study has been appropriately vetted within the School in respect of its aims and methods; that I have discussed this application for Ethics Committee approval with the applicant and approve its submission; that I accept responsibility for guiding the applicant so as to ensure compliance with the terms of the protocol and with any applicable ethical code(s); and that if there are conditions of the approval, they have been met.

Enter your name here: Helen Ellis-Caird

Date 16/05/2018



## SCHOOL OF LIFE AND MEDICAL SCIENCES

## RISK ASSESSMENT

Ref No:	
Date:	
Review Date:	

***For assistance in completing this form, please see the Guidance Notes at the end***

ACTIVITY INFORMATION	
Name of Assessor/ Contact details	Your Name: Becky Grace Email address: *****@herts.ac.uk Telephone no: ***** / *****
Title of Activity	Towards a model of ethical competence in Clinical Psychology. Research with qualified clinical psychologists including reviewing vignettes, an online questionnaire and a semi structured focus group.
Location of Activity	Online survey platform and UH bookable group room for focus group. Analysis of obtained data may be done on UH campus or at home.
Description of Activity Please attach a copy of the protocol, procedure, SOP etc applicable.	Recruiting up to 58 qualified clinical psychologists currently working in the UK. Completion by participants of questionnaire following review of vignettes, and a semi structured focus group. Please see attached example vignettes and questions. Analysis of data.

Personnel Involved	Becky Grace (Trainee Clinical Psychologist)  Dr Helen Ellis-Caird (University of Hertfordshire, Supervisor)  Dr Tony Wainwright (University of Exeter, External Supervisor)
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TYPES OF HAZARD LIKELY TO BE ENCOUNTERED		
<ul style="list-style-type: none"> <li><input type="checkbox"/> Animal Allergens</li> <li><input type="checkbox"/> Biological Agents (see COSHH)</li> <li><input type="checkbox"/> Chemical Compounds (see CoSHH)</li> <li><input type="checkbox"/> Compressed/liquefied gases</li> <li>X Computers</li> <li> </li> <li><input type="checkbox"/> Electricity</li> <li><input type="checkbox"/> Falling Objects</li> <li><input type="checkbox"/> Farm Machinery</li> <li><input type="checkbox"/> Fire</li> <li><input type="checkbox"/> Glassware Handling</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Hand Tools</li> <li><input type="checkbox"/> Ionising Radiation</li> <li><input type="checkbox"/> Office Equipment</li> <li><input type="checkbox"/> Laboratory Equipment</li> <li><input type="checkbox"/> Ladders</li> <li><input type="checkbox"/> Manual Handling</li> <li><input type="checkbox"/> Non-ionising Radiation</li> <li><input type="checkbox"/> Hot or cold extremes</li> <li><input type="checkbox"/> Repetitive Handling</li> <li><input type="checkbox"/> Severe Weather</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Sharps</li> <li><input type="checkbox"/> Slips/trips/falls</li> <li>X Stress</li> <li><input type="checkbox"/> Travel</li> <li> </li> <li><input type="checkbox"/> Vacuum systems</li> <li><input type="checkbox"/> Pressure systems</li> <li><input type="checkbox"/> Vehicles</li> <li><input type="checkbox"/> Aggressive response, physical or verbal</li> <li> </li> <li><input type="checkbox"/> Workshop Machinery</li> </ul>
<p>The above is not an exhaustive list – all other hazards should be listed here.</p> <p>Possible minor emotional distress to participants following the content of some of the vignettes or their responses.</p> <p>Possible disclosure of values or behaviours inconsistent with professional (HCPC / BPS) codes of conduct.</p>		

HAZARD ASSESSMENT						
Severity of Consequences	Score	Risk Classification				
No or minor injury/ health disorder Minor Damage or Loss Insignificant Environmental Impact Group 1 Biological agents	1	Trivial (1)	Trivial (2)	Trivial (3)	Trivial (4)	Tolerable (5)
Injury or Health Disorder – resulting in absence up to 3 days Moderate Damage or Loss Moderate Environmental Impact Group 2 Biological agents	2	Trivial (2)	Trivial (4)	Tolerable (6)	Tolerable (8)	Moderate (10)
Injury or Health Disorder – resulting in absence over 3 days Substantial Damage or Loss Serious Environmental Impact Group 3 Biological agents	3	Trivial (3)	Tolerable (6)	Moderate (9)	Moderate (12)	Substantial (15)
Long Term Injury or Sickness – resulting in permanent incapacity	4	Trivial (4)	Tolerable (8)	Moderate (12)	Substantial (16)	Intolerable (20)

Extensive Damage or Loss Major Long Term Environmental Impact						
Death Serious Structural Damage Environmental Catastrophe Group 4 Biological agents	5	Tolerable (5)	Moderate (10)	Substantial (15)	Intolerable (20)	Intolerable (25)
Note on Risk Classification:	→	1	2	3	4	5
		Almost Impossible	Unlikely – possible exposure every 1-3 years	Harm is possible	Harm is likely to occur	Harm will occur or is very likely to occur.
1-4 Trivial	Likelihood					
5-7 Tolerable						
8-12 Moderate						
13-16 Substantial						
>20 Intolerable						

RISK CONTROL MEASURES
Are the local code of practice and/or local rules adequate to control the risks identified?
Yes
Please list.
Please list all additional measures required.





<p>Local Code of Practice and Local Rules applicable: University of Hertfordshire UPRs (University policies and regulations; specifically but not limited to, those on internet usage, use of bookable rooms, and information storage)</p> <p>Additional Measures: BPS Code of Ethics &amp; Conduct (2009) BPS Code of Human Research Ethics (2014)</p>
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ASSESSMENT OF RESIDUAL RISK			
Hazard	Likelihood Score	Severity Score	Risk Classification
Possible minor emotional distress	2	2	Trivial
Computers	1	1	Trivial
Disclosure of values or behaviours inconsistent with professional codes of conduct	1	2	Trivial

EFFECT OF RISK CLASSIFICATION	
Risk Classification	Action
Trivial	No further action required. Activity can begin.
Tolerable	No additional controls required. Current controls must be maintained and monitored.
Moderate	Reduce risks if cost effective. Implement new controls over an agreed period.
Substantial	Activity cannot begin without major risk reduction.
Intolerable	Activity must not begin.

HEALTH SURVEILLANCE ISSUES	
Persons at Special Risk	Qualified clinical psychologists with pre-existing upper limb disorders / repetitive strain injuries completing online survey using computer.
Health Surveillance Measures (including symptoms and signs of exposure)	N/A
Exclusions	None

SIGNATURES				
	Staff/PhD student/MSc student/Undergraduate	Name (Print)	Signature	Date
Assessor	DClinPsy student	Becky Grace		08/05/2018
Supervisor (if Assessor is a student)	Supervisor, Staff	Helen Ellis-Caird		16/05/18
Local Health and Safety Advisor / Laboratory Manager	Staff	John Bain		16/05/18

## **APPENDIX 1 – INCREASED HAZARDS AND RISKS**

This section is to be completed if the work you/your students plan to undertake involves the administration of substances and/or invasive procedures, whether there is a risk of physical or emotional harm, or whether aftercare and/or support might be required (please refer to Question 8 on Form EC1A/Question 7 on Form EC1B)

Name: Becky Grace

Title of study/activity: Towards a model of ethical competence in Clinical Psychology

Date completed: 06/05/2018

**QA1.** Please give details of the procedures to be used and any harm, discomfort or distress that their use may cause to participants and/or investigator(s). (See GN 2.2.10)

Vignettes about ethical dilemmas in clinical psychology may cause emotional distress for participants (qualified clinical psychologists) in focus group or on online survey, as may participant's concerns about how their answers (what they say about how they would respond to the vignettes and why) are received by other participants.

There is also a small, although unlikely, possibility that a participant may disclose a value or behaviour that is inconsistent with their professional codes of conduct when discussing hypothetical vignettes.

Indicate here what precautions will be taken to avoid or minimise any adverse effects.

It is unlikely that there will be emotional harm to participants that arises as a result of reading or responding to vignettes in the online survey or focus group. However, if any distress does arise, this will be managed in the following ways.

In the information sheet, participants will be invited to only share what they feel comfortable sharing in terms of how they would respond to vignettes.

Participants will have the opportunity to withdraw and have their data removed from the study. However, as subsequent iterations of the study will be based on answers from previous ones, this period may be only one week for the online survey method and could be slightly longer for the focus group or final round (this will be made clear at the consent stage).

At the start of the focus group, the importance of confidentiality will be emphasised to participants. For online surveys, although participant's answers will be shared with each other in subsequent rounds as per the Deplhi Method, these will be anonymised and participants will not know who other participants are.

The vignettes are designed to be realistic and reflective of ethical dilemmas likely to occur in clinical practice for UK clinical psychologists. Therefore it is believed that these will be no more distressing than the participant group would be likely to encounter in their everyday lives

All participants will be given a debrief sheet signposting them to further emotional support if needed. The research team, who have experience of managing emotional distress individually and in groups, will be contactable should participants wish to discuss concerns further.

Participants will not be asked to discuss real examples of their clinical practice either online or in the focus group, questions focus on hypothetical vignettes. Participants will be made aware at the information sheet stage that the normal limits to confidentiality apply, and if there are disclosures of unsafe or unethical practice then confidentiality may need to be broken. If this instance were to arise, this would be discussed within the research team, discussed with the participant who may be encouraged to seek relevant professional support, advice sought from the University's legal team, and potentially reported to the police, local safeguarding authority or professional body HCPC / BPS.

**QA2.** Will the study involve the administration of any substance(s)?

YES

NO (if 'no' go to QA.3)

If YES, is the substance to be administered commercially manufactured for human consumption or use?

YES

NO

Is the substance in pre-prepared dosage form (e.g. tablets etc)?

YES

NO

If you have answered 'No' to this question you are required to explain here why the substance is being used in non-standard form and reference and include the Standard Operating Procedures (SOPs) governing the procedure/s.

Give details here of the substance(s), the dose or amount to be given, likely effects (including duration) and any potential hazards to participant(s) and/or investigator(s). You must include the recommended daily dosage (dated and referenced) and the proposed dosage for this study.

Please also indicate the maximum dose that has been administered without adverse effects.

Indicate here what precautions will be taken to avoid or minimise any adverse effects.

**QA3.** Are there any potential hazards to participant(s) and/or investigator(s) arising from the use of the proposed invasive procedures? (See GN 2.2.10)

YES

NO

If YES,

Indicate their nature here.

Indicate here what precautions will be taken to avoid or minimise any adverse effects.

**QA4.** Will or could the study cause discomfort or distress of a mental or emotional character to participants and/or investigator(s)? (See GN 2.2.11)

YES	NO
If YES,	
Indicate its nature here Please see QA1	
Indicate here what precautions will be taken to avoid or minimise such adverse effects. Please see QA1	
<p><b>QA5.</b> Medical or other aftercare and/or support must be made available for participants and/or investigator(s) who require it where invasive procedures have been used in the study. Please detail what aftercare and/or support will be available and in what circumstances it is intended to be used. (See UPR RE01, S 2.3 (ii) and GN 2.2.8)</p>	
Participants will be offered a debrief and signposted to emotional support which they can seek out if necessary.	
<p><b>QA6.1</b> Please state here previous experience (and/or any relevant training) of the supervisor (or academic member of staff applying for a standard protocol) of investigations involving hazards, risks, discomfort or distress as specified. (See GN 2.2.8)</p>	
Supervisors are trained clinical psychologist with many years experience working with people experiencing emotional distress, both individually and in groups, with considerable experience of conducting psychological research, and significant experience with ethical dilemmas in clinical psychology.	
<p><b>QA6.2</b> Please describe in appropriate detail what you would do should the adverse effects or events which you believe could arise from your study, and which you have mentioned in your replies to the previous questions, occur.</p>	
It will be made clear to participants from the start and again at the end that should they feel adversely affected by participating in the research (online or focus group), to raise this with the research team who will ensure that the participant is offered appropriate emotional support and is signposted to further appropriate support if needed.	

## UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS  
(‘ETHICS COMMITTEE’)

## FORM EC5 – STANDARD RISK ASSESSMENT FORM

Name of applicant: Becky Grace

Date of assessment: 07/05/2018

Title of Study/Activity: Towards a model of ethical competence in Clinical Psychology

If you are also required to complete a School specific risk assessment, please append it to your completed EC5 before submission. Use this form to note any hazards/risks **not** already included in your School specific risk assessment. It is acceptable to state ‘Included in <school> risk assessment’ where appropriate on this form.

Activity Description							
1. IDENTIFY RISKS/HAZARDS		2. WHO COULD BE HARMED & HOW?		3. EVALUATE THE RISKS		4. ACTION NEEDED	
<u>Activities/tasks and associated hazards</u>		<u>Who is at risk?</u>	<u>How could they be harmed?</u>	<u>Are there any precautions currently in place to</u>	<u>Are there any risks that are not controlled</u>	<u>List the action that needs to be taken to reduce/manage the risks arising</u>	

