COUNSELLORS' SELF-MONITORING
OF DAY-TO-DAY ETHICAL PRACTICE

by

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We accept this thesis as conforming
to the required standard

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October 1999

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ABSTRACT

The purpose of this research was to explore how counsellors self-monitor their day-to-day ethical practices. A qualitative methodology, interpretive description (Thorne, Kirkham, & McDonald-Emes, 1997), was selected as a means of attaining a description of the monitoring process that would depict the commonalities among the participant sample while preserving the unique experience of the individual.

Counsellors who had two to seven years of post-graduation (Master's level) experience and who were thought to be self-reflective and familiar with the ethical codes of the counselling profession were nominated by their former University professors. Participants included six female and two male Caucasian counsellors between the ages of 39 and 47. The counsellors engaged in individual audio taped interviews in which they answered the following question: What are the ways that you self-monitor your ethics of practice? The interview began with a free-form description of the monitoring process and concluded with a series of questions pertaining to particular aspects of the monitoring process (e.g., precipitating cues, frequency of engagement).

Data analysis involved immersion in individual audio tapes and transcripts, searching for common themes within the individual case, and reflection on the data set as a whole asking, “What is happening here?” and “What am I learning about this?” (Thorne et al., 1997). Results suggest that the monitoring process 1) is a component of day-to-day ethical practice; 2) consists of a set of strategies considered to be either reactive or proactive; and 3) evolves with time and may be somewhat developmental. Results are considered in relation to previous and future research, counsellor training, and regulation of ethical practices of current members of the counselling profession.
# TABLE OF CONTENTS

ABSTRACT .............................................................................................................. ii
LIST OF TABLES ........................................................................................................ vii
ACKNOWLEDGEMENTS ............................................................................................ viii
CHAPTER I – INTRODUCTION ..................................................................................... 1
  Purpose of Study ..................................................................................................... 16
CHAPTER TWO – LITERATURE REVIEW ..................................................................... 18
  Conceptual Model of Ethical Practice ...................................................................... 18
  Overview of Research on Practitioners and Their Ethical Practice ...................... 21
  Research on Frequency and Types of Ethical Dilemmas Encountered .............. 22
  Research on Practitioners’ Beliefs .......................................................................... 24
  Research on Practitioners’ Willingness to Apply Ethical Standards .................. 25
  Research on Incidence of Unethical Behavior .................................................... 26
    Competency ......................................................................................................... 28
    Informed Consent and Confidentiality .................................................................. 31
    Dual Relationships ............................................................................................... 32
    Financial Relationships ....................................................................................... 33
  Research on Practitioners’ Maintenance of Ethical Practice ............................... 34
  Research on Practitioner Characteristics ............................................................ 37
  Summary .................................................................................................................. 38
CHAPTER THREE – METHODOLOGY ........................................................................ 41
  Personal Assumptions/Biases .................................................................................. 42
  Participants .............................................................................................................. 46
    Criteria for Participation ....................................................................................... 46
TABLE OF CONTENTS CONTINUED

Characteristics of Participants ............................................. 48
   Sex, Age, and Ethnicity .................................................. 48
   Degree Specialization and Theoretical Orientation ................. 49
   Target Population and Work Setting .................................. 49

Professional Membership and Formal Ethics
   Training Post-Graduation ............................................... 50

Procedure ........................................................................... 50
   Recruitment ...................................................................... 50
   Professor Contact .......................................................... 51
   Participant Contact ......................................................... 51

Sample Selection ................................................................. 53
   The Interview .................................................................... 53
   Journaling ........................................................................ 56
   Data Analysis .................................................................... 56
   Follow-up Interview ......................................................... 57

CHAPTER FOUR – RESULTS .................................................. 59

Domains in Which Participants’ Monitored Their Ethical Practice
   Their Ethical Practice ........................................................ 63
      Competence .................................................................... 64
      Counsellor Needs and Reactions ...................................... 65
      Confidentiality .................................................................. 67
      Harm to Client .................................................................. 68
      Informed Consent .......................................................... 70
# TABLE OF CONTENTS CONTINUED

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual Relationships</td>
<td>70</td>
</tr>
<tr>
<td>Monitored by a Few Counsellors</td>
<td>70</td>
</tr>
<tr>
<td>Role of Formal Ethics Codes and Standards of Practice in Self-Monitoring</td>
<td>72</td>
</tr>
<tr>
<td>The Self-Monitoring Process</td>
<td>74</td>
</tr>
<tr>
<td>Proactive Component</td>
<td>76</td>
</tr>
<tr>
<td>Reactive Component</td>
<td>83</td>
</tr>
<tr>
<td>Cues that Set the Self-Monitoring Process in Motion</td>
<td>89</td>
</tr>
<tr>
<td>Counsellor Cues</td>
<td>90</td>
</tr>
<tr>
<td>Magnitude of Internal Cue</td>
<td>93</td>
</tr>
<tr>
<td>Client-Driven Cues</td>
<td>93</td>
</tr>
<tr>
<td>Other-Driven Cues</td>
<td>95</td>
</tr>
<tr>
<td>Dynamic Nature of Cues</td>
<td>95</td>
</tr>
<tr>
<td>Frequency of Engagement in Self-Monitoring Process</td>
<td>96</td>
</tr>
<tr>
<td>Evolution of Self-Monitoring Process</td>
<td>98</td>
</tr>
<tr>
<td>Similarity with Self-Monitoring Prior to Receiving Contact Letter</td>
<td>103</td>
</tr>
<tr>
<td>Response to Nomination and Impact of Participation</td>
<td>104</td>
</tr>
<tr>
<td>Validity of Research Data and Conceptions of Self-Monitoring Process</td>
<td>106</td>
</tr>
<tr>
<td>Research Data</td>
<td>106</td>
</tr>
<tr>
<td>Conceptions of Self-Monitoring Process</td>
<td>108</td>
</tr>
<tr>
<td>Summary</td>
<td>111</td>
</tr>
<tr>
<td>CHAPTER FIVE - DISCUSSION</td>
<td>118</td>
</tr>
<tr>
<td>Implications of Research Findings</td>
<td>119</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS CONTINUED

Theoretical Implications .......................................................... 119
Implications Pertaining to Ethics Codes .................................... 126
Implications for Research ........................................................... 131
Implications for Future Studies ................................................. 138
Practical Implications ............................................................... 141
  Counsellor Training ............................................................... 141
  Practicing Counsellors ........................................................... 145
Limitations of the Study ............................................................ 148
Conclusion .................................................................................. 151
REFERENCES .............................................................................. 153

APPENDICES

Appendix A – Certificate of Research Approval ......................... 158
Appendix B – Initial Contact Letter to Counselling
  Psychology Professors ............................................................. 159
Appendix C – Initial Contact Letter to Participants ..................... 161
Appendix D – Informed Consent Form ........................................ 163
Appendix E – Orienting Statement .............................................. 166
Appendix F – Specific Questions that Followed Initial Interview .... 168
Appendix G – Permission to Distribute Questionnaire ................. 169
LIST OF TABLES

Table 1 – The Importance of Self-Monitoring Ethical Practice Within

the Counselling Profession ................................................................. 11

Table 2 – Self-Monitoring: Domains, Characteristics and Strategies ................ 61
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CHAPTER ONE

Introduction

"There is no profession more potentially useful or devastating than psychotherapy."

(Van Hoose & Kottler, 1985, p. 113)

When I first considered a career as a counsellor I remember imagining the various ways that my work with future clients would be beneficial and helpful. Although I had heard the stories circulating in the media of mental health practitioners “gone bad” (i.e., physically, sexually, or emotionally abusing their clients), I never imagined that any interaction that I might have with a future client would in any way be harmful to him or her. However, after learning more about this field, both from my employment as a mental health worker and in my academic pursuit of a master’s degree in counselling psychology, I realized that there were some subtle ways in which a counsellor’s behavior could be potentially harmful.

The experiential component of my academic training program challenged my naïve conception that only serious issues of abuse or neglect constituted ethical transgressions. In two of the introductory courses of my counselling program classmates were paired such that one student took the role of “client” and the other took the role of “counsellor.” Each student was both a client and a counsellor. The dyads met for ongoing 50 minute “counselling sessions.” Although the relationships generally progressed smoothly, it was not unusual for the needs of the beginning counsellor to detract from their application of recently learned counselling skills and have a somewhat negative impact upon the student in the client role. To illustrate this I will briefly describe a composite example of this type of counsellor-client interaction.
In the initial skills courses students were often quite eager to start helping their clients make changes in their lives. This enthusiasm sometimes translated such that the counsellors would prematurely tell the client what his or her problem was and then proceed to tell the client what they believed to be the “right” solution. As these courses were students’ first opportunity to start applying counselling skills the students commonly had some anxiety concerning how well they were performing in the counsellor role. Sometimes, at the expense of the client’s needs, the beginning counsellors’ anxiety further increased their desire to demonstrate to their instructor and classmates how much they knew about client concerns and interventions. This tendency is often referred to as the counsellor “pushing his or her agenda.” Working with such a counsellor might have led the student in the client role to feel unsafe when disclosing personal experiences and emotional reactions, and, he or she may have become more guarded. Feeling unheard by the counsellor might also have led to feelings of frustration and anger.

Becoming aware of situations such as these in my training program heightened my appreciation for some of the more subtle day-to-day ways that interactions with clients can potentially result in some degree of harm even when counsellor intentions were well-meaning. When I encountered a situation such as that described above I often wondered, “Does this counsellor not see how his or her behavior is affecting the client? What would these experiences be like for real clients in the real world?” Citing the above example is not meant to insinuate that the degree of harm resulting from a counsellor “pushing his or her agenda” is on par with that which results from an abusive counsellor. Rather, I chose this example as a means to demonstrate that (1) harm and ethical transgressions do not have to be intentional; (2) subtle ethical transgressions can occur outside of the counsellor’s awareness as the beginning counsellors often did not
immediately realize the effect that their needs were having on clients; and (3) the concepts of harm and ethical transgression embody a range of experiences and thus may be best conceptualized as continua.

Given that an implicit goal among the mental health professions (i.e., psychiatry, psychology, counselling, and social work) "...is to improve counselors' ethical sensitivity and reduce the incidence of unethical behavior..." (Pelsma & Borgers, 1986, p. 311), organizations representing these professions have created guidelines that articulate ethical considerations and standards of practice. Although there is thought to be a high degree of similarity between the codes of each of the mental health professions (Overholser & Fine, 1990), the following discussion is specific to those put forth by psychological and counselling organizations such as the American Psychological Association (APA), first published in 1953 (Neukrug, Lovell, & Parker, 1996), and the American Counselling Association (ACA), first published in 1961 (Neukrug et al., 1996), as these are the documents most commonly referred to in the literature relevant to this study. Thus, the majority of the literature in this area pertains specifically to the ethics code of the American organizations. It is however, worth noting that the ethical documents put forth by Canadian professional organizations such at the Canadian Psychological Association (CPA, 1991) and the Canadian Guidance and Counselling Association (CGCA, 1989) are, in general, consistent with the American codes in terms of the ethical principles and standards of practice included in the documents.

In an attempt to bring these documents to life, let us re-examine the behavior of the aforementioned beginning counsellor through the lens of the ACA Code of Ethics (1995). The following sections depict the areas of ethical practice that the student could be considered to be violating:
A.1.a Primary Responsibility.

The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients.

A.1.c Counseling Plans.

Counselors and their clients work jointly in devising integrated, individual counseling plans that offer reasonable promise of success and are consistent with abilities and circumstances of clients...

A.5.a Personal Needs.

In the counseling relationship, counselors are aware of the intimacy and responsibilities inherent in the counseling relationship, maintain respect for clients, and avoid actions that seek to meet their personal needs at the expense of clients.

C.2.d Monitor Effectiveness

Counselors continually monitor their effectiveness as professionals and take steps to improve when necessary...

As can be seen from these excerpts, the wording in these documents is often somewhat vague. In fact, the reader may even disagree that the beginning counsellor’s behavior relates to or violated these particular sections of the code.

It is not surprising that within the field of counselling the ethics codes are often at the center of debate. Many authors suggest that establishing a fixed set of professional responsibilities is a worthy endeavor in that the document serves as a tool for training, screening, regulating, increasing awareness, and improving the behavior of members of that profession (e.g., Gottlieb, 1994; Kitchener 1984; Pope & Vasquez, 1991; Pope,
Tabachnick, & Keith-Spiegel, 1987; Sinclair, Simon, & Pettifor, 1996; Sinclair, Poizner, Gilmour-Barrett, & Randall, 1987). Additionally, it is thought that, by elucidating a statement of moral principle and identifying the particular areas that require attention, the document can potentially support and guide the individual both in terms of acceptable and unacceptable behaviors as well as in resolving ethical dilemmas (Pope & Vasquez, 1991; Sinclair et. al., 1987).

Although the potential impact of the ethical codes on counsellor behavior is profound, the mere existence of a document that outlines the expectations and standards for professional behavior does not in and of itself ensure that such behaviors are actually practiced (Bersoff 1994; Cooper, 1992; Kitchener, 1984; Lazarus, 1994; Mabe & Rollin, 1986; Pope et al., 1987; Sherry, Teschendorf, Anderson, & Guzman, 1991; Tennyson & Strom, 1986, Welfel, 1998; Welfel & Lipsitz, 1984). The existence of the document alone does not guarantee that practitioners believe in, endorse, or practice the guidelines (Sherry et al., 1991). In fact, some findings indicate that, even when counsellors and psychologists explicitly endorse and support standards of conduct, they simultaneously report that were they to be in a situation that warranted applying such a standard they would do less than they know that they should do (Bernard & Jara, 1986; Smith, McGuire, Abbott, & Blau, 1991; Welfel & Lipsitz, 1984; Wilkins, McGuire, Abbott, & Blau, 1990). Therefore, although the ethical codes hold much aspirational potential for counsellor behavior they do not necessarily reflect the actual norms of therapeutic practice (Pope et al., 1987).

Other concerns regarding the ethical documents are in reference to practitioners overly conforming to the guidelines of the ethical codes. For example, Welfel (1998) and Tennyson and Strom (1986) discourage practitioners from relying on such documents as
“cookbooks” or “prescriptions” for professional behavior. They caution that such a quick, “thoughtless” approach could potentially result in neglecting essential moral issues. A controversial article regarding rigid adherence to ethical codes was recently written by Lazarus (1994). The main point in his argument was as follows:

...I am asserting that those therapists who always go by the book and apply predetermined and fixed rules of conduct (specific dos and don’ts) across the board will offend or at the very least fail to help people who might otherwise have benefited from their ministrations. (p. 257)

Several authors (e.g., Borys, 1994; Gottlieb, 1994; Gutheil, 1994) responded to Lazarus’s contention (the interested reader is referred to the publication for more details). The aspects of Lazarus’s argument that particular authors took issue with were unique; however, most would likely agree with the quote by Gutheil (1994) in which he said, “Sound risk management is also not antithetical to spontaneity, warmth, humanitarian concerns, or flexibility of approach” (p. 295).

Briefly summarized, additional concerns regarding the ethics codes are as follows: ethical guidelines are always subject to different interpretations as a function of such things as individual viewpoint, time and context (Cooper, 1992); not all issues can be handled by the code (i.e., there are contradictions and gaps in the codes) (Kitchener, 1984; Mabe & Rollin, 1986); there are potential difficulties in enforcing the code (Mabe & Rollin, 1986); interests of the client, or research participant, are not systematically incorporated into the construction of ethics codes (Mabe & Rollin, 1986); there is a possibility for conflict between professional codes, between the code and the individual, and within the code (Mabe & Rollin, 1986); and finally, the strong position held by Bersoff (1994):
The code’s [APA 1992] pervasive use of qualifiers and its deliberate ambiguity raise the question of whether it can be used to enforce anything but the most serious moral and ethical transgressions, behavior that is so egregiously wrong that no code would be necessary to condemn it. (p. 384)

Although the ethics codes are regarded as insufficient in many ways, to my knowledge there are at present no alternatives that serve to guide the professional’s behavior that are as prevalent within the profession. Therefore, one way for the profession to attempt to keep the potential for harm at a minimum is to ensure that counsellor’s behavior is in line with the ethical codes despite the aforementioned difficulties of such a task. One of the main factors that makes this professional regulation difficult is the confidential nature of the therapeutic relationship (Gabbard, 1997; Pettifor, 1996). The following questions thus arise, “How would anyone know if the counsellor was practicing outside of the ethical guidelines?” and “How in fact does the profession ensure that individual counsellors are practicing within the prescribed boundaries?”

One way that the practice of individual practitioners is monitored is by regulating who is allowed into the profession by subjecting interested individuals to an initial screening process. Criteria against which one is measured include evaluation of academic credentials, supervised practice, written examinations, oral examinations, and reviews of work samples (Pettifor, 1996). However, once the practitioner has been admitted into the profession, Pettifor (1996) states there are few, if any, “…mechanisms for ensuring compliance with professional standards or ensuring quality services” (p. 91).

Although they may not necessarily ensure compliance of ethical standards, there are four formal mechanisms of accountability in place providing it somehow becomes
known that a counsellor is practicing outside of the boundaries of ethical practice (Pope & Vasquez, 1991). They include (1) the professional ethics committees (such as those of the ACA, APA, CGCA, or CPA); (2) state or provincial licensing boards; (3) civil courts (e.g., malpractice suits); and (4) the criminal courts. Each of these mechanisms may play a crucial role in ensuring that consequences are received when ethical transgressions become public. However, as the following quotes illustrate, caution should be exerted regarding relying only on these mechanisms:

Much that we do that is unethical may never come to light and may never trigger inquiry by one of these mechanisms of accountability.

(Pope & Vasquez, 1991, p. 34)

...Most, if not all, of these committees rely on complaints or on voluntary approaches by individual psychologists, it is quite possible that many instances of unethical practice never come to light and are never corrected. (Sinclair et al., 1987, p. 3)

Additionally, dependence upon these mechanisms of accountability as a means to minimize potential for harm has been criticized as remediation occurs only after the harm has been done and has been brought to the attention of the appropriate regulatory agency (Pettifor & Sinclair, 1991). Perhaps for that reason some Canadian provinces (e.g., The Corporation professionnelle des psychologues du Quebec and Alberta’s Psychology Profession Act) have implemented a more preventative professional regulatory approach that involves formally instituting consultation and practice reviews in order to monitor professionals and promote education and professional development on an ongoing basis (Pettifor & Sinclair, 1991).
A less formal mechanism for regulating ethical practice is found among practitioner's colleagues as the following section of the ACA Code of Ethics illustrates:

H.2.a. Ethical Behavior Expected

Counselors expect professional associates to adhere to Code of Ethics. When counselors possess reasonable cause that raises doubts as to whether a counselor is acting in an ethical manner, they take appropriate steps.

In terms of endorsement of this practice the majority of both counsellors (Gibson & Pope, 1993) and psychologists (Pope et al., 1987) surveyed responded that they did regard such behavior as ethical. However, in terms of actual behavior regarding this ethical practice, a study that asked psychologists how they had responded to a colleague that they knew to be in some way impaired (i.e., sexual overtures, substance use, or depression/burnout) found that only half of the respondents reported that they intervened (42% offered to help and/or refer colleague to a therapist and 8% had either referred or reported such a colleague to a regulatory agency) (Wood, Klein, Cross, Lammers, & Elliot, 1985). The authors of this study expressed concern with these findings and asked: "...if the experienced practitioners in our sample...avoid aiding and/or controlling the impaired practitioners of whom they are aware, then who will police the profession?" (Wood et al., 1985, p. 849). Although representing different participant samples this discrepancy between endorsement and actual behavior lends support to the previous finding that counsellors often do less than they know they should do (Smith et al., 1991; Wilkins et al., 1990; Bernard & Jara, 1986; Welfel & Lipsitz, 1984).

The answer, then, to the initial questions, "How does the profession ensure that individual counsellors are practicing within the prescribed boundaries?" and "How would anyone know if the counsellor was practicing outside of the ethical guidelines?" is, in my
opinion, somewhat unsettling. Especially when we consider that, "it is the translation
of a code's principles into practical directions for conduct that is the greatest challenge
for most of us [counsellors]" (Gibson & Pope, 1993, p. 330). In light of the confidential
nature of the therapeutic relationship, unless the counsellor voluntarily comes forward or
the client makes a complaint, an ethical transgression that fell anywhere on the harm
continuum would likely go unnoticed. I would hypothesize that only those transgressions
that resulted in severe harm (e.g., sexual abuse of a client) would become public while
the less severe transgressions (e.g., that of the previously mentioned inexperienced
counsellor) are most likely to go unnoticed by external sources and quite possibly by the
counsellors themselves. Additionally, after gaining entry into the field, the average
counsellor is not monitored by an external source to ensure that he or she is implementing
and following the ethical codes and standards of practice on a routine basis.

At this point, it is clear that the majority of responsibility seems to fall on the
shoulders of the individual practitioner to self-monitor that his or her practice is in line
with the ethics and standards of practice governing the profession of which he or she is a
member. As such, some authors have written about the importance of fostering and
strengthening individual practitioner qualities such as responsibleness (Tennyson &
Strom, 1986) or virtues such as prudence, integrity, respectfulness, and benevolence
(Meara, Schmidt, & Day, 1996). Several authors speak explicitly about the importance
of professionals routinely self-monitoring their practices and regard the process as an
essential component of practicing within the ethical boundaries of the counselling
profession (see Table 1). Stemming from the fact that self-monitoring is regarded as
integral to ethical counselling practice one would expect this area to have received much
### Table 1

**The Importance of Self-Monitoring Ethical Practice Within the Counselling Profession**

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<tr>
<td>Benningfield (1994; quoted in Corey, Corey, &amp; Callanan, 1998)</td>
<td>&quot;...as Benningfield (1994) points out, all therapists have an ethical responsibility to themselves, their clients and students, and to their colleagues to monitor their own professional practice...therapists should engage in an ongoing process of self-assessment to increase their awareness of problematic attitudinal and behavioral patterns that may lead to serious impairment.&quot; (p. 61)</td>
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<td>Corey, Corey, &amp; Callanan (1998)</td>
<td>&quot;If practitioners are not aware of the more subtle ways in which their behavior can adversely affect their clients, such behavior can go unnoticed, and the clients will suffer.&quot; (p. 5-6)</td>
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<td>Pettifor (1996)</td>
<td>&quot;Maintaining professional conduct in daily practice requires an ongoing commitment of psychologists to an ethic of caring, self-evaluation, and validation of practice against effectiveness of client outcome.&quot; (p. 100)</td>
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<td>Pope et al. (1987)</td>
<td>&quot;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 own 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.&quot; (p.1004)</td>
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<td>Van Hoose &amp; Kottler (1985)</td>
<td>&quot;...practitioners, in order to maintain acceptable standards of ethical practice in serving their clients and profession, must continually monitor their own behavior...&quot; (p. 108)</td>
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### Table 1 Continued

**The Importance of Self-Monitoring Ethical Practice Within the Counselling Profession**

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<td>Watkins (1983)</td>
<td>&quot;...it is the counselor's responsibility to be accountable for one's actions and engage in self-monitoring of actions, thoughts, feelings that are experienced in the counselling milieu. Therefore, should destructive behaviors be manifested during the counseling hour, it is incumbent upon the helper to correct such behavior. In essence, it is the counselor's moral and ethical obligation to protect one's clients...&quot; (p. 422)</td>
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<td>Webb (1997)</td>
<td>Ethical practice is &quot;...not just an occasional activity, isolated from their normal functioning and usually prompted by an external dilemma&quot; it should be regarded as &quot;...part of the fabric of their daily working lives and their internal processing of their counselling.&quot; (p. 184)</td>
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<td>Welfel &amp; Lipsitz (1984)</td>
<td>&quot;...members must be able to self-monitor impulses and strong feelings that may threaten to overwhelm their better judgement.&quot; (p. 31)</td>
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<td>Welfel (1998)</td>
<td>&quot;The professional has the duty to self-monitor and to take steps to amend or interrupt practice, if necessary, to prevent harm to clients.&quot; (p. 77)</td>
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<td>&quot;Counselors who fail to acknowledge their vulnerability to misconduct are naïve at best, and frightening at worst.&quot; (p. 353)</td>
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empirical and practical attention, however, such is not the case; the activity, as it relates to ethical practice, is not even explicitly defined.

To prevent any confusion, clarification regarding the self-monitoring construct, as it appears in the psychological literature, is in order. A literature search on the term, as it relates to ethical practice, failed to reveal much research. However, the term, has been conceptualized as a personality variable and has received a great deal of empirical attention. These studies follow Snyder’s (1974) description of self-monitoring, which he defined as a person’s tendency to observe and control his or her expressive behavior.

The two uses of the term differ in regards to what is being monitored. In the personality research, the term “self-monitoring” describes the extent (high versus low) to which one monitors and then modifies his or her behavior across different situations. High self-monitors are considered to be less consistent across situations than are low self-monitors (Snyder, 1974). In the theoretical literature on self-monitoring ethical practice the term appears to refer to a process by which the practitioner assesses and regulates the fit between his or her actions and the profession’s ethical standards. Within the ethics literature, the self-monitoring term is not used to describe a trait or personality variable and there is no speculation as to factors that might impact one’s self-monitoring practices. The existence of two unrelated definitions of the term “self-monitoring” in the psychological literature leads to confusion. As the application of the construct within the personality literature is well-established, perhaps another term should be adopted to describe the process by which practitioners ensure that their practices reflect the professional ethical standards.

Some writers have used terms other than self-monitoring to describe the process by which the counsellor ensures the fit of one’s behavior with the ethical standards of the
profession. For example, some authors have used the term self-evaluation (e.g., Pettifor, 1996) or self-regulation (e.g., Pope et al, 1987). This, too, can be potentially confusing as the terms seem to describe the same process. Given the variation in terminology, it should be noted that literature searches utilizing the key words “self-regulation” and “self-evaluation” in combination with “professional ethical standards” (or something similar) within the databases of several similar fields (e.g., social work, nursing, psychiatry) also failed to identify many studies in this area. Although there is variation in terminology, and the self-monitoring term has been widely used in another area of the literature, it is the label that the majority of writers in this area use to describe this regulatory process (e.g., Welfel, 1998; Van Hoose & Kottler, 1985). Therefore, for the purposes of the present study, the process under investigation will be termed “self-monitoring.”

As no definition of the self-monitoring construct as it relates to ethical practice has been documented I will describe the sense that I had, prior to data collection, of what is meant by the self-monitoring term as used within the area of ethical practice. The process seems to involve some type of inner conversation that occurs both within, and outside of, the counselling session in which the counsellor might consider, question, or modify his or her behavior and/or practices such that it is consistent, to the best of one’s ability, with what he or she knows and/or believes concerning ethical practice (i.e., professional standards of practice and ethics codes; and personal values, morals, and ethics). I suspected that this inner dialogue was typically initiated either externally by an action of the client’s (e.g., something said, a tone of voice, a body movement, etc.) or internally within the counsellor (e.g., a desire, a feeling, a conflict, etc.). The intention of the present study was to articulate a definition of the process of self-monitoring as it
pertains to ethical practice that was grounded within counsellors' reports of engaging in the activity.

In regards to the small amount of empirical attention that self-monitoring has received relating to ethical practice, I am only aware of studies that survey counsellors' use of external sources (e.g., colleagues and literature) as a means to monitor ethical practice (Gibson & Pope, 1993; Pope et al., 1987; Haas, Malouf, & Mayerson, 1986; Hayman & Covert, 1986). To my knowledge, there are no studies that look at the individual's process of monitoring their ethical behavior. In regards to the practical attention that self-monitoring ethical practice has received (i.e., strategies or techniques regarding how to), I am aware of only two versions of questionnaires suggested as a means by which counsellors can independently monitor their day-to-day ethical practice. One of the questionnaires is suggested and described by Pettifor (1996) and actually constructed by Peterson (1996). The other questionnaire is conceptualized and designed by Epstein and Simon (1990). Both questionnaires are discussed in greater detail in chapter two. Given the importance of self-monitoring in the confidential practice of counselling, in combination with the aforementioned gaps in the existing external monitoring mechanisms of ethical practice, it seems long overdue that self-monitoring receive practical and empirical attention.

After reviewing the quotes in Table 1, the reader may have been surprised to learn that there is very little practical or empirical attention devoted to this process that many authors consider to be an essential activity for ethical practice (e.g., Pettifor, 1996; Pope et al., 1987; Van Hoose & Kottler, 1985; Welfel & Lipsitz, 1984: Welfel, 1998). As this area has been virtually neglected within the empirical literature the extent and manner in which counsellors are familiar with and engage in the self-monitoring process has
remained undefined: There is no empirical data on counsellors’ awareness of the term, what it means to self-monitor, how often or in how many ways individuals engage in the process, or whether there are ways to improve upon one’s capacity to self-monitor. It was hoped that the results of this study would begin to fill in some of these gaps. The specific research question of the current study was, “Do experienced counsellors self-monitor their day-to-day ethical practice, and if so, what does the process look like, or how do they describe it?”

**Purpose of the Study**

I have presented information attesting to the importance of self-monitoring ethical practice within the field of counselling. I have also demonstrated that, thus far, as it pertains to ethical practice, this essential process has remained ill-defined. The purpose of this study was to make explicit both the extent and the manner in which experienced counsellors self-monitor their ethical practice on a day-to-day basis. As this study was a preliminary investigation into this topic, and thus far little is known about the process, it was well-suited to qualitative methodology. A relatively new paradigm borne out of the nursing discipline, interpretive description (Thorne, Kirkham, & McDonald-Emes, 1997), was selected as a means by which to attain a description of the monitoring process that would depict the commonalities among the counsellors’ pertaining to this process while preserving the unique experiences of the individual.

The central intention of this study was to attain a description of the monitoring process that captured 1) the particular areas that counsellors attend to when self-monitoring their ethical practice; 2) the cues that typically set the process in motion; and 3) the particular self-monitoring strategies utilized by counsellors. It was hoped that such a description would make a contribution to both the existing knowledge on ethical
practice and the manner in which beginning and experienced counsellors self-monitor their ethical practice. In a profession that relies so heavily on the individual’s ability to self-monitor and regulate his or her own day-to-day ethical practice, it seems that explicating and refining this process might further reduce the risk of ethical transgressions and harm to clients. As well, operationalizing, refining, and assessing the self-monitoring process may give further assurance that individual professionals are, in fact, practicing within the boundaries of ethical practice as defined by the counselling profession.
CHAPTER TWO

Literature Review

In keeping with the requirements of the selected methodology, interpretive description, attention will now turn to a critical review of the theoretical and empirical literature concerning the ethics of practice that are considered to be most relevant to this study (Thorne et al., 1997, p. 173). As previously mentioned, there is little empirical research that focuses directly on the self-monitoring process. Therefore, much of the following discussion will serve to familiarize the reader with the aspects of ethical practice that have been studied and the common research methodologies that have been employed. Before proceeding, however, a conceptual model of ethical practice will be briefly reviewed.

Conceptual Model of Ethical Practice

At the risk of stating the obvious, one can approach the area of ethics from a multitude of perspectives. In order to clarify the focal point of the present study, a brief review of a conceptual model of an ethical system will follow. It is hoped that this explanation will serve to articulate that with which this study is, and is not, concerned. As well, it will demonstrate to the reader the connection between various dimensions within the topic area of ethics that have already been explicitly (e.g., the ethical codes) and implicitly (e.g., the ethical principles such as beneficence) discussed in Chapter One.

A popular model within the counselling literature for conceptualizing ethical justification, or moral reasoning, is one that involves two levels: the intuitive and the critical-evaluative (Kitchener, 1984). The intuitive level is thought to include personal dispositions, habits of thought, and moral intuitions that individuals acquired during their upbringing (Hare, 1984). It is regarded as both one’s conscience (Hare, 1984), and one’s
personal and unique set of beliefs, knowledge and assumptions (Kitchener, 1984). In regards to counsellors, Kitchener (1984) includes the acquired knowledge of the ethics codes in this level. Decisions made at this level are described by Hare (1984) as “time saving rules:” they are immediate and without reflection. Subsequently, Kitchener (1984) points out that intuition “...cannot always be trusted to lead to good ethical decisions” (p. 44).

The second level of moral reasoning, critical evaluative, involves a more active evaluation and reflection on the implications of one’s behavior and decisions (Kitchener 1984). The thoughts and questions that one asks oneself when engaging in critical evaluation have the potential to eventually become assimilated into the individual’s automatic ethical responses (i.e., the intuitive level) (Kitchener, 1984). This level is generally conceptualized as multi-tiered (Beauchamp & Childress, 1979; Kitchener, 1984; Steer, 1984). At the top of the tier is the Ethical Theory (i.e., Deontological or Utilitarian) upon which the Principles (e.g., beneficence) are based, that then serve as the foundation for the Rules (e.g., professional codes of ethics). One might refer to any of these tiers when self-monitoring one’s ethical practice or when faced with an ethical dilemma. However, I hypothesize that the rules and the principles are more influential than the grand ethical theory in terms of assisting with this process, as counsellors might ask themselves something like, “Was that interaction or decision in line with the principles or ethical standards of counselling? If not, how do I justify it or what will I do to correct it?”

As the ethical principles may play a role in the self-monitoring process, they will be briefly described. According to Kitchener (1984), the ethical principles that are most relevant to the practice of counselling are autonomy, beneficence, nonmaleficence,
justice, and fidelity. They are, briefly defined, as follows: the principle of autonomy involves an individual’s right to make choices, to act as she or he chooses, and includes extending this right to others. Beneficence is defined as essentially the doing of good for others. Nonmaleficence entails doing no harm. The principle of justice includes the obligation to be fair (i.e., not discriminate) while also acknowledging inequalities when an individual’s difference is of relevance. Lastly, the principle of fidelity includes loyalty, truthfulness, and promise keeping. In practice, considering ethical actions in light of particular principles is thought to potentially improve the decisions that one makes (Kitchener, 1984). Recall the hypothetical example of the beginning counsellor. Perhaps, if the counsellor were engaging in a conscious evaluation of his or her behavior as it pertained to the principles of autonomy or nonmaleficence, he or she might have avoided or adjusted his or her need oriented approach.

In Chapter One a great deal of attention was devoted to the role of The Rules (i.e., ethics codes) in counselling practice. As such, in this chapter I will simply cite a few examples that illustrate the intimate connection between the rules and the principles (for a more in-depth analysis of this connection the interested reader is referred to Welfel, 1998). The sections of the professional ethics code that address working within one’s area of competence and promoting public welfare can be traced to the ethical principle of beneficence (Welfel, 1998). Elements of the codes that stem from the principle of autonomy include standards of informed consent or maintaining confidentiality (Welfel, 1998). Of course, some aspects of the codes can be traced to more than one ethical principle; for example, informed consent promotes both the principle of autonomy and nonmaleficence (Welfel, 1998).
Although Kitchener (1984) presents this conceptual model as a means to assist in ethical decision making when faced with a particularly challenging situation (i.e., ethical dilemma), it can also serve to clarify the focus of the present study. For example, as conceptualized by the researcher, the self-monitoring of ethical practice could be regarded as a day-to-day manifestation of the processes involved at the critical evaluative level. Therefore, counsellors’ intuitive, immediate, non-reflective, time-saving processes (i.e., those characteristics that represent the intuitive level) are not considered to be as central in self-monitoring ethical practice. This study concentrated on articulating counsellor’s day-to-day process of conscious reflection, deliberation, and consideration, specifically in regards to ensuring that his or her practice was in line with the guiding principles and rules of the counselling profession.

**Overview of Research on Practitioners and Their Ethical Practice**

In a review of the literature on professional ethics, Fuqua and Newman (1989) concluded that the body of work is best described as “position papers” that approach ethics from a theoretical perspective. Welfel and Lipsitz (1984) reached a similar conclusion in their literature review of the material on the ethical practice of mental health practitioners: “…The profession needs to improve the quality as well as the quantity of the empirical research in this area” (p. 38). In addition, the percentage of those empirical studies that do attend specifically to the application of ethics in counselling practice is relatively small (Bernard & Jara, 1986; Robinson & Gross, 1989). Although these conclusions are based on somewhat dated sources it seems, based on my more recent literature review, that their summations continue to be representative of this area.
That being said, there are six general areas of inquiry around which the empirical studies of counsellor's ethical practice tend to cluster. One area that has received such attention is the incidence of ethical dilemmas (e.g., Hayman & Covert, 1986; Pope & Vetter, 1992) and practitioners' resolutions when they encounter such dilemmas (e.g., Haas et al., 1986; May & Sowa, 1992; Shertzer & Morris, 1972). A second area of concentration is practitioners' beliefs about ethical practice (e.g., Gibson & Pope, 1993; Pope, Tabachnick, Keith-Spiegel, 1988). A third focus is counsellors' willingness to apply ethics. This area includes the well-known “should vs. would” studies (e.g., Bernard & Jara, 1986; Smith et al., 1991; Wilkins et al., 1990). Given the finding that practitioners do not always do what they know they should, a fourth area of study includes the incidence of unethical behaviors among counsellors (e.g., Pope et al., 1987; Sherry et al., 1991; Wood et al., 1985). The fifth area of concentration pertains to practitioner's maintenance of ethical practice (e.g., Epstein & Simon, 1990; Gibson & Pope, 1993; Haas et al., 1986; Hayman & Covert, 1986; Peterson, 1996; Pettifor, 1996; Pope et al., 1987). And, a final area that has received much empirical and theoretical attention is the role that personality, developmental, demographic, and experiential factors play in terms of ethical practice and decision making (e.g., Cooper, 1992; Haas, Malouf, & Mayerson, 1988; Kimmel, 1991; Overholser & Fine, 1990; Rest, 1984; May & Sowa, 1992; Neukrug et al., 1996; Olarte, 1991; Tennyson & Strom, 1986; Trevino & Youngblood, 1990). Each of these topic areas will be reviewed.

**Research on Frequency and Types of Ethical Dilemmas Encountered**

Much of the inquiry into the ethics of practice among mental health practitioners is concentrated in the area of ethical dilemmas (Fuqua & Newman, 1989). A dilemma is thought to exist when “... there are good, but contradictory ethical reasons to take
conflicting and incompatible courses of action" (Kitchener, 1984, p. 43). An example of an ethical dilemma that was included in a study by Haas et al. (1986) is as follows:

During the course of your treatment of a 45-year-old male who has drinking problems, his wife telephones and tells you that he has been sexually molesting his 7-year-old stepdaughter (her daughter of a previous marriage).

Situations of this type do not however occur on a frequent basis (Haas et al., 1986; Hayman & Covert, 1986). Of 17 possible areas of ethical concern that were presented to members of the APA, none were regarded to be more than an occasional concern (Haas et al., 1986). When a dilemma does arise it most frequently involves one of the following issues: confidentiality which is closely linked with dangerousness (i.e., harm to self or other); blurred, dual, or conflictual relationships between counsellor and client; counsellor competence; and payment sources, plans, settings, and methods. (Hayman & Covert, 1986; Pope & Vetter, 1992). Those dilemmas that are regarded as most difficult to resolve involve competence and confidentiality (Hayman & Covert, 1986), while dangerousness is typically regarded as least challenging (Hayman & Covert, 1986 - note that financial concerns were not considered in this study).

Level of agreement among practitioners concerning the appropriate response to hypothetical ethical dilemmas is not particularly high. A study conducted by Shertzer and Morris (1972) found that, after reviewing 12 hypothetical ethical dilemmas, 60% of participants chose the ethical response (out of a response set that included four plausible unethical responses) in two-thirds of the incidents. Although not explicitly stated by the authors, this finding seems to imply that in two-thirds of the cases 40% of the participants chose an unethical response and in the remaining one third of the cases 100% of the
participants chose what was considered by the authors to be an unethical response. It is hoped that were such a study to be replicated today a higher percentage would chose the “correct” response more often.

A similarly designed study conducted by Haas et al. (1986) presented psychologists with 10 vignettes depicting ethical dilemmas such as that previously described and asked them to chose which of three choices was their preferred course of action. Results are discussed in terms of level of agreement among responses as opposed to correct ethical choice as in the above study. High agreement among practitioners was apparent for only one-third of the vignettes. However, in a subsequent study, with a similar design, these same authors concluded that results indicted that there was “substantial agreement” among participants though they did not report the supporting data (Haas et al., 1988).

Research on Practitioner’s Beliefs

A major contribution in the area of practitioner beliefs is a study by Pope et al. (1987). These authors surveyed psychologists regarding the degree (as indicated on a 5-point scale) to which they considered 83 different behaviors (e.g., kissing a client, selling goods to a client) to be ethical. In another publication, these same authors (Pope et al., 1988) reported psychologists’ beliefs regarding the degree to which these same 83 behaviors were viewed as good or poor practice (as indicated on a 5-point scale).

Similar studies have been conducted with counsellors. For example, Gibson and Pope (1993) surveyed certified counsellors’ beliefs concerning 88 behaviors. In the previous studies, responses tended to fall predominantly on the extremes of the Likert scale. Therefore, the participants in this study were asked whether or not they believed a behavior to be ethical and then indicated their confidence (on a 10-point scale) in making
that judgement. Another study that looked specifically at college center counselling professionals used the same format as the initial study by Pope et al. (1987) modifying the behaviors (49 in total) to be more relevant to counsellors working in that particular setting (Sherry et al., 1991).

Although counsellor beliefs are obviously relevant to ethical practice, it is beyond the scope of this presentation to summarize the findings from the above studies given the high number of behaviors included in the surveys. The interested reader is thus referred to the publications for further inquiry. These studies were included as a means to illustrate the application of one of the most popular research methodologies, surveys, in the area of ethical practice (Welfel & Lipsitz, 1984).

Research on Practitioner’s Willingness to Apply Ethical Standards

A somewhat stable finding in the field of ethical practice is that a large percentage of counselling practitioners, from graduate students to those with doctoral degrees, report that when it comes to responding to an ethical dilemma they would do less than they know they should do in regards to the professional ethics codes (Bernard & Jara, 1986; Smith et al., 1991; Wilkins et al., 1990). Initial exploration into this phenomenon was conducted by Bernard and Jara (1986). In their study they presented a group of clinical psychology students with two scenarios requiring ethical action. Both vignettes involved intervening with a colleague, also described as a close friend, who was 1) sexually involved with a client and 2) whose alcohol consumption was interfering with practice. Participants then indicated what they should do and what they would actually do in response to the situation. Fifty percent of the participants reported that they would do less than they thought they should do. The authors stated that such a response is akin to saying, “I know what I should do as a ethical psychologist, but I wouldn’t do it” (p. 315).
In an extension of this study, Wilkins et al. (1990) asked members of the APA what they think they should do and what they actually would do if they encountered four hypothetical situations. In addition to the ethical dilemmas of the above studies, they also included dilemmas that involved confidentiality, and the need to refer a client due to competency limits. The variable of the person involved in the scenario was manipulated and included you, a good friend, a colleague, or an acquaintance. These researchers wanted to examine the impact of the person involved in terms of what one would actually do. Consistent with previous findings, except in the confidentiality vignette, clinicians reported that they would do less than they previously stated that they should do. Contrary to expectations this pattern was stable regardless of who the involved person was.

A third study conducted by Smith et al. (1991) further extended these findings as they explored mental health professionals (e.g., social workers’, clinical psychologists’, and counsellors’) rationales for doing less than they knew they should. Participants first responded to 10 vignettes, describing a variety of ethical dilemmas, as to what they should do in relation to APA Ethical Principles and what they actually would do. Across all vignettes, participants indicated that they would act less in accordance with the APA Code than they knew that they should. The rationales for such a discrepancy included personal or situational reasons such as financial need, upholding personal moral values/standards or protection of personal/professional reputation.

**Research on Incidence of Unethical Behavior**

Given the above finding that mental health practitioners often report that they would do less than they know is required in the professional standards and ethics of their profession, it should not be surprising that ethical transgressions occur. Every year the APA Ethics Committee publishes reports on the incidence of reported ethical
transgressions. Unfortunately, the professional counselling associations do not make such information as accessible (Schwab & Neukrug, 1994). According to the most recent publications of the APA Ethics Committee, the number of formal complaint forms filed was 129 (1994), 118 (1995), and 89 (1996). These numbers represent 0.19%, 0.14%, 0.11% of the total membership in those years respectively (APA, 1997). Of the cases opened in 1996 (i.e., a form could be filed and not necessarily result in opening a case), the majority of concerns fell within the categories of “inappropriate professional practice” (primary concern in 22 cases, secondary concern in 41 cases) and “dual relationships” (primary concern in 7 cases, and secondary concern in 30 cases) (APA, 1997).

Given the relatively low number of complaints filed per year (i.e., not even one percent of the membership) one might wonder about the previous findings regarding the should vs. would studies as it appears that practitioners are in fact doing an excellent job of practicing in accordance with the ethical standards of the profession. Such a conclusion based on these numbers alone would, however, be premature as such numbers are generally regarded as underestimating the actual occurrence of unethical practice for a variety of reasons (Overholser & Fine, 1990; Pettifor & Sinclair, 1991; Pope & Vasquez, 1991; Sinclair et al., 1987; Welfel & Lipsitz, 1984; Welfel, 1998). Firstly, those who lodge the complaints “…tend to be resourceful, articulate, rankled and persevering [while] the hurt, frightened, unassertive, unresourceful, or inarticulate may not complain” (Pettifor & Sinclair, 1991, p. 64). Secondly, violations rarely lead to a formal complaint (Pope & Vasquez, 1991). Thirdly, some violations may be difficult to prove (Pope & Vasquez, 1991). And lastly, resolution of ethical transgressions may be informal and thereby never become a formal case (Pope & Vasquez, 1991).
The following discussion will summarize the findings regarding the incidence of specific unethical practices as reported by the APA Ethics Committee and the reports of practitioners on both their own behavior and that of their colleagues. Ethical transgressions are commonly classified and most often pertain to the following areas: competency issues, informed consent and confidentiality, dual relationships, and financial relationships (Hayman & Covert, 1986; Peterson, 1996; Pope & Vetter, 1992). The findings will thus be presented in regards to these categories.

**Competency**

As competency is a relatively general term, ethical transgressions that fall within this category have been further broken down by Peterson (1996) to include practicing outside of the limits of training; misuse of tests; practicing while physically or mentally impaired; failure to diagnose, treat, or refer a client; and failure to warn in terms of harm to self or others (note that this last point is considered by Hayman & Covert, 1986, as a component of confidentiality). Each of these subsections of competency will be reviewed.

In 1995, of those new cases that were opened by the APA, eight cases involved practicing outside the boundaries of competence while in 1996 this was a concern in only two cases (APA, 1997; APA, 1996). However, in response to a survey question, approximately one-quarter of the sample of psychologists reported that they had at one time provided services that were outside of the limits of their training (Pope et al., 1987). Thus it seems, at least for this unethical practice, that the Report of the APA Ethics Committee does not reflect the actual incidence of this behavior.

In regards to misuse of tests, this was a concern in 12 of the newly opened cases in 1995 (APA, 1996) and in four of those opened in 1996 (APA, 1997). However, of
those college counsellors surveyed by Sherry et al. (1991) approximately one-half of
the participants reported that they had administered tests with clients of different ethnic
backgrounds without proper norms, 20% of the respondents stated that they had utilized
tests in which they were unable to interpret the results, and 19% stated that they had
utilized tests that were beyond their ability to administer. In a group of surveyed
psychologists (Pope et al., 1987) and among surveyed counsellors (Sherry et al., 1991)
approximately one-half of the respondents indicated that they had at one time allowed a
client to take a test at home. Again, it seems that the numbers reported by the APA
Ethics Committees do not adequately reflect the norms of practice.

Interestingly, the APA Ethics Committee Reports do not include a category that in
any way refers to practicing while physically or mentally impaired. As I reviewed the list
of categories I could not surmise how such a case would be categorized. This exclusion
is somewhat shocking in light of the fact that practitioners’ reports of both their own and
their colleagues behavior indicate that compromising the service provided to clients as a
result of substance use, depression, burnout, or personal distress are central ethical
concerns.

In regards to alcohol or drug use 38.5% of psychologists report that they have
known colleagues whose work has been impaired by these substances and over half of the
respondents regard practitioners’ impairment due to substance use as at least a somewhat
serious problem (Wood et al., 1985). When this group was asked to estimate the overall
percentage of colleagues whose work was affected by drugs or alcohol, the median was
5.45% (the mean was skewed by extreme estimates thus the median, in this case, was
regarded by the authors to be more meaningful). In terms of self-reports of work being
affected at one time by drug or alcohol use, percentages range from 4.2% (Wood et al.,
1985) to 5.9% (Pope et al., 1987) to 9% of one sample of psychologists who reported
that their work often to very often was affected by alcohol use (Thoreson, Miller, &
Krauskopf, 1989 – these authors unfortunately do not report the response rate for the
never, rarely, or sometimes categories).

In terms of practicing while emotionally or physically distressed, 62% of
psychologists (Pope et al., 1987) and 70% of college counsellors (Sherry et al., 1991)
reported that they had, at least on a rare occasion, worked when they were too distressed
to be effective and thereby compromised the level of care received by their clients. In
another group of psychologists who stated that they had experienced distress as a result of
job stress, illness in family, and marital problems, 36.7% reported that it had resulted in a
decreased quality of care received by their clients (Guy, Polestra, & Stark, 1989). Wood
et al. (1985) surveyed psychologists specifically in regards to the degree to which
depression or burnout had affected their work and that of their colleagues. Sixty-three
percent of their sample reported that they were aware of colleagues whose work had been
impaired by these factors, although the estimated percentage of colleagues whose work is
affected by these factors was only judged to be 15.2% (again reported in terms of the
median). The percentage that reported that their own work had been compromised as a
result of either burnout or depression was 32.3%. Perhaps the participants believe that
their work is more often compromised as a function of depression or burnout than their
colleagues and again, maybe they regard the person that they know to be affected as more
of an anomaly than he or she actually is.

In relation to the component of competency that includes failure to diagnose,
treat, or refer a client, the above mentioned surveys did not ask about such behaviors, nor
does the APA Ethics Committees Report include a category on this issue. In regards to
the final component of competency, failure to warn in terms of harm to self or others, the closest category that seems to pertain to this ethical transgression within the APA report is “inappropriate response to crisis.” No new cases were opened in 1996 under this classification though it was a concern in 4 of those cases opened in 1995. Findings from the Pope et al. (1987) survey, however, indicate that a somewhat high percentage of psychologists may not be responding appropriately to crisis. For example, 25.2% of the research participants stated that they rarely or never broke confidentiality if a client was homicidal; 40.8% rarely or never broke confidentiality if a client was suicidal; and 41.2% rarely to never broke confidentiality to report child abuse (Pope et al., 1987).