<p>Describe the activities involved in the study and any associated risks/ hazards, both physical and emotional, resulting from the study. Consider the risks to participants/the research team/members of the public.</p> <p>In respect of any equipment to be used read manufacturer's instructions and note any hazards that arise, particularly from incorrect use.)</p>	<p>e.g. participants, investigators, other people at the location, the owner / manager / workers at the location etc.</p>	<p>What sort of accident could occur, e.g. trips, slips, falls, lifting equipment etc., handling chemical substances, use of invasive procedures and correct disposal of equipment etc.</p> <p>What type of injury is likely?</p> <p>Could the study cause discomfort or distress of a mental or emotional character to participants and/or investigators? What is the nature of any discomfort or distress of a mental or emotional character that you might anticipate?</p>	<p><u>prevent the hazard or minimise adverse effects?</u></p> <p>Are there standard operating procedures or rules for the premises?</p> <p>Have there been agreed levels of supervision of the study? Will trained medical staff be present?</p> <p>Etc/</p>	<p><u>or not adequately controlled?</u></p>	<p><u>from your study</u> for example, provision of medical support/aftercare, precautions to be put in place to avoid or minimise risk or adverse effects</p> <p>NOTE: medical or other aftercare and/or support <b>must</b> be made available for participants and/or investigator(s) who require it where <b>invasive procedures</b> have been used in the study.</p>
<p>Vignettes about ethical dilemmas in clinical psychology may cause emotional distress for participants</p>	<p>Participants – qualified clinical psychologists</p>	<p>Discomfort or distress of a mental or emotional character to participants. Participants may find the nature of the vignettes emotionally upsetting in and of itself, or this may remind them of</p>	<p>The vignettes are designed to be realistic and reflective of ethical dilemmas likely to occur in clinical practice for UK clinical psychologists. Therefore it is believed</p>	<p>n/a</p>	<p>All participants will be given a debrief sheet signposting them to further emotional support if needed. The research team, who have experience of managing emotional distress individually and in groups, will be</p>

		difficult situations they have been/are in.	that these will be no more distressing than the participant group would be likely to encounter in their everyday lives		contactable should participants wish to discuss concerns further.
Participants may be concerned about how their answers (what they say about how they would respond to the vignettes and why) are received by other participants.	Participants – qualified clinical psychologists	Discomfort or distress of a mental or emotional character to participants. Participants may be concerned about how their answers and personal vales reflect on them, as these are shared with other participants.	In the information sheet, participants will be invited to only share what they feel comfortable sharing in terms of how they would respond to vignettes.  At the start of the focus group, the importance of confidentiality will be emphasised to participants. For online surveys, although participant's answers will be shared with each other in subsequent rounds, as per the Deplhi Method,	n/a	All participants will be given a debrief sheet signposting them to further emotional support if needed. The research team, who have experience of managing emotional distress individually and in groups, will be contactable should participants wish to discuss concerns further.  Participants will have the opportunity to withdraw and have their data removed from the study. However, as subsequent iterations of the study will be based on answers from previous ones, this period may be only one week for the online survey method and

			these will be anonymised and participants will not know who other participants are.		could be slightly longer for the focus group or final round (this will be made clear at the consent stage).
Participant may disclose a value or behaviour that is inconsistent with their professional codes of conduct when discussing hypothetical vignettes.	Participants – qualified clinical psychologists,  Investigators	Discomfort or distress of a mental or emotional character to participants and investigators. If participants disclose unethical or unsafe practice this may be distressing in and of itself for investigating team to learn to learn of, and also of how to manage the potential consequences. If faced with a situation that causes investigators to need to breach confidentiality, participants may become distressed at the potential consequences of such a disclosure.	Participants will not be asked to discuss real examples of their clinical practice either online or in the focus group, questions focus on hypothetical vignettes. Participants will be made aware at the information sheet stage that the normal limits to confidentiality apply, and if there are disclosures of unsafe or unethical practice then confidentiality may need to be broken.	n/a	If this instance were to arise, this would be discussed within the research team, discussed with the participant who may be encouraged to seek relevant professional support, advice sought from the University's legal team, and potentially reported to the police, local safeguarding authority or professional body HCPC / BPS.  Support for investigators is also available from the wider research team and DClinPsy department, should this be necessary.

Signed by applicant: Becky Grace

Dated: 07/05/2018



*Appendix D. Approval notice from the University of Hertfordshire Health, Science, Engineering and Technology ECDA for the present research.*



HEALTH SCIENCE ENGINEERING & TECHNOLOGY ECDA

## ETHICS APPROVAL NOTIFICATION

TO Becky Grace  
CC Dr Helen Ellis-Caird  
FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair.  
DATE 21/06/2018

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Protocol number: LMS/PGT/UH/03358

Title of study: Towards a model of ethical competence in Clinical Psychology.

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

This approval is valid:

From: 21/06/2018

To: 01/06/2019

Additional workers: No additional workers named.

Please note:

If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and your completed consent paperwork to this ECDA once your study is complete. You are also required to complete and submit an EC7 Protocol Monitoring Form if you are a member of staff. This form is available via the Ethics Approval StudyNet Site via the 'Application Forms' page [http://www.studynet1.herts.ac.uk/ethics/common/ethics\\_net/Teaching-Documents?OpenView&count=9999&restricttocategory=Application-Forms](http://www.studynet1.herts.ac.uk/ethics/common/ethics_net/Teaching-Documents?OpenView&count=9999&restricttocategory=Application-Forms)

Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval (if you are a student) and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

*Appendix E. Application to the University of Hertfordshire Health, Science, Engineering and Technology ECDA for first amendments to the present research.*

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS  
(‘ETHICS COMMITTEE’)

## FORM EC2: APPLICATION FOR MODIFICATION AND/OR EXTENSION TO AN EXISTING PROTOCOL APPROVAL

Please note: this form may be used to amend a study approved after January 2013. For studies approved pre-January 2013, please complete a new EC1 form for review and approval.

1 **Title of original application:**  
Towards a model of ethical competence in Clinical Psychology

**Protocol Number:**  
LMS/PGT/UH/03358

**Is this the first modification/extension request for this study?**

Yes X No

**If no, please include the most recent approval notification document with your application.**

### 2 Protocol holder details

Applicant name: Becky Grace

Student/Staff number : \*\*\*\*\*

Applicant e-mail address: \*\*\*\*@herts.ac.uk

Work address (if appropriate): c/o DClinPsy, Health Research Building, UH

Supervisor’s name: Dr Helen Ellis-Caird

Supervisor’s School & Department: LMS, Psychology & Sports Sciences; DClinPsy

Supervisor’s e-mail address: \*\*\*\*@herts.ac.uk

### 3 Specify the nature of the modification/extension (please tick all that apply and complete Q4 & 5).

- Revised title of study.  
Please state amended title here
- Amend/extend dates

From: [Click here to enter a date.](#) To: [Click here to enter a date.](#)

- Additional worker(s):

Names and student/staff numbers for any additional investigators involved in this study

[Click here to enter text.](#)

- Change of supervisor from: [Click here to enter text.](#) to: [Click here to enter text.](#)  
Please complete declaration below and give reason in Q4

Declaration by new supervisor:

I have reviewed the ethics protocol paperwork for this study and am aware of any conditions which must be adhered to.

Signed [Click here to enter text.](#) Date: [Click here to enter a date.](#)

- Location of study

Detail new location here

- Other

Please specify here:

1. Minor change to participant demographic

From: Qualified Clinical Psychologists, working in the UK, registered with HCPC (Healthcare professions council) and qualified for at least two years.

To: Qualified Clinical Psychologists, working in the UK, registered with HCPC (Healthcare professions council), and qualified for any length of time.

2. Addition of the Moral Foundations Questionnaire (MFQ30; Graham, Haidt & Nosek, 2008). This is a 32 item, validated, self-report questionnaire in which participants are asked to rate to what extent they consider each of the five "moral foundations" (e.g. fairness, authority etc.), when approaching moral dilemmas. It is estimated that this will take participants an additional five minutes. Please find the measure attached.

Please also find attached updated participant information sheet (EC6) with changes highlighted in yellow (sections 5, 7, 14).

4 **Reason for extension/modification request**

1. Following discussion more recent within the research team, it was felt that the sample would represent greater diversity if participants who have been qualified for any length of time were also included (not just those who have been qualified for two years or more).

2. In the original application it was outlined that participants would be asked demographic information (such as age, gender,

political affiliation etc.) in order to determine generalisability or potential confounds in the results. Through more recent discussion in the supervisory team, it was also felt that in addition to this demographic information, it would be useful to know how participants identify in terms of the moral frameworks they draw on, or their affiliations to different “moral foundations”. As this information may not be readily cognitively accessible to participants, it was felt that use of a standardised tool will assist this process.

#### 5 Hazards

Does the modification or extension present additional hazards to the participant/investigator?

YES  NO

If YES, please complete a new risk assessment EC5 form. Subject specific forms may also be necessary; you should therefore contact your Supervisor or School to see whether this is the case.

If you are required to complete a School risk assessment, please append this to your EC5 form. In this case the EC5 form should be used to note any risks **not** already noted on your School risk assessment. It is acceptable to state 'Included in <School> risk assessment' in the relevant spaces of the EC5 where applicable.

Signature of Applicant : Becky Grace

Date: 28/06/2018

Support by Supervisor: Helen Ellis-Caird

Date: 02/07/2018

*Appendix F. Approval notice from University of Hertfordshire Health, Science, Engineering and Technology ECDA for first amendments to the present research.*



## HEALTH SCIENCE ENGINEERING & TECHNOLOGY ECDA

### ETHICS APPROVAL NOTIFICATION

TO Becky Grace  
CC Dr Helen Ellis-Caird  
FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair.  
DATE 04/07/2018

---

Protocol number: aLMS/PGT/UH/03358(1)  
Title of study: Towards a model of ethical competence in Clinical Psychology

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below.

**Modification:** Detailed in EC2 Form

This approval is valid:

From: 04/07/2018

To: 01/06/2019

**Additional workers:** No additional workers name.

**Please note:**

If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and your completed consent paperwork to this ECDA once your study is complete. You are also required to complete and submit an EC7 Protocol Monitoring Form if you are a member of staff. This form is available via the Ethics Approval StudyNet Site via the 'Application Forms' page <http://www.studynet1.herts.ac.uk/pti/common/ethics.nsf/Teaching+Documents?OpenView&count=3333&restricttcategory=Application+Forms>

Any conditions relating to the original protocol approval remain and must be complied with.

Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1/EC1A or as detailed in the EC2 request. Should you amend any further aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval (if you are a student) and must complete and

*Appendix G. Application to the University of Hertfordshire Health, Science, Engineering and Technology ECDA for second amendment to the present research.*

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS  
(‘ETHICS COMMITTEE’)

**FORM EC2: APPLICATION FOR MODIFICATION AND/OR EXTENSION TO AN EXISTING PROTOCOL APPROVAL**

Please note: this form may be used to amend a study approved after January 2013. For studies approved pre-January 2013, please complete a new EC1 form for review and approval.

1 **Title of original application:**  
Towards a model of ethical competence in Clinical Psychology

**Protocol Number:**  
aLMS/PGT/UH/03358(1)

**Is this the first modification/extension request for this study?**

Yes

No X

**If no, please include the most recent approval notification document with your application.**

---

2 **Protocol holder details**

Applicant name: Becky Grace  
 Student/Staff number : \*\*\*\*\*  
 Applicant e-mail address: \*\*\*\*@herts.ac.uk  
 Work address (if appropriate): c/o DClinPsy, Health Research Building, UH  
 Supervisor’s name: Dr Helen Ellis-Caird  
 Supervisor’s School & Department: LMS, Psychology & Sports Sciences; DClinPsy  
 Supervisor’s e-mail address: \*\*\*\*@herts.ac.uk

---

3 **Specify the nature of the modification/extension (please tick all that apply and complete Q4 & 5).**

Revised title of study.

Please state amended title here

- Amend/extend dates

From: [Click here to enter a date.](#) To: [Click here to enter a date.](#)

- Additional worker(s):

Names and student/staff numbers for any additional investigators involved in this study

[Click here to enter text.](#)

- Change of supervisor from: [Click here to enter text.](#) to: [Click here to enter text.](#)  
Please complete declaration below and give reason in Q4

Declaration by new supervisor:

I have reviewed the ethics protocol paperwork for this study and am aware of any conditions which must be adhered to.

Signed [Click here to enter text..](#) Date: [Click here to enter a date.](#)

- Location of study

Detail new location here

- Other

*Please specify here:*

*1. Change to consent form – removal of the following sentence "I understand that my participation in this study may reveal findings that could indicate that I might require medical advice. In that event, I will be informed and advised to consult my GP. If, during the study, evidence comes to light that I may have a pre-existing medical condition that may put others at risk, I understand that the University will refer me to the appropriate authorities and that I will not be allowed to take any further part in the study."*

*Please see attached for amended form.*

**4 Reason for extension/modification request**

This sentence is in the standard consent form, it was left in by error on my part. I meant to remove it prior to submission to the ethics committee but noticed upon proof reading that unfortunately I had not. However, it is irrelevant to participants in the present study as there is no opportunity for participants to enter information of this sort, no questions about their medical status and no questionnaires that are also used as diagnostic tools for example. Indeed it may cause more confusion or concern if they are inadvertently led to believe there may be a medical query behind some questions when in fact there is not.

**5 Hazards**

Does the modification or extension present additional hazards to the participant/investigator?

YES

NO

If YES, please complete a new risk assessment EC5 form. Subject specific forms may also be necessary; you should therefore contact your Supervisor or School to see whether this is the case.

If you are required to complete a School risk assessment, please append this to your EC5 form. In this case the EC5 form should be used to note any risks **not** already noted on your School risk assessment. It is acceptable to state 'Included in <School> risk assessment' in the relevant spaces of the EC5 where applicable.

Signature of Applicant : Becky Grace

Date: 13/08/2018

Support by Supervisor: Helen Ellis-Caird

Date: 13/08/2018



*Appendix H. Approval notice from University of Hertfordshire Health, Science, Engineering and Technology ECDA for second amendment to the present research.*



## HEALTH SCIENCE ENGINEERING & TECHNOLOGY ECDA

### ETHICS APPROVAL NOTIFICATION

**TO** Becky Grace  
**CC** Dr Helen Ellis-Caird  
**FROM** Dr Simon Trainis, Health, Science, Engineering & Technology ECDA  
**DATE** 15/08/2018

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Protocol number: aLMS/PGT/UH/03358(2)

Title of study: Towards a model of ethical competence in Clinical Psychology.

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

**Modification:** Details in Completed EC2

This approval is valid:

From: 15/08/2018

To: 01/06/2019

**Additional workers:** no additional workers named.

**Please note:**

If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and your completed consent paperwork to this ECDA once your study is complete. You are also required to complete and submit an EC7 Protocol Monitoring Form if you are a member of staff. This form is available via the Ethics Approval StudyNet Site via the 'Application Forms' page <http://www.studynet1.herts.ac.uk/pti/common/ethics.nsf/Teaching+Documents?OpenView&count=9999&restricttocategory=Application-Forms>

Any conditions relating to the original protocol approval remain and must be complied with.

Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

*Appendix I. Email to University Hertfordshire Data Protection Officer to discuss ethical concern with Qualtrics survey platform on 16/07/2018.*

*Note. Followed up with phone call on 26/07/2019 who confirmed that there were no concerns with using this platform.*

Hi there Ian

I hope you don't mind me getting in touch with you. My supervisor (Helen Ellis-Caird) and course director (Pieter Nel) suggested that you might be able to help with a query I have re data protection for my thesis.

I am a second year DClinPsy student just looking at starting my data collection, for part of which I will be doing some surveys. In my ethics application, I outlined that my data would be stored securely. Some of this will be sensitive data but I am going to ask participants to identify by a number and keep the ID numbers and names separately. However, I have since been looking at the terms of service for Qualtrics [www.qualtrics.com/terms-of-service](http://www.qualtrics.com/terms-of-service) and I am unsure about some of the points (around confidentiality, ownership and secure storage), specifically as highlighted below. I didn't really understand a lot of the language and didn't want to just go ahead with using it.

I wondered if you had any more information or experience on the uni's legal position for using Qualtrics in research? Or perhaps the University has produced any plain english guidance on what their specific agreements with the site are, and whether this software is OK to use in research? (I couldn't see anything on studynet).

Many thanks in advance for any thoughts you may have.

Kind regards,  
Becky Grace

*Appendix J. Example email to participants with link to survey platform and information about data collection.*

Dear \*\*\*

Thank you for agreeing to take part in the delphi study entitled: Towards a model of ethical competence in clinical psychology (LMS/PGT/UH/03358).