**Informed Consent and Confidentiality**

The APA does not have a category for violations relating specifically to informed consent, nor did the Pope et al. (1987) survey ask psychologists questions pertaining to this ethical standard. Results from the group of surveyed counsellors, however, indicate that 44% of respondents stated that they never to sometimes obtain written consent prior to taping (Sherry et al., 1991). Of course, it is not clear if this number includes those who may simply not tape clients, thus they would have no need to obtain permission. Of those same respondents, 38% stated that they never to sometimes verbally inform clients of their rights (Sherry et al., 1991).

In 1995, 11 of the cases opened in that year involved the issue of confidentiality (APA, 1996) while in 1996 it was a concern in six of the cases (APA, 1997). A relatively high number of psychologists (62% - Pope et al.,1987) and counsellors (55% - Sherry et al., 1991) report that they have, at least on a rare occasion, unintentionally disclosed confidential data.
**Dual Relationships**

This is a central concern in the ethics of practice literature and has received much attention as the following points illustrate. First, it seems from my literature review that dual relationships are the most commonly studied ethical transgressions (e.g., Gabbard, 1997; Kagle & Giebelhausen, 1994; Plaut, 1997). Secondly, a large proportion of the cases opened by the APA Ethics Committee involved dual relationships (41% in 1996; 47% in 1995) (APA 1997, APA, 1996). And thirdly, of those ethical violations that resulted in termination of APA membership, dual relationships were the most common reason (in 1996, 18 were terminated for sexual, three for nonsexual dual relationships; in 1995, 21 were terminated for sexual, one for nonsexual dual relationships) (APA, 1997; APA, 1996).

Reports from practitioners also suggest that the issue of dual relationships is a central concern. Of the psychologists who were asked if they were aware of other practitioners whose work had been impaired by sexual overtures, 39.5% stated that they were though they estimated that this was a problem for only 4.94% (median response) of the total profession (Wood et al., 1985). In terms of self-reports among this same group of psychologists, 0.6% reported that their work had been impaired by sexual overtures (Wood et al., 1985). Of another group of sampled psychologists, 1.9% stated that they had engaged in sexual contact with a current client, while 2.6% reported that they had engaged in erotic activities with a client (Pope et al., 1987). These percentages are similar to the 2% of college counsellors that reported that they had been sexually intimate with a current client (Sherry et al., 1991).

The percentage of both counsellors and psychologists that report engaging in non-sexual dual relationships is much higher than reports of sexual dual relationships (Pope et
al., 1987; Sherry et al., 1991). For example, between 25 and 40 percent of counsellors and psychologists reported that they had, at least on a rare occasion, provided therapy to a supervisee, friend, or relative (Pope et al., 1987; Sherry et al., 1991). Approximately 16% of surveyed psychologists reported that they had invited a client to a party or social event (Pope et al., 1987) while approximately 38% of surveyed counsellors reported that they had initiated informal social contact with a client (Sherry et al., 1991).

Financial Relationships

The final category of ethical practice to be discussed, and the area in which there seems to be little agreement concerning what is and what is not ethical, is the area of fees and payment (Gibson & Pope, 1993). Situations of this type were predominately regarded as “difficult judgements” by counsellors surveyed by Gibson and Pope (1993). Some examples of such controversial behavior include terminating counselling if a client cannot pay, accepting services from clients in lieu of payment, raising the fee during the course of treatment, performing work for a contingency fee, or earning a fee that is a percentage of a client’s salary (Gibson & Pope, 1993). The authors attribute their findings regarding the difficulty of such judgements to the recent surge in private practice and counsellors having to make these decisions instead of relying on a fixed salary.

In regards to practitioners behavior in the area of finances, according to the APA Ethics Committee reports in 1995, 19 of the opened cases involved insurance/fee problems (APA, 1996) while in 1996 only 5 of the cases involved this concern (APA, 1997). Due to the controversial nature of this area it seems difficult to report the findings regarding unethical practices as it is not clear what constitutes unethical practice in this area. Therefore, the incidence of psychologists engaging in behaviors that involve finances will be reported, but it is not to suggest that these behaviors are necessarily
unethical. In the Pope et al. (1987) survey psychologists reported that they had, at least on a rare occasion, participated in the following behaviors (approximate percentages reported in brackets): terminated counselling if a client cannot pay (62%), accepted goods (43%) or services (31%) from clients in lieu of payment, raised the fee during the course of treatment (72%), performed work for a contingency fee, or earned a fee which is a percentage of a client’s salary (23%), charged a client no fee for therapy (65%), and allowed a client to run up a large unpaid bill (88%).

To summarize the findings in the area of unethical practice it is clear that the number of ethical transgressions that become formal cases opened by the APA Ethics Committee seem to be far less than the actual incidence of occurrence. In addition, this discrepancy was found to be true across all categories of ethical transgressions. One would assume that such is also the case for the cases opened by the ACA Ethics Committee. For a review of possible explanations of this inconsistency the reader is referred to the introduction of this section. As it is also possible that research participants under-reported the rate of occurrence of unethical practices it is possible that the incidence of unethical practices is actually greater than the highest number reported (Pope & Vasquez, 1991; Welfel & Lipsitz, 1984). Of all of the categories of unethical practice, it seems that those transgressions involving dual relationships and competency issues are of the biggest concern.

**Research on Practitioners’ Maintenance of Ethical Practice**

Although the majority of research on ethical practice concentrates on unethical practices, there are some studies that include an exploration of strategies utilized by practitioners to maintain their ethical practices. As is characteristic of much of the research on ethical/unethical practice (Welfel & Lipsitz, 1984), inquiry is often directed
at resolution of ethical dilemmas such that the question often becomes, “What are the means by which counsellors maintain that their practice is ethical when faced with an ethical dilemma?” The most utilized resources in this regard are colleagues and ethical documents.

Consultation with colleagues is regarded as the most helpful resource when faced with an ethical dilemma and therefore it is also the resource most frequently utilized by practitioners when they are experiencing ethical concerns (Gibson & Pope, 1993; Haas et al., 1986; Hayman & Covert, 1986; Pope et al., 1987). Getting another’s viewpoint is essential for ethical practice as one’s own perspective “…will always be imperfect and will always be subject to the vagaries of counter-transference, bias, denial, and unconscious wishes for the patient to meet the therapist’s needs” (Gabbard, 1997, p. 324). As well, the importance of dialoguing with colleagues is echoed in Tennyson and Strom’s (1986) conception of the responsible practitioner which includes both critical self-reflection and dialoguing with colleagues. Although dialoguing with others is beneficial one must remember that consultation, on its own, does not guarantee a high level of ethical practice as the discussion is still subject to the consultee’s rendition of events which may be subject to bias (Gabbard, 1997). As such, I agree with Tennyson and Strom (1986) in that the highest ethical performance is likely most possible when practitioners engage in solitary critical self-reflection and are honest and forthcoming during the consultation process.

The second commonly reported strategy that counsellors utilize when faced with ethical dilemmas is to consult the ethics codes and/or the literature. In terms of the available literature, psychologists regarded the APA Ethical Principles as the most helpful information source (Pope et al., 1987) while for counsellors the ACA Ethical...
Standards and the *Journal of Counseling and Development* were rated high (Gibson & Pope, 1993). However, among college counsellors surveyed by Hayman and Covert (1986) only one-third had consulted ethical standards or guidelines to assist with resolving ethical dilemmas. In terms of effectiveness of published research psychologists did not regard this source as very helpful (Pope et al., 1987) nor did counsellors consider published clinical and theoretical work, in general, to be of much use in terms of resolving ethical dilemmas (Hayman & Covert, 1986; Gibson & Pope, 1993).

As previously mentioned, these two strategies, consulting with colleagues or the literature, are generally regarded as ways to gain guidance and/or support when faced with an ethical dilemma. Although regular utilization of these strategies could potentially improve one's day-to-day ethical functioning they, in and of themselves, may not be sufficient in terms of ensuring a high standard of everyday ethical practice. Within the literature, and thus perhaps within the counselling profession, there is a definite lack of information regarding how counsellors themselves ensure that their day-to-day practice falls within the boundaries of ethical practice. As ethical dilemmas have been demonstrated to be somewhat infrequent is there not a need to attend to what constitutes ethical practice in between the occurrence of dilemmas? Few authors have examined counsellor’s day-to-day ethics of practice, the times between the dramatic dilemmas, the time in which most interactions with clients occur. There are, however, four authors that have suggested that counsellors periodically utilize a self-assessment inventory as a means to reflect upon their day-to-day practices (Peterson, 1996; Pettifor, 1996; Epstein & Simon, 1990).

Pettifor’s (1996) conception of such an instrument is one that is rooted in the principles and standards of practice of the major ethical documents (e.g., APA, CPA,
A questionnaire of this type was developed by Peterson (1996) and contains questions such as "Do I maintain records for each client?", "Do I withdraw from practice if my health is impaired?" and "Am I able to define the scope and limitations of my practice?" Responses may be yes, no, needs improvement or not applicable.

The self-assessment tool suggested by Epstein and Simon (1990), the Exploitation Index (EI), is intended to assist practitioners in identifying concerns around boundary violations. Examples of questions are "Do you accept gifts or bequests from patients?", "Do you take great pride in the fact that such an attractive, wealthy, powerful, or important person is seeking your help?", or "Do you make exceptions for your patient because you are afraid she/he will otherwise become extremely angry or self-destructive?" Responses are given in terms of frequency of engaging in the particular behavior in the past 2 years (e.g., never, rarely, sometimes, or often).

The advantages to such self-assessment instruments are that they can serve to both alert counsellors to the areas of their daily practice that require more attention, and they can also serve to assure them of their areas of competence (Pettifor, 1996; Epstein, 1994). If, while self-monitoring, one becomes aware that she or he has compromised an ethical principle or standard of practice Welfel (1998) suggests that the practitioner ask him or herself two questions: "What damage have I done and how can I undo or ameliorate that damage?" and "What steps should I take to ensure that I do not repeat this mistake?"

**Research on Practitioner's Characteristics**

Some of the more recent articles in the area of practitioners' ethical practice are theoretical papers that describe and substantiate (by utilizing case studies) the individual characteristics thought to influence ethical practice. For example, Overholser and Fine (1990) suggest that the following five factors potentially affect counsellor competence:
Factual knowledge, generic clinical skills, orientation-specific technical skills, clinical judgement, and interpersonal skills. Cooper (1992) describes the influence of beliefs, feelings, and conscious and unconscious processes on ethical practice. Meara et al. (1996) write about the need for counsellors to possess the following virtues: prudence, integrity, respectfulness, and benevolence. And lastly, counsellor's level of cognitive-moral development has been described as impacting the process by which counsellors make ethical decisions (Pelsma & Borgers, 1986; Neukrug et al., 1996).

In terms of the empirical literature in this area, many of the studies mentioned in previous sections have looked at the interaction between individual characteristics and ethical decision-making, behaviors or beliefs. Some of the factors that have accounted for variation among participants' responses include: theoretical orientation (Haas et al., 1988; Pope et al. 1988), sex (Gibson & Pope, 1993; Haas et al., 1988; Kimmel, 1991; Schwab & Neukrug, 1994; Sherry et al., 1991; Pope et al., 1988; Pope, et al. 1987); age (Gibson & Pope, 1993; Pope et al. 1988); work setting (Gibson & Pope, 1993; Kimmel, 1991); years of counselling experience (Haas et al., 1988); area of concentration of degree and time passed since attained degree (Kimmel, 1991); and external or internal ethical orientation (May & Sowa, 1992). Interestingly, formal ethics training does not seem to account for response variation (Gibson & Pope, 1993; Haas et al., 1988).

Summary

As was previously stated, the process of self-monitoring has not been studied despite the essential role of such a process in terms of maintaining day-to-day ethical practice. In general, the majority of attention on the ethical practice of counselling professionals has focussed on ethical dilemmas. For example, the incidence and prevalent types of ethical dilemmas has been examined (e.g., Hayman & Covert, 1986;
Pope & Vetter, 1992); practitioner’s resolutions when they encounter such dilemmas have been explored (e.g., Smith et al., 1991; Wilkins et al., 1990); level of agreement among professionals concerning resolution alternatives has been investigated (e.g., Haas et al., 1986; May & Sowa, 1992; Shertzer & Morris, 1972); practitioners have responded to hypothetical dilemmas and indicated what they believe that they should do and what they actually would do (e.g., Bernard & Jara, 1986; Smith et al., 1991; Wilkins et al., 1990); and differences in response to dilemmas have been examined as a function of characteristics of the professional (e.g., Haas et al., 1988; Schwab & Neukrug, 1994). Of course, such exploration and deliberation regarding the nature of ethical dilemmas, practitioners’ responses to them, and the generation of ideal responses to particular dilemmas can potentially contribute to enhancing ethical practice. However, as said by Pope and Vasquez (1991), if research continues to focus predominantly on ethical dilemmas “...we may overlook the numerous, less dramatic, but no less significant ethical decisions that each of us – no matter what our setting, clientele, or approach – faces in our day-to-day clinical work” (p. 49). The present study appreciates and seeks to better understand the processes involved in the day-to-day maintenance of ethical practice.

While reading the above review of the literature, the astute reader likely noticed that the favoured research methodologies in the area of ethical practice are of a quantitative descriptive design. Specifically, they consist primarily of paper and pencil survey studies in which research participants are asked to either indicate on a Likert scale the strength of a belief (e.g., Pope et al., 1988; Sherry et al., 1991) or the frequency of behavior (e.g., Pope et al., 1987; Sherry et al., 1991; Wood et al., 1985); or, participants are asked to chose from a set of responses (e.g., Bernard & Jara, 1986; Haas et al., 1986;
Shertzer & Morris (1972) or describe their own response (e.g., Smith et al., 1991; Wilkins et al., 1990) in relation to a hypothetical dilemma. With a topic as complex as ethics it seems that stripping beliefs, behaviors, and situations of their context is a somewhat rudimentary approach and the actual application of research findings to real life may be somewhat weak. One study that appears to reflect this problem was conducted by Schwab and Neukrug (1994) who reported that, when they presented participants with vignettes and then asked them to respond, some participants wrote on the survey that they were unable to comment as not enough information was provided. Welfel and Lipsitz (1984), in their literature review, proposed that more imaginative and sophisticated approaches are needed to replace "...the primitive research designs [generally survey and analogue studies] that have characterized the field..." (p. 38). They also recommended that future research attend not only to the outcome of ethical decision making but also to the process involved. The design of this research study was intended to capture the complexity of day-to-day ethical practice.
CHAPTER THREE

Methodology

This chapter will detail the methodological design of this study, the researcher's biases and assumptions, the characteristics of the participants, and the procedures involved in this research. The procedures involved in this research project were approved by the Behavioural Research Ethics Board at the University of British Columbia (see Appendix A). Although the methodology, interpretive description, will be referred to throughout the chapter, at this time I will briefly describe the shared and unique features of this methodology in relation to some of the more traditional qualitative methods (i.e., ethnography, phenomenology, and grounded theory). The research product that results from an interpretive descriptive study is intended to "...reflect a respect for knowledge about aggregates in a manner that does not render the individual case invisible" (Thorne et al., 1997, pg. 171). The final product thus differs from that of phenomenology, for example, which seeks to capture the essence of a human experience.

Some of the assumptions and procedures that interpretive description seems to share with other qualitative methods are as follows. First, the method requires that the researcher make explicit biases and assumptions that may affect the research process and product. Second, the use of journaling throughout the research process is recommended. Third, those who experience the phenomenon under study are regarded as "experts" in the topic area. Fourth, information is collected through interview and observation, the result of which is considered to be the research data. Fifth, during data collection adjustments may be made as new information arises and these modifications are always made explicit. Sixth, the researcher immerses oneself and comes to have an intimate knowledge of the research data.
Seventh, data analysis is inductive in nature. And lastly, before analysis is finalized, it is brought back to the participant for verification and/or modification.

Some of the unique features of interpretive description in relation to other qualitative methods are, firstly, the aforementioned research product. Second, in addition to the traditional data sources of interview and observation, interpretive description makes use of other sources such as “lay print” or media reports in data collection. Third, the process of analyzing the research data involves reflecting on what is becoming known as a whole, the overall picture, as opposed to isolating small units for analysis or developing intricate coding systems as in grounded theory. And lastly, it is these beginning impressions of the data as a whole, as opposed to that of an individual story, that are brought back to research participants for refinement. Many of these commonalities and unique features will be apparent in the following sections.

**Personal Assumptions/Biases**

As is characteristic of qualitative research studies, the method of interpretive description calls for an explicit statement of the researcher's biases and their possible manifestations (Thorne et al., 1997). A central assumption that I hold, and one that shaped my initial interest in this topic area, is that being ethical is not an automatic, naturally occurring process. I believe that to consistently practice within the ethical boundaries of the counselling profession there must be some consciousness, reflection and self-awareness regarding one's actions. Additionally, I assume that most counsellors endorse the basic proponents of ethical practice as defined in the ethical codes. And, I expect that most counsellors are guided by and consider the ethical codes and standards of practice to some degree in their practice.
A second bias that I hold is that I regard the self-monitoring process as essential to ethical practice. Without engaging in this process, I can not imagine how one would know to adjust his or her behavior, to seek consultation with a colleague, or refer to the literature or ethical documents. As the literature reports that counsellors do engage in such consultation, to varying degrees (Gibson & Pope, 1993; Haas et al., 1986; Hayman & Covert, 1986; Pope et al., 1987), I thereby assume that most counsellors must first engage in some degree of self-monitoring. That being said, however, I assume there to be a range in terms of the individual's consciousness of engaging in this activity and the attention that individual's devote to the process in their daily practice. Stemming from my belief that self-monitoring is essential to ethical practice is my assumption that all practitioners struggle with ethics and, from time to time, make mistakes. In my opinion, to be ethical does not mean to be perfect. Instead, I regard an ethical practitioner as one that has made a commitment to on-going reflection and refinement as she or he strives to improve upon and further develop his or her ethical practice. In my view, self-monitoring plays a role in this developmental process. However, in terms of the best way to go about self-monitoring, I have no preconceived notions.

A third bias pertains to the importance of certain abilities which, although relevant to many professional positions, are, in my opinion, of paramount importance in the counselling profession. I regard the counselling profession as demanding of its members 1) a high degree of self-awareness; 2) a high capacity to critically reflect upon one's actions and motives and adjust one's behavior accordingly; and 3) the ego strength required to temporarily push aside, or suspend, one's needs, values, desires, or emotional reactions when necessary in order to provide the best service to a client.
A fourth bias that I hold that may have impacted upon this research is that I regard the subtle day-to-day ethical transgressions as deserving as much attention, from both the individual and the profession, as the more obvious dramatic violations. For example, if the client cited in the hypothetical example described in Chapter One were a real-life client and had believed that the beginning counsellor knew better about his or her concerns than he or she did the impact of the counsellor might have been as follows: the client might have believed his or her problem to be much worse than it was; he or she may have discounted any progress that had already been made in working towards his or her goal; and the client might have been left with the message that not only does he or she not adequately understand his or her world but he or she is also unable to generate his or her own solutions. Such an outcome would not be in keeping with the general goals of counselling intervention and may represent an ethical transgression with potentially serious consequences.

Lastly, before proceeding, I will briefly describe my personal conception of ethical practice. I regard the ethical documents and standards of practice as providing an essential foundation for ethical practice. However, simply possessing or memorizing a document, or the “rules,” is, in my opinion, not in itself ethical practice. I regard ethical practice as an interactive, daily process that involves reflection, questioning, and deliberation. A guiding question in my own active ethical practice is, “What needs to happen or what do I need to do to sleep at night?” As I reflect upon the answer to this question some of the things that I consider include what I know of the codes, principles, and professional standards; the particularities of the specific situation; my motives; what I or others have done when faced with similar situations; and how I can justify my actions and choices to myself and others. My conception of ethical practice thus includes a high
degree of self-awareness, reflection, and accountability as I believe these factors to be essential to practicing in a manner that best serves the client.

The above paragraphs were composed prior to beginning data collection and data analysis. Thus throughout both phases of this project I was consciously aware of my biased positions and thus deliberately did my best to ensure that they were not limiting what I might be seeing while conducting the interviews or analyzing the data. To do this I drew upon my developing ability as a counsellor to suspend my judgement and to see through another’s lens and understand their unique perspective. Nonetheless, when listening to the first two interviews that I conducted I was aware of some instances in which I had paraphrased a participant’s comment in such a way that seemed more founded in my beliefs than in what they had just said. In order to ensure that this tendency was not overly contaminating the data, two tape segments of two different interviews, which I believed to be my worst moments, were given to two members of my thesis committee as a means to obtain another’s opinion on the soundness of the data being collected. Overall, both listeners stated that the data was “usable.” Listening to myself as the interviews progressed further assisted me in heightening my awareness of the manner in which my biases and assumptions could manifest in data collection and knowing this aided me in better controlling them.

As the reader will see when reading Chapter Four, the descriptions and conceptualizations of the self-monitoring process share much in common with the researcher’s personal understanding of the process. As this similarity emerged I became extra cautious when interpreting the data always going back to the raw data to ensure, to the best of my ability, that my conclusions were grounded in the participants’ understanding and not my understanding of the process. Chapter four thus contains many
participant quotes intended as a means of substantiating that descriptions and
conceptions of the monitoring process are grounded in the raw data. As well, when
meeting with participants in the follow-up interview I did my best to establish a safe
space in which the participants could disagree, modify or refine my description and
conception of the monitoring process.

Participants

Criteria for Participation

In order to participate in this study participants were required to meet three pre-
established criteria. The first criterion was that the counsellors have at least two years
post-graduation clinical counselling experience. This criterion parallels the membership
requirements for professional counselling associations such as that of the British
Columbia Association of Clinical Counsellors (BCACC). It is thus inferred that the
profession considers one to be a member of the counselling profession after having had at
least two years work experience. All participants met this criterion. The years of post-
graduation counselling experience that participants had acquired ranged from two to
seven years with a mean of four and one-half years. It is perhaps worth noting that one
participant stated that she had 20 years experience in total though only seven of those
were post-graduation.

A second criterion for participation was that the participants had graduated from
the University of British Columbia’s (UBC) Counselling Psychology Master’s program
after the year 1989 - the year in which the program was first approved by Council for
Accreditation of Counselling and Related Educational Programs (CACREP). The years
in which participants had graduated from the program ranged from 1991 to 1997, with
the mean being 1994. Although this criterion may limit the transferability of the findings,
the benefit of participants having had a similar training experience in an accredited program was thought to outweigh the potential disadvantages.

In particular, it was hoped that the learning process that characterizes the accredited program would serve to orient research participants to the present focus of inquiry. Before proceeding with a description of the learning process, it should be established that such a characterization of the program is based solely on the researcher's observations while attending the program and is not stated as such within the program.

Completion of the training program at UBC involves a shift from a high level of external monitoring (i.e., from professors and classmates) to more independent self-monitoring of one's counselling practice. In the initial phases of learning the practical skills of counselling, students are almost constantly observed (on video tape or live through video monitors or a one-way mirror) and subsequently receive feedback on their counselling from classmates and instructors. Near the end of the program, students are placed in practicum sites and receive very little external monitoring. Although still under the supervision of an on-site supervisor and a university professor, many students no longer video or audio tape their counselling sessions and they typically spend only one hour a week receiving supervision. Therefore, as one progresses through the program, one's counselling becomes a much more private (i.e., less public) practice. As graduates of this program all received external public monitoring, it was hoped that this common experience would have served to orient them to what was meant by the private process of self-monitoring.

Another preconceived benefit to the requirement that participants be graduates of the same accredited program was the increased potential that participants would have encountered, at some time in their training, a formal ethical document, such as that of the
ACA, and received some formal ethical training. However, in order to ensure that this was in fact a component of the counsellors’ training, participants were explicitly asked if they recalled such exposure. Such a recollection and familiarity with current standards of practice constituted the third criteria for participation. All participants did meet this criterion and recalled learning about the ethical dimensions of counselling in the theoretical/instructive component of the program.

**Characteristics of Participants**

Traditionally in qualitative research a “thumbnail sketch” of each research participant is provided. Because the research participants attended the academic institution at which this research was conducted it was thought that to provide such a description of each participant would compromise their assurance of confidential participation. As such, characteristics of participants as a whole are presented. This clustering of participants does of course obscure the uniqueness of each participant but was thought to better protect participants’ anonymity. Each of the participants selected a pseudonym with which to be referred when quoted or discussed in this study. The chosen names were as follows: Aaron, Anne, Jane, June, Lynn, Phillip, Sarah and Tess.

**Sex, age, and ethnicity.** Of the eight counsellors interviewed six were female and two were male. Although it would have been preferable to have an equal number of male and female participants the majority of students in the counselling program at U.B.C. are female, thus more females were nominated and thereby more females contacted the researcher. The age range of the interviewed counsellors was 39 to 47 with a mean of 42.5. Again, it would have been preferable to have interviewed a wider age range of counsellors; however, given the criteria set for graduating year, the Department’s tendency to select more “mature” applicants into the program, and the requirement that
participants be experienced this narrow age range was difficult to avoid. The ethnicity of the participants in this study was also unfortunately not of a wide scope as all of the counsellors were Caucasian. In my experience in the counselling program the majority of the students are Caucasian thus it is likely that the majority of nominees were also Caucasian, although this information was not collected.

**Degree specialization and theoretical orientation.** In the U.B.C. Masters program students are required to chose an area of focus or specialization. Options include School Counselling (elementary or secondary); Counselling in Higher Education; or Community and Agency Counselling (adult, gender fair, family, or intercultural). The areas of focus chosen by participants were as follows: One counsellor had an elementary focus, four of the counsellors had an adult focus, one had chosen the intercultural option, and two had specialized in family.

The theoretical orientations that participants utilized were quite varied, and when combined, include most of the dominant counselling approaches. All of the counsellors described their work as involving more than one conceptual framework. The orientations cited by participants were as follows: Adlerian, Art Therapy, Body work, Buddhism, Cognitive, Existentialism, Family of origin work, Family Systems, Feminist, Gestalt, Jungian, Narrative, Psychodynamic, Relational, Rogerian, Self-psychology, and Solution-focused models.

**Target population and work setting.** The populations that the participants work with are as follows: three of the counsellors work solely with adults while five work with a varied population (i.e., children, adolescents, adults, couples, and families). In regards to work setting, two of the participants work in an agency setting; two work in a private practice (one alone and one with associates); one works in an Employee Assistance
Program (EAP); two work within an EAP and have a private practice; and another works in both an agency setting and has a private practice.

**Professional membership and formal ethics training post-graduation.** Five of the participants are presently members of the BCACC and two stated that they had recently applied. Three of the counsellors stated that they had attended professional-development workshops that focused on aspects of ethical practice.

**Procedure**

**Recruitment**

This study utilized a nomination procedure for participant recruitment. In order to protect individuals' privacy, the design of this procedure involved several steps. First, professors within U.B.C.'s Counselling Psychology program were contacted via letter (see Appendix B) and asked to nominate former students whom they thought would be suitable candidates for this study. Criteria for recommendation included at least two years post-graduation counselling experience; basic familiarity with the formal ethical codes and standards of practice of the counselling profession; self-reflective; and residents of the Lower Mainland or Fraser Valley. (Gradating after the year 1989 was inadvertently excluded from the letter to professors though it was a criteria for participation.)

After a professor had generated a list of suitable candidates, he or she contacted the researcher and disclosed only the first names of their nominees. The researcher then addressed the participant contact letter (see Appendix C) using only the first name of the individual. These letters were then signed by the nominating professor, the thesis research supervisor, and the researcher. Signed letters and stamped envelopes were forwarded to a third party (a Counselling Psychology secretarial staff member). The professor forwarded the full name and address (if known) of the nominee to the same third party. The third party
then addressed the letters and mailed them. Therefore, the full identity of the nominated students only became known to the researcher if the recipient of the contact letter decided to get in touch with the researcher directly. Letters were mailed by the third party shortly after both components (full names and signed letters) were received. The letters were mailed every few days over a period of approximately one month. The third party kept a “master list” of all the nominees in order to ensure that multiple letters were not being sent to the same person. This record was destroyed by the third party after the interviews were completed.

Professor contact. Initially, contact letters were sent to five professors who were thought to have the most involvement in the clinical components of the counselling program. As response rates from these professors was somewhat poor additional letters were sent out to all U.B.C Counselling Psychology professors, all of whom had some degree of involvement in the clinical components of the program. In total, 19 professors were contacted. Nine professors did not respond to the letter nor to a follow-up phone call or email. Six professors contacted the researcher and stated that they were unable to help. Four professors participated in the study and nominated former students. Combining their recommendations, and excluding double nominations, these four professors generated a list of 37 counsellors that they thought would be suitable for this study.

Participant contact. Thirty-seven initial contact letters were sent out to the nominated students and interested recipients were asked to contact the researcher directly. The initial contact letter briefly described the researcher’s area of interest, the format of the study (i.e., interview), and the criteria for participation. The letter also informed recipients that in appreciation of their participation upon completion of the study they would receive a self-monitoring questionnaire. In total, 17 recipients of the letter contacted the researcher. Eight individuals were scheduled for an interview, one person called to say that she was too
busy to participate, one counsellor did not fit the criteria, one respondent stopped calling after a few rounds of "telephone tag," and six individuals contacted the researcher after the number of participants needed for the study had been attained. These six counsellors gave their permission for the researcher to keep a record of their name and to contact them if the need arose. Two of the 37 letters were "returned to sender" and received by the third party.

When the interested individuals contacted the researcher by telephone the following procedure was used. I briefly described my interest in the area of ethical practice, my intention in conducting the study, and reviewed the time commitment and format of the interview. Following this introduction it was confirmed that the nominee was interested in participating and she or he was invited to ask questions. After confirming the nominee's interest I ensured that she or he fit the criteria for participation. Potential participants were thus asked the year that they graduated; how many years of post-graduation experience they had acquired; and if they recalled being exposed to the ethics of counselling while in their program and if they are presently familiar with the standards of the profession. If they met the criteria (all but one did) we then set up an interview time and meeting place that was most convenient for them.

Of those who were selected for participation several additional questions were asked during the initial telephone contact. Questions were in relation to the counsellor's age; area of concentration of Master's degree; formal ethics training; theoretical orientation; work setting; client population; and professional organization membership. The reason for asking these questions was two-fold. First, most of these variables have been shown to play a role in ethical practice (Gibson & Pope, 1993; Haas et al., 1988; Kimmel, 1991; Pope, et al. 1988; Pope et al., 1987; Schwab & Neukrug, 1994; Sherry et al., 1991) and second, they would
result in providing a description of some of the qualities and characteristics of the counsellors included in the study.

Each participant was also asked which professor had nominated him or her. This was done in order to ensure that one of the thesis committee members, who was also one of the referring professors, did not hear a section of tape of one of her nominees as the voice would likely be recognizable and confidentiality would thus be violated. Three of the eight participants were nominated by the committee member.

**Sample Selection**

When initially proposing this study it was projected that eight to twelve counsellors would be interviewed. As such, the first eight appropriate candidates that contacted the researcher were scheduled for interview appointments. The names of those who subsequently contacted the researcher were recorded to be contacted and interviewed if a saturation point was not reached after the eighth interview. As this point was reached after the eighth interview (i.e., no new information was arising) the researcher did not find a need to contact the six counsellors who had left their names.

**The Interview**

The specific aim of the interview was to attain a description, and thereby make explicit, the internal process by which counsellors monitor that their daily practices are within the boundaries of the ethics and standards of practice of the profession. The interviews were conducted at a mutually convenient time and place. All but one of the interviews took place at the participant's place of employment with the door closed and no interruptions. One interview was conducted at a participant's home and, again, there were no disruptions. All of the interviews were audio taped and later transcribed. When conducting the first interview the microphone was mistakenly not turned on until 10 minutes into the
interview. Immediately after the microphone was turned on the participant and researcher reviewed and summarized that which had been previously said. The entirety of the other seven interviews was recorded.

Each interview involved the following procedures. After initial introductions the participant and I engaged in a few minutes of casual small talk to begin to establish some rapport. Some examples of topics discussed were the weather, the immediate surroundings, ease or difficulty with which the researcher found the location, or participants' recollections of conducting their thesis. After establishing some level of comfort participants were reminded of the purpose of the interview; the format of the interview was described (i.e., an open-ended component followed by some direct questions); and the confidential nature of the interview was addressed and individuals were invited to select a pseudonym. Prior to beginning the interview I asked about the time constraints as I saw it as my responsibility to ensure that the interview did not impose upon their work day. (For those who said that they had nothing after and did not mind if the interview took longer than one hour when we got to the one hour mark I always confirmed that they were okay with continuing.) Participants were then given two copies, one for each of us, of the ethical consent form (see Appendix D) to read and sign if in agreement.

The interview then began with a reading of the orienting statement (see Appendix E) and the tape recorder was turned on. When the participant was ready he or she began to describe his or her process of self-monitoring. The conversation was audio-taped for later transcription. During the interview I would often ask participants to elaborate on their descriptions asking questions such as, "Please tell me more about ________?", "What do you mean by ________?", "Can you give me another example of ________?", "Is there
anything more that you’d like to add concerning ______?" As well, in many of the
interviews participants were often asked, “Does this relate to ethical practice?” in order to
clarify that the discussion was still on track as it would sometimes appear that
participants were describing their conceptions of “good practice” or their theoretical
beliefs. This question often had the effect of focussing the participants’ descriptions
explicitly on ethical practices or clarifying to the researcher that they were in fact
articulating their monitoring of ethical practices.

Following the open-ended portion of the interview participants were asked six
follow-up questions (see Appendix F). The first question asked counsellors to define their
conception of ethical practice. This was explicitly asked as it was thought to represent
the criteria against which the counsellors would be monitoring themselves. Questions
two, three, and four focussed on the specifics of the self-monitoring activity (i.e.,
familiarity with the construct, cues that initiate the process, and frequency in which they
engage in the process). These questions were included as “insurance” that these points be
addressed in the interview for later analysis. The fifth question asked participants how
closely the preceding description of the self-monitoring process characterized what they
actually do as opposed what they would ideally like to do or think that they should be
doing. The final question asked participants if there was anything that they wanted to add.
If a participant said something to the effect of “I’m sure I missed something and forgot to
mention something I do.” They were invited to contact the researcher by telephone if
there was something that he or she wanted to add to his or her description. One
participant did contact the researcher in this manner.
Journaling

As recommended by Thorne et al. (1997), a journal was kept throughout the data collection and analysis phases of the study. The journal contained such things as the researcher's thoughts, reactions, observations, impressions, ideas, suppositions, rationales, and critical reflections. The journal served to assist the researcher in tracking the development of ideas and provided a venue in which to explore and reflect on the impact of biases in the research process.

Data Analysis

Following each interview the recorded interviews were transcribed verbatim by a professional transcriber (i.e., not the researcher). In keeping with the requirement of the selected methodology, analysis began with the researcher repeatedly listening to the individual tapes and reviewing the transcripts several times as a means to become immersed in the data and familiarize myself with each individual case (Thorne et al., 1997). The process began by simultaneous listening to the audio-tape and reading the transcript. This was done as a means of ensuring that the transcription was accurate and also served as an opportunity to note the participants' inflections and tones. After repeatedly reading and reflecting on the transcripts some common themes and trends began to emerge such that an initial understanding of the monitoring process and the inclusive components began to take shape.

Throughout this analysis process, as a means to comprehend the overall picture and as recommended by Thorne et al. (1997), I repeatedly asked myself the following questions, "What is happening here?" and "What am I learning about this?" Reflecting on this question served as a means to keep the researcher focussed on the acquisition of an understanding of the research as a whole. When answers to these questions were
generated the researcher would continually refer back to the transcripts to check if a hunch or idea was grounded in the actual research data as opposed to being “shaped” by the researcher’s biases. This approach was in keeping with Thorne et al.’s (1997) description of research findings as producing “...a species of knowledge that will itself be applied back to individual cases” (p. 175). After the initial conceptions of the research had been generated the researcher did a final reading of each transcript searching for aspects of participants’ descriptions that did not fit what had been generated. This process served to further refine the researcher’s description and conception of the process of self-monitoring ethical practice.

**Follow-up Interview**

As is common in qualitative analysis (Krefting, 1991), the research findings were brought back to the research participants for verification. Within the descriptive interpretation method this process is regarded as most fruitful if the researcher brings developing conceptualizations based on the data as a whole (i.e., not simply interpretations of the participant’s interview) back to individuals for verification and refinement (Thorne et al., 1997). The resulting feedback from participants that may either confirm or challenge the preliminary descriptions is then incorporated into the findings with the aim of further strengthening the validity of the final research product (Thorne et al., 1997). As such, the researcher summarized the findings and formulated a preliminary description of the data set. This summary included descriptions of the following:

Counsellors’ conceptions of ethical practice and the areas that they monitor; the cues that were said to set the process in motion; the self-monitoring process (proactive and reactive components and accompanying procedures); frequency of engagement in the process; and development of the process.
This summary was then faxed or mailed to participants prior to the scheduled follow-up meeting. Prior to our meeting participants were asked to read the synopsis and reflect on the degree to which the description of the data did or did not reflect their experience of self-monitoring their ethical practice. It was estimated that the follow-up meeting would last approximately 30 minutes. The interviews were tape recorded, with the participants permission, though not transcribed. The interviews were recorded as a means of minimizing a biased listening and selective recollection of participants’ feedback and reflections. At the conclusion of the interview the participants received a copy of the “Professional Conduct and Discipline in Psychology Self-Evaluation” questionnaire (Peterson, 1996). Written permission for such distribution was attained by the researcher (see Appendix G).
CHAPTER FOUR

Results

When conceptualizing this study it was estimated that the interviews would be contained to 60 minutes. Such was the case for only three of the interviews. The other five interviews were closer to 80 minutes in length. In total, the research data was comprised of approximately 10 hours of audio-taped interviews resulting in 306 pages (250 words per page) of transcribed dialogue. The results reported below are based predominantly on the data attained in the initial interview. Although the developing conceptions of the self-monitoring process were brought back to participants to be challenged and refined, for the most part, it seemed that the researcher had accurately described the participants' monitoring process as they generally had little to add. Typically, in the follow-up interviews participants expressed one or more of the following. One, relief that they had not neglected something crucial in their monitoring of their ethical practice. Two, reassurance that other practitioners upheld the same high standards and utilized similar monitoring strategies as they did. Or, three, a recognition of some component of the monitoring process that was true for them yet they had neglected to articulate in the interview. One of the participants, Aaron, spoke about his difficulty in describing the monitoring process stating, "it's the water I swim in." A detailed reporting of the follow-up interview including further discussion on these and other trends in participants' reactions will conclude this chapter. Within this chapter if the reported findings were modified as a function of the follow-up interview or if information attained in the follow-up interview is particularly relevant to a certain finding it will be explicitly noted.
The central research question posed in this study was, “Do experienced counsellors self-monitor their day-to-day ethical practice, and if so, what does the process look like, or how do they describe it?” Results indicated that all of the participants did engage in a process of self-monitoring their day-to-day ethical practice and they were able, to varying degrees, to generate a description of what that process looked like for them. An overview of the monitoring process as well as the domains to which participants attended when monitoring their ethical practice is reported in Table 2. The process was described by participants as involving, what seemed to the researcher to be two separate, yet slightly overlapping, components – a proactive and a reactive – each including specific strategies.

In an attempt to prevent any confusion resulting from the terms used to describe the two components of the monitoring process, the terms, proactive and reactive, will be defined. These terms were selected as the most suitable descriptors of the process as 1) they were both repeatedly cited by participants in their descriptions of the process and 2) the definitions seemed to best capture the characteristics of the two components of the monitoring process. The Webster’s Ninth New Collegiate Dictionary (1991) defines proactive as “acting in anticipation of future problems, needs, or changes” (p. 937). To this I would add that the definition of the term proactive, as it pertains to the monitoring process, also includes an attempt to minimize or prevent future ethical problems from arising. The same source defines reactive as “readily responsive to a stimulus” (p. 979). Therefore, the term reactive, as it relates to the monitoring process, is not meant to imply that the counsellors were acting on impulse or without thought as the term may be commonly understood. The reactive monitoring process was both thoughtful and deliberate and involved a readiness to respond to internal or external stimuli. For that
Table 2

Self-Monitoring: Domains, Characteristics and Strategies

<table>
<thead>
<tr>
<th>Domains</th>
<th>Proactive Monitoring</th>
<th>Reactive Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Characteristics</td>
<td>Strategies</td>
</tr>
<tr>
<td>competence (8)</td>
<td>planned</td>
<td>self-awareness (8)</td>
</tr>
<tr>
<td>counsellor needs &amp;</td>
<td>routine</td>
<td>self-care (8)</td>
</tr>
<tr>
<td>reactions (8)</td>
<td>no cues</td>
<td>review literature (8)</td>
</tr>
<tr>
<td>confidentiality (8)</td>
<td>consultation (7)</td>
<td>internal-emotion(8)</td>
</tr>
<tr>
<td>harm to client (7)</td>
<td>straight forward (6)</td>
<td>internal-physical (8)</td>
</tr>
<tr>
<td>informed consent (6)</td>
<td>ensure cl. has GP (1)</td>
<td>internal-thought (8)</td>
</tr>
<tr>
<td>dual relationships (6)</td>
<td>check-in (1)</td>
<td>external-client (8)</td>
</tr>
<tr>
<td>power (3)</td>
<td>case notes (1)</td>
<td>external-other (1)</td>
</tr>
<tr>
<td>practice of</td>
<td>cl. assist with</td>
<td></td>
</tr>
<tr>
<td>colleagues (2)</td>
<td>process(1)</td>
<td></td>
</tr>
<tr>
<td>balance support and</td>
<td>½ hr. between</td>
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</tr>
<tr>
<td>challenging clients (2)</td>
<td>sessions (1)</td>
<td></td>
</tr>
<tr>
<td>accurate case notes (2)</td>
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<tr>
<td>not waste clients' time</td>
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<tr>
<td>and money (2)</td>
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<tr>
<td>alignment with</td>
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<td>couple (2)</td>
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<tr>
<td>small things (1)</td>
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<tr>
<td>how speak about work</td>
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<td></td>
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<td>to lay people (1)</td>
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Note. The number in parentheses indicates the number of participants that mentioned the domain or strategy.
reason reactive was selected as the most suitable term that would capture the responsive characteristic of this stream of the monitoring process.

Stemming from participants’ descriptions, the reactive component of the monitoring process appeared to be dependent on and be precipitated by a cue that originated in the counsellor (e.g., emotional reaction) or the client (e.g., observable change in body language). The six commonly mentioned reactive strategies cited by participants were solitary reflection; utilization of pre-established policies, procedures, or responses; referral; consultation; adjusting personal or professional life; and discussing concerns with client. The proactive strategies, initiated by the counsellor, were incorporated into practice regardless of what occurred in a particular therapy session; they were a routine aspect of the counsellor’s day-to-day practice. The five proactive strategies consistently mentioned by participants included a commitment to expanding self-awareness; taking care of themselves (i.e., self-care); routine reference to literature sources; formal and informal supervision; and being clear and straight forward with clients. The two components of the monitoring process and the common and unique strategies included in participants’ descriptions, thought by the researcher to be representative of the reactive or proactive components, will be further expanded upon in this chapter. The description of the monitoring process will be followed by a review of present research findings as they pertain to the internal and external cues associated with the reactive component; frequency of engagement in the process; development of the process; participants’ familiarity with the self-monitoring construct prior to being contacted by the researcher; and the impact on participants of being nominated and interviewed. This chapter will conclude with a discussion of the validity of the both the raw data and the researcher’s conceptualizations. Before proceeding with the description
of the monitoring process, however, it was thought essential that the reader be familiar with the general areas to which the participants reportedly attend when self monitoring their ethical practice.

**Domains in Which Participants Monitored Their Ethical Practice**

When conceptualizing this study it was assumed that the domains in which the counsellors would be monitoring themselves would be similar to their conceptions of ethical practice. Thus, if one aspect of a counsellor's conception of ethical practice was to “do no harm” it was expected that he or she would be monitoring themselves along this domain. In general, the participants in this study were consistent in terms of what they personally believed constituted ethical practice and that which they reportedly monitor regarding their ethical practice. As conceptions of ethical practice and the domains in which ethical practices were monitored overlapped it was deemed redundant to discuss the findings separately. It was thus decided to report these results as they pertain to the domains in which the practitioners reportedly monitor their ethical practices as that seems of most relevance to the present inquiry.

This section will begin with a description of the six most consistently mentioned areas of focus which included the following: counsellor competency, counsellor needs and reactions, confidentiality, harm to client, informed consent, and dual relationships. Following this description will be a brief review of the aspects of ethical practice that were mentioned by a few participants in the initial interview. However, according to participants’ responses in the follow-up interviews, these areas were also said to be monitored by the majority of counsellors as well. Although each of the monitoring domains are discussed individually there does seem to be a great deal of overlap among them. For example, monitoring intrusion of counsellor needs and reactions also involves
monitoring counsellor competence and harm to client. The section will conclude with a reporting of the role that the ethical codes and standards of practice were said to play in the monitoring process.

**Competence**

All of the counsellors mentioned in the initial interview that they monitor their competence when working with clients. For example, Tess states, "....the principle of competence in practice...that's a day to day kind of ongoing area that I feel has an ethical component to it." Anne, who particularly stressed the importance of this concern, said:

...my competence is something that I take extremely seriously and so, um, I maybe go above and beyond some of the things in terms of competence... so that I'm highly skilled you know, and that I've, you know, learned what I need to learn in order to provide them the best kind of service possible.

As stated by Anne, and mentioned by several participants, monitoring one’s competency often encompassed working within the areas in which they were trained as well as monitoring that they were taking responsibility for ongoing training and learning. Phillip discusses why it is important to him to be adequately trained, “With critical incidents stuff, it's again getting the adequate training so that when you go in with a group you are not traumatizing people more than you need to, so that is an edge.” Also related to competence is monitoring the need to refer clients if the counsellor thinks that he or she does not have the adequate expertise or if counsellor needs or unresolved issues are perceived as possibly compromising the quality of service received by the client. Lynn articulates the strength of her commitment concerning this issue: “...around referrals you know I try and be pretty vigilant about referring someone to the right place if I can’t help them.”
Counsellor Needs and Reactions

Preventing intrusion of counsellor needs and reactions was mentioned by all of the participants as a domain in which they monitor their ethical practice. Participants repeatedly referred to this as ensuring that their "stuff" did not dominate the counselling relationship. The "stuff" seemed to include such things as their needs, issues, or tendencies.

Some of the needs that the participants reported that they monitor included their eagerness to try a new intervention; financial interests; intimacy or connection needs; and a desire to be liked or admired. June describes monitoring her ego:

...if I let my ego run the show then I think what I am doing is I am literally putting on a show to feel good about myself, to impress whomever...and this will have nothing to do with the whole purpose which is to help the clients try to progress from A to B over a fairly short period of time.

A commonly mentioned need described by most of the participants as an area in which they monitor themselves pertained to their desire to "run the show" or "push their agenda." Phillip describes this,

...being aware of what your purpose for being there is for, what you are there for, you are primarily there to address the needs of the clients, of the client, and that you pay attention to what he or she perceives as their needs and you negotiate within what you perceive as their needs so you are not there to push your agenda.

For Aaron, a key component of preventing intrusion of his needs and reactions involved an awareness
...of your own identification with your clients cause otherwise - I mean, it's counter-transference - otherwise you're not working on your client's issues, you're working on your own issues.

Some counsellors mentioned that they attend to certain tendencies in themselves as a means to monitor that they are acting in the best interest of the client. For example, Lynn states that she is “...careful not to keep the ones I’m attracted to and terminate the ones I’m, I feel aversive towards.” Sarah said that she monitors her tendency to rescue clients, ...I can kinda be a rescuer, you know the occupational hazard with this profession, so sometimes that’s the other side, sometimes when I worry too much, or taking too much on, that’s also not good for the client because they are getting confirmed that they can’t...[so]...sometimes it’s just seeing that tendency, you know, how does that come out in the session, what message am I getting across in terms of you know, care taking or not, you know, letting people make their mistakes...

A component of monitoring that the counsellor’s “stuff” did not dominate their work included attending to how the counsellor was functioning in general. Thus there seemed to be a shared assumption by the majority of counsellors that they needed to tend to themselves (i.e., self-care) in order to minimize the potential of acting from their “stuff.” Lynn articulates this:

...I’m the instrument, right. Like if you are a carpenter you need a hammer. Well, I’m a therapist and myself is the instrument, that’s my tool, so I’ve got to work on that thing and, and monitor it.

Before concluding this section it is important to note that in regards to monitoring their issues, needs, and tendencies there seemed to be a shared acknowledgement among the participants that they cannot completely push their “stuff” aside. Instead, it seemed to
be approached more as a commitment to heighten their awareness and take responsibility as best as they can. The following quotes illustrate this acknowledgement:

I think, I think the ongoing challenge...is how do you keep your own needs separate from what is going on, and I don't know if you always successfully do that. (Phillip)

...to look after myself, that my life, of course I'm going to have my own problems, but that I'm not trans, counter-transferring all over the place and knowing my limits (Jane)

...of course your own stuff gets in the way, all the time, you know and like uh, who, who, give me someone who says it doesn't, I'd like to know who they are, you know, that's unethical. (Sarah)

Confidentiality

All of the participants mentioned that they monitor confidentiality which was said to include both maintaining it and breaking it when necessary (i.e., risk of harm). Tess describes some of the complexities involved in monitoring her responsibilities around safety issues:

Sometimes, working with people who are disclosing...[and I'm] not sure if they are going to harm themselves...there isn't necessarily a history of self-harm it might just be their need to talk about their state. So I'm not too sure whether I really have all the pieces together and you're in that kind of vague sense of, you know, holding that material as something that they need you to do versus acting on that material to phone family or physician. So, sometimes it's in that unclear place, actually, most times it's in that, you know, like it's not a definite kind of sense that you have of imminent danger but you're also not sure whether, if you don't act, something could happen.
The specific concerns that monitoring confidentiality entails seemed to often be related to the counsellor's work setting or client population. For example, June who works in an agency setting said the following,

"...confidentiality becomes a treatment team thing as opposed to just between me and my client...so I have to somehow work with what level of information is it respectful and appropriate for the treatment team to share...ya, that comes up for me on a daily basis, to not just be careless on that kind of thing."