I am pleased to let you know that **the research has now commenced!** So I am writing to you with the link to the first survey. **Please can you complete this survey** as soon as possible, and **within two weeks** at the latest, as results cannot be collated until everyone has responded.

**How to complete the survey:**

Please click on the link below:

[https://herts.eu.qualtrics.com/jfe/form/SV\\_8IUTmryWqt0CO9f](https://herts.eu.qualtrics.com/jfe/form/SV_8IUTmryWqt0CO9f)

When prompted after the consent form, please enter your unique, 3-digit participant identification number: **\*\*\***. This is to protect your identity. Please do not share this link with anyone else.

**Note on data protection:** by clicking on this link, Qualtrics (a third party survey platform, used widely in academic research), will collect the IP address of the device that you are using. This is so that you may exit the survey and return to it later and your answers will be saved. If you wish to do this, you must use the same device and the same internet browser software (e.g. Google Chrome, Internet Explorer etc.) each time you open the survey. Please bear in mind that responses in progress are automatically submitted one week after your last activity and you would then need to restart the survey.

Qualtrics (as with other survey platforms) collects aggregate usage data for their analytics purposes, in line with their privacy statement (available here: <https://www.qualtrics.com/privacy-statement/>). Your responses within the survey are therefore considered to be confidential between Qualtrics and the research team. Qualtrics will not receive your name or contact details. This information is linked to your identification number which is stored in a password protected word document and this email by the research team.

I will write to you with a prompt to complete the survey in 1 week's time. In the meantime, please do not hesitate to get in touch if you need to discuss any aspect of the study.

Your participation is highly valued.

Kind regards,

**Becky Grace**  
**Trainee Clinical Psychologist**

*Appendix K. Participant information sheet.*

*Note. Sent in advance of beginning the research and available for review at the start of each survey.*

**UNIVERSITY OF HERTFORDSHIRE**

**ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS  
(‘ETHICS COMMITTEE’)**

**FORM EC6: PARTICIPANT INFORMATION SHEET**

**1 Title of study**

Towards a model of ethical competence in Clinical Psychology

**2 Introduction**

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

<http://sitem.herts.ac.uk/secreg/upr/RE01.htm>

Thank you for reading this.

**3 What is the purpose of this study?**

The researchers are looking to investigate ethical dilemmas in Clinical Psychology and how they are approached. This will include finding out what is believed to be appropriate courses of action and justifications in response to vignettes. The researchers are looking to form an anonymous group of qualified clinical psychologists who are willing to try to work towards reaching a consensus on the what are appropriate courses of action and justifications in response to vignettes. From a theoretical point of view, the researchers will then analyse the information to try to gain an understanding of how this ethical decision-making process comes about.

**4 Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to

complete it. You are free to withdraw at any stage without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not affect any treatment/care that you may receive (should this be relevant).

**5 Are there any age or other restrictions that may prevent me from participating?**

Although there are no specific age restrictions, participants must be a HCPC registered Clinical Psychologist, working in the UK.

**6 How long will my part in the study take?**

If you decide to take part in this study, you will be sent links to an online survey platform containing vignettes and questions, approximately one a month for 3-4 months. Each survey will take approximately 30 minutes to complete.

**7 What will happen to me if I take part?**

You will be sent a link to an online survey containing vignettes describing fictional (but realistic) ethical dilemmas relevant to the field of clinical psychology. You will be asked some questions about these vignettes and about yourself. You are asked not to comment on real examples of your own clinical practice. The first time you complete this survey, you will also be asked to complete a short questionnaire about the considerations you draw upon when deciding what is right and wrong. You will be contacted up to three more times after this and provided with anonymous feedback on what other participants said about these vignettes. You will then be asked to rate the answers given by everybody with the aim of reaching an overall agreement about the most appropriate courses of action and justifications in each of the vignettes. It is anticipated that the questionnaires will only be sent to you over no longer than a 4-month period. We would encourage you to complete each set of questionnaires within 2 weeks for your answers to be taken to the next stage.

**8 What are the possible disadvantages, risks or side effects of taking part?**

There are no known possible side effects of taking part. Some of the material described in the vignettes may be distressing, however it is anticipated that this will be no more so than you might reasonably be expected to encounter in the normal course of your professional life. Your participation will involve you giving up your time.

**9 What are the possible benefits of taking part?**

There are no specific individual benefits identified to you for taking part. However, it is hoped that this research will support the field's understanding of how ethical decision making is done in Clinical Psychology, with the possible production and implementation of further guidance and training tools.

**10 How will my taking part in this study be kept confidential?**

Once data is collected, and prior to being stored, it will be pseudo-anonymised, meaning your name will be replaced with an identifying number.

No details identifying you will be released to anyone else other than the Principle Researcher (Trainee Clinical Psychologist) and Supervisory team. Although your responses to the vignettes may be shared with other participants, your responses will not be personally identifiable. Your data will be fully anonymised for the purposes of writing up the results of the present study for publication.

The data collected will be stored electronically, in a password-protected environment until the study has been accepted for publication, after which time it will be destroyed under secure conditions;

## 12 What will happen to the data collected within this study?

12.1 The data collected will be stored electronically, in a password-protected environment, until aggregate data is published after which time it will be destroyed under secure conditions.

12.3 The data will be anonymised prior to storage.

## 13 Will the data be required for use in further studies?

13.2 You are consenting to the re-use or further analysis of the data collected in a future ethically-approved study; the data to be re-used will be anonymised and will only be used in studies undertaken within the University of Hertfordshire.

The data collected will be stored electronically, in a password-protected environment, until aggregate data is published after which time it will be destroyed under secure conditions.

## 14 Who has reviewed this study?

This study has been reviewed by:

The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is LMS/PGT/UH/03358

## 15 Factors that might put others at risk

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities.

## 16 Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me by email: Becky Grace, Trainee Clinical Psychologist, [\\*\\*\\*\\*@herts.ac.uk](mailto:****@herts.ac.uk). Please also feel free to contact my supervisor by phone, email or writing: Dr Helen Ellis-Caird, [\\*\\*\\*\\*@herts.ac.uk](mailto:****@herts.ac.uk); Tel: \*\*\*\*; Address: University of Hertfordshire, Hatfield, AL10 9AB.

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

Secretary and Registrar  
University of Hertfordshire  
College Lane  
Hatfield  
Herts  
AL10 9AB

**Thank you very much for reading this information and giving consideration to taking part in this study.**

*Appendix L. Participant consent form.*

*Note. Informed consent taken electronically at the start of iteration one. This form was available for review at the start of each subsequent survey.*

**University of Hertfordshire**

**Ethics committee for studies involving the use of human participants ('ethics committee')**

**Form EC3: Consent form for studies involving the use of human participants**

I hereby freely agree to take part in the study entitled:  
**Towards a model of ethical competence in clinical psychology  
(UH protocol number: LMS/PGT/UH/03358)**

I confirm that I have been given a participant information sheet giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants.

I have also been informed of how my personal information on this form will be stored and for how long.

I have been given details of my involvement in the study.

I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

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

I have been given information about the risks of my suffering harm or adverse effects.

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

I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

I have been told that I may at some time in the future be contacted again in connection with this or another study.

**Name of (principal) investigator: Becky Grace, Trainee Clinical Psychologist**




Appendix M. Example slides used to disseminate the present research (Grace, Wainwright & Ellis-Caird, 2019; Grace, 2019).

### Ethical Identity in Clinical Psychology: Towards a Model of Ethical Competence


Becky Grace, University of Hertfordshire  
 Helen Ellis-Caird, University of Hertfordshire  
 Tony Wainwright, University of Exeter

### Would you, as a clinical psychologist, undertake an internet search of a client?

- What factors would influence your decision?
- What justifications would you draw upon when making this decision?




### We are not immune....



### Developmental theory of moral judgment


Rest (1986; based on Kohlberg, 1973)

- Personal Interests Schema
- Maintaining Norms Schema
- Post-Conventional Reasoning Schema




### Participants

<b>Gender Identity</b> <ul style="list-style-type: none"> <li>• Female = 16</li> <li>• Male = 9</li> <li>• Other response = 4</li> <li>• No response = 2</li> </ul>	<b>Settings</b> <ul style="list-style-type: none"> <li>• Community = 55%</li> <li>• Inpatient = 10%</li> <li>• Community &amp; Inpatient = 19%</li> <li>• Other = 16%</li> </ul>	<b>Employers</b> <ul style="list-style-type: none"> <li>• 14 NHS only</li> <li>• 5 Private sector only</li> <li>• 3 NHS + Private sector</li> <li>• 3 Private sector + 3rd sector</li> <li>• 2 NHS + Private sector + 3rd sector</li> <li>• 2 Local Authority only</li> <li>• 1 Education only</li> <li>• 1 Other</li> </ul>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------



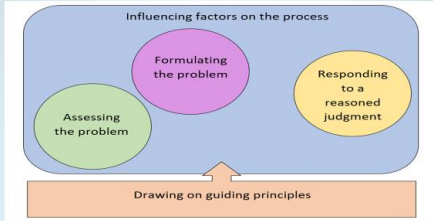
### Method - Round 1

- Five fictional vignettes illustrating ethical dilemmas in clinical psychology practise, presented in a random order per participant.
- Based on ethical principles from BPS Code of Ethics and Conduct (2018):




- Dilemma designed to have no obvious right or wrong response, piloted with trainee colleagues.
- Mean score for realistic = 76% (st. dev. 22.99)
- Mean score for relevant = 81% (st. dev. 19.55)

### A model of ethical decision-making in clinical psychology



### Conclusions, Implications & Next Steps

- Model of the process of ethical decision-making in this (representative) participant group has been developed
- Ethical dilemmas been derived through consultation and empirically tested - use for future research or teaching
- Next step, consult more widely with the profession. Is the model ethically competent? Is this the ideal to promote, or does the model need adjusting?
- Taken forward into review of BPS guidelines on teaching and assessment of ethical competence in psychology education.



*Appendix N. Feedback sent electronically to participants and consultants to the project.*

**Ethical competence: An Analysis of Decision-Making in Clinical Psychology.**

May 2019

Dear Participant

Thank you for your time and contribution to this research. This research is now complete, and I am writing with a summary of the results. Preliminary results were presented at the DCP Annual Conference (January 2019) and the University of Hertfordshire School of Life and Medical Sciences Annual Research Conference (April 2019). This will also be submitted for journal publication shortly.

**Aims**

This research aimed to develop understanding of ethical competence in clinical psychology by exploring responses to ethical dilemmas presented in clinical vignettes. It investigated what psychologists considered to be appropriate justifications for ethical decisions made (i.e. Would you, as a clinical psychologist do X? *Yes* or *No* and *why*); and whether these justifications could be best explained using existing frameworks or through the development of a new model. Existing models include Rest's (1986) moral schemas, intermediate profession-specific concepts (such as confidentiality and informed consent; Bebeau & Thoma 1999) or ethical principles such as care (Gilligan, 2008) or justice (Kohlberg, 1973). However, to date no empirically derived or tested models of ethical decision-making in clinical psychology have been identified.

**Method**

A mixed-methods Delphi methodology was employed using quantitative questionnaire data and qualitative justifications given for quantitative scores. As ethical decision-making in psychology can be seen as a culture (Handelsman, Gottlieb & Knapp, 2005), constructed, to a large extent, within the discipline, this led to the selection of clinical psychologists working in the UK as the participant group (n = 31) and consensus they reached as the best way of gaining knowledge in the subject area. Participants were recruited using opportunistic sampling and responded to ethical dilemmas via online questionnaires. Through controlled feedback (n = 28), participants rated and ranked the collective justifications. Participants were then given the opportunity to adjust their scores (n = 25), in light of seeing the collective scores.

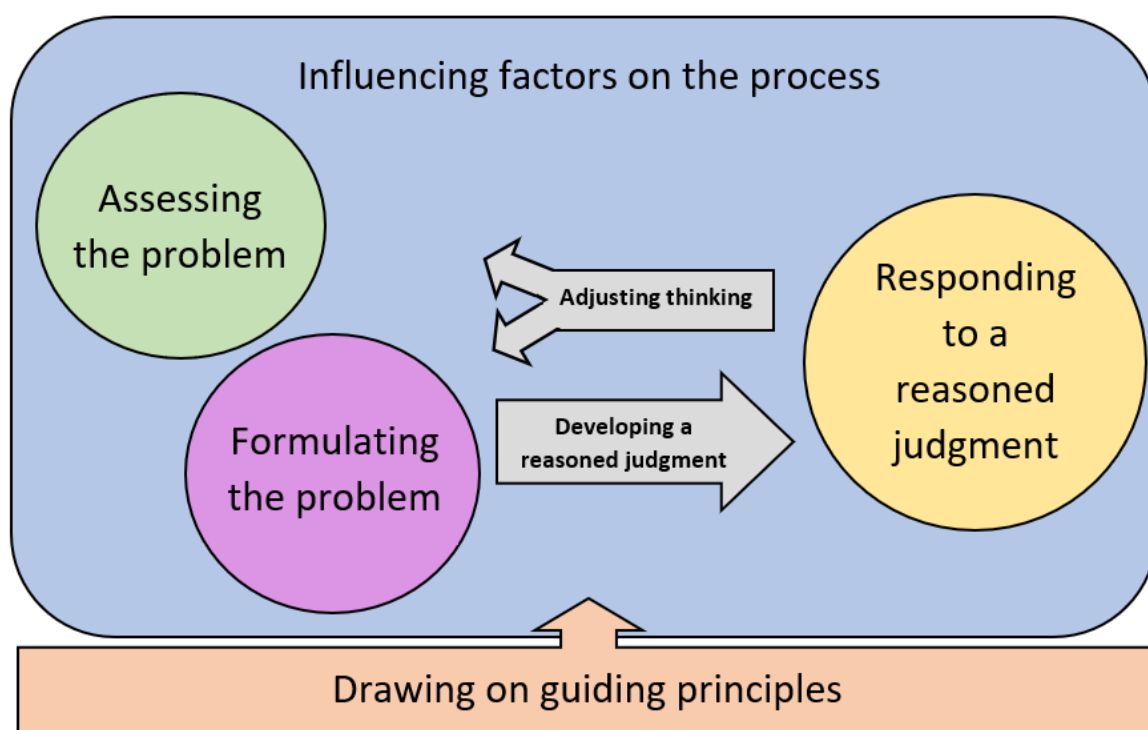
**Analyses**

Quantitative analyses indicated that the vignettes used in the present research were seen as realistic and relevant. Qualitative data was analysed using thematic analysis which identified five key themes within ethical decision-making which draw on three elements of the cycle of professional practice's core competencies of: *assessing an ethical problem*, *formulating an ethical problem*, *responding to a reasoned judgment* (intervention / implementation) (BPS, 2017). Existing models of ethical decision-making described above fitted with the present model mainly at the formulating phase. However, these models alone were insufficient to explain the process of ethical decision-making in this research. During this process, *avoidance of harm* and *client's best interests* tended to be prioritised. This process occurs within a context of *influencing factors* (such as the dilemma context and the decision-maker context), and throughout the process participants reported *drawing on guiding*

*principles* (of taking a critical stance, a reflective stance, drawing on multiple perspectives and multiple justifications). A model incorporating these themes is presented below, describing ethical decision-making in clinical psychology as a process.

### Discussion and implications

Vignettes representing ethical dilemmas in UK clinical psychology were developed through consultation with members of the profession and empirically tested with this participant group. The vignettes were felt to be realistic and relevant and to have had an impact on participants' thinking and practice in relation to ethical competence. It was felt the vignettes would be particularly useful for teaching. By analysing responses to the dilemmas presented in these vignettes, a model of decision-making in this participant group was developed.



The next phase will involve consulting more widely amongst the profession about whether this model is felt to be ethically competent, and will lead to ethically competent decisions, or whether other aspects need adding when these decisions are made in practice as opposed to hypothetically (such as an evaluative component). This research has key implications for ethical instruction and the development of ethical competence which in turn have significant effects for clinical psychologists, those using services and how the profession is viewed. It is hoped that these findings will be taken forward to support the review and development of the BPS Guidelines on Teaching and Assessment of Ethical Competence in Psychology Education (2015).

Thank you again for your interest and contributions. Please do not hesitate to get in touch if you would like to discuss any aspect of this research.

Kind regards,

Becky Grace

Trainee Clinical Psychologist, University of Hertfordshire (UH) ([\\*\\*\\*\\*@herts.ac.uk](mailto:****@herts.ac.uk)).

Supervisors: Helen Ellis-Caird & Wendy Solomons (UH), Tony Wainwright (University of Exeter)

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Appendix O. Example feedback from a pilot questionnaire testing question wording for one of the vignettes (Maria).

learning disability, then no further child protection action will be  
 However, your team is strictly commissioned only to provide support to people who meet the  
 criteria for a diagnosis of a learning disability. If she was assessed and found not to have a learning  
 disability she would need to be discharged from your service.

1. Would you, as a Clinical Psychologist, undertake a neuropsychological assessment of Maria's  
 learning disabilities?

I would want to know if I could do the  
 assessment but refuse to share outcome with  
 social care either way, or I'd refer to adult  
 mental health as they can see people without  
 an IQ score.

2. Please state why you gave the answer you did to question 1

I would want Maria to get help from our  
 services as it would not be fair to prevent  
 her from mental health support + lack of support  
 could further impact her  
 & her child.

3. Please add any further comments you wish here

There are many other things that could be  
 done, eg. MCA assessment, functional  
 assessment only, professionals meeting with  
 social care ... You need to balance  
 child protection & protecting Maria.

*Appendix P. Summary of questionnaire structure and example questions used in iteration one.*

1. Introduction.
2. Information sheet.
3. Consent form.
4. Professional demographic information.
  - a. Are you currently practising in the UK as a clinical psychologist? (Yes, No)
  - b. Which geographical region most closely covers the area in which you are predominantly working?
  - c. In which year did you qualify as a clinical psychologist?
  - d. How would you describe the theoretical orientation(s) you draw upon in your practise as a clinical psychologist?
  - e. Which organisational context(s) are you currently working in?
  - f. Which client group(s) and service type(s) describes your current work?
  - g. Which service delivery context are you working in?
5. Vignette Introduction.

You will now be shown five fictional vignettes depicting ethical dilemmas in clinical psychology. After each one, you will be asked questions about how you would respond and why. You will also have the opportunity to provide feedback on the vignettes.

Please do not comment specifically on real life examples of your own clinical practise.
6. Each of the five vignettes presented in random order with ethical decision question and *yes, no*, no response options.
  - a. Please state why you gave the answer you did to the above question.
  - b. How would you justify your answers?
  - c. Please rate the above vignette on the following dimensions using the scale of 0 = Not at all, 100 = Fully.
    - i. The dilemma is realistic to current practise of clinical psychology in the UK.
    - ii. The dilemma is relevant to current practise of clinical psychology in the UK.
7. Please use this box to add any further comments you wish about the above vignette.
8. MFQ-30.
9. Personal demographic information.
  - a. How do you describe your gender identity?
  - b. How do you describe your political orientation?
  - c. How do you describe your faith, spiritual, or religious beliefs?
10. Debrief sheet.

*Appendix Q. Moral Foundations Questionnaire (MFQ-30; Graham, Haidt & Nosek, 2008).*

### Moral Foundations Questionnaire

*Part 1. When you decide whether something is right or wrong, to what extent are the following considerations relevant to your thinking? Please rate each statement using this scale:*

[0] = not at all relevant (This consideration has nothing to do with my judgments of right and wrong)

[1] = not very relevant

[2] = slightly relevant

[3] = somewhat relevant

[4] = very relevant

[5] = extremely relevant (This is one of the most important factors when I judge right and wrong)

- \_\_\_\_\_ 1. Whether or not someone suffered emotionally
- \_\_\_\_\_ 2. Whether or not some people were treated differently than others
- \_\_\_\_\_ 3. Whether or not someone's action showed love for his or her country
- \_\_\_\_\_ 4. Whether or not someone showed a lack of respect for authority
- \_\_\_\_\_ 5. Whether or not someone violated standards of purity and decency
- \_\_\_\_\_ 6. Whether or not someone was good at math
- \_\_\_\_\_ 7. Whether or not someone cared for someone weak or vulnerable
- \_\_\_\_\_ 8. Whether or not someone acted unfairly
- \_\_\_\_\_ 9. Whether or not someone did something to betray his or her group
- \_\_\_\_\_ 10. Whether or not someone conformed to the traditions of society
- \_\_\_\_\_ 11. Whether or not someone did something disgusting
- \_\_\_\_\_ 12. Whether or not someone was cruel
- \_\_\_\_\_ 13. Whether or not someone was denied his or her rights
- \_\_\_\_\_ 14. Whether or not someone showed a lack of loyalty
- \_\_\_\_\_ 15. Whether or not an action caused chaos or disorder
- \_\_\_\_\_ 16. Whether or not someone acted in a way that God would approve of

*Part 2. Please read the following sentences and indicate your agreement or disagreement:*

[0]	[1]	[2]	[3]	[4]	[5]
Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree

- \_\_\_\_\_ 17. Compassion for those who are suffering is the most crucial virtue.
- \_\_\_\_\_ 18. When the government makes laws, the number one principle should be ensuring that everyone is treated fairly.
- \_\_\_\_\_ 19. I am proud of my country's history.
- \_\_\_\_\_ 20. Respect for authority is something all children need to learn.
- \_\_\_\_\_ 21. People should not do things that are disgusting, even if no one is harmed.

- \_\_\_\_\_ 22. It is better to do good than to do bad.
- \_\_\_\_\_ 23. One of the worst things a person could do is hurt a defenseless animal.
- \_\_\_\_\_ 24. Justice is the most important requirement for a society.
- \_\_\_\_\_ 25. People should be loyal to their family members, even when they have done something wrong.
- \_\_\_\_\_ 26. Men and women each have different roles to play in society.
- \_\_\_\_\_ 27. I would call some acts wrong on the grounds that they are unnatural.
- \_\_\_\_\_ 28. It can never be right to kill a human being.
- \_\_\_\_\_ 29. I think it's morally wrong that rich children inherit a lot of money while poor children inherit nothing.
- \_\_\_\_\_ 30. It is more important to be a team player than to express oneself.
- \_\_\_\_\_ 31. If I were a soldier and disagreed with my commanding officer's orders, I would obey anyway because that is my duty.
- \_\_\_\_\_ 32. Chastity is an important and valuable virtue.

-----

To score the MFQ yourself, you can copy your answers into the grid below. Then add up the 6 numbers in each of the five columns and write each total in the box at the bottom of the column. The box then shows your score on each of 5 psychological "foundations" of morality. Scores run from 0-30 for each foundation. (Questions 6 and 22 are just used to catch people who are not paying attention. They don't count toward your scores).

Question #	Your Response	Question #	Your Response	Question #	Your Response	Question #	Your Response	Question #	Your Response		
1		2		3		4		5		6	
7		8		9		10		11			
12		13		14		15		16			
17		18		19		20		21		22	
23		24		25		26		27			
28		29		30		31		32			

Harm / Care	Fairness / Reciprocit	In-group/ Loyalty	Authority / Respect	Purity / Sanctity

The average politically moderate American's scores are: 20.2, 20.5, 16.0, 16.5, and 12.6. Liberals generally score a bit higher than that on Harm/care and Fairness/reciprocity, and much lower than that on the other three foundations. Conservatives generally show the opposite pattern.

The Moral Foundations Questionnaire (MFQ-30, July 2008) by Jesse Graham, Jonathan Haidt, and Brian Nosek. For more information about Moral Foundations Theory, scoring this form, or interpreting your scores, see: [www.MoralFoundations.org](http://www.MoralFoundations.org). To take this scale online and see how you compare to others, go to [www.YourMorals.org](http://www.YourMorals.org)



*Appendix R. Summary of questionnaire structure and example questions used in iteration two.*

1. Introduction.
2. Opportunity to review information sheet and consent form.
3. Vignette Introduction.
4. Each of the same five vignettes from iteration one presented in random order with forced choice ethical decision question (*yes, or no*).  
Below are a number of justifications given for and against the clinical psychologist[*'s ethical decision*] in the above vignette.
5. Each of the 30-37 justifications per vignette presented in a random order per participant.
  - a. With ethical thinking in mind, which justifications would you take into account when making this decision, as a clinical psychologist?  
Please use the scale of 1 (I definitely would not take this into account) to 7 (I definitely would take this into account) to rate each of the justifications. [*4 = I might or might not take this into account*].
  - b. With ethical thinking in mind, please rank, in order, the top four justifications you would be most likely to take into account when making this decision, as a clinical psychologist?
  - c. With ethical thinking in mind, please rank, in order, the three justifications you would be least likely to take into account when making this decision, as a clinical psychologist?
  - d. If this dilemma happened to you next week in your clinical practise, would there be any difference in what you feel you *should* do, with ethical thinking in mind, compared to what you probably *would* do?  
What would influence this?  
If there would be any differences, what would this be?
  - e. Please use this box to add any further comments you wish about any aspects of the above vignette and questions, as presented in this survey:
6. Debrief.

*Appendix S. Summary of questionnaire structure and example questions used in iteration three.*

1. Introduction
2. Opportunity to review information sheet and consent form.
3. Vignette Introduction.
4. Each of the same five vignettes from iteration one presented in random order with summary of forced choice ethical decision responses from iterations one and two.
  - a. Feedback on own score and group mean, standard deviation and range for vignette realistic rating from iteration one.  
 In light of the group's responses, consider your original score (in blue) for this question and decide whether you wish to adjust your response (or not). Keep in mind that we are aiming to explore whether there is a consensus on this issue. Please enter your score for this round in the box below, using the same scale of 0 (not at all) to 100 (fully).
  - b. Feedback on own score and group mean, standard deviation and range for vignette relevant rating from iteration one.  
 In light of the group's responses, consider your original score (in blue) for this question and decide whether you wish to adjust your response (or not). Keep in mind that we are aiming to explore whether there is a consensus on this issue. Please enter your score for this round in the box below, using the same scale of 0 (not at all) to 100 (fully).
  - c. Below is a list of some of the justifications given in round I for and against the clinical psychologist the clinical psychologist[*'s ethical decision*] in the above vignette. Underneath each justification is the rating that it was given by you in round II (in blue), and descriptive statistics of the group's scores as a whole.
    - i. Out of the different justifications given, the top five that the group said they would be most likely to take into account are listed below, in order. Please review this list and in light of the group's responses, consider your original scores for these highest rated justifications and decide whether you wish to adjust your responses (or not). Keep in mind that we are aiming to explore whether there is a consensus on these issues. Please use the same scale of 1 (I definitely would not) to 7 (I definitely would), to indicate your score for this round, as to how likely you would be to take each of these justifications into account.
    - ii. Out of the different justifications given, below are the group's five lowest scoring items. These are the justifications that the group said they would be least likely to take into account, in order. Please review this list and in light of the group's responses, consider your original scores for these lowest rated justifications and decide whether you wish to adjust your responses (or not). Keep in mind that we are aiming to explore whether there is a consensus on these issues. Please use the same scale of 1 (I definitely would not) to 7 (I definitely

would), to indicate your score for this round, as to how likely you would be to take each of these justifications into account.

- d. If a clinical psychologist made their decision by drawing on the above list (i.e. being more likely to take into account the higher-rated justifications above and less likely to take into account those rated lower), to what extent would you regard this as an ethically competent decision?  
Please use the scale below of 0 (not at all) to 100 (fully).
  - e. Please say why you gave this answer.
  - f. If a clinical psychologist made their decision by drawing on the above list (i.e. being more likely to take into account the higher-rated justifications above and less likely to take into account those rated lower), to what extent would you expect this to lead to ethically competent behaviour(s)?  
Please use the scale below of 0 (not at all) to 100 (fully).
  - g. Please state why you gave this answer.
  - h. Are there any justifications from the above list, or other justifications which you feel people may be likely to take into account when responding to this vignette, that you would consider to be unacceptable, and therefore not ethically competent within clinical psychology?
  - i. Please use this box to add any further comments you wish about any aspects of the above vignette and questions, as presented in this survey.
5. General feedback.
- Below is a summary of the vignettes and the highest rated justifications. Please review this table and answer the questions below.
- a. To what extent do you think there is a difference (or not) between the ethical justifications drawn upon across the different vignettes? Please use the sliding scale below to record your answers (0 = No difference, 7 = A lot of difference).
  - b. Please explain why you gave the rating above.
  - c. Having seen these vignettes, the range of different responses from the group, and the group's scores, to what extent do you feel that taking part in this study has impacted your thinking and practice, in relation to ethical competence?  
To what extent do you think that these vignettes would be helpful in the context of teaching ethical competence in clinical psychology in the UK?
  - d. Please use this scale of 0 (not at all) to 100 (fully) below to record your answers.
  - e. Why did you give the scores above?
  - f. Are there any ethical dilemmas which you feel are common to clinical psychology that are not represented in the vignettes used in this study, and would be important in developing ethical competence in the profession? If

so, please outline these below.

- g. Are there any ethical principles, or different facets of ethical-decision making which you feel are commonly drawn upon in clinical psychology that have not been represented in the responses to this study, and would be an important part of developing ethical competence in the profession? If so, please outline these below.
- h. Finally, please use this box to add any additional comments on any aspect of the study.

6. Debrief sheet.

*Appendix T. Participant debrief sheet.*

**Thank you for your time spent taking this survey.  
Your responses have now been recorded and you can close this window.  
Please see below for debrief information.**

---

Thank you for giving your time to take part in part III of this research project. It is anticipated that this will be the final round of the survey, however, there is a possibility that there may be one further round, depending on the results. You will be contacted by email in March 2019 to let you know what has been decided.