Jane describes how confidentiality is a particular concern in her work with children and teens,

"...I will monitor confidentiality by not only saying it in my initial interview with the parents that whatever I talk about with your child is confidential unless he or she gives me permission to talk to you and I monitor that probably at the end of every session by saying to the child, "Is there anything that you would like...or is there anything you would like to share with your Mom or your Dad about what we talked about today"...

Three participants explicitly spoke about monitoring their adherence to confidentiality when they encounter a client outside of the clinical setting. And lastly, one participant mentioned that she watches herself around thanking one client for referring another as doing so would obviously compromise the second client's confidentiality.

**Harm to Client**

To do no harm was among the first things mentioned by seven of the eight counsellors when articulating their conception of ethical practice and when describing the domains in which they monitor their ethical practice. Therefore, as the following quotes
by Sarah and June (respectively) demonstrate, harm to client seemed to be a pervasive area in which these participants self-monitored their practices:

The thing I always come back to is do no harm, like what’s harmful and what’s helpful.

...I am monitoring that [doing harm] in terms of how I work with my clients, all the way from what I might say at any given moment to my sort of overall treatment plan for them through to follow-up and so on.

Although consistently mentioned by participants, there was variation regarding what doing harm specifically meant to each of them. For example, a key component of not doing harm, for Tess, included an awareness of “...what’s going on for me so that I don’t harm the client.” June, on the other hand, said, “I think I am doing harm, or at least I am somehow allowing harm to be happening, if I see somebody going backwards...” While for Jane,

To do harm would be to uh, pretend, to meddle into somebody’s life with my own agenda, that would certainly be harmful. Uh, to try some weird intervention that I don’t believe is founded, founded or sound in the research.

Sarah states,

...I think it’s harmful to get too much into um, people’s psyche in some ways without letting them have a way to get out...I think it’s way more helpful to find out what that change is and how to help them towards that than to um, not do that and just kind of get into a whole bunch of retrospective that can be not very useful.

Although doing no harm was consistently mentioned by all but one of the counsellors it seemed to be the domain in which there was the most variation regarding the particular aspects of practice to which the participants were attending.
Informed Consent

In the initial interview six counsellors mentioned the importance of informed consent as an area in which they self monitor. Included within this domain were actions such as attaining client’s signature prior to speaking about them with another professional; being explicit with clients about one’s therapeutic approach; informing clients if trying an intervention that is relatively new to the counsellor; and explicitly informing clients of their rights concerning participation and termination of counselling.

Dual Relationships

A sixth area that was explicitly mentioned by six of the participants in the initial interview as area in which they monitor their practice involved dual relationships. Several of the participants seemed to share Aaron’s belief: “...I think that there does need to be a clear separation, and I do avoid dual relationships.” As one would expect, monitoring themselves around dual relationships was more of a daily concern for one of the participants that worked in a small town and one who worked with a minority population of which she is a member. When dual relationships were unavoidable the counsellors stated that they would monitor themselves around maintaining the previously established therapeutic boundaries and keep the interaction to a minimum.

Mentioned By a Few Counsellors

Three counsellors spoke about monitoring their abuse of the inherent power of the counsellor role. For example, Jane said:

...if you don’t understand how powerful you are I don’t think that you will be careful not to misuse it...they [clients] will brush aside what a peer will say to them but they will take what I say as the gospel truth half the time, just because I am a counsellor, you know, so I have to be pretty careful.
In the initial interview two counsellors mentioned that they monitor that they take the necessary steps if they become aware of a colleague practicing outside of the boundaries of ethical practice. June mentions some of the difficulties involved in bringing this to life in practice,

...the part I find really the hardest is when I think that there might be something going on in my organization where I work that isn’t really ethical. It isn’t major, if it was really major it would be a simple matter for me, right? I would take that as far as I had to and I would quit in a hurry if it didn’t get fixed, but when there are little things that I think are not all that ethical, in other words, they may not be doing super major harm but I think they are not that great, it is really hard to keep up the struggle of raising it and trying to change it...

Two counsellors stated that they monitor that they are maintaining a balance between supporting and challenging clients. Keeping accurate and respectful case notes was mentioned by two counsellors as an aspect of their practice that they monitor. Two participants reported that they regard it as unethical to waste clients’ time and money thus this constituted an area to which they attended when monitoring their practices. Sarah described this as follows:

Well I see it as part of an ethical practice because I could, there are some clients I could just go on forever with, with them not even going anywhere and I, I know that and I feel it’s exploitative and you know, I’m making people pay me so...I want them to get their money’s worth and I don’t want to be taking advantage of their vulnerability...

Two counsellors said that they monitor that they are not disproportionately aligning with one member of a couple. And lastly, one counsellor said that he monitors what he
referred to as “small things” (e.g., phones covered, length of lunch break) and another counsellor said that she monitors how she speaks about her work to interested lay people.

Role of Formal Ethical Codes and Standards of Practice in Self-Monitoring

The reader is reminded of the prerequisite for participation in this study that counsellors recall being exposed to a formal ethical document, often that of the ACA or APA, in their training program. One of the questions posed to the participants thus pertained to the role that the formal ethical codes and standards of practice played regarding the domains in which they self-monitored. Based on the participants’ responses it seemed that all of the counsellors endorsed and seemed to regard the formal documents as providing a contribution to their ethical practice. As five of the participants were members of the BCACC, these were the formal documents that were currently most meaningful to them though all of the participants had initially encountered the ethical codes of the ACA or the APA. The central contribution of the codes appeared to be in relation to establishing “guidelines,” setting the “parameters,” or providing the “backbone” to their ethical practice. For example Sarah states, “...I think they are good guidelines to go back to and to, to keep in check with, yeah.” The following quotes illustrate the range in which the documents were reportedly utilized by participants:

...I do try and adhere to them, partly for legal reasons as well. I guess I probably don’t know really what a lot of them are in great detail cause I don’t, haven’t had the need to um, look that much up... (Lynn)

...I refer to them. I read them. I um, you know, not daily, but I certainly refer. I think they’re a good backbone and a good guideline. (Jane)

For many of the participants rather than refer to the actual documents they described having an internal representation of the formal documents:
I have internalized some of those that are written down, and that have been taught to me and then I have personalized them in a way that I understand them and if I am not being congruent then that inner sense tells me that I am responsible for something that I am not acting on here, ya. (June)

I would say for my part that I sort of internalize what I see as the key ones, and there is the formal ethical code from the APA and there is also the ones that I am tied to that I have to follow because of the organization, and I am aware of them but I am not always sure that I am that consciously aware of them in the sense that I, you know, that I think about where they come from or have a running check list or anything like that. (Phillip)

It [formal ethical codes] guides me. You know I don't have a copy of it in my office, um, but I have a very strong sense of what it's all about, you know, just from my own education, my own practicing experience... (Anne)

...there's nothing in there that I would have forgotten. That's kind of why I was looking into it, you know, what is here that I need to be reminded of. And it's all - common sense would dictate every one of those points. (Aaron – when speaking of reviewing BCACC code prior to interview)

Despite the role that the formal ethical codes and standards may have played in setting the initial parameters by which to monitor ethical practice, my sense was that many of the counsellors thought that there was something beyond the codes that served as a dimension along which they monitored their practices. In general, this “something more” seemed to be the commitment to monitor, and ensure to the best of their ability, that their needs and reactions did not intrude upon the counselling session. My hunch is that most of the participants would agree with the following quote by Tess:
I don't think there's enough in there [formal documents] about, probably what I spent the full time here today talking about which is our own stuff...for me that's, that's the whole ballgame right now, yes. I know not to have dual relationships now...I would be really upset with myself if I ever got in trouble for that [confidentiality] because... it's just so basic to me.

**The Self-Monitoring Process**

The manner, or the process, by which participants monitored that their practices were ethically sound in relation to the above areas of concern will be addressed in this section. As stated in the introduction to this chapter, but should again be explicitly stated, all of the counsellors interviewed in this study reported that they do self-monitor specifically in regards to the above domains of ethical practice. Participants’ description of the monitoring process and the particular strategies involved led the researcher to conceptualize the process as involving two separate, but slightly overlapping, components – reactive and proactive. This section will illustrate the evolution of the researcher’s conceptualization, define the proactive and reactive components, and describe the strategies by which the participants reportedly monitor that their day-to-day practice is ethically sound. Although participants did not differentiate between reactive and proactive strategies in their descriptions (the distinction was made by the researcher) the strategies will be presented in terms of those that were regarded by the researcher to be more characteristic of the proactive or the reactive self-monitoring process.

Before proceeding, however, it is important to explicitly note that the following results are based solely on the descriptions attained in the initial interview, despite the trend in the follow-up interviews for participants to express recognition of strategies that were a part of their monitoring process but were not mentioned in the initial interview.
Recall Aaron’s description of the difficulty of articulating this process: “it’s the water I
swim in.” Although combining the data from the initial interview and the follow-up
interview would result in a more cohesive and consistent description of the process, it
was decided to describe only the data attained in the initial interview as that which was
attained in the follow-up interview may have been influenced by social desirability.

During the interview process, perhaps midway through data collection, I began to
detect a trend in participants’ descriptions. It appeared that two, somewhat separate, streams
of the monitoring process and the accompanying strategies were emerging. Following the
initial interview with June a way to conceptualize the data and these two streams was sparked
as it occurred to me that one stream was more proactive while the other seemed more
reactive. After acquiring the language and a possible lens through which to analyze
participants’ descriptions it became clear that each counsellor had included in his or her
description of the monitoring process some strategies that could be considered to be more
preventative or proactive and some that seemed more reactive or “deal with it as it happens”
in nature.

Although each counsellor’s process of self-monitoring included some degree of the
proactive and reactive elements, there was variation regarding the proportion of each
individual’s monitoring process that lay in either stream. That is, one counsellor may have
described his or her monitoring practices as being more proactive while another described it
as a more reactive process. Also varying were the specific strategies that each counsellor
reportedly utilized in both the streams of the monitoring process. The proactive and reactive
components of self-monitoring ethical practice and the accompanying strategies will be
reviewed in the following segment.
Proactive Component

The proactive component of self-monitoring ethical practice seems to involve positioning oneself in a particular way (e.g., being straightforward with clients) or putting in place standard procedures (e.g., give clients a contract) in order to minimize the potential of transcending the boundaries of ethical practice. For example, a strategy such as periodically reviewing the formal ethical codes may serve to assure the counsellor that he or she is aware of his or her responsibilities as outlined in the document should a situation arise. As implied in this example, once a proactive strategy is incorporated into practice, participants seem to regard the procedure as serving to decrease the incidence of ethical violations thereby strengthening the foundation of their day-to-day ethical practice. Thus, if one were routinely reviewing the ethical codes there is an expectation that they would be less likely to unknowingly transcend an ethical boundary than if they were not engaging in this monitoring strategy. Another characteristic of the proactive process is that it does not seem to be dependent on internal or external cues in order to set the process in motion (description of cues to follow the reactive component). Instead, it seems to be an automatic routine that the counsellor does as part of his or her regular practice regardless of what is occurring within the counselling session. As well, the routine seems to provide some assurance to the counsellors that they are generally practicing within ethical boundaries. Anne and Tess were the two counsellors that expressed the most comprehensive proactive approach; the following quotes further describe the characteristics of the proactive monitoring process:

Well, ninety-nine percent of the time I’m just with the client. The one percent of the time I’m cognitively having to be aware of something that’s an ethical concern. And the reason for that is because of the things that I have safeguarded and built into my practice where I’m not constantly questioning my competence, worried about
confidentiality, informed consent, responsibility, I mean all those things, because I’ve set the stuff, everything up from the moment somebody walks in the door and signs a consent and the financial agreement when they get in here, everything’s done, everything is prepped… if I can do all that stuff, then I can prevent for the large part maybe situations that are going to become to, into play. (Anne)

…informed consent and some of the nuts and bolts about confidentiality are fairly tight I think. Personally I am kind of rigid there so it’s….I don’t get myself in trouble with those things very often. (Tess)

Although seeming to require little attention on a day-to-day basis, according to the interview data, it appears that periodically new approaches might be added, or existing procedures may be expanded or refined, after learning something new or making a mistake regarding ethical practices. Jane, for example, after getting into a sticky situation as a result of not attaining both parents’ signature when seeing a minor, describes this adaptive process: “[I] got it like right the same day because it was not going to happen again.” The strategies mentioned by participants that seemed to the researcher to be representative of the proactive stream of the monitoring process will now be reviewed.

A central strategy, considered by the researcher to be proactive, that was mentioned by all of the participants includes the ongoing expansion of self-awareness. Phillip and Tess, respectively, describe the importance of self-awareness in their monitoring process:

If I am not aware of it, then I am being driven by it, it is kind of Jungian notion of what is in the shadow, what’s in unconscious will drive you unless you bring it into an awareness.
...I need to be as in tune to my own kind of health – mental and emotional health – what’s going on in my life – or I bring it, counterproductively, into the client’s space. For me, that’s a big, that’s an ethical issue personally.

Although all of the counsellors mentioned heightening self-awareness as a monitoring strategy the manner in which they sought to accomplish this showed some variation. Lynn, for example described her reliance on journaling as assisting with this process:

...I would just like to just emphasize this point about journaling. I really think that it’s a good, I don’t journal that much about clients, but I just journal about myself and what’s going on in my life and I really think that’s a good way to kind of know yourself. I think it’s, you can’t monitor yourself unless you really know yourself.

While Jane stated that at the end of most working days she engages in reflection and wonders, “...did I leave enough flexibility to deal with the client’s needs...[did I]...have my own agenda?” Aaron said that one of the ways that he expands his self-awareness is by receiving regular personal counselling: “Obviously...an ongoing part of being an ethical therapist is to do your own therapy. For me that’s a given for the rest of my life, as long as I'm a therapist doing therapy.”

A second strategy that was mentioned by all of the participants, to varying degrees, involved taking care of themselves or “self-care” as termed by the researcher. The means by which the counsellors reportedly took care of themselves included the following: regular meditation, grounding and breathing exercises, solitary walks, getting adequate rest, taking regular holidays, working at a “fun job” unrelated to counselling, maintaining healthy relationships, and setting limits by saying “no” to extra work.

Although self-care and expansion of self-awareness may seem unrelated to ethical practice these participants did seem to regard them as linked. Specifically, the intent of
these strategies seemed to be to reduce the incidence of ethical transgressions pertaining to intrusion of counsellor needs and reactions, counsellor competence, and harm to client.

A third strategy mentioned by all of the participants, considered by the researcher to be representative of the proactive component, involved some type of routine reference to literature sources pertaining to ethics. This strategy included reviewing the ethical codes, educating students or co-workers of formal codes and ethical practices, keeping abreast of new techniques and theories, and reviewing the latest legislation pertaining to ethics (regularly disseminated by their professional organization). June describes the role that a somewhat routine (i.e., every few months) reading of the documents plays for her:

...when I reread them [formal documents of APA] I am reminded it is not just about my relationship with a client, it is about my relationship with my colleagues, it is about getting the training and education I need to keep being, you know, abreast of things in the field, it is about the use of testing, it is about payment and I tend to forget those things unless I am revisiting the written standards.

A fourth strategy that was mentioned by seven of the participants involved routine participation in what was commonly referred to as “formal” consultation. Two of the counsellors stated that they meet one-on-one every month with a privately contracted supervisor. Two of the counsellors meet monthly with their workplace supervisor (in the follow-up interview one of these counsellors stated that this formal consultation does not actually happen this regularly). Two of the counsellors stated that they attend a supervision group facilitated by a registered psychologist (one group meets every two weeks while the other participant’s meets approximately six times per year). One counsellor said that she meets every two weeks with a peer supervision group. Most of the participants seemed to
regard routine formal consultation as an essential component of ethical practice. As said by Aaron, “...for me it's an absolute. You don't practice unless you've got something like that in place. So it's a cost of doing business.”

In addition to the formal supervision, three of the participants stated that they meet monthly for what was referred to as “informal” consultation with a group of counsellors from their graduating class. Lynn describes her group;

...we meet once a month...at one of our houses. There’s about eight of us I guess, not everybody can come every time, and this group has been going for about two years and we basically all work in different sorts of settings and so we come together and primarily it’s about friendship, you know and having a few laughs and talking about stuff, but we also uh, bounce ethical issues off each other um, situations that are happening at work, either with co-workers or with clients, um, and we talk about our work environments and different things that are going on and we share articles or if anyone went to a workshop, we’ll photocopy and handouts and give it to the other people in the group...

In the initial interview Sarah mentioned that she had tried to set up a group of this type but has not yet been successful as “...on one hand I feel isolated and I would like to do that while on the other hand, I’m pretty picky I guess with who I would do it with.” As mentioned by Lynn, these groups were not solely intended for the purpose of ethical consultation, however, the participants did mention that it sometimes played that role. As well, two counsellors spoke about establishing an accessible support network to approach for consultation when questions or concerns arose.

A fifth strategy mentioned by six of the counsellors involved being clear and straightforward (verbally and/or in writing) with clients in the first session by addressing such things
as limits to confidentiality, therapeutic approach, boundaries of therapeutic relationship, client’s rights, etc. Anne describes her utilization of this approach:

...I just really try to be as straight as I can with everybody about what I’m doing, what my expectations are, what are the confines of the relationship, just with anybody who comes in this office so there’s absolutely no surprises because you can get into some sticky situations.

Three of the counsellors stated that each new client receives a written contract to read and sign before beginning counselling. In general, the issues covered in this contract include confidentiality and limits, client’s rights and responsibilities, fees and cancellation policy, and counsellor’s therapeutic approach. According to the participants who utilize a contract it serves as a “framework” and provides a “boundary” in which to do the therapeutic work and it is also viewed as a resource to be revisited if a concern arises or clarification is needed as the therapeutic relationship develops.

Other strategies mentioned by a single participant in the initial interview and considered by the researcher to be proactive included the following. Sarah stated that she ensures that every client has a medical doctor with whom she can contact if safety issues arise. As well, Sarah does a routine “check-in” after six-weeks to see if the client is satisfied with the service he or she is receiving and if they are working on the right issues. June stated that when writing her case notes she imagines that the client is watching over her shoulder as a means of ensuring that she is being respectful and accurate. Anne reported that she routinely asks clients to assist with monitoring that she does not offend, misinterpret, or make inaccurate assumptions when working with a male client or a member of a culture that differs from her own. Aaron said that he structures his day such that between sessions there is a half hour of time to reflect and complete case notes.
In summary, the proactive component of the monitoring process seems to involve a routine, somewhat automatic, utilization of a standard procedure (e.g., give clients a contract) or positioning of oneself (e.g., be clear and straight forward) in an attempt to minimize the incidence of unethical practices. The five consistently mentioned means by which to achieve this goal included a commitment to expanding self-awareness, taking care of themselves, routine reference to literature sources, formal and informal consultation, and being clear and straight forward with clients. Several other strategies were mentioned by a single participant; however, in the follow-up interview, most of the counsellors reported that they too engage in those strategies but did not articulate this in the initial interview. As suggested throughout this discussion on the proactive monitoring process, utilization of both the common and unique strategies was intended to reduce the incidence of ethical transgressions.

Although participants were not asked to specifically describe the proactive strategy involved in monitoring each domain of ethical practice, results do suggest that the above strategies address the core areas of concern for these counsellors. For example, counsellor competence may be proactively monitored by engaging in regular formal and informal consultation and routine involvement with literature sources. Counsellor needs and reactions seem to be attended to by expanding self-awareness, self-care, and formal and informal consultation. Maintaining confidentiality and its limits are addressed by being clear and straight forward with clients. The risk of harm to clients may be reduced by expanding self-awareness, self-care, and informal and formal consultation. And lastly, ensuring informed consent and monitoring dual relationships seem to be addressed in the strategy of being clear and straight forward with clients.
Reactive Component

The reactive monitoring process, like the proactive component, is considered to include several strategies. Unlike the proactive component, however, the strategies included in this component of the monitoring process seem to be dependent on the counsellor’s perception of an internal (e.g., emotional reaction) or external cue (e.g., disclosure from client) to set them in motion. June, who described herself as being much more reactive than proactive in her self-monitoring, described the process as follows,

...[it is set off by] an incident as opposed to any plan to do it. Some incident that sets off an imbalance, a feeling of discomfort...its very reactive come to think of it, it is not a proactive thing at all, it is reactive. I am reacting to something when I start to think, okay, what is going on here, what do I need to do or say or whatever?

As this quote illustrates, after being set in motion by one’s perception of a cue, or incident as stated by June, it seemed that the counsellor would engage in some type of reflection. This reflection, a central strategy mentioned by all of the counsellors, was described by some as “checking in” or “working it through in my head.” Some of the questions that the counsellors asked themselves included “what is my stuff and what belongs in session?”, “what are my motives for such and such?”, “is this for me or is this for the client?”, “what’s going on?”, “what is in the best interest of this client?” or “what should I do?” The reflection was said to occur either before, during, or after a session and sometimes involved either going for a walk, journaling or writing freeform notes, or “buying some time” by telling client that they will get back to them with a reply or a plan.

A second strategy mentioned by all of the participants, considered by the researcher to be reactive, was related to particular situations and involved incorporating or utilizing a
pre-established policy, procedure, or response as a means of monitoring ethical practice.

The following quotes describe some examples:

There is the APA Guidelines, we also have internal guidelines as well about how long we keep records and things like that about informed consent so I always make sure, as in some cases clients are wanting to talk to a manager or to a GP or something so we have a consent form that is just automatic, I always just ask them, so there is kind of standard procedures that certain questions or certain situations may trigger that, I guess that is a form of self monitoring. (Phillip)

But very often people will call me and ask my opinion of another counsellor in the community. So, ya, I guess it does make, you know, that red light goes off a little bit but I have a pretty standard response, just like I, you know, it is not in my code of ethics as a teacher, we are not to talk about one another its not professional. (Jane)

...so I do a policy, of, for confidentiality of not approaching them [when encounter clients outside of clinical setting] unless they approach me. (Sarah)

Generally, these pre-established responses, policies and procedures were a function of 1) the guidelines established by either the workplace or the ethical codes, or, 2) the counsellors’ past experiences (i.e., they were unprepared in past when faced with a particular situation and developed some way of responding if faced with similar situation in future). As this strategy requires minimal reflection and is generally automatic it shares much in common with the proactive strategies, however, as it is dependent on some cue to set the process in motion it was classified as reactive. In those instances for which there was no pre-established response the participants stated that they engaged in one of the following activities in order to monitor that their practices were ethical.
A third strategy that was mentioned by all of the participants, that seemed representative of the reactive component, was to refer the client to another professional. Generally this would be done if the counsellor decided that the client’s needs lay outside of the counsellor’s area of expertise or if the counsellor’s personal issues/needs/reactions were difficult to manage with the particular client or situation at hand. When speaking about the referral process most of the counsellors stated that they would only refer a client to someone that they personally felt comfortable with. The following quote by Anne captures some of these points,

...I really feel that I have a real strong responsibility to clients if for whatever reason that I’m, can’t provide what they need, I make absolutely sure that they can get it somewhere else. And however I do that, there’s just a few people that I would refer to, so I would do that too recognize my particular limitations, right.

A fourth strategy that all of the counsellors mentioned that they might utilize to monitor that they were within the boundaries of ethical practice was to consult with one or more of the following individuals or organizations. Seven of the participants spoke of informally consulting with colleagues as the need arose. For most of the participants this involved co-workers and a few said that would approach counsellors in their “circle” for informal consultation. The following quotes describe this informal consultation process,

If I come out of group still feeling that kind of, eeh, I wonder if I pushed too hard, I wonder if I am treading too softly, again, I will take it to a couple of my trusted team members, whose way of working I really respect and who I know will give me honest feedback, call me on my stuff if they see it or to my supervisor, same thing, talk it through, you know, and say what do you think? (June)
...so even if I am having a feeling of discomfort about something or a question, I very often just go and kind of bounce it off her [colleague] and we have a good working relationship so, it is not so much looking to her for advice as just a place to kind of sound it out. (Phillip)

In addition to the informal consultation, six counsellors stated that at various times they had consulted other professionals such as lawyers, police, SAFER (a suicide attempt counselling service and resource center), visiting professionals, staff at resource center at workplace, or representatives of their professional organization (BCACC) to assist in determining an action plan or provide factual information. As well, four of the participants mentioned that they have access to a supervisor at work or their contracted supervisor between regular meetings and they contact them as the need arises. Lastly, in relation to consultation three of the counsellors said that they “consult” with an internalized role model when faced with a particular incident (i.e., imagine what their mentor might do or say in this situation). The following quotes illustrate this consultation process,

...I guess we all have models, people who we would like to be more like so it will come up for me around all these kinds of issues, I will picture what somebody else who I admire in that particular situation would do and then I try and think what would they do and then I imitate it or not... Yes, and I find I just kind of spontaneously, like I’ll be sitting there and be talking and somebody will come into my head that was brought up by that situation so it is kind of, I will have a dialogue with that person, a talk with myself. (Phillip)

...like I hear her voice sometimes, I have internalized my supervisor’s voice, sometimes right, I ask myself the kind of questions that she would ask me. (Sarah)
A fifth strategy that was mentioned by seven of the participants was that they would make adjustments in either their personal or professional lives. Pertaining to their personal lives, participants spoke about either managing their issues themselves or seeking personal counselling to work through their concerns. It is perhaps worth noting that seven of the participants stated that they have in the past and would again seek personal counselling if the need arose. The following quotes describe this working-through process:

I just make sure that I guess with regard to going for therapy or doing what I need to do to make sure my, my mental health is optimum. Like if I see myself sliding into a place where I feel like I’m not functioning very well at work, um, I might take steps to correct that and get some help around that. Um, especially you know, in our line of work, if we don’t have our mental health, we ain’t got a job. (Lynn)

...you are there for the client and that where you are having issues and problems, it is your responsibility to go and deal with them, it is not the client's responsibility. (Phillip)

Well, if, if it’s something that I can figure out myself I’ll just leave it, and, and be different, right, like if it’s just my own shit in a way, then I’ll just try and get it out of the way and see what’s going on for me... (Sarah)

Other strategies relating to their personal lives included making adjustments in their relationships (e.g. spending more time with partner), or, as mentioned by Tess, attend to getting more time alone: “I find one thing that I need is the solitude too, as much as I need the support, I need the spare time to just kind of put things together for myself...to listen to what is being evoked in me.” Sarah said that she might focus on incorporating more enjoyment into her life: “Well, if I get too drained and I’m not having fun in my life, and I’m just doing counselling, my work really suffers...” In terms of adjustments that some of the
participants stated that they might make in their professional lives several counsellors spoke about taking time off or saying "no" to extra work.