Hopefully this research will help improve our understanding of how clinical psychologists approach professional ethical decision-making, and provide avenues for further support and training in this.

The information that you have provided will be kept confidential and all personally identifiable data will be destroyed after the completion of the research. You can ask to have your contribution removed from this part of the study without giving a reason up to 1 week after participation.

If participation in this research has caused you any distress, discomfort or upset, you may wish to contact immediate sources of support such as those in your professional network, your GP or a therapist.

The British Psychological Society (BPS) Ethics Committee promotes the ethical practice of psychology and is responsible for the Code of Ethics and Conduct and other ethical guidance within the Society ([available here](#)). If you need guidance on ethical matters relating to psychology in your professional practice, you may wish to consult these or other BPS guidelines. There is a dedicated ethics area on the Society's website which provides a range of resources, including Frequently Asked Questions ([FAQ](#)). Members of the BPS can also contact the committee for support in the consideration and resolution of ethical dilemmas ([ethical.enquiries@bps.org.uk](mailto:ethical.enquiries@bps.org.uk)).

If you have any further questions or concerns about the project or how it has affected you, or any complaints about the study, please contact the researcher:

Becky Grace, Trainee Clinical Psychologist ([\\*\\*\\*\\*@herts.ac.uk](mailto:****@herts.ac.uk))

Or one of the project supervisors:

Dr Helen Ellis-Caird, Clinical Psychologist ([\\*\\*\\*\\*@herts.ac.uk](mailto:****@herts.ac.uk)),

Dr Tony Wainwright, Clinical Psychologist ([\\*\\*\\*\\*@exeter.ac.uk](mailto:****@exeter.ac.uk)).

Please also contact Becky Grace if you would be interested in being informed of the outcome of this study.

Thank you again for your participation and support.

Appendix U. Example of development of themes showing how nodes were grouped using NVivo 11.

**Final five themes**

The screenshot shows the NVivo 11 interface with a search bar at the top. On the left, there is a navigation pane with sections: Quick Access (Files, Memos, Nodes), Data (Files, File Classifications, Externals), Codes (Nodes), Cases, Notes, and Search. The main window displays a table of nodes under the heading 'Nodes'.

Name	Files	References
Feedback on the study	0	0
Process of ethical competence	0	0
Assessing the ethical problem	0	0
Consideration of what is influencing	0	0
Drawing on guiding principles	0	0
Formulating the ethical problem	0	0
Responding to a reasoned judgment	0	0

**Development of *Assessing the ethical problem* theme and sub-themes**

The screenshot shows the NVivo 11 interface with a search bar at the top. On the left, there is a navigation pane with sections: Quick Access (Files, Memos, Nodes), Data (Files, File Classifications, Externals), Codes (Nodes, Relationships, Relationship Types), Cases, Notes, and Search. The main window displays a table of nodes under the heading 'Nodes'.

Name	Files	References
Feedback on the study	0	0
Process of ethical competence	0	0
Assessing the ethical problem	0	0
Systematic	1	12
Objective	1	3
Thoughtful, well considered	1	17
Important	1	5
Relevant	1	5
Reliance on checklist, not tho	1	2
Consideration of what is influencing	0	0
Drawing on guiding principles	0	0
Formulating the ethical problem	0	0
Responding to a reasoned judgment	0	0

**Development of *formulating the ethical problem* theme and sub-themes of *justifiable* and *specific considerations***

The screenshot shows a software interface with a sidebar on the left and a main window titled 'Nodes'. The sidebar includes sections for 'Quick Access' (Files, Memos, Nodes), 'Data' (Files, File Classifications, Externals), 'Codes' (Nodes, Relationships, Relationship Types), 'Cases', 'Notes', 'Search', 'Maps', and 'Output'. The main window has a search bar and a table with columns 'Name', 'Files', and 'References'. The tree structure is as follows:

Name	Files	References
Formulating the ethical problem	0	0
Justifiable, defensible	1	9
clinical judgement	1	2
ethically competent	1	12
Fairness	1	1
Reasonable	1	4
Transparent	1	2
Specific considerations	0	0
Maintaining norms schema	0	0
Policies, laws, guidelines	0	0
research evidence	1	3
Supervision discussions	1	5
Personal interests schema	0	0
Less ethically incompete	0	0
Post-conventional reasonin	0	0
Client focused factors	1	4
Wider systemic factors t	0	0

**Development of *formulating the ethical problem* theme and sub-themes of *weighing up*, and *useable***

The screenshot shows the same software interface as above, but with a different tree structure. The 'Formulating the ethical problem' node is highlighted in blue. The tree structure is as follows:

Name	Files	References
Consideration of what is influencin	0	0
Drawing on guiding principles	0	0
Formulating the ethical problem	0	0
Justifiable, defensible	1	9
Specific considerations	0	0
Weighing up	1	3
Core factors and then indivi	1	1
Hierarchy of importance of	1	2
Rounded or balanced	1	8
Workable, useable	1	1
flexible	1	1
Pragmatic	1	1
Realisable	1	1
Responding to a reasoned judgme	0	0
comparison with colleagues de	1	4
Judgment v behaviour	0	0

**Development of *responding to a reasoned judgment* theme and sub-themes**

Name	Files	References
Feedback on the study	0	0
Process of ethical competence	0	0
Assessing the ethical problem	0	0
Consideration of what is influencing	0	0
Drawing on guiding principles	0	0
Formulating the ethical problem	0	0
Responding to a reasoned judgment	0	0
comparison with colleagues deci	1	4
Adjustment of thinking	1	1
Recognition of subjectivity in	1	9
Validity can be checked by se	1	13
professional consensus	1	8
Judgment v behaviour	0	0
Decision does not guarantee	1	19
No difference, unsure, or no	1	50

**Development of *influencing factors on the process* theme and sub-themes**

Name	Files	References
Feedback on the study	0	0
Process of ethical competence	0	0
Assessing the ethical problem	0	0
Consideration of what is influencing	0	0
Context - meeting of dilemma a	0	0
Availability of resources	0	0
level of trust in others	0	0
Decision maker factors	0	0
Familiarity with dilemma cont	1	5
level of experience and learni	0	0
Dilemma factors	0	0
Complexity of dilemma	0	0
Specifics of the dilemma imp	1	6
Drawing on guiding principles	0	0
Formulating the ethical problem	0	0
Responding to a reasoned judgment	0	0

Drag selection here to code to a new node



**Development of *guiding principles* theme and sub-themes**

The screenshot displays a software interface for managing project nodes. On the left is a sidebar with navigation categories: Quick Access (Files, Memos, Nodes), Data (Files, File Classifications, Externals), Codes (Nodes, Relationships, Relationship Types), Cases, Notes, Search, Maps, and Output. The main area is titled 'Nodes' and contains a table with a search bar and columns for Name, Files, and References. The table lists various nodes, with 'Drawing on guiding principles' highlighted. Below the table is a note: 'Drag selection here to code to a new node'.

Name	Files	References
Consideration of what is influencin	0	0
<b>Drawing on guiding principles</b>	0	0
Critical stance	0	0
Ourselves	0	0
What we don't know	0	0
What we know	0	0
Importance of considering wide	1	45
Some factors subsumed wit	1	2
importance of multiple perspec	1	15
Commissioners only as pro	1	2
Consider things I hadn't tho	1	4
Interesting to have others' v	1	4
Mitigtes lack of familiarity	1	2
to reduce biases	1	10
Reflective stance	1	13
Formulating the ethical problem	0	0
Responding to a reasoned judgme	0	0

Drag selection here to code to a new node

*Appendix V. Example transcript with codes for qualitative responses to iteration three, analysed thematically using NVivo 11.*

Note. Bold is qualitative questions that were presented in the survey, followed by participant responses.

Coding related to model of ethical decision making:

Statements in **green** coded under *assessing the ethical problem* theme

Statements in **purple** coded under *formulating the ethical problem* theme

Statements in **yellow** coded under *responding to a reasoned judgment* theme

Statements in **blue** coded under *influencing factors on the process* theme

Statements in **red** coded under *drawing on guiding principles* theme

Coding related to feedback on the present research:

Statements in **teal** coded under *coming across difficulties in the present research* theme

Statements in **olive** coded under *recognising strengths in the present research* theme

Statements in **grey** coded under *identifying other ethical dilemmas* theme

**Maria vignette:** Drawing on the above list, in order, would lead to an ethically competent decision. Please use the scale below of 0 (not at all) to 100 (fully). Please say why you gave this answer:

Similar to my answer in relation to the other vignettes, **this would likely mean that a range of factors important to multiple clinical psychologists would have been considered. As opposed to those that one individual feels are important, which could be biased by their own views and experiences.**

**Drawing on the above list, in order, would lead to ethically competent behaviour(s). Please use the scale below of 0 (not at all) to 100 (fully). Please say why you gave this answer:**

Similar to my answers regarding the other vignettes, **thus provides a more transparent and systematic way of considering a range of different factors when responding. Again it also means that a response could be clearly justified if needed later down the line.**

**Are there any justifications from the above list, or other justifications which you feel people may be likely to take into account when responding to this vignette, that you would consider to be unacceptable, and therefore not ethically competent within clinical psychology?**

Similar to my response to the other vignettes, anything related to the individual's purely financial gain.

**Please use this box to add any further comments you wish about any aspects of the above vignette and questions, as presented in this survey:**

**Marco vignette:** Drawing on the above list, in order, would lead to an ethically competent decision. Please use the scale below of 0 (not at all) to 100 (fully). Please say why you gave this answer:

Similar to my answers in relation to the other vignettes, this would provide a more rounded decision considering a range of different factors important to multiple clinical psychologists, not just one individual's own thoughts.
Drawing on the above list, in order, would lead to ethically competent behaviour(s). Please use the scale below of 0 (not at all) to 100 (fully). Please say why you gave this answer:
As with my responses to the other vignettes, this offers a more open, systematic and transparent way to make a decision on a tricky issue. [Also coded under formulating theme] [Also coded under influencing factors theme] [Also coded under coming across strengths in the present research theme]
Are there any justifications from the above list, or other justifications which you feel people may be likely to take into account when responding to this vignette, that you would consider to be unacceptable, and therefore not ethically competent within clinical psychology?
Anything related purely to an individual's own financial gain.
Please use this box to add any further comments you wish about any aspects of the above vignette and questions, as presented in this survey:
<b>Norman vignette:</b> Drawing on the above list, in order, would lead to an ethically competent decision. Please use the scale below of 0 (not at all) to 100 (fully). Please say why you gave this answer:
Similar to the previous vignette, this would allow consideration of a range of factors deemed important by multiple clinical psychologists rather than just going on one or two people's own judgements based on their own individual experience and beliefs. Therefore would likely be more objective [Also coded under guiding principles theme]
Drawing on the above list, in order, would lead to ethically competent behaviour(s). Please use the scale below of 0 (not at all) to 100 (fully). Please state why you gave this answer:
This would offer a more systematic way to think about and consider a response to a situation that could also be justified if it was questioned later down the line.
Are there any justifications from the above list, or other justifications which you feel people may be likely to take into account when responding to this vignette, that you would consider to be unacceptable, and therefore not ethically competent within clinical psychology?
Again, anything that was based on the individual's own financial gain.
Please use this box to add any further comments you wish about any aspects of the above vignette and questions, as presented in this survey:

<p><b>Alissa's dad vignette:</b> Drawing on the above list, in order, would lead to an ethically competent decision. Please use the scale below of 0 (not at all) to 100 (fully). Please say why you gave this answer:</p>
<p>Again similar to my responses to the other vignettes, this would allow consideration of a number of factors identified as important by multiple clinical psychologists.</p>
<p>Drawing on the above list, in order, would lead to ethically competent behaviour(s). Please use the scale below of 0 (not at all) to 100 (fully). Please state why you gave this answer:</p>
<p>Similar to my responses to the other vignettes, this prompts the individual to consider a range of different factors systematically so is less open to the bias of an individual's own experience. Decision making in this way could be more easily justified.</p>
<p>Are there any justifications from the above list, or other justifications which you feel people may be likely to take into account when responding to this vignette, that you would consider to be unacceptable, and therefore not ethically competent within clinical psychology?</p>
<p>Anything related to an individual's purely financial gain.</p>
<p>Please use this box to add any further comments you wish about any aspects of the above vignette and questions, as presented in this survey:</p>
<p><b>Commissioning vignette:</b> Drawing on the above list, in order, would lead to an ethically competent decision. Please use the scale below of 0 (not at all) to 100 (fully). Please say why you gave this answer:</p>
<p>Various different factors are considered above in a way that may be more objective and systematic than just going on what may 'pop into your head' as I imagine this is more likely to be biased by the individual's own experience etc. [Also coded under the guiding principles theme]</p>
<p>Drawing on the above list, in order, would lead to ethically competent behaviour(s). Please use the scale below of 0 (not at all) to 100 (fully). Please state why you gave this answer:</p>
<p>Again this seems more systematic and objective and allows you to 'step back' and consider all the different factors and rate them, which feels more objective and balanced than just going on gut feeling. [Also coded under the guiding principles theme]</p>
<p>Are there any justifications from the above list, or other justifications which you feel people may be likely to take into account when responding to this vignette, that you would consider to be unacceptable, and therefore not ethically competent within clinical psychology?</p>
<p>Anything that is related to purely furthering one's own financial interests.</p>
<p><b>General feedback:</b> To what extent do you think there is a difference (or not) between the ethical justifications drawn upon across the different vignettes? 0 = no difference, 3.5 = neutral, 7 = a lot of difference. Please state why you gave this answer:</p>
<p>To me it depends on different factors in the situation that may make individuals more vulnerable to exploitation. For those vignettes that were more relevant to the areas I work</p>

in, I was able to consider these in more detail.

For the areas I don't work in, I was less familiar with the relative risks/importance of factors that would need to be considered. This is why I think the views of different clinical psychologists working in a range of areas need to be considered when trying to reach a consensus about what factors are important when trying to act as ethically as possible.

*[Also coded under the guiding principles theme]*

*[Also codes under the influencing factors theme]*

**Taking part in the present research has impacted my thinking about ethical competence. It has impacted, or would be likely to impact my practise in relation to ethical competence. The vignettes would be helpful for teaching ethical competence. Please use the scales below of 0 (not at all) to 100 (fully). Why did you give the scores above?**

I thought that the study presented some very real dilemmas in a way that enabled me to step back and consider them more systematically and perhaps consider things that I may not have done had I just reacted based on my own gut feelings and experience.

*[Also coded under formulating theme]*

*[Also coded under the guiding principles theme]*

*[Also coded under the influencing factors theme]*

*[Also coded under coming across strengths in the present research theme]*

It was also useful reviewing how others had rated/responded as this prompted me to review why I had responded in a certain way and if it was different to the general consensus, to think about why that may be so and any factors that I may not have thought about that others (eg someone working in an area I am unfamiliar with) may hve considered that would explain their different rating.

*[Also coded under the guiding principles theme]*

**Are there any ethical dilemmas which you feel are common to clinical psychology that are not represented in the vignettes used in this study, and would be important in developing ethical competence in the profession?**

Examples around dilemmas relating to others' practice, eg colleagues outside our profession, supervisees and also those above us in terms of seniority. Whistleblowing. Also how people behave outside of work, eg on social media.

**Are there any ethical principles, or different facets of ethical-decision making which you feel are commonly drawn upon in clinical psychology that have not been represented in the responses to this study, and would be an important part of developing ethical competence in the profession?**

No I thought that a wide range of issues were covered relating to the BPS ethical principles.

*[Also coded under coming across strengths in the present research theme]*

It is more about embedding these in relevant and up to date vignettes I think.

*[Also coded under coming across strengths in the present research theme]*

**Finally, please use this box to add any additional comments on any aspect of the study:**

I may have given fuller responses if... [removed for confidentiality] simply due to time constraints. However these may also have made me give more concise answers! My overall opinion and ratings would not have been different.  
[Also coded under coming across difficulties in the present research theme]

*Appendix W. Extract from reflective diary kept during qualitative data analysis phases.*

### **Iteration one**

Some queries about whether these are all ethical justifications or more practical justifications? E.g. “pragmatism” vs. “clients’ best interests”. Decided to include both types of justifications as codes to go ahead to the next round, as practical considerations may also influence ethical decision-making. It would be interesting and worthwhile to understand if ethical decisions are influenced by practical considerations.

Starting to see some links to the literature. E.g. dentist study - intermediate concepts, confidentiality in Norman vignette, and Kohlberg’s model such as rules and laws. I want to make sure I am not looking to find this structure in the data, but participants have mentioned quite explicitly justifications around BPS/HCPC guidelines for example.

Maria vignette – reviewed initial codes with supervisor, feeling a little unsure about the ‘my accuracy’ with this method but when asked to explain and justify choice of codes I was able to do this. I continue to remind myself that it is important to keep reflecting on this and ensure the codes are grounded in what the data says.

Alissa vignette – participants talking a lot about their personal values and personal ethics. I am wondering if this is considered as separate from professional ethics. I think I have seen this elsewhere (E.g. Maria vignette) but I didn’t think it fitted my search to code for ‘justifications’ i.e. I had not categorised “it wouldn’t be ethical” previously. Following a discussion with supervisor we decided to code these types of statements as related to personal feelings of what is ethical. The advantage of the rounds in this method is that, if it was not seen as a legitimate code by participants then it probably would get filtered out through participants scoring.

**Iteration three**

Participants seem to have used lots of adjectives around why decisions are justifiable “thoughtful,” “balanced,” “systematic,” “objective,” “rounded” etc. I feel these could be drawn together somehow. One participant described this as like doing an assessment and coming to a formulation. I am early into the analysis but this does appear to fit quite strongly. Intuitively it fits that assessments should aim to be objective etc. This leads me to wonder if ethical decisions are any different to other types of clinical decisions and whether they are or not, what this might mean.

There are some participants whose views seem similar to mine. I feel quite supportive of their arguments, whereas I have felt somewhat distant from others (e.g. not trusting colleagues). Following reflection with supervisors, I recognise that it is important to understand if workplace culture for example, impact ethical decision making. I keep going back to the data each time and am trying to make sure I include these aspects that are not what I might have expected (e.g. lack of trust).

There seems to be quite a lot of repetition within participants, across different vignettes. For example, may have answered the questions quite similarly: the decision is competent because it follows a systematic process and draws on the views of lots of different clinical psychologists. Perhaps this is something common about decision-making, regardless of what the particular dilemma is, which will be interesting to explore. I wonder if participants felt this was a bit repetitive at times, however I don't think asking participants to comment on the decisions as a whole would have worked so well, as the dilemmas are so different and there may have been very different reasons why one ethical decision is deemed to be competent.



*Appendix X. Ethical decision justification codes generated from qualitative analysis in iteration one, and rating and ranking scores from iteration two for the Maria vignette.*

<u>The decision to undertake neuropsychological testing or not was based on...</u>	<u>M</u>	<u>Median</u>	<u>Range</u>	<u>High rank</u>	<u>High rank n</u>	<u>Low rank</u>	<u>Low rank n</u>
...Maria's best interests.	6.43	7	4	31	12	0	0
...seeing the capacity to parent as separate from whether Maria has an intellectual disability.	6.14	7	5	27	12	0	0
...the child's best interests.	6.07	6	5	38	12	1	1
...whether I felt Maria had capacity to give informed consent to undertake neuropsychological testing.	6.04	6	4	13	6	0	0
...the extent to which I felt it was clinically justified.	5.89	6	4	16	6	0	0
...avoiding doing emotional harm to Maria.	5.89	6	5	12	5	2	1
...how having an intellectual disability identity confirmed or refuted may impact Maria.	5.75	6	4	9	4	0	0
...remaining consistent with my personal feeling of what is ethical.	5.71	6	4	7	2	0	0
...having discussed with Maria what she felt to be the most appropriate course of action.	5.61	6	5	33	12	6	3
...the extent to which I felt this would determine additional or the most appropriate support for Maria.	5.54	6	6	10	5	0	0
...opportunities for ongoing support for Maria.	5.29	5	5	5	2	0	0
...seeing limitations in neuropsychological testing and intellectual disability diagnosis.	5.14	5	6	6	3	5	4
...how much Maria needs the intellectual disability service.	5.04	5	6	6	2	0	0
...professional guidelines.	5.00	5	6	7	4	2	1
...having clarified social service's views.	5.00	5	6	2	1	0	0
...the law(s).	4.93	5	6	5	2	3	2
...what the team thinks.	4.93	5	6	6	3	1	1

...an objective exploration of the facts, rather than being an emotional one.	4.75	5	6	8	3	3	1
...the likely nature and outcome of the child protection proceedings.	4.68	5	6	6	2	1	1
...erring on the side of not intervening unless there is a rationale to do so.	4.57	5	6	0	0	0	0
...the extent to which I believe I have the expertise to assess parenting.	4.54	5	6	0	0	5	2
...research evidence.	4.43	4	5	0	0	8	3
...seeing the intellectual disability service as having a responsibility if Maria was accepted into the service erroneously.	4.32	4	6	6	2	7	3
...the extent to which I believe access to intellectual disability services should be based on meeting clear and consistent eligibility criteria.	4.32	4	6	9	3	12	5
...supporting the parenting assessment.	4.18	4	6	2	2	5	2
...the extent to which this would allow the intellectual disability service to retain control over the process and outcome of the neuropsychological assessment.	4.18	4	5	2	1	5	2
...the extent to which I believe it is someone else's (or another agency)'s role or responsibility to undertake neuropsychological assessment.	4.14	4	6	3	1	9	4
...pragmatism.	4.14	4	6	0	0	12	6
...avoiding doing financial harm to Maria.	3.82	4	6	0	0	9	4
...the extent to which I believe the intellectual disability service resources should go to someone else if Maria does not meet the criteria for accessing the service.	3.57	4	6	4	1	14	7
...having been asked to.	3.43	3	6	0	0	20	9
...how it may reflect on the service.	2.68	3	4	0	0	29	16

*Note. Mean (M) scores can range from:*

*1 = I definitely would not take this justification into account,*

*4 = I might or might not take this justification into account,*

*7 = I definitely would not take this justification into account.*

*Highest ranking items. Higher number = group more likely to take this justification into account.*

*Lowest ranking items. Higher number = group less likely to take this justification into account.*

*Appendix Y. Ethical decision justification codes generated from qualitative analysis in iteration one, and rating and ranking scores from iteration two for the Marco vignette.*

<u>The decision to treat Marco's PTSD or not was based on...</u>	<u>M</u>	<u>Median</u>	<u>Range</u>	<u>High rank</u>	<u>High rank</u> <u>n</u>	<u>Low rank</u>	<u>Low rank</u> <u>n</u>
...getting adequate supervision.	6.32	7	3	15	7	0	0
...avoiding doing more harm than good.	6.25	7	4	36	13	0	0
...the extent to which I see this is outside my competence.	6.18	7	4	39	13	3	1
...Marco's needs.	6.04	6	2	21	7	0	0
...consideration of how risk would or would not be managed if Marco's difficulties escalate.	5.93	6	5	12	5	0	0
...remaining consistent with my personal feeling of what is ethical.	5.86	6	4	11	6	3	1
...being able to be transparent with Marco.	5.79	6	3	3	3	0	0
...the presence or absence of support for me from other professionals.	5.64	6	4	6	3	3	1
...professional guidelines.	5.39	6	5	12	5	3	2
...the evidence base.	5.39	5	5	7	4	0	0
...the extent to which I could increase my competency before and during working with Marco.	5.32	5	5	10	4	1	1
...being able to offer other psychological interventions to Marco.	5.25	6	5	8	3	6	3
...a formulation about Marco's difficulties with management of his diabetes.	5.14	5	5	7	2	1	1
...finding other options for Marco.	5.14	5	6	7	4	2	1
...how my lack of confidence might impact the work.	5.04	5	6	6	2	5	2
...Marco's preference.	4.89	5	4	11	4	0	0
...the boundaries of the service.	4.89	5	5	6	2	5	2
...the possible consequences for service provisions if gaps aren't highlighted to those commissioning services.	4.79	5	5	3	1	5	3
...Marco having already built a relationship with me.	4.79	5	5	12	5	5	3
...wanting to feel I've done everything I can.	4.75	5	5	3	1	4	3

...the potential impact on me professionally (such as having a heavy caseload, maintaining my registration and avoiding litigation).	4.71	5	6	2	2	10	4
...the number of sessions we have agreed being insufficient.	4.50	4	6	6	2	8	6
...seeing myself as always learning, including from Marco.	4.39	4	5	7	3	4	2
...the extent to which I see it as useful to consider PTSD as a distinct diagnostic entity.	4.32	4.5	6	10	3	13	6
...a recognition of some input for Marco being better than none.	4.25	4	5	7	2	11	4
...the impact on the service.	4.07	4	6	0	0	10	5
...economic, political and systemic pressures.	3.78	4	6	0	0	9	5
...resources needing to go to someone else, if Marco does not meet the criteria for accessing the service.	3.68	4	6	0	0	10	6
...the potential emotional impact on me.	3.57	4	5	0	0	11	6
...disagreeing that treatment is an accurate description for what clinical psychologists do.	3.36	3	6	8	3	30	13

*Note. Mean (M) scores can range from:*

*1 = I definitely would not take this justification into account,*

*4 = I might or might not take this justification into account,*

*7 = I definitely would not take this justification into account.*

*Highest ranking items. Higher number = group more likely to take this justification into account.*

*Lowest ranking items. Higher number = group less likely to take this justification into account.*

*Appendix Z. Ethical decision justification codes generated from qualitative analysis in iteration one, and rating and ranking scores from iteration two for the Norman vignette.*

<u>The decision to undertake an internet search of Norman or not was based on...</u>	<u>M</u>	<u>Median</u>	<u>Range</u>	<u>High rank</u>	<u>High rank n</u>	<u>Low rank</u>	<u>Low rank n</u>
...Norman's best interests.	6.46	7	3	24	8	0	0
...avoiding harm for Norman.	6.43	7	3	15	5	0	0
...possible implications for Norman's treatment and care.	6.14	7	5	15	7	0	0
...the extent to which I would see this as useful in assessing risk.	6.07	6	5	33	10	0	0
...the extent to which I see this as useful for intervention purposes.	6.04	6.5	5	23	9	0	0
...the extent to which I see this as useful to inform the formulation.	6.00	6.5	4	30	12	1	1
...information on the internet being in the public domain.	5.75	6	6	13	6	2	1
...what I see as my responsibility in this situation.	5.75	6	4	2	2	0	0
...remaining consistent with my personal feeling of what is ethical.	5.71	6	4	6	2	1	1
...the extent to which I would see this as aiding differential diagnosis.	5.57	6	4	17	6	2	1
...the law(s).	5.57	5.5	5	5	2	0	0
...having weighed up the pros and cons.	5.50	6	6	56	5	0	0
...clarifying the extent to which Norman's claims are factual.	5.46	6	6	9	4	1	1
...seeing this as part of the assessment process.	5.39	5	6	8	2	0	0
...Norman's right to confidentiality.	5.32	5.5	5	1	1	0	0
...Norman's right to privacy.	5.29	5	5	2	1	0	0
...the extent to which I could take steps to preserve Norman's confidentiality (for example by searching the band name only or using a trust computer).	5.21	5.5	6	3	3	3	1
...the possible benefits or detriment to the therapeutic relationship.	5.21	5.5	5	8	4	2	1
...professional guidelines.	5.14	5.5	6	9	4	3	1
...consideration as to whether there would be any other way of getting this information.	5.14	6	6	7	3	0	0

...the extent to which I feel I need Norman's consent.	5.07	5	6	3	1	0	0
...having discussed this further with the team.	5.07	5	5	0	0	0	0
...what Norman thinks about me doing the search.	4.93	5	6	7	3	1	1
...workplace policies about internet searching.	4.89	5	6	5	2	3	2
...questioning the validity of information found on the internet.	4.71	5	6	2	1	2	2
...consideration of where specifically, on the internet I would be looking (e.g. search engine only or social media).	4.71	5.5	6	0	0	3	2
...having the support of my seniors.	4.71	5	6	0	0	0	0
...pragmatism.	4.32	4.5	6	0	0	5	3
...what research says.	4.21	4	5	0	0	11	4
...the potential for information needing to go the criminal justice system.	3.89	4	6	0	0	6	4
...the extent to which I believe this should be expected in the modern age.	3.86	4	6	0	0	12	6
...seeing this as no different to discussing details with the team.	3.82	4	6	2	1	2	2
...seeing this as a distraction from working with Norman. (cc).	3.61	4	6	3	2	15	8
...the level of effort involved for me.	2.61	2	5	0	0	36	16
...personal curiosity.	2.04	1	5	0	0	46	20

*Note. Mean (M) scores can range from:*

*1 = I definitely would not take this justification into account,*

*4 = I might or might not take this justification into account,*

*7 = I definitely would not take this justification into account.*

*Highest ranking items. Higher number = group more likely to take this justification into account.*

*Lowest ranking items. Higher number = group less likely to take this justification into account.*

*Appendix AA. Ethical decision justification codes generated from qualitative analysis in iteration one, and rating and ranking scores from iteration two for the Alissa's dad vignette.*