The sixth action that may result after perceiving an internal or external cue that was mentioned by four of the participants was to bring up their feelings, reactions, or mistakes with the client if they felt that it was in the client’s (i.e., not the counsellor’s) best interest. The following quotes describe this process:

...I can go back to group tomorrow and fairly simply say, “Know what, I wanted to pick up on something yesterday because this is what I said and this is what I saw and I just want to check out with you, you know, were you hurt? Were you angry? Can you tell me about it?” And I can fix it fairly easily, right? (June)

...so you know you are just up front and when you screw up you are up front... (Anne)

...when the other person came in I said, “You know, I blew it I thanked the referral before I checked with you I’m really sorry.” And uh, oh I mean she was fine with it, but you know that was lucky that she was fine with it. (Sarah)

In summary, the reactive component of the monitoring process is thought to be comprised of six strategies that are utilized after the counsellor has become aware of an internal or external cue (described in detail below). As well, the reactive monitoring process appears to involve conscious reflection on aspects of the counsellor’s ethical practices, as the need arises. The six means by which these participants reactively monitored their ethical practice included the following: solitary reflection; utilization of a pre-established procedure or response; referral; consultation; making adjustments in personal or professional life; and bringing up the concern/mistake with clients. Unlike the proactive component of the monitoring process, most of the strategies considered to be reactive were consistently mentioned by participants; there were no reactive strategies
that were mentioned by only one participant thus suggesting that there was slightly more cohesion among participants’ responses regarding the strategies considered to be reactive.

As stated in the previous section, although participants were not directly asked how they monitor each particular domain of ethical practice, it seems that the strategies thought to be reactive, like those considered to be proactive, address all of the participants’ central areas of concern. For example, counsellor competence may be reactively monitored by engaging in solitary reflection, referral, or consultation. Counsellor needs and reactions could be attended to by engaging in solitary reflection, referral, making adjustments in personal and professional life, or bringing concerns up with client. Maintaining confidentiality and its limits may be addressed by consultation or utilizing pre-established policies, procedures or responses. The risk of harm to clients may be reduced by engaging in solitary reflection; utilizing pre-established policies, procedures or responses; referral; consultation; making adjustments in personal or professional life; or addressing concerns with client. Ensuring informed consent may be addressed by utilizing pre-established policies, procedures or responses. And lastly, monitoring dual relationships may be attended to by engaging in solitary reflection; utilizing pre-established policies, procedures or responses; referral; consultation; making adjustments in personal or professional life; or addressing concern with client.

Cues That Set the Self-Monitoring Process in Motion

This section will detail the various cues described by research participants in relation to their description of the general monitoring process. Recall that, at the time of the initial interview, the monitoring process had not yet been conceptualized as consisting of two components; however, the researcher’s understanding of the data and subsequent conceptions
suggest that the cues are predominantly related to the reactive monitoring process. It should thus be clear that the link between cues and reactive self-monitoring strategies was generated by the researcher and not the participants (though this link was validated by participants in the follow-up interview).

Before progressing with a description of the cues, the reader is reminded that when planning this study the researcher held the assumption that the monitoring process would be preceded by some type of cue. As such, participants were explicitly asked if in fact there were such cues and if so to describe them. It is important to note that, according to the data, it seems that the researcher's assumption was valid as the cues were described by participants in the freeform segment of the interview to the extent that when they were explicitly asked about cues they frequently had little to add to their previous description.

In general, there was a great deal of consistency among participants concerning the areas in which the cues clustered. For example, all of the participants mentioned cues that originated in themselves. Described by Phillip, but seemingly true for all of the participants, the cues that originated in the self (i.e., internal) included either "....a feeling, or physical sensation, or a thought [that] sort of says, you know, pay attention to something here." The other cluster of cues consistently mentioned by all of the counsellors were those that seemed to originate with client. Examples of this type of external cue include a disclosure of sexual abuse or a shift in client's body language. A third cue source was mentioned by only one counsellor, June, and involves feedback from colleagues or supervisors.

**Counsellor cues.** In regards to the emotional cues that precede the monitoring process all eight counsellors mentioned one or more of the following emotional reactions: fear, discomfort, "icky," anxiety, guilt, boredom, attraction, aversion, over-identification, or judgement. These emotional reactions to the client seem comparable to that which is
frequently referred to as countertransference. The following quote by Phillip describes how emotional reactions may effect a session for him:

...some kind of feeling of dislike or feelings of frustration, boredom, anger, you know...so that basically I am kind of finding it hard to maintain a kind of a counsellor stance and my own kind of feelings are getting in the way...it can also work where I am quite attracted to someone, you know, emotionally or even physically, I might try to find ways to prolong sessions...

Five of the participants also described a somewhat generalized feeling such as “something is wrong,” “something is not right,” “an intuitive hunch,” “it doesn’t feel right,” or something is “gnawing at me.” The following quotes further describe this generalized emotional cue:

So day to day when I become aware of something, ehhh, that doesn’t quite fit, it just automatically happens that I get this niggling feeling that, oops, I probably should say something, do something, change something.... (June)

Um, usually I kind of know when something’s a bit off in myself. And I might have made a mistake or offended someone, or you know somehow did something that could be construed as unethical. (Sarah)

All of the participants spoke of an internal physical sensation as setting the self-monitoring process in motion. For seven of the counsellors this was described as a “gut feeling.” Although such a consistent and prevalent cue for most of the counsellors, Jane wondered if it was an appropriate place from which to get cues: “...I don't know if this sounds very professional but I do a lot of my self-monitoring just with my gut feeling, when things just don't feel right.” Anne describes her gut feeling and how it sets the monitoring process in motion for her as follows:
It’s a feeling in my gut. I go yeah, it actually is, I go “ackkkk.” Something’s going on here and um, it just doesn’t feel right. There’s something going on...I’ve really got to watch what I’m doing here. And uh, and then I just go, I just reflect what I’m going to do in that particular instance in terms of that case and who I want to talk to and whatever, it’s infinite.

For the eighth counsellor, Aaron, the physical sensation was described as originating more in his chest and was described as a “solidness.”

In general, the types of thoughts that were said to set off the monitoring process seemed to involve a heightened awareness in one of six areas. One of such areas that was mentioned by all of the counsellors involved an awareness that their personal needs, issues, or tendencies may be interfering with their work. For further discussion on this area the reader is referred to the previous section entitled “counsellor needs and reactions.” A second cognition that was said to serve as a cue for three of the participants, described below by Anne, involved an awareness of the responsibilities inherent in the counsellor role:

...I’m just more acutely aware of my role as a professional here, my boundaries and all of that...it just puts it right in your face....It’s amazing how it’s just right there.

Gotta be aware of it.

A third cognition that was mentioned by three counsellors involved an awareness that they were talking too much or going into what was referred to by June as “teaching mode” or what Sarah described as “lecturing.” Two counsellors mentioned a fourth awareness that may precipitate the monitoring process that involved “obsessing” about something or trying to convince themselves of something. A fifth element of awareness that may set off the monitoring process that was mentioned by one counsellor was an awareness that she was
“unloading” or “beating up” on her husband. Lastly, one counsellor mentioned that when she notices that she is being argumentative with a client this awareness can set the self-monitoring process in motion for her.

Magnitude of internal cue. When describing the internal cues many of the participants’ descriptions included varying degrees of the strength of the cue. For example, on the extreme end of the spectrum five counsellors compared the cue to something like “a warning,” “a red light,” “an alarm,” or “an electric shock.” When describing the lower end of the spectrum descriptions such as a “niggling feeling,” a “little pin prick,” or a “yellow light” were used. For some of the counsellors (e.g., Tess) there seemed to be a relation between the magnitude of the internal reaction and the resulting plans:

...sometimes it’s such a strong, internal feeling that I know right away I have to do something very assertive or I have to take a stand right away. And that can be a very clear, you know, the more intense the feeling, the more clearly I know what I’m supposed to do.

Client-driven cues. All of the counsellors spoke about the process also being set off by a cue originating from the client. There were six types of client cues mentioned by the participants. The most consistently mentioned client-driven cue (stated by six of the participants) was some type of disclosure from the client. For example, if a client disclosed suicidal ideation the counsellor would often consciously start monitoring their ethical practices. Lynn describes how a disclosure from a client speaking about sex can initiate the monitoring process for her,

...sometimes it’s the, the topic like um, let’s say when that client [is talking about something sexual]...in the back of my head I’m thinking, “Am I allowed to talk to clients about sex? Should I be doing this? Do I need to refer him elsewhere? Do I
have training in this? Is he sucking me in to talk about something? Is he just giving me a bogus story?” like I’ve got a lot of that stuff going on.

Other cues that were not as consistently mentioned by the participants include the following five observations. A change in client’s non-verbal communication was mentioned by three counsellors as initiating the monitoring process. June describes this cue:

…I think we can see in the body language, quite often, if a woman is like going too deep back into a shell and then I have to say okay, what did I just do or what did I just say that caused that reaction on her part...and is there any way of backtracking on that one or fixing it in any way...?

A third client-driven cue that was mentioned by three counsellors was observing in the client some degree of disengagement. Phillip describes this: “...I have had times when I have kind of self-disclosed when...the client just kind of went elsewhere and disengaged, so clearly that was more my need at that point.” Three of the participants spoke about a fourth client-driven cue that included receiving direct feedback from the client about their practices which would obviously initiate some reflection on their practices. The following quote by Tess includes a description of this cue:

…they will show me that something has been inappropriate; that something has been violating or misread and by all sorts of ways they will dissociate maybe or, you know, they will back away in the chair, or they will tell me, or they will come back extremely depressed next time and start to fragment so some cohesion has been lost and I’ll get those cues either directly, in some cases I get it right back, or indirectly.

Two counsellors cited a fifth client-driven cue that can induce reflection on one’s ethical practices which was a lack of growth or movement or lost growth in a client (stated above by
Tess). Lastly, the sixth client-driven cue was mentioned by one counsellor and involved observing emotive distress in the client as a cue to setting the monitoring process in motion.

**Other-driven cues.** June, the counsellor that worked in the most team-like work setting, was the only counsellor to mention that the monitoring process could be launched by someone other than herself or the client. The following quote describes how feedback from another initiates engagement in the process for her:

It [self-monitoring] would be set off if ever I were, if my attention were drawn to it [ethical practices] by a colleague, by a supervisor for sure. I have, for instance, had a colleague question whether I am too easy going with my clients, right, or question whether it is appropriate to use any kind of self disclosure with a client...and again I go back to the gut thing, whose interest was at stake when I made the decision. Was it done because it was something to do with my comfort level or my needs, or was it the need of the client as perceived by me for sure, or was it in somehow in her best interest? And as long as I can feel good within myself about why I made the decision I have no difficulty with challenges from my peers, I can answer to them and feel comfortable. But if I made the decision for the wrong reason I would not feel comfortable or be able to justify my decision, so it goes back to gut level again.

**Dynamic Nature of Cues.** Although the preceding description isolates the cue sources, in practice they seem to be more dynamically related. For example, pertaining to the internal cues a thought would likely lead to a physical or emotional sensation and a physical or emotional sensation may result in a heightened awareness. As well, a cue considered to originate in the client (e.g., disclosure of suicidal ideation) will likely lead to a shift in the counsellor’s internal state and may evoke an emotional response such as fear or anxiety. Conversely, if a counsellor is feeling bored in a session this may effect
how the client is presenting. The preceding quote by June described the interplay between feedback from a colleague, her physical sensation, and her thoughts.

**Frequency of Engagement in Monitoring Process**

Although notably difficult to assign a number to the frequency in which one engages in a process, participants were nonetheless explicitly asked to estimate the frequency in which they engage in the monitoring process. Before proceeding with the description of frequency two trends were noticed when analyzing the frequency data which will first be reported. The first trend was that half of the participants, as demonstrated in the following quotes, identified themselves as extreme monitors saying something to the effect of “it’s just who I am.” The second trend was that participants would sometimes use different words to describe what seemed to be a similar, if not the same, process that the researcher conceptualized as self-monitoring. For example, Lynn refers to the process as self-awareness while Jane refers to it as self-evaluating.

In terms of the frequency in which the participants stated that they engaged in the self-monitoring process, three of the counsellors stated that, in general, they engaged in the process to some degree every session, every time they met with a client. The following quotes substantiate this finding,

I would say every session...like I’m, I’m uh, I guess, I’m not sure, I guess I’m defining self monitoring as self awareness. And, I mean, that’s part of every session.

(Lynn)

I don't think I could honestly say that I'm always self-monitoring. I certainly am monitoring every session, but not every moment. (Aaron)
Moment-to-moment...yes, I would like to not do it. I’m looking forward to holidays (laughs) but I, I, it’s daily...especially when I work in this other setting

[EAP] I’m aware of ethics with every client I sit down with. (Tess)

Four of the participants estimated that they consciously monitored their ethical practice on a daily basis:

...I do it quite a lot, so it’s kind of part of who I am...like I self monitor too much probably...I would say probably you know, that its probably daily I would have to say...If it was a scale of very often, often, sometimes, rarely, never; very often - how’s that. Very often. (Sarah)

...so I guess I do it in the beginning of the day and the end of day, probably do it in the middle of the day too, if I’ve got a busy day. I’m always self evaluating. I self evaluate myself to death. I don’t think that’s a bad thing, that’s how I am. (Jane)

...I would say, you know, a few times a day probably and as I said I think it comes up in a lot of situations, not just in a session with a client...I don't know, maybe I obsess about those kinds of things, ensuring there is adequate service here...so in my role as a counsellor, and how I am doing my job, and I would say that that is ongoing, so yes there is definitely heightened moments, there are times when it is more in my awareness, but would I put a number on it, I don't think I can. (Phillip)

Well, daily when I am counselling, because if it doesn’t come up any other way it comes up in the way I am...it is there any time that I am working with a client and it is there when I am recording what has happened with a client...I guess I do self monitor on a regular basis... (June)

When asked directly about the frequency of engaging in the self-monitoring process the eighth counsellor, Anne, had difficulty putting a number to it stating, “It happens when it
needs to happen and, and that's all I can say about that.” In the freeform segment of the interview Anne said, as previously quoted on page 75, ninety-nine percent of the time she is simply being with the client while one percent of the time she is consciously aware of an ethical concern.

Evolution of Self-Monitoring Process

As previously stated, it was expected that the external monitoring that these participants received in their training would have served to orient them to the internal monitoring process in regards to ethical practice. This, however, did not seem to be the case. When reading the orienting statement (Appendix E) to participants and citing several experiences that they may have had in which their ethical practices were externally monitored, five of the participants stated that they did not recall receiving such feedback. For example, Sarah said the following, “If it was monitored I didn’t know about it because I didn’t get feedback around ethics.” Interestingly, Sarah thought that the lack of external monitoring that she received around her ethical practices may have made her more “vigilant” to self-monitoring the ethical dimensions of her practice. My sense then, after conducting the interviews, was that for many of the counsellors the process of self-monitoring their ethical practice was initiated and developed on their own and thus was not as much a function of internalizing the external process of monitoring ethical practice. As some of the participants did recall being externally monitored it was thought that the variation may have been a function of the years in which the program was attended (i.e., perhaps more recent graduates had received this training). There was, however, no clear relationship between graduating year and training experience as several of the more recent graduates had not been externally monitored while two of the counsellors that graduated five and six years ago stated that this experience had been a
part of their training. My hunch is that the variation may be attributed to the extent to which monitoring of ethical practice was included by professors that taught the participants’ clinical components of the program.

Although many of the participants were not externally monitored in their training program, all of the counsellors did recall being exposed to a formal ethical document while in their university program. This familiarity with the ethical codes and standards of practice, as previously mentioned, did play a role in providing some guidelines along which the counsellors monitored their practices. As stated by June, “...it’s that thing about you can’t be triggered if you don’t know...every course I took, almost, set standards given what they were teaching.” Despite the importance that this initial exposure to the standards of ethical practice seemed to play it appeared that these counsellors regarded counselling experience as playing an even stronger role in both shaping their ethical practice and defining and refining the monitoring of their practices. The following quotes describe the role experience played for these counsellors.

It's kind of like - I think when you start practice, you have to experiment a lot... it's impossible for us to learn what we need to learn about ethical issues in practice. We simply have to, well not simply, we have to get into practice and make sure that we've got as much contact grounding us as possible...I imagine I will feel like an ethical therapist, a truly ethical therapist, when I've had enough experience. (Aaron)

I think I knew what it (ethical practice) was, but I don’t think I was practicing it all that well, yeah. So it was more like putting it into practice...when I could see, see it in operation how some of those things we talked about [in training program] actually worked or didn’t work, then it was easier to apply. Cause sometimes you know I
thought it was just like this is over the top...you hear that, I'll think oh my god
really, right and then when I started to experience that, then it's like right, I see. Yeah.

(Sarah)

In addition to work experience some of the counsellors, such as Tess, also mentioned that
increased self-awareness, personal growth and development, and alignment with a theoretical
orientation had also made contributions to their ability to monitor their ethical practices:

I think it was more of a process in my kind of self-development which parallels my
professional development (laughter) and my own therapy that I received for a number
of years, way, way back and experiencing that process helped me to kind of know
more about my limits and my boundaries and that kind of thing. But more so, or just
as much an influence has been my focus in a particular area of specialization and my
theoretical perspective. After, I'd say, well over 12 years and long after I finished my
degree, I found the theoretical perspective that works best for me. And ever since I
defined that and I felt a real affinity, a real match, I've been able to hold the position
of myself that this is who I am, this is what I believe, these are my fundamental
assumptions about being here. I know that, I feel very strong there. It's now
something that is definable, it's not some kind of loose, vague thing.

As well, it seemed to me that these counsellors, for the most part, regarded the process of
self-monitoring ethical practice as one that will continue to develop and be further refined
with additional experience. This supposition is rooted in participants' descriptions in both
the initial interview (see the quote by Aaron on previous page) and their reflections on the
evolution of the proactive and reactive components of self-monitoring as described in the
follow-up interview (results to follow). Data obtained in the follow-up interview suggested
that several participants held the assumption that the more experience they acquired the more
proactive and preventative their monitoring would become in effect strengthening their ethical practice.

During the initial interviews with participants, the monitoring process had not yet been conceptualized as having a proactive and a reactive stream thus the development of the proactive and reactive aspects of practice were not directly commented upon by all of the participants in the initial interview. That being said, however, a few of the participants did say that their monitoring of their ethical practice had become more proactive with experience. As it was considered of interest to explore if this correlation held true for all of the participants in the follow-up interview, each counsellor was explicitly asked if experience had effected the proactive or reactive dimensions of the self-monitoring process. One of the counsellors responded to this question in somewhat abstract terms thus making it difficult to relate the counsellor’s description to the more concrete examples given by others. As such, the following results are based on the responses of seven of the counsellors.

Five of the counsellors stated that as they became more experienced their monitoring of ethical practice relied more on proactive strategies and, as previously mentioned, acquiring more proactive strategies seemed to provide assurance that their practice was more ethically sound. Thus, the underlying assumption seemed to be something to the effect of “the more proactive strategies that can be built into my practice the more ethically sound my practice will be.” This developmental process, as described by these participants, seemed to go as follows. When they began counselling they spent more time reactively monitoring their ethical practice (i.e., something occurred and they had to figure out how to handle it in the moment). Following the more reaction-focussed stage they would (when possible) put some type of proactive strategy in place such that the situation would not reoccur or, if it did, something would be in place to reduce the impact. Anne described the result as being a more
detailed, formalized, and organized ethical practice. These counsellors reported that the more proactively they monitored their ethical practice the less frequently they had to reactively monitor their ethical practice.

For one participant who did not describe this positive correlation, between experience and proactive strategies, she said that in the beginning of her practice she had established proactive strategies that have remained consistent throughout her practice (i.e., she has not added new strategies). She does, however, speak about wanting to become more proactive in the future (see June's quote on pg. 105). The other participant that did not describe the evolution of her proactive monitoring practices as clear cut as those previously mentioned said that in some ways she has become less proactive with experience while in other ways she has become more proactive. Specifically, she said that she has become less explicit about client rights and boundaries and devotes less time to reading current literature. However, she also states that she has become more proactive in areas such as receiving regular consultation and participating in activities aimed at increasing her self-awareness.

The above two participants were the only ones to speak about the role that experience had played in terms of the development of the reactive component of their self-monitoring process; they both stated that they utilized more reactive strategies particularly in terms of bringing something up with a client or listening to what was being evoked in them as they acquired experience. As well, experience was said to have given them more confidence and they felt more comfortable when reactively monitoring their practices. Additionally, one of these participants spoke about having more options, being more flexible, and recognizing more situations as deeming a response after acquiring experience. It is perhaps worth noting that these two participants both had two years counselling experience while four of the five
counsellors whose monitoring process was described as becoming more proactive with experience had over 5 years experience (the fifth participant had 2.5 years experience).

**Familiarity with “Self-Monitoring” Prior to Receiving Contact Letter**

Given the attention within the literature that the activity of self-monitoring has received in relation to ethical practice, it was decided to explicitly ask participants if, prior to being contacted by the researcher, they had considered the activity of self-monitoring. As the following quotes illustrate three of the counsellors stated that they had not previously given the activity much thought:

I, I wasn’t really aware um, of what I did specifically. Um, I don’t know if self-monitoring if I had given it thought, but I would like to think that I have always given ethical, I have always made ethical considerations, but not necessarily what I do. (Jane)

Not consciously, not consciously. I used to when I was involved in the clinic [at UBC] and whenever a problem crept up I do, whenever I got that kind of niggling kind of you know, I do it but am I observing myself doing it? Probably not, you know, and that is what you mean, I think, to stand back and say am I conscientiously paying attention? Probably not. (June)

I don't think I have sat down and thought about it formally, no. As I said, you know, I am reflecting that I think it is all over into everything I do. In the work it is there but I don't think I had sort of sat down about now how do I do that, not particularly. (Phillip)

Five of the counsellors stated that they had previously considered the role that they played in monitoring their ethical practice prior to being contacted by the researcher as the following quotes illustrate:
Mm hm. Yup....in, in counselling, in therapy, you need to be really sure about what you are doing ethically and professionally, you know it goes together um, because you can get yourself in some very dicey situations very, very quickly if you are not aware of that...you have to do it [monitor ethical practice] all the time with things that creep up on you... (Anne)

Yes. Tons. Like actually, constant...And um, yeah, I’ve always, I’ve always had a very keen interest in ethics and in self monitoring...(Lynn)

Well I would say I do it quite a lot, so it’s kind of part of who I am. I, like I self monitor too much probably and uh, you know, I think all of what I’ve talked about, like it wasn’t a new idea, oh that’s nice...sounds like fun...its what I do everyday ad nauseam hope she [the researcher] knows what she’s in for. (Sarah)

Yeah. Through my supervision group. Pretty well constant. (Aaron)

I think I wouldn’t have necessarily defined it in this way, as ethical self-monitoring, it’s probably just self-monitoring and health, healthy practice for me is how I would have defined it. Regulating myself and upgrading and learning. I think it probably, it was assumed for me under the whole area of competence you know and learning and you know, workshops and training and all that stuff. (Tess)

**Response to Nomination and Impact of Participation**

Several participants stated to the researcher, either in the initial phone call or at the beginning of the interview, that they were surprised that they stood out and were nominated by former professors on the basis of their awareness of ethics and ethical practice. Often accompanying such expressions was something to the effect of, “I hope I measure up.” Unfortunately, the potential significance of these comments was neglected by the researcher at the time they were stated; thus, no record was kept as to how many
counsellors made such comments or what exactly was said. A retrospective estimation is that at least half of the counsellors made such a comment. This trend in response may suggest that participants were in fact not particularly knowledgeable or conscientious pertaining to ethics and perhaps should not have been nominated. A second possibility, and in my opinion more likely given participants’ descriptions of monitoring their ethical practice, is that the participants were not aware that they are more knowledgeable and conscientious of the ethical dimensions of counselling than perhaps is characteristic of the average counsellor. Perhaps also worth noting is that several participants (again the number was not recorded at the time) stated that they were flattered to be remembered and seen as distinct by their former professors. One participant, that I am aware of, contacted the professor that nominated her to express her appreciation.

The counsellors’ responses to participating in the interview are also noteworthy. Following the initial interview half of the participants voluntarily informed the researcher that participating in this study and reflecting on their ethical practice and how they monitor them had a somewhat validating effect as the following quotes demonstrate:

...I’m just thinking about it because you know, how often do you have this conversation where you [discuss] ethical standards and practices, I mean when you’re out there practicing, it’s just when things come up, right, so um, I’m just, it’s made me just really realize how much I do incorporate into my practice.” (Anne)
It’s been good to, to talk about it and say yeah, this is good sound stuff, this is good practice. (Jane)
It's kind of interesting to talk about...I don't talk about this aspect of myself very much. I do it, and you know, like I say sometimes I think it can be a bit over the top, so, you know, to put it in kind of a frame of good ethical practice, that's nice. (Sarah)

I found it really interesting, really kind of got me thinking about things and kind of put those two pieces together more so for me about self-monitoring and ethics too...[and that] basically what I'm doing is ethical, I'm being ethical when I do that and I can't be ethical if I don't do that. (Tess)

In the follow-up interview Phillip reflected on what it had been like to be a participant in this study and he too said that he appreciated having the opportunity to step back and reflect on his ethical practices as he stated that an awareness of what he does tends to get lost in the day-to-day. After reflecting on their ethical practice, although not explicitly asked, I suspect that several of these counsellors were no longer as surprised at being nominated.

**Validity of Research Data and Conceptions of Self-Monitoring Process**

**Research Data**

As a means of measuring the validity of each participant's description each counsellor was asked the following question, “During the interview how closely did your description reflect what you actually do as opposed to what you think that you should do or what you would like to ideally do?” All of the participants stated that they had pretty much described what they do. As the participants replies to this question are of importance in terms of the validity of this research their responses to this question are reported verbatim:

I'd say in this day and age it's what I do. I wouldn't even have known about this years back. It wasn’t even in sort of awareness but it’s the meat and potatoes of it now...[its] very accurate to my practice. To myself. Yes. (Tess)

No, it's what I do do. (Anne)
Oh, I've been, I've been open, I, no, that's what I do, absolutely... No, I'm not formulating that, no, that's, that's how it is. (Jane)

That is actually what I do do. What I think I should be doing? Ideally I would like to be more proactive, I would like to pay more attention to doing that on a regular basis. Realistically, will I find the energy and the time in a day to do it, I honestly don't know. (June)

Um, I would say it is pretty close because I was trying to kind of describe rather than just idealize. There was probably some wishful thinking there but when you are talking about monitoring I don't see that so much as measuring how I am doing, it is just like saying, you know, what do I notice going on, so I would say it is pretty close to what I do, I mean, I didn't feel like I was pressured into having to kind of portray myself in a certain light. (Phillip)

Oh, it's very close. Yeah, I, I haven't, told you anything I think I should be doing...[and what] I think I should be doing, I told you I should've. (Sarah)

I think I pretty well talked about what I do do. (Lynn)

I think it's pretty accurate. I hope that I'm still doing it to this degree ten years from now. And this is one of these really difficult questions because you don't know what you're not doing. So, what was described is what I'm doing. I feel pretty congruent in terms of this is what I want to do, and this is what I'm doing. (Aaron)

My personal sense, while conducting the initial interviews, was that the participants were generally quite genuine in their descriptions. I did not find myself thinking that the they were "giving me the party line" or telling me what they thought that I wanted to hear as they all seemed quite passionate and committed to maintaining their
ethical practice. Furthermore, at one time or another each participant either explicitly expressed some self-consciousness regarding their ethical practice (e.g., "is it good enough?"); "confessed" their areas of weakness (e.g., managing boundaries around time); or recounted situations in which they felt they had erred (e.g., mismanaged a dual relationship or failed to attain written consent). To me, these disclosures suggest that, in general, participants were not tailoring their responses and descriptions such that they were always trying to present themselves in the best possible light to the researcher. This is not to say that social desirability played absolutely no role in participants’ descriptions as perhaps it influences most of our social interactions in some manner. However, based on participants’ reports and my perception, it did not seem that social desirability dominated the counsellors’ descriptions of their process of monitoring their ethical practice.

**Conceptions of Self-Monitoring Process**

As previously mentioned, the participants received, in writing, the developing conceptions of the research data and were asked to give their reactions in the follow-up interview. Although the interviews were estimated to last approximately 30 minutes, such was true for only two of the interviews. Four of the interviews were approximately 45 minutes, and two were closer to one hour. In general, the response to the information was fairly uniform among participants as the following consistencies in participants’ responses suggest.

When reviewing the summaries of the domains in which they self-monitor, the cues that initiate the process, or the proactive/reactive strategies all of the participants stated that they recognized aspects that were true for them but which they had not articulated in the initial interview. In the few instances that participants mentioned
something that they identified as being not true for them, this discrepancy seemed to be a function of variation in work settings (i.e., agency or private practice), client population, or their theoretical orientations. This hunch is rooted in comments from the participants in which they said things to the effect of, "though I agree with that it hasn’t come up for me" or "I’d imagine that’d be more of a concern in an agency/private setting."

A second trend in participants’ responses was the expressed relief that they weren’t missing anything crucial in their ethical practice. However, a few participants did say that they planned to incorporate some of the proactive strategies into their daily practices. For example, Aaron said that he was going to ensure that his clients had a medical doctor and stated that he had already started imaging that a client was standing over his shoulder while writing case notes. A third theme in participants’ responses was an expressed interest in the topic area. As well, the description of the process seemed to be regarded as somewhat of a valuable resource by several of the counsellors. A fourth reaction shared by many participants was the reassurance that others were operating under similarly high standards as themselves. Those that expressed this often wondered what the norm might be if the researcher had interviewed a cross section of counsellors (i.e. not ones that were nominated). It seemed that they suspected that the standards would not be as high.

The final trend in participants responses was that all of the counsellors said that the descriptions and conceptualizations of the self-monitoring process as it pertained to their day-to-day ethical practice accurately described their experience. General reactions to the researchers description was quite positive as participants said things like, “it resonates very much,” “it fits,” “you framed it,” “you gave it a language,” “its valid,” “it
describes my experience, “you captured it,” “nothing was alien,” and “I wouldn’t have worded it that way, but that’s what it is.” Additionally, the participants had very little to add though a few participants did say that they thought that some points should be further described or expanded.

Lynn, for example, thought that more attention should be devoted to the monitoring of counsellor’s feelings as for her it represents a large component of monitoring her ethical practices. Phillip spoke about emphasizing his approach in which he is monitoring his ethical practices in all of his roles (i.e., father, friend, romantic partner, etc.) not just in the counsellor role. Phillip also clarified that he utilizes his feelings and reactions in session and thus is not always pushing them aside. Lastly, Aaron wondered if some of the aspects that other participants considered to be ethical practice were more representative of their theoretical orientations. One such example was the point mentioned by a few counsellors that they monitor that they are maintaining a balance between supporting and challenging their client.

One of the participants had a unique reaction to the description of the research data. In the follow-up interview she stated that seeing that all of the other counsellors except herself had mentioned “doing no harm” brought up what she described as an “insecurity” concerning her ethical practices. Additionally, she wondered if some of the other participants had “studied” prior to meeting with the researcher in order to generate the “right” answers (she had purposefully not done this). During the ensuing conversation it seemed clear to the researcher and the participant that this counsellor does ascribed to the “do no harm” tenet yet simply did not make it explicit in the initial interview. The researcher attempted to reassure the participant by informing her that of the counsellors that the researcher had previously met with they had all stated that they
too had not articulated some aspect of their practice that they recognized in the
description. It seemed, as the discussion progressed that the counsellor renewed her
confidence in her ethical practices. In response to the description of the monitoring
process this counsellor said that it represented what she referred to as the implicit and
explicit elements of her self-monitoring practices.

Summary

A central aim in selecting interpretive description as the method of inquiry was to
attain a description of the monitoring process that would capture both the shared and the
unique aspects of the process as described by experienced counsellors. This was a
preliminary investigation into a topic that, up until this point, has remained ill-defined
and somewhat vague. Therefore, it was deemed essential that the articulation of the
monitoring process include both the common and uncommon elements of participants’
descriptions. As these findings represent the first documentation and illustration of self-
monitoring in practice, disregarding a particular aspect of the process simply because it
was mentioned by a single participant could hinder further understanding of the process.
The current sample is small and deliberately selected; it may be that an aspect of self-
monitoring mentioned by one participant in the current sample is, in fact, common
practice for counsellors in general. The present chapter will thus conclude with a
summary of research findings that highlight both what was shared and unique in the
counsellors’ descriptions.

Approximately half of the domains in which the participants reportedly attend
when self-monitoring their ethical practices were consistently mentioned by six or more
of the participant sample. One such domain included practitioner competence which
included the practitioners’ qualifications, areas of expertise, and training. A second area
consistently mentioned by participants, monitoring counsellor needs and reactions, involved ensuring that the counsellor’s “stuff” (i.e., needs, issues, or tendencies) was not interfering with the therapeutic process. The domain of confidentiality, an area mentioned by all of the participants, included both regulating that confidentiality was maintained and that, in the case of harm to self or others, the confidential contract was appropriately broken. A fourth area that was consistently mentioned by participants involved regulating that their practices were not resulting in harm to the client (conceptions of harm varied). Informed consent was another area in which the counsellors stated that they were monitoring their ethical practices this included ensuring that the client’s signature was attained when releasing information to another professional, or, being explicit about one’s therapeutic approach and selected interventions. A final domain that was consistently described by several of the participants concerned dual relationships. In the instances in which the counsellors stated that dual relationships were unavoidable, they spoke about monitoring that the boundaries of the therapeutic relationship were maintained in the second relationship.

The other half of the domains were described by a few counsellors (i.e., one to three) as areas that they attend to when monitoring their ethical practice. One area, mentioned by three participants, involved monitoring that the counsellors were not abusing the power that they believed to be an inherent part of the counsellor role. Regulating that colleagues are maintaining ethical standards was included in the description of ethical domains to which they attend by two of the participants. Monitoring that one’s approach did not overly support or challenge a client was mentioned by two of the participants. Attending to writing accurate and respectful case notes and regulating that one was making the best use of, and not wasting, the client’s
time and money were domains mentioned by two participants as areas in which they self-monitor their practices. Two counsellors stated that they monitored that they were not overly identifying with one, more than another, member of a couple. Lastly, one participant stated that he attends to what was termed “small things” which included ensuring that the services were available to clients throughout the day (e.g., ensuring that the phones were covered).

Clearly the domains to which participants reportedly attend when self-monitoring their ethical practice included both consistent and unique areas of attention. However, of those areas that were mentioned by only a few participants the reader is reminded that in the follow-up interview several counsellors said that they too monitored along those domains but had not articulated it in the initial interview. This suggests that there was even more commonality regarding the domains in which the participants monitored than data from the initial interview would indicate. Also consistent among participants’ responses was that each counsellor, in response to a question posed by the researcher, stated that the ethics codes also served to “guide” or “set the parameters” of their monitoring of ethical practice.

Participants’ description of the monitoring process, like that of the domains, included both shared and unique elements. There was consistency among the participants regarding the frequency that they engaged in the monitoring process as seven participants said that they engaged in the activity at least once a day. One participant said that she engaged in the process one percent of the time stating that it happens “when it needs to happen.” Another common feature among participants’ descriptions of the monitoring process was that each participant described monitoring strategies that were considered by
the researcher to be both reactive and proactive. These strategies will be briefly summarized.

Of the strategies considered to be proactive, the following five strategies were articulated by six or more of the participant sample: expanding self-awareness by engaging in routine self-reflection; participating in self-care activities outside of work (e.g., getting adequate rest, taking regular holidays, working at a “fun job” unrelated to counselling); routinely referring to the ethics codes, literature, or legislation in the area of ethical practice; seeking out and participating in regular formal (i.e., with supervisor) and informal (i.e., with peer group) consultation; and, when interacting with clients, being clear and straightforward by indicating either in writing or verbally the confines of the therapeutic relationship and the counselling process.

Five strategies, considered by the researcher to be proactive, that were mentioned by a single participant included the following. One counsellor stated that she would ensure that all new clients had a GP to consult with should safety issues arise and she also stated that she “checked-in” with clients approximately every six weeks to ensure that they were working on the right issues. As a means of monitoring that case notes were accurate and respectful, one counsellor stated that she imagines that the client is watching over her shoulder when she writes the notes. Another counsellor said that he ensured that there was a half hour between counselling sessions in order to reflect and complete case notes. Lastly, one of the participants stated that when working with a client in which the potential for faulty assumptions and misunderstanding might be heightened (e.g., client of different gender or cultural background) she asks the client to assist with the monitoring process.
In regards to the monitoring strategies considered to be reactive five were consistently mentioned by seven or more participants. One such strategy included engaging in solitary reflection which was said to occur either before, during, or after a counselling session. Often participants would ask themselves questions such as "what is in the best interest of this client?" or "what should I do?" Another reactive strategy included utilizing either a pre-established policy, procedure, or response. Some examples of this strategy included attaining client's signature before speaking about them to another professional or not acknowledging a client when seen outside of the counselling office. Two other reactive strategies consistently cited by participants included referring the client to another practitioner and consulting with another professional or an internalized role model to attain more information and formulate an action plan in response to the particular concern. Lastly, making adjustments in one's personal or professional life such as spending more time alone or saying "no" to extra work was also a monitoring strategy cited by the majority of the counsellors in this sample. One strategy, that was mentioned by half of the participant sample involved addressing one's concerns or ethical mistakes with the client.

As with the domains in which the participants monitored their ethical practice, there was both consistent and unique features in the participants' descriptions of the self-monitoring strategies. Descriptions were consistent in that each participant included strategies considered by the researcher to be reactive and proactive. This consistency lends support to the researcher's conceptualization of the process as consisting of two components. When comparing the strategies considered to be proactive and reactive there is more consistency in participants' initial descriptions of the reactive strategies as several of the proactive strategies were cited by a single participant. However, as with the
domains, of those proactive strategies that were mentioned by a single participant several counsellors in the follow-up interview stated that they too use that strategy but had not mentioned it in the initial interview. This suggests that there may have been consistency among the proactive strategies as well.

As with the domains and strategies, the cues that were thought to precede the reactive component of the monitoring process also demonstrated shared and unique features. For example, all of the counsellors mentioned the occurrence of internal cues that included a thought, an emotional reaction, or a physical sensation; and, of those described, there was a great deal of overlap in the examples provided (e.g., seven of the participants spoke of a "gut feeling"). In relation to the client-driven cues, although all of the participants mentioned this source there was much variation regarding the particular observation that might set the monitoring process in motion. The most consistently mentioned client-driven cue, stated by six participants, was some type of disclosure from the client (e.g., thoughts of suicide or discussion of sexual practices). Other client-driven cues included the following (with the number of participants that stated it in parentheses): change in body language (3); client disengagement (3); feedback from client (3); lack of growth (2); and emotive distress (1). One participant mentioned that the monitoring process could be "set off" after receiving feedback from a colleague or supervisor.

In regards to the cues thought to precipitate the reactive monitoring process, the descriptions attained from this sample of participants suggest there to be the most cohesion in the counsellor-driven cues. And, although they all looked to the client for cues it seems that they were generally looking for different signals. Interestingly, only one participant mentioned that feedback from others could set the process in motion, however, given this samples' reliance on supervision I suspect that such might be true for
other participants as well despite the fact that it was not explicitly articulated in the initial interview.

A particularly noteworthy trend in the present findings was the developmental nature of the monitoring process in relation to the proactive and reactive strategies. Generally speaking, those counsellors that had less experience (i.e., approximately two years) described their monitoring practices as being more concentrated on the reactive strategies while those with the most experience (i.e., more than five years) indicated that they utilized more proactive strategies. The more experienced participants, when reflecting on their own development as counsellors, spoke of becoming more proactive. The counsellors with less experience, though they spoke of wanting to incorporate more proactive strategies into their practice, focussed more on the development of their reactive monitoring practices when reflecting on the role that experience had played in their monitoring practices. It may be that, in the first years of experience, counsellors refine the reactive component of their monitoring process and after additional years of experience the proactive components of the process become the central focus.

The above summary clearly demonstrates that participants’ descriptions of the monitoring process held both shared and unique features. For the most part, however, the researcher was struck by how much overlap there was between participants in their independent descriptions of self-monitoring their ethical practice. The implications of the present findings as they pertain to past and future research, the ethics codes, counsellor training and professional regulation will be discussed in the following chapter.
CHAPTER FIVE

Discussion

The individual practitioner's ability to self-monitor is considered to be an essential component of ethical practice (Pettifor, 1996; Pope et al., 1987; Van Hoose & Kottler, 1985; Watkins, 1983; Webb, 1997; Welfel & Lipsitz, 1984; Welfel, 1998). As such, the purpose of this study was to provide some initial answers to the question, "Do experienced counsellors self-monitor their day-to-day ethical practice, and if so, what does the process look like, or how do they describe it?" The counsellors who participated in the present study, in answering the above question, described the monitored process as follows. Generally speaking, the activity of self-monitoring seemed to be self-initiated, (as participants stated that it was not learned in their training program). It was reportedly engaged in at least once every working day. It appeared, for the most part, to be guided by professional ethics codes and standards of practice, although several participants mentioned that they engaged in activities considered to be ethical that are not consistently represented in the ethics codes (e.g., self-care). There were both common and unique domains in which the counsellors monitored their ethical practice. The process was conceptualized, by the researcher, as consisting of two separate, yet slightly overlapping, components – proactive and reactive – each involving different monitoring strategies. As with the domains, there were both common and unique strategies mentioned in participants descriptions of the self-monitoring process. Lastly, there was some indication that the process of self-monitoring had a developmental component.

This final chapter will first consider the implications of the above findings as they relate to the literature on ethical practice, particularly considering the existing theory, the ethics codes, and previous studies. Following this will be a consideration of future
directions for research in the area of ethical practice. Suggestions for both counsellors-in-training and practicing counsellors will then be articulated. This chapter will conclude with a reflection on some of the limitations to the research findings.

**Implications of Research Findings**

**Theoretical Implications**

There are several possible implications of the research findings pertaining to the literature in the area of ethical practice. As repeatedly stated throughout this paper, there is very little theoretical and empirical information on this aspect of ethical practice beyond attesting to the importance of self-monitoring. Kitchener's (1984) theoretical model of ethical justification, initially posited in relation to ethical dilemmas, was thus considered in relation to the day-to-day ethical monitoring process. Although noted in the literature review, a brief review of the two-levelled model, encompassing the intuitive and critical-evaluative levels, provides a context for understanding the current results. The intuitive level is thought to consist of one's conscience, personal dispositions, habits of thought, and acquired knowledge of the ethical codes (Hare, 1984; Kitchener, 1984). Decisions made at this level are considered to be “time saving rules” that are immediate and without reflection (Hare, 1984). This appears to share some elements with the reactive strategies noted in the current research. The second level, the critical evaluative, is thought to include reasoned judgements and conscious evaluation by way of the information contained in an ethical theory, ethical principles, or professional ethical codes and laws (Kitchener, 1984). This level also has elements in common with the reactive component of the monitoring process as described by participants in the present study. The two levels are related in that the product of one’s critical reflection can be incorporated into the intuitive level and subsequently serve to guide the decisions made at
the intuitive level. Because I think that the two levels of Kitchener's model show up most clearly in the counsellors descriptions of what I've called the reactive strategies, several examples are provided below to illustrate the manner in which present findings can be linked to her model.

When describing a strategy considered by the researcher to be characteristic of the reactive monitoring process, solitary reflection, all of the counsellors stated that they engaged (either before, during or after a session) in some critical reflection on their ethical practice. The reflective process was often expedited by going for a walk, journaling, or writing freeform notes. Other times, the counsellor "bought some time" by telling the client that he or she would get back to the client with a reply or a plan. To foster the reflection process, participants stated that they would routinely ask themselves questions such as, "what are my motives for such and such?," "what is in the best interest of this client?" or "what should I do?" Although not explicitly stated as such, it seemed that the questions upon which the counsellors reflected would generate answers that were rooted in the tenets of the ethical principles (e.g., beneficence) and the ethical codes (e.g., do no harm). Participants' descriptions of this reflective process seems to parallel the critical-evaluative level of ethical justification as described above (Kitchener, 1984).

A second strategy, of utilizing a standard form, procedure or response, also considered to be representative of the reactive monitoring process was described by participants to be somewhat of a routine response to a particular situation; little reflection was seemingly involved when deciding what particular action to take. The chosen activity appeared to be a function of either the guidelines of their workplace or the ethical codes or the counsellors' past experiences. Such decision making seems consistent with Kitchener's conception of the intuitive level in which decisions are thought to be "time
saving rules” requiring little reflection (Hare 1984; Kitchener, 1984). Another parallel with Kitchener's model is the apparent relationship observed between the selected action and previous experience or the knowledge of the ethical codes. Kitchener’s conception of the intuitive level, is also evident in the finding that several counsellors stated that they had internalized the information contained in the formal ethical documents.

Participant responses described here as a reactive process of self-monitoring ethical practices demonstrate some similarities to both levels of Kitchener’s (1984) model of ethical justification. It is not surprising that those strategies considered to be reactive and not proactive would demonstrate similarities to Kitchener’s model as both the reactive process and Kitchener’s model are conceptualizations of what occurs following detection of an internal or external cue or an ethical dilemma, respectively. This overlap, between the present findings and Kitchener’s model leads the researcher to wonder if perhaps the identified cues in the present study might be akin to the day-to-day manifestation of an ethical dilemma. Also significant, as to my knowledge Kitchener’s model has not yet been empirically explored, is that the parallels between present findings and Kitchener’s model may lend some preliminary empirical support to the validity of her model.

Within the theoretical literature on ethical practice, several authors have postulated what they consider to be effective means by which to maintain ethical practice (although not described as “self-monitoring” strategies per se) (e.g., Epstein & Simon, 1990; Peterson 1996; Pettifor, 1996; Tennyson & Strom 1986; Watkins, 1983; Welfel, 1998). Such postulations have not, to my knowledge, been empirically explored; thus, at
this point, they are considered to be theoretical in nature. Present findings, as they relate to this area of the literature, will be considered.

None of the counsellors who participated in this study appeared to have engaged in a comprehensive reflection on their ethical practice prior to their participation. This conclusion was based on the following: 1) several participants explicitly stated that participating in this study represented the first time that they had had such a conversation and reflected on their ethical practice to this degree; and, 2) not one participant stated that they had utilized a self-assessment instrument in order to monitor their ethical practice (this strategy has been recommended in the literature: e.g., Epstein & Simon, 1990; Peterson 1996; Pettifor, 1996). Participation in this study seemed to expand the counsellors' awareness of themselves as ethical practitioners, as several participants made comments like "this is good sound stuff" or "to put it in kind of a frame of good ethical practice, that's nice." Heightening awareness of ethical practice both in what the practitioner does well and that which may need improvement is thought to be among the beneficial effects of completing an ethical self-assessment inventory (Epstein, 1994; Pettifor, 1996). Current findings lend support to such a claim.

The focus of the present study was on the process of maintaining ethical practice and not on how counsellors recover from an ethical transgression. However, in their descriptions of self-monitoring, all of the participants cited examples of times in which they had made an ethical mistake. One implication of this finding might be that a component of monitoring ethical practice includes taking responsibility for mistakes. In their narratives of mistakes, participants would include a description of both how they had recovered from the mistake and how they had incorporated an action into their monitoring practice in order to prevent or minimize the potential of repeating that
particular mistake. Both of these strategies are suggested by Welfel (1998) as a means by which to minimize the damage of ethical mistakes or transgressions, as she suggests that counsellors ask themselves the following two questions: "What damage have I done and how can I undo or ameliorate that damage?" and "What steps should I take to ensure that I do not repeat this mistake?" I think that this similarity between what is thought, in theory, to reduce the impact of ethical mistakes and what these practitioners were reportedly doing is meaningful for two reasons. Firstly, it lends credibility to Welfel's suggestions as reflection on these questions (or versions of them) does appear to be what practitioners' do and reportedly find helpful in the development of their ethical practice. Secondly, the observation that all of these counsellors reflected on how they could reduce the immediate impact and prevent or reduce the occurrence of subsequent mistakes suggests that these were conscientious practitioners naturally doing what is recommended in the literature in this area.

The theoretical literature on ethical practice presents the conception of the responsible practitioner (Tennyson & Strom, 1986) and, again, the current findings include examples that seem to parallel the description presented in the literature. The responsible practitioner, as defined by Tennyson and Strom, engages in both routine critical self-reflection and dialogue with colleagues. When both strategies are incorporated into practice, these authors contend that the practitioner is most likely to have an ethically sound counselling practice. Both of these strategies were cited by all of the participants and both were represented in the reactive and the proactive components of ethical practice. Furthermore, it seemed that these two strategies, in both their proactive and reactive manifestations, were central to the self-monitoring process for counsellors in the current sample. The essential role that critical self-reflection and
dialogue with colleagues seemed to play for these counsellors suggests that, as conceptualized by Tennyson and Strom, this participant sample was representative of the "responsible practitioner."