<u><i>The decision to report the information Alissa's dad gave about his benefits to the relevant authorities or not was based on...</i></u>	<u>M</u>	<u>Median</u>	<u>Range</u>	<u>High rank</u>	<u>High rank n</u>	<u>Low rank</u>	<u>Low rank n</u>
...avoiding doing harm to Alissa and her dad.	6.33	7	4	28	9	0	0
...avoiding doing harm to Alissa.	6.33	7	4	18	7	0	0
...Alissa's best interests.	6.30	7	5	21	7	0	0
...the potential impact on the therapeutic relationship.	5.85	6	3	5	3	0	0
...being transparent with Alissa's dad.	5.85	6	5	0	0	0	0
...having weighed up the pros and cons of both courses of action.	5.74	7	6	24	8	0	0
...the potential impact on the intervention.	5.70	5	4	16	7	0	0
...seeing my responsibility as meeting Alissa and her dad's needs.	5.63	6	6	9	3	0	0
...wanting to find appropriate support for Alissa's dad.	5.59	6	5	7	2	0	0
...the extent of harm being caused by Alissa's dad's actions.	5.56	6	5	12	4	0	0
...seeing the impact of disclosing as disproportionate to the act to be disclosed.	5.52	6	5	14	6	0	0
...the extent to which I see this as a breach of confidentiality.	5.41	6	6	3	2	1	1
...consideration of whether I have any other options.	5.33	6	6	3	2	0	0
...considering law enforcement as outside of my role.	5.30	6	5	12	5	4	2
...doubt about the veracity or sufficient level of detail about what I have been told.	5.30	5	6	4	2	2	2
...discussion with my supervisor.	5.26	5	6	7	4	1	1
...understanding the cause of these financial difficulties for Alissa's dad.	5.22	5	5	4	1	0	0
...my personal values.	4.96	5	6	6	2	4	2
...the extent to which I agree the policy is justifiable.	4.96	5	6	6	3	2	2

...professional guidelines.	4.85	5	6	2	2	1	1
...the law(s).	4.85	5	6	14	4	1	1
...having an awareness of this policy.	4.85	5	6	0	0	1	1
...the potential impact on my professional life.	4.63	4	6	5	2	5	2
...discussion with the team.	4.63	4	6	0	0	9	4
...encouraging Alissa's dad to take an alternate course of action.	4.52	4	6	2	1	4	2
...the extent to which I felt able to challenge the policy.	4.52	4	6	0	0	9	3
...the impact of the extra work itself on Alissa and her dad.	4.48	4	6	2	2	5	2
...the extent to which I felt my actions would be supported by my seniors.	4.37	4	6	1	1	2	2
...the extent to which Alissa's dad continues to do this, even if I have discussed this with him.	4.30	4	6	3	2	11	5
...the extent to which I see Alissa's dad as my client.	4.07	4	6	0	0	11	4
...seeing this as relevant to the formulation.	4.07	4	6	4	2	7	3
...Trust policies.	4.00	4	6	15	4	11	5
...my beliefs about the benefits system.	4.00	4	6	2	2	11	6
...the extent to which I felt I could advocate for Alissa's dad.	3.93	4	6	0	0	5	3
...it being my choice (or not) to work for an organisation with this policy.	3.48	4	6	0	0	13	6
...the emotional impact on me.	3.30	3	6	1	1	15	7

*Note. Mean (M) scores can range from:*

*1 = I definitely would not take this justification into account,*

*4 = I might or might not take this justification into account,*

*7 = I definitely would not take this justification into account.*

*Highest ranking items. Higher number = group more likely to take this justification into account.*

*Lowest ranking items. Higher number = group less likely to take this justification into account.*



*Appendix BB. Ethical decision justification codes generated from qualitative analysis in iteration one, and rating and ranking scores from iteration two for the Commissioning vignette.*

<u>The decision to take the additional £70,000 or not was based on...</u>	<u>M</u>	<u>Median</u>	<u>Range</u>	<u>High rank</u>	<u>High rank n</u>	<u>Low rank</u>	<u>Low rank n</u>
...avoidance of harm.	6.36	7	4	33	10	0	0
...consideration of whether the service could be more cost effective.	5.89	6	3	3	1	0	0
...having consulted colleagues.	5.82	6	5	13	5	0	0
...how well I feel the current service is working.	5.71	6	3	3	3	0	0
...consideration of different intervention options.	5.71	6	4	14	5	0	0
...research evidence.	5.71	6	5	3	2	3	1
...the extent to which I believe the costings are realistic.	5.68	6	3	3	3	0	0
...having discussed this further with the commissioner.	5.64	6	5	24	8	0	0
...this being an opportunity to demonstrate the need for additional funding.	5.61	6	3	13	7	1	1
...the extent to which I feel I would need to meet what I have agreed.	5.61	6	5	19	8	4	2
...a recognition of limitations to NICE guidelines.	5.50	5	3	6	3	0	0
...professional guidelines.	5.43	6	6	5	2	3	2
...the effect this may have on service sustainability.	5.43	5.5	4	3	2	4	2
...meeting clients' unmet needs.	5.36	5.5	5	14	5	0	0
...a recognition of limitations within evidence bases.	5.36	5	3	3	2	0	0
...my personal values.	5.29	5	5	12	4	5	3
...my clinical experience.	5.29	5	5	4	2	6	3
...consideration of using the money differently within the service (for example through looking at the salaries and skill mix within the team, whether this could be used to pay for supervision or training etc.).	5.25	5	6	14	5	3	1

...the extent to which I felt there were no other options.	5.21	5	5	4	1	7	3
...my opinions about accepting a shortfall in the current financial climate.	5.14	5	5	0	0	1	1
...developing practice-based evidence.	5.11	5	4	3	2	5	3
...seeing this as compromising the service's values.	5.11	5	5	5	2	3	2
...the length of the waiting list.	5.11	5	5	2	1	2	1
...seeking additional funding from elsewhere.	5.07	5	5	7	2	2	1
...NICE guidelines.	5.07	5	5	3	1	15	6
...consultation with experts by experience.	5.00	5	5	6	3	4	2
...a recognition that referral rates may not be able to be accurately predicted.	5.00	5	6	3	2	0	0
...pragmatism.	4.89	5	5	9	3	6	2
...avoiding putting pressure on clinicians.	4.89	5	5	4	2	4	2
...developing an intervention which might help other services in the long term.	4.82	5	5	5	2	8	4
...a recognition of offering some service to clients as being better than not being able to offer anything.	4.79	5	4	18	6	8	5
...anticipation of this being the best offer we would be likely to receive.	4.79	5	6	0	0	4	2
...the perspective of management.	4.61	5	6	0	0	15	7
...consideration of whether another provider (who may be in a better or worse position to provide a service than my own) may take the money if I do not.	4.54	5	6	8	3	14	8
...the extent to which I see decisions that commissioners make as outside of my responsibility.	3.57	4	5	0	0	33	15

*Note. Mean (M) scores can range from:*

*1 = I definitely would not take this justification into account,*

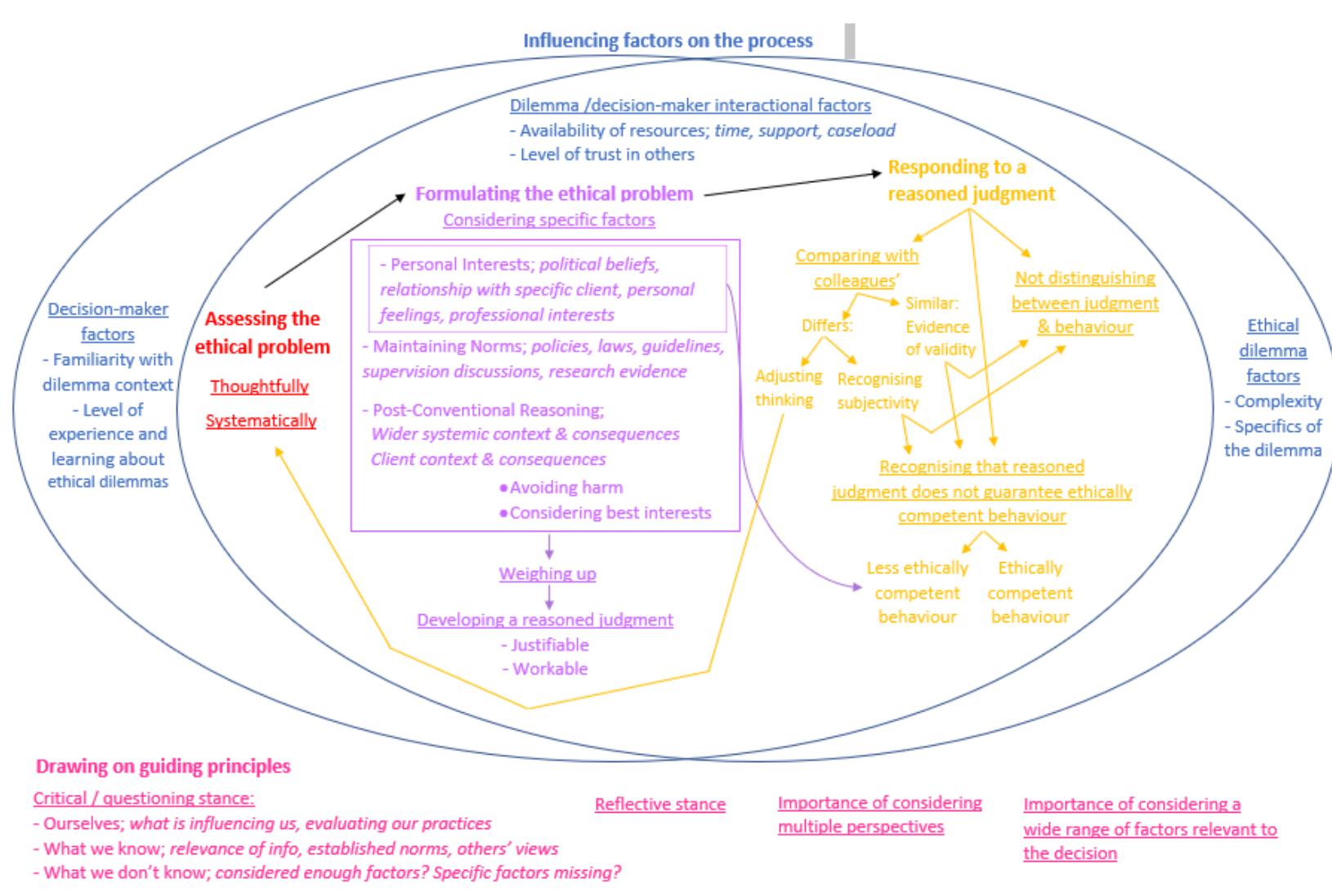
*4 = I might or might not take this justification into account,*

*7 = I definitely would not take this justification into account.*

*Highest ranking items. Higher number = group more likely to take this justification into account.*

*Lowest ranking items. Higher number = group less likely to take this justification into account.*

Appendix CC. First draft of an empirically derived model of ethical decision-making in clinical psychology, before consultation.



*Appendix DD. Recommendations for the Conducting and REporting of DELphi Studies*

*(CREDES; Jünger, Payne, Brine, Radbruch & Brearley, 2017).*

Rationale for the choice of the Delphi technique

**1. Justification.** The choice of the Delphi technique as a method of systematically collating expert consultation and building consensus needs to be well justified. When selecting the method to answer a particular research question, it is important to keep in mind its constructivist nature.

Planning and design

**2. Planning and process.** The Delphi technique is a flexible method and can be adjusted to the respective research aims and purposes. Any modifications should be justified by a rationale and be applied systematically and rigorously.

**3. Definition of consensus.** Unless not reasonable due to the explorative nature of the study, an a priori criterion for consensus should be defined. This includes a clear and transparent guide for action on (a) how to proceed with certain items or topics in the next survey round, (b) the required threshold to terminate the Delphi process and (c) procedures to be followed when consensus is (not) reached after one or more iterations.

Study conduct

**4. Informational input.** All material provided to the expert panel at the outset of the project and throughout the Delphi process should be carefully reviewed and piloted in advance in order to examine the effect on experts' judgements and to prevent bias.

**5. Prevention of bias.** Researchers need to take measures to avoid directly or indirectly influencing the experts' judgements. If one or more members of the research team have a conflict of interest, entrusting an independent researcher with the main coordination of the Delphi study is advisable.

**6. Interpretation and processing of results.** Consensus does not necessarily imply the 'correct' answer or judgement; (non)consensus and stable disagreement provide informative insights and highlight differences in perspectives concerning the topic in question.

**7. External validation.** It is recommended to have the final draft of the resulting guidance on best practice in palliative care reviewed and approved by an external board or authority before publication and dissemination.

Reporting

**8. Purpose and rationale.** The purpose of the study should be clearly defined and demonstrate the appropriateness of the use of the Delphi technique as a method to achieve the research aim. A rationale for the choice of the Delphi technique as the most suitable method needs to be provided.

**9. Expert panel.** Criteria for the selection of experts and transparent information on recruitment of the expert panel, sociodemographic details including information on expertise regarding the topic in question, (non)response and response rates over the ongoing iterations should be reported.

**10. Description of the methods.** The methods employed need to be comprehensible; this includes information on preparatory steps (How was available evidence on the topic in question synthesised?), piloting of material and survey instruments, design of the survey instrument(s), the number and design of survey rounds, methods of data analysis, processing and synthesis of experts' responses to inform the subsequent survey round and methodological decisions taken by the research team throughout the process.

**11. Procedure.** Flow chart to illustrate the stages of the Delphi process, including a preparatory phase, the actual 'Delphi rounds', interim steps of data processing and analysis, and concluding steps.

**12. Definition and attainment of consensus.** It needs to be comprehensible to the reader how consensus was achieved throughout the process, including strategies to deal with non-consensus.

**13. Results.** Reporting of results for each round separately is highly advisable in order to make the evolving of consensus over the rounds transparent. This includes figures showing the average group response, changes between rounds, as well as any modifications of the survey instrument such as deletion, addition or modification of survey items based on previous rounds.

**14. Discussion of limitations.** Reporting should include a critical reflection of potential limitations and their impact of the resulting guidance.

**15. Adequacy of conclusions.** The conclusions should adequately reflect the outcomes of the Delphi study with a view to the scope and applicability of the resulting practice guidance.

**16. Publication and dissemination.** The resulting guidance on good practice in palliative care should be clearly identifiable from the publication, including recommendations for transfer into practice and implementation. If the publication does not allow for a detailed presentation of either the resulting practice guidance or the methodological features of the applied Delphi technique, or both, reference to a more detailed presentation elsewhere should be made (e.g. availability of the full guideline from the authors or online; publication of a separate paper reporting on methodological details and particularities of the process (e.g. persistent disagreement and controversy on certain issues)). A dissemination plan should include endorsement of the guidance by professional associations and health care authorities to facilitate implementation.

*Appendix EE. Summary of SPSS outputs from tests of normality and tests of difference for realistic and relevant ratings for all vignettes (in iterations one and three).*

	<u>Shapiro-Wilk test for normality</u>			<u>Wilcoxon S-R test of differences</u>	
	<u>Statistic</u>	<u>df</u>	<u>Sig.</u>	<u>Sig.</u>	<u>Decision</u>
Maria Realistic I1	0.864	31	0.001	0.952 (n.s.)	No difference between Maria realistic rating I1-I3
Maria Realistic I3	0.854	31	0.001		
Maria Relevant I1	0.872	31	0.002	0.831 (n.s.)	No difference between Maria relevant rating I1-I3
Maria Relevant I3	0.830	31	0.000		
Marco Realistic I1	0.875	31	0.002	0.130 (n.s.)	No difference between Marco realistic rating I1-I3
Marco Realistic I3	0.705	31	0.000		
Marco Relevant I1	0.839	31	0.000	0.465 (n.s.)	No difference between Marco relevant rating I1-I3
Marco Relevant I3	0.889	31	0.004		
Norman Realistic I1	0.868	31	0.001	0.935 (n.s.)	No difference between Norman realistic rating I1-I3
Norman Realistic I3	0.782	31	0.000		
Norman Relevant I1	0.902	31	0.008	0.872 (n.s.)	No difference between Norman relevant rating I1-I3
Norman Relevant I3	0.928	31	0.038		
Alissa's dad Realistic I1	0.788	31	0.000	0.255 (n.s.)	No difference between Alissa's dad realistic rating I1-I3
Alissa's dad Realistic I3	0.804	31	0.000		
Alissa's dad Relevant I1	0.865	31	0.001	0.715 (n.s.)	No difference between

Alissa's dad Relevant I3	0.883	31	0.003		Alissa's dad relevant rating I1-I3
Commissioning Realistic I1	0.917	31	0.020		No difference between
Commissioning Realistic I3	0.902	31	0.008	0.570 (n.s.)	Commissioning realistic rating I1-I3
Commissioning Relevant I1	0.878	31	0.002		No difference between
Commissioning Relevant I3	0.897	31	0.006	0.903 (n.s.)	Commissioning relevant rating I1-I3

*Note. For iteration 1 (I1): Marco relevant n = 1 value replaced with mean from iteration 1*

*For iteration 3 (I3):*

*Maria realistic and relevant, Marco realistic n = 6 values in each replaced with the mean*

*Norman realistic and relevant n = 8 values replaced with the mean*

*Alissa's dad realistic and relevant, Marco relevant, Commissioning realistic and relevant n = 7 values in each replaced with the mean*

*Appendix FF. Summary of SPSS outputs from tests of normality and tests of difference for mean ratings for Maria vignette (in iterations two and three).*

<i>The decision to undertake neuropsychological testing or not was based on...</i>	<u>Shapiro-Wilk test for normality</u>			<u>Wilcoxon S-R test of differences</u>		
	<u>Statistic</u>	<u>df</u>	<u>Sig.</u>	<u>Sig.</u>	<u>Decision</u>	
1. Maria's best interests.	12	0.620	28	0.000	0.238 (n.s.)	No difference between 1. I2-I3
	13	0.605	28	0.000		
2. seeing the capacity to parent as separate from whether Maria has an intellectual disability.	12	0.686	28	0.000	0.090 (n.s.)	No difference between 2. I2-I3
	13	0.694	28	0.000		
3. the child's best interests.	12	0.759	28	0.000	0.209 (n.s.)	No difference between 3. I2-I3
	13	0.803	28	0.000		
4. whether I felt Maria had capacity to give informed consent to undertake neuropsychological testing.	12	0.808	28	0.000	0.259 (n.s.)	No difference between 4. I2-I3
	13	0.818	28	0.000		
5. the extent to which I felt it was clinically justified.	12	0.851	28	0.001	0.495 (n.s.)	No difference between 5. I2-I3
	13	0.857	28	0.001		
6. avoiding doing emotional harm to Maria.	12	0.786	28	0.000	0.314 (n.s.)	No difference between 6. I2-I3
	13	0.765	28	0.000		
29. avoiding doing financial harm to Maria.	12	0.938	28	0.100	0.095 (n.s.)	No difference between 29. I2-I3
	13	0.921	28	0.037		
30. the extent to which I believe the intellectual disability service resources should go to someone else if Maria does not meet the criteria for accessing the service.	12	0.937	28	0.093	0.464 (n.s.)	No difference between 30. I2-I3
	13	0.916	28	0.027		
31. having been asked to.	12	0.930	28	0.061	0.111 (n.s.)	No difference between 31. I2-I3
	13	0.887	28	0.006		
32. how it may reflect on the service.	12	0.870	28	0.002	0.194 (n.s.)	No difference between 32. I2-I3
	13	0.911	28	0.021		

*Note. Paired samples with n = 3 missing values per justification in iteration three (I3) replaced with the mean for iteration 3.*



*Appendix GG. Summary of SPSS outputs from tests of normality and tests of difference for mean ratings for Marco vignette (in iterations two and three).*

<u>The decision to treat Marco's PTSD or not was based on....</u>	<u>Shapiro-Wilk test for normality</u>			<u>Wilcoxon S-R test of differences</u>	
	<u>Statistic</u>	<u>df</u>	<u>Sig.</u>	<u>Sig.</u>	<u>Decision</u>
1. getting adequate supervision.	12	0.763	28	0.000	0.498 (n.s.) No difference between 1. I2-I3
	13	0.779	28	0.000	
2. avoiding doing more harm than good.	12	0.672	28	0.000	0.490 (n.s.) No difference between 2. I2-I3
	13	0.699	28	0.000	
3. the extent to which I see this is outside my competence.	12	0.711	28	0.000	0.200 (n.s.) No difference between 3. I2-I3
	13	0.704	28	0.000	
4. Marco's needs.	12	0.808	28	0.000	0.305 (n.s.) No difference between 4. I2-I3
	13	0.836	28	0.000	
5. consideration of how risk would or would not be managed if Marco's difficulties escalate.	12	0.805	28	0.000	0.073 (n.s.) No difference between 5. I2-I3
	13	0.820	28	0.000	
26. the impact on the service.	12	0.944	28	0.138	0.545 (n.s.) No difference between 26. I2-I3
	13	0.916	28	0.028	
27. economic, political and systemic pressures.	12	0.928	27	0.061	0.566 (n.s.) No difference between 27. I2-I3
	13	0.831	27	0.000	
28. resources needing to go to someone else, if Marco does not meet the criteria for accessing the service.	12	0.933	28	0.073	0.206 (n.s.) No difference between 28. I2-I3
	13	0.893	28	0.008	
29. the potential emotional impact on me.	12	0.936	28	0.087	0.248 (n.s.) No difference between 29. I2-I3
	13	0.858	28	0.001	
30. disagreeing that treatment is an accurate description for what clinical psychologists do.	12	0.884	28	0.005	0.776 (n.s.) No difference between 30. I2-I3
	13	0.944	28	0.139	

*Note. Paired samples with n = 4 missing values per justification in iteration three (I3) replaced with the mean for iteration 3. One missing pair for justification 27 (I2 & I3 not completed by same participant, so not replaced with mean values and calculated separately.*

*Appendix HH. Summary of SPSS outputs from tests of normality and tests of difference for mean ratings for Norman vignette (in iterations two and three).*

<u>The decision to undertake an internet search of Norman or not was based on...</u>	<u>Shapiro-Wilk test for normality</u>			<u>Wilcoxon S-R test of differences</u>		
		<u>Statistic</u>	<u>df</u>	<u>Sig.</u>	<u>Sig.</u>	<u>Decision</u>
1. Norman's best interests.	12	0.684	28	0.000	0.089 (n.s.)	No difference between 1. I2-I3
	13	0.665	28	0.000		
2. avoiding harm for Norman.	12	0.722	28	0.000	0.089 (n.s.)	No difference between 2. I2-I3
	13	0.731	28	0.000		
3. possible implications for Norman's treatment and care.	12	0.710	28	0.000	0.107 (n.s.)	No difference between 3. I2-I3
	13	0.753	28	0.000		
4. the extent to which I would see this as useful in assessing risk.	12	0.756	28	0.000	0.450 (n.s.)	No difference between 4. I2-I3
	13	0.827	28	0.000		
5. the extent to which I see this as useful for intervention purposes.	12	0.719	28	0.000	0.524 (n.s.)	No difference between 5. I2-I3
	13	0.828	28	0.000		
31. the extent to which I believe this should be expected in the modern age.	12	0.902	28	0.012	0.257 (n.s.)	No difference between 31. I2-I3
	13	0.933	28	0.076		
32. seeing this as no different to discussing details with the team.	12	0.910	28	0.020	0.340 (n.s.)	No difference between 32. I2-I3
	13	0.916	28	0.028		
33. seeing this as a distraction from working with Norman.	12	0.905	28	0.015	0.916 (n.s.)	No difference between 33. I2-I3
	13	0.953	28	0.234		
34. the level of effort involved for me.	12	0.824	28	0.000	0.402 (n.s.)	No difference between 34. I2-I3
	13	0.870	28	0.002		
35. personal curiosity.	12	0.757	28	0.000	0.100 (n.s.)	No difference between 35. I2-I3
	13	0.787	28	0.000		

*Note. Paired samples with n = 5 missing values per justification in iteration three (I3) replaced with the mean of iteration 3 and n = 1 additional value replaced for I3 justification 3.*

Appendix II. Summary of SPSS outputs from tests of normality and tests of difference for mean ratings for Alissa's dad vignette (in iterations two and three).

<u>The decision to report the information Alissa's dad gave about his benefits to the relevant authorities or not was based on...</u>		<u>Shapiro-Wilk test for normality</u>			<u>Wilcoxon S-R test of differences</u>	
		<u>Statistic</u>	<u>df</u>	<u>Sig.</u>	<u>Sig.</u>	<u>Decision</u>
1. avoiding doing harm to Alissa and her dad.	12	0.683	27	0.000	0.106 (n.s.)	No difference between 1. I2-I3
	13	0.704	27	0.000		
2. avoiding doing harm to Alissa.	12	0.683	27	0.000	0.050*	Statistically significant difference between 2. I2-I3
	13	0.691	27	0.000		
3. Alissa's best interests.	12	0.601	27	0.000	0.044*	Statistically significant difference between 3. I2-I3
	13	0.621	27	0.000		
4. the potential impact on the therapeutic relationship.	12	0.800	27	0.000	0.248 (n.s.)	No difference between 4. I2-I3
	13	0.820	27	0.000		
5. being transparent with Alissa's dad.	12	0.812	27	0.000	0.521 (n.s.)	No difference between 5. I2-I3
	13	0.832	27	0.001		
32. Trust policies.	12	0.949	27	0.205	0.297 (n.s.)	No difference between 32. I2-I3
	13	0.906	27	0.018		
33. my beliefs about the benefits system.	12	0.916	27	0.032	0.348 (n.s.)	No difference between 33. I2-I3
	13	0.901	27	0.014		
34. the extent to which I felt I could advocate for Alissa's dad.	12	0.941	27	0.126	Parametric assumptions met therefore paired samples t-test used. t = 0.086, df(26), p = 0.932, two-tailed (n.s.). No difference between 34. I2-I3	
	13	0.928	27	0.062		
35. it being my choice (or not) to work for an organisation with this policy.	12	0.888	27	0.007	0.310 (n.s.)	No difference between 35. I2-I3
	13	0.864	27	0.002		
36. the emotional impact on me.	12	0.922	27	0.044	0.036*	Statistically significant difference between 36. I2-I3
	13	0.843	27	0.001		
	12	0.885	27	0.006	0.822	

37. what research says about different aspects of this dilemma.	I3	0.931	27	0.075	(n.s.)	No difference between 37. I2-I3
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*Note. Paired samples with n = 4 missing values per justification in iteration three (I3) replaced with the mean for iteration 3. n = 27 as one participant did not complete questions this vignette in either iteration two or three, mean scores not replaced for this.*

*Within pairs I2-I3 normality S-W one or both justifications are significantly differently ( $p < 0.05$ ) distributed from normal distribution, so non-parametric for all pairs except justification 34. Tests for homogeneity of variance revealed that the variances were equal (Within groups sum of squares both = 0.00) so therefore parametric test was applied, see below (n.s.).*

### SPSS Output ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
I2 34. the extent to which I felt I could advocate for Alissa's dad.	Between Groups	79.852	26	3.071	.	.
	Within Groups	.000	0	.		
	Total	79.852	26			
I3 34. the extent to which I felt I could advocate for Alissa's dad.	Between Groups	53.826	26	2.070	.	.
	Within Groups	.000	0	.		
	Total	53.826	26			

*Appendix JJ. Summary of SPSS outputs from tests of normality and tests of difference for mean ratings for Commissioning vignette (in iterations two and three).*

		Shapiro-Wilk test for normality			Wilcoxon S-R test of differences	
		Statistic	df	Sig.	Sig.	Decision
1. avoidance of harm.	12	0.674	28	0.000	0.319 (n.s.)	No difference between 1. I2-I3
	13	0.713	28	0.000		
2. consideration of whether the service could be more cost effective.	12	0.855	28	0.001	0.917 (n.s.)	No difference between 2. I2-I3
	13	0.822	28	0.000		
3. having consulted colleagues.	12	0.821	28	0.000	0.137 (n.s.)	No difference between 3. I2-I3
	13	0.861	28	0.002		
4. how well I feel the current service is working.	12	0.877	28	0.003	0.251 (n.s.)	No difference between 4. I2-I3
	13	0.896	28	0.009		
5. consideration of different intervention options.	12	0.886	28	0.006	0.436 (n.s.)	No difference between 5. I2-I3
	13	0.874	28	0.003		
6. research evidence.	12	0.835	28	0.000	0.082 (n.s.)	No difference between 6. I2-I3
	13	0.827	28	0.000		
31. a recognition of offering some service to clients as being better than not being able to offer anything.	12	0.862	28	0.002	0.646 (n.s.)	No difference between 31. I2-I3
	13	0.947	28	0.166		
32. anticipation of this being the best offer we would be likely to receive.	12	0.933	28	0.074	0.522 (n.s.)	No difference between 32. I2-I3
	13	0.893	28	0.008		
33. the perspective of management.	12	0.938	28	0.096	0.377 (n.s.)	No difference between 33. I2-I3
	13	0.926	28	0.048		
34. consideration of whether another provider (who may be in a better or worse position to provide a service than my own) may take the money if I do not.	12	0.917	28	0.029	0.503 (n.s.)	No difference between 34. I2-I3
	13	0.774	28	0.000		
35. the extent to which I see decisions that commissioners make as outside of my responsibility.	12	0.898	28	0.010	0.676 (n.s.)	No difference between 35. I2-I3
	13	0.927	28	0.051		

*Note. Paired samples with n = 4 missing values per justification in iteration three (I3) replaced with the mean for iteration 3. n = 2 additional values replaced for I3 justification 3.*