In my final search of literature, conducted after data analysis, I came across a paper by Watkins (1983) that, given the similarity between the present research findings and his recommended interventions for what he terms counsellor "acting out" behavior, should be briefly reviewed. Watkins draws a link between counsellor acting out and ethical practice as acting out typically results in some level of harm to the client (e.g., an aggressive outburst or demonstrating boredom to client). The five remedial and preventative strategies suggested by Watkins are as follows: self-reflection, supervision, personal counselling, referral, and self-disclosure. Except for self-disclosure, which was cited by half of the participants, almost all of the present sample of counsellors reported that they utilized the strategies recommended by Watkins.

The above review of current findings, as they pertain to the theoretical literature on the ethics of practice, demonstrate that the counsellors in this sample, for the most part, reported doing that which has been suggested by those who write about possible courses of action (i.e., strategies) when the practitioner 1) is faced with an ethical dilemma (Kitchener, 1984), 2) has made an ethical mistake (Welfel, 1998), 3) is to maintain an ethically sound practice (Tennyson & Strom, 1986), or 4) wants to prevent or recover from acting out behavior (Watkins, 1983). The overlap in strategies mentioned by the above authors with those cited by this sample included the following: solitary or critical reflection; utilizing a standard form, procedure or response; consultation or supervision; seeking personal counselling; referring a client; and self-disclosure.
In addition to substantiating the apparent usefulness of these strategies in day-to-day ethical practice, the present findings also make a contribution to the literature in this area by extending the repertoire of available strategies. The strategies that were cited by research participants but have not been previously mentioned in the literature most related to the monitoring process include: routine reference to ethical literature sources; ensuring that the client has a GP; routine six-week check-in with client; imagining that the client is watching over one's shoulder when writing case notes; asking the client to assist with monitoring process; including a half hour between sessions to reflect and complete case notes; and making adjustments in personal or work life. Explicating additional "how to" strategies of monitoring ethical practice makes a worthwhile contribution to the literature on application of ethical practice.

Another manner in which results from the present study contribute to existing theory in the area of ethical practice pertains to the preliminary evidence that the self-monitoring process may have a developmental component. Support for this supposition emerged from both the initial and the follow-up interview. In their initial descriptions of the monitoring process, several counsellors spoke about becoming more proactive with experience. In the follow-up interview, participants were presented with the researcher's conceptions of the reactive and proactive monitoring process and were explicitly asked if experience had played a role in either of the components of self-monitoring ethical practice. Results indicated that the more experienced practitioners (those with five or more years of experience) had become increasingly proactive with experience which, reportedly, had the effect of minimizing the amount of time spent reactively monitoring their ethical practice. The two counsellors who met the minimum experiential requirement for research participation (i.e., two years) stated that it was their reactive
monitoring processes that had demonstrated the most refinement with experience.
The one exception to this pattern was the counsellor with two and one-half years of experience who responded in a manner similar to the more experienced counsellors.

This pattern suggests that, in the initial years of entering the profession, counsellors may adopt strategies aimed at improving their abilities to respond to day-to-day ethical concerns. As they acquire more experience, they may begin to realize that some situations can be avoided or minimized by incorporating preventative, or proactive, monitoring strategies. Both of the less experienced counsellors spoke of wanting to become more proactive and the one counsellor with two and one-half years experience spoke about refining his proactive strategies; thus, perhaps this shift occurs sometime between the two and three year mark. It is possible that after being in the field for a period of time, one may begin to learn that some situations can be avoided and, therefore, the practitioner may begin to strategize and incorporate proactive strategies into their practice. I wonder if the beginning counsellors' concentration on the reactive aspects of the monitoring process might be a function of the emphasis within the literature, and possibly in training programs as well, on managing ethical dilemmas or responding to situations as they happen. If this hunch is accurate perhaps more attention, both from the ethics writers and training programs, should be devoted to the proactive aspects of ethical practice as a means of possibly avoiding or reducing ethical transgressions. Additional inquiry into these areas is required to further substantiate the above suppositions.

**Implications Pertaining to the Ethics Codes**

As this study explored how counsellors self-monitored their ethical practice, a consideration of implications of the present findings in relation to the ethics codes of the mental health professions is in order. Although the ethics code of the ACA (1995) is
most relevant to the current study, the codes of both the APA (1992) and the CPA (1991) will also be considered as they, especially that of the APA, are most prevalent in the literature in this area. The reader is reminded that the dominant codes of the mental health professions are generally considered to share much in common (Overholser & Fine, 1990). One such example of this commonality is that, although the self-monitoring term emerged out of the literature, and is not actually referred to within either of the three codes, each of the documents does include a statement similar to section III.35 of the CPA code which states that it is the practitioners’ responsibility to “familiarize themselves with, and demonstrate, a commitment to maintaining the standards of their discipline.”

The literature surrounding the ethics codes, as noted in chapter one, asserts that a strength of a code of ethics is the potential that it has to increase practitioners’ awareness and guide them both in terms of acceptable and unacceptable behaviors (e.g., Kitchener 1984; Pope & Vasquez, 1991; Pope et al., 1987; Sinclair et al., 1996; Sinclair et al, 1987). Some authors, however, cautioned the professional organizations against overly relying on these documents to govern practices, as the mere existence of them does not, in and of itself, ensure that such behaviors are actually practiced (e.g., Bersoff 1994; Cooper, 1992; Kitchener, 1984; Lazarus, 1994; Mabe & Rollin, 1986; Pope et al., 1987; Sherry et al., 1991; Tennyson & Strom, 1986, Welfel, 1998; Welfel & Lipsitz, 1984). Current results suggest that the group of counsellors that participated in this study were both aware of, and seemingly, did their best to ensure that their day-to-day practices were in line with the core standards of the mental health professions.

The domains in which almost all of these counsellors reported to be monitoring their day-to-day ethical practice seem to be representative of the areas in which the ACA
(1995), APA (1992), and CPA (1991) ethics codes converge. The domains that were consistently mentioned by the present sample of counsellors included: counsellor competence, counsellor needs and reactions, confidentiality, harm to client, informed consent, and dual relationships. Other domains mentioned by a few participants, and represented, though not as consistently across the three codes, include the following: counsellor power, colleagues' practices, supporting and balancing clients, case notes, client's time and money, alignment with member of couple, and "small things" (e.g., phones covered). Additionally, all of the participants stated, that, to some degree, the formal ethics codes had "guided" them and "set the parameters" of their ethical practice. The ethics codes of the ACA or APA that participants received in their training program initially served to guide their ethical practice, however, several of the participants currently rely more on the ethics code of the BCACC (1998). Although the ethics code of the BCACC is not considered in the present discussion, it should be noted that, for the most part, it is quite similar to the codes of the larger professional organizations (i.e., ACA, APA, and CPA).

Further support to the observation that these counsellors were reportedly monitoring their practices in such a way that demonstrated consistency with the standards outlined in the ethics codes is evidenced in the fact that, in general, these counsellors described the strategies, proactive and reactive, that represent the expectations, responsibilities, or duties of the mental health practitioner as outlined in the codes. It is beyond the scope of this paper to review and consider all of the standards of each of the three codes as they relate to present findings. However, in general, when reviewing the codes, there was nothing in them that failed to correspond to participants' descriptions of the areas to which they attend or the strategies by which they monitor their ethical
practice. What did surface during this perusal of the codes were omissions in the codes of some of the monitoring strategies cited by participants in this study.

The strategy, considered to be proactive, of expanding self-awareness (mentioned by all of the participants in this study) was cited in two ethics codes; both the APA (1992) and the CPA (1991) documents contain statements similar to section II.10 of the CPA: “[psychologists] evaluate how their own experiences, attitudes, culture...and stresses influence their interactions with others, and integrate this awareness into all efforts to benefit and not harm others.” I am left curious as to why the ethics code of counsellors, a profession that seems to place a high value in heightened self-awareness, would not also incorporate this expectation into their standards of practice.

Again, the proactive strategy (as classified by the researcher) of “self-care” was mentioned by all of the participants in this study and was not expected to be represented in either of the three codes. However, section II.12 of the CPA (1991) ethics code states that psychologists, “Engage in self-care activities which help to avoid conditions (e.g., burnout, addictions) which could result in impaired judgement and interfere with their ability to benefit and not harm others.” It seems to me that, in recent years, the mental health professions have begun to develop an appreciation for the importance of self-awareness and self-care as important aspects of both ethical and good practice. I am thus curious as to why the ethics code that was most recently revised, the ACA (1995), does not include either of these as components of ethical practice.

A third strategy thought to be characteristic of the proactive component of the monitoring process that was mentioned by most participants in this study, to engage in regular informal and formal consultation, was again represented only in the CPA (1991) ethics code, which states that it is the responsibility of the individual psychologist “to
assess and discuss ethical issues and practices with colleagues on a regular basis.”

Each of the three codes include the expectation that the practitioner seek consultation when an ethical concern arises, but only that of the CPA speaks about assessing and discussing ethical issues on a regular basis.

Of those proactive strategies that were mentioned by only a few of the participants, only that of doing a routine check-in with clients was included in the ethics code of the ACA (1995). The remaining strategies of ensuring that the client has a GP; imagining one’s client watching over one’s shoulder when writing case notes; asking one’s client to assist with the monitoring process; or including a half hour between sessions to reflect and complete case notes were not mentioned in any of the codes. Given the specific nature of these strategies it is not surprising that they would not be included in the ethics codes. Perhaps this exclusion of specific ways to actualize some of the aspirations of the codes, in a day-to-day manner, might be something worth considering when revising the ethics codes especially considering the common critique that the codes are written in such general terms that interpretation and application to practice can pose a challenge (Cooper, 1992).

An interesting pattern in regards to the strategies considered by the researcher to be reactive is that, for the most part, the strategies were included in all three of the ethics codes with the exception of the strategy to discuss concerns with clients. However, this strategy was alluded to in the ethics code of the CPA (1991) which states, in the “ethical decision-making process” section of the code, that psychologists are to take responsibility and correct negative consequences if they make an ethical mistake. Perhaps one such way of taking responsibility and ameliorating the damage might be discuss one’s mistake with their client.
The above discussion has several implications. The first is that some practitioners do seem to be aware of and are monitoring themselves in relation to the ethics codes of the mental health professions. This observation lends support to the supposition that the codes can serve to both heighten practitioners’ awareness and guide them both in terms of acceptable and unacceptable behaviors. Second, some of the strategies cited by research participants were not consistently mentioned in the ethical codes. This suggests that these counsellors may be monitoring themselves “over and above” the required standards. Third, the ethics code of the CPA, and not those of the ACA or the APA, included several strategies that were considered by the researcher to be proactive. Perhaps members of the CPA conceptualize ethical practice as more of a proactive process than do members of the ACA and the APA. Fourth, given the exclusion of several of the specific strategies considered to be proactive from the three ethics codes, perhaps consideration of more detailed strategies relating to day-to-day ethical practice might be considered when revising the ethics codes. And, lastly, the most convergence both within the participant sample, between the ethics codes, and between the codes and the current results is found in relation to those strategies considered to be reactive components of the monitoring process. Perhaps this pattern reflects an underlying assumption within the mental health professions, in general, that ethical practice is best approached in a “deal with it as it happens” manner.

Implications for Research

In addition to reflecting the points at which the ethical codes of the ACA, APA, and CPA seemingly converge, the domains in which the participants stated that they self-monitor their ethical practice also demonstrated much similarity to those areas of the ethical codes in which practitioners’ transgressions most often occur. The ethical
transgressions tend to cluster in the following areas: informed consent; confidentiality; dual or conflictual relationships; financial relationships; and competency issues, which includes practicing outside of the limits of training, misuse of tests, practicing while physically or mentally impaired, and failure to diagnose, treat, or refer a client (Hayman & Covert, 1986; Peterson, 1996; Pope & Vetter, 1992). Those areas that were not repeatedly mentioned by the participant sample (i.e., financial relationships and misuse of tests) were, however, stated by a few counsellors. Perhaps these areas were only mentioned by a few as they are more pertinent to some more than other work settings (e.g., private practice vs. agency). The overlap in the present findings with the documented areas in which practitioners have ethically transgressed suggest one, that this sample were aptly attending to the appropriate areas and two, that the documented areas in which ethical transgressions occur do seem to be the areas that conscientious practitioners realize to be potential “trouble spots.”

According to the reports of the APA Ethics Committee (1997; 1996) of the areas in which ethical transgressions cluster, in relation to the APA code of ethics, the two most frequently occurring are dual relationships and counsellor competency. Although dual relationships seem to be the most frequent, and thereby have received the most attention within the literature, for the counsellors interviewed in this study it seemed that monitoring their competency was the central area of concern pertaining to day-to-day ethical practice. All of the counsellors did discuss how they have monitored their practices in relation to dual relationships though they did not seem to find resolution of these concerns to be particularly challenging. For example, several counsellors described situations that they had encountered in the past (e.g., counselling a friend of a friend, being invited to social events by clients, teaching a former client) and then described their
particular strategy for ensuring that they kept the therapeutic boundary in place, either by avoiding the second relationship or keeping the interaction to a minimum and doing their best to preserve the boundaries of the counselling relationship outside of the context of the therapeutic environment. Monitoring their competency, particularly attending to monitoring that the needs and reactions of the counsellor did not override that of the client, seemed to receive the most consideration and pose the greatest challenge when monitoring their day-to-day ethical practice. (Though presented separately in the previous chapter, preventing intrusion of counsellor needs and reactions was described as being closely related to both competency and doing no harm.)

As stated throughout this paper, no studies to date have explored the area of self-monitoring ethical practice. However, present findings do have implications in relation to the key topics that have been investigated in the area of ethical practice. One trend that was observed in this study, that relates to previous studies, pertains to my sense that participants in this study essentially had to do what they believed they should regarding bringing the ethical codes and standards to life in their daily practice. It seemed to me as though their conscience would not “let up” until they followed through with what they knew they should. This hunch is rooted in the statements made by several participants in which they explicitly said that, if they didn’t confront something or follow through with implementing some aspect of their ethical conception, the result would be something to the effect of “it eats away at me” or “I get really guilty.” It appeared that the only way to “let go” of what was “eating away” at them seemed to be to do what they knew should be done. This observation contrasts with the well documented finding in the literature that practitioners, as a group, report doing less than they know that they should in terms of practicing in line with the ethical codes and standards of practice (Bernard & Jara, 1986;
Smith et al., 1991; Welfel & Lipsitz, 1984; Wilkins et al., 1990). Perhaps this distinction between this participant sample and the documented tendencies of a typical practitioner indicate that one aspect of what sets the exceptional practitioner apart from the average might be some drive, or need, to act as they know they should; or, perhaps there is some internal factor that makes them somehow less capable than average practitioners of operating below the ethical standards to which they subscribe.

Another trend in the findings of the current study is that consultation with resources, such as colleagues and ethics codes – previously demonstrated to be helpful resources when faced with an ethical dilemma (Gibson & Pope, 1993; Haas et al., 1986; Hayman & Covert, 1986; Pope et al., 1987) – were considered by these participants to be useful in maintaining day-to-day ethical practice. Considering the role of consultation with colleagues as it relates to the proactive monitoring process, all but one of the counsellors reported that they engaged in regular formal consultation and some also attended regular informal meetings with peers. In regards to what was conceptualized as the reactive component of the monitoring process, all of the participants spoke about consulting with others such as co-workers, contracted supervisors, work-place supervisors, lawyers, police, SAFER, visiting professionals, staff at resource center at workplace, representatives of their professional organization, or their internalized role model when faced with an ethical question or concern.

Participants cited the strategy of consultation with others in a manner that was considered to be both reactive and proactive; however, such was not the case for consulting the ethical codes. Pertaining to the proactive process, several of the participants stated that they regularly reviewed the ethical codes or routinely educated students or co-workers on the formal codes. (Several participants also stated that they
routinely kept abreast of new techniques and theories and reviewed the latest legislation pertaining to ethics.) Interestingly, in regards to the reactive monitoring process, not one participant stated that he or she consulted with the ethical codes when faced with a particular ethical concern or question. This finding is in contradiction to the previously documented value that such documents seemed to have for practitioners when faced with an ethical dilemma. Possibly the participants interviewed in this study simply did not mention consulting the codes as a reactive strategy. Or, perhaps they had internalized the codes to the extent that they were familiar with them and had no need to consult the actual document for further guidance. Or, it is possible that in relation to the day-to-day ethics of practice the codes are not considered to be particularly helpful in assisting the practitioner.

Present findings both parallel and possibly extend the results of previous studies that have surveyed practitioners on helpful resources in relation to encountering an ethical dilemma. Findings are similar in that ethics codes and colleagues were, in general, cited as helpful in both maintaining day-to-day ethical practice and in resolving ethical dilemmas. Previous findings are extended in that the ethics codes are seemingly only helpful in the proactive components of self-monitoring day-to-day practices and seem to provide little assistance in terms of reactively monitoring day-to-day ethical practice. Given the finding that the ethics codes are regarded to be useful when faced with an ethical dilemma (Gibson & Pope, 1993; Haas et al., 1986; Hayman & Covert, 1986; Pope et al., 1987), I wonder if they may be more helpful when faced with a large scale ethical dilemma than when one encounters a smaller day-to-day ethical decision as no participants in the present study stated that they utilized the ethics codes in reaction to an ethical situation. Participants’ descriptions contribute to this area of research as several
other sources besides the ethics codes and colleagues were considered to be helpful in regards to maintaining day-to-day ethical practice (e.g., internalized role model). Perhaps these additional resources might also serve to be helpful in the resolution of ethical dilemmas.

The interaction between individual characteristics of the practitioner and ethical practice represents another area in which present findings lend some support to previous studies. Some authors have commented on the impact of various counsellor virtues (e.g., prudence, integrity, respectfulness, and benevolence) or level of cognitive moral development as impacting upon ethical practice (e.g., Meara et al., 1996; Pelsma & Borgers, 1986; Neukrug et al., 1996). In this regard, no comment can be made as to how such factors may affect the monitoring process as these variables were not measured in the present study. However, some of the observable factors that previous studies have shown to affect practitioners' ethical practice can be reviewed. Such variables include counsellor experience, sex, theoretical orientation, work setting, client population, counsellor age, and concentration of degree (Gibson & Pope, 1993; Haas et al., 1988; Kimmel, 1991; Pope, et al. 1988; Pope et al., 1987; Schwab & Neukrug, 1994; Sherry et al., 1991). For the most part, this sample was generally homogenous in both their characteristics and in their descriptions of the monitoring processes, thus the following review is best considered as tentative hypothesizing.

Practitioner experience was the main factor that seemed to account for variation in participants' descriptions, particularly in regards to the evolution of the monitoring process. As previously stated, several of the participants had reportedly become more proactive with experience and sought to continue evolving in that direction. The two participants with the least experience in the group focussed more on the manner in which
experience had effected the reactive component of the monitoring process (although they, too, spoke about wanting to become more proactive). Perhaps the practitioner initially hones his or her ability to recognize and manage ethical concerns as they arise, eventually becoming secure and confident in the immediacy of monitoring ethical practice. The more experienced practitioner, after developing confidence in the reactive component of the process, may then begin to implement more proactive strategies recognizing the role that he or she can play in preventing ethical concerns from arising.

Another factor that may have accounted for a particular variation in participants’ descriptions was counsellor sex. Again, this possibility is based on responses from only two male counsellors thus it is presented, and should be received, as simply a hunch. Both of the male counsellors that participated in this study, when speaking about monitoring their “stuff,” spoke about the fact that they can not be fully aware of all that is occurring in the counselling session. There was some concern about the manner in which they might be unknowingly abusing their power or favouring their needs over that of the client. Although possibly a concern for the female counsellors as well, it was not articulated to the degree that it was by the male participants. As a result, I found myself wondering what part, if any, gender role socialization might play in self-monitoring one’s ethical practice.

Regarding additional practitioner characteristics that may interact with the monitoring process, the following linkages are presented even more tentatively than those above as the support is founded in a small number of participant responses. However, as they may be kernels eventually leading to future research they were considered worthy of inclusion. The first slight interaction relates to theoretical orientation as it may have accounted for a few differences concerning the domains in which the counsellors
monitored themselves and what they perceived to be a cue setting the process in motion. One example of such a cue was the concern mentioned by two counsellors for monitoring their balance between supporting and challenging their clients. One counsellor in the follow-up interview said that, in his opinion, such a concern represented an aspect of theoretical orientation as opposed to ethical practice. As well, one participant spoke about the importance of finding a theoretical orientation to which she aligned herself in terms of defining the ideals and domains in which she was monitoring her ethical practice. Work setting (i.e., agency, private practice, EAP) and client population (i.e., adults/children, couples/singles) also may have accounted for slight variation in participants’ descriptions of the domains in which they attended when monitoring ethical practice. For example, one counsellor spoke about monitoring confidentiality as it pertained to information sharing with co-workers, and two counsellors stated that they monitored their alignment with a couple. Nothing notable was observed pertaining to area of concentration of degree or counsellor age.

**Implications for Future Studies**

The current research findings, in my opinion, challenge the manner in which the topic of ethical practice has traditionally been approached and suggest a multitude of directions for subsequent studies to explore. Before addressing these points, however, an essential “next step” concerning the research in this area will be addressed. This next step pertains to what Guba (1981; in Krefting, 1991) has termed “consistency.” Consistency, in qualitative research, refers to the extent to which present findings would be consistent with future findings were the study to be replicated. One of the ways that have been suggested as a means of increasing the consistency of qualitative data involve using multiple researchers or a research team in data collection or data analysis (Krefting,
1991). As this study was conducted and analyzed through the lens of a single researcher it is possible that results might not prove to be consistent with future findings. Therefore, one of the first steps for subsequent studies in this area would be to investigate this topic either utilizing the perspectives of several researchers or replicating the current study as a means of assessing the consistency of current findings.

The present research findings challenge the manner in which the area of professional ethics has traditionally been researched. To date, the body of the literature in the area of ethical practice consists primarily of theoretical position papers (Fuqua & Newman, 1989; Welfel & Lipsitz, 1984). Additionally, of the relatively small number of empirical studies that exist, few have attended specifically to the application of ethics in counselling practice (Bernard & Jara, 1986; Robinson & Gross, 1989). It is hoped that the present findings perhaps illuminate the value in investigating the extent to which theories of ethical practice and proposed interventions dynamically relate to counsellors' experiences. The current findings, for example, suggest that 1) some counsellors do seem to be monitoring their ethical practice (suggested by many as essential to ethical practice as cited in Table 1); 2) Kitchener's (1984) theory of ethical justification may relate to day-to-day ethical practice; 3) Tennyson and Strom's (1986) conception of the qualities of a responsible practitioner may be identifiable in actual counsellor behavior; and 4) the strategies suggested by Watkins (1983) and Welfel (1998) are utilized and seemingly are considered to be helpful when self-monitoring ethical practice. Current findings potentially make a contribution to extending the theory in this area as well by expanding upon the repertoire of the potentially useful monitoring strategies and demonstrating that there may perhaps be a developmental component to the self-monitoring process.
A second characteristic of previous research in this area has been the predominant focus on the resolution of ethical dilemmas (Fuqua & Newman, 1989). The present findings challenge the notion that such a disproportionate focus on ethical dilemmas, as opposed to day-to-day ethical concerns, is warranted. Results of this study demonstrate that practitioners’ do seem to be regulating their ethical practice on a day-to-day basis, thus suggesting that this is an aspect of ethical practice worthy of further inquiry. In addition, several authors have noted that ethical dilemmas are infrequent in occurrence (Haas et al., 1986; Hayman & Covert, 1986). Considered together, it seems long overdue that studies begin illuminating patterns, areas of neglect, domains, cues, challenges, and resolutions as they pertain to what may be considered the more mundane but, in my opinion, no less important, daily aspects of ethical practice.

A final characteristic of the research in this area is the favoured design of forced choice pencil and paper surveys (Welfel & Lipsitz, 1984). It is proposed that the results attained in this study might provide further justification for the recommendation made by Welfel and Lipsitz (1984) that research in this area utilize more complex research designs. As the present findings were based on counsellors’ descriptions, a potentially rich initial description that is grounded in practitioner experience of the monitoring process was attained. Utilization of the interpretive descriptive research paradigm (Thorne et al, 1997) resulted in a description that captured both the common and unique components of the process. Additionally, as this appeared to be the first time that participants had spoken in such detail about their ethical practice, it seemed that the process of engaging in a discussion was somewhat essential in attaining a detailed description of the process. For example, occasionally participants might be stuck and draw a blank. At such times the researcher would pose a question such as, “Can you tell
Reflecting on such questions seemed to foster additional articulation of aspects of the monitoring process. I suspect that, were these counsellors to receive a forced-choice survey on self-monitoring their ethical practice, the resultant description of the process would likely be embedded predominantly within the researchers’ conception of the process and many of the details and complexities of the process would be lost or overlooked.

Future research might utilize the present findings as a springboard from which to design subsequent studies, as there are numerous possibilities. For example, it would be of interest to do a follow-up study with the present sample of counsellors to explore if participating in this study had any long term effect on their ethical practices. As well, further exploration into the area of what sets the exceptional practitioner apart from that of the average counsellor in terms of self-monitoring ethical practice might prove to be meaningful. Alternately, it might be of interest to isolate the factors that interfere with one maintaining their day-to-day ethical practice. Another area of future inquiry might be the manner in which the monitoring process is affected by the traits, characteristics, or developmental levels of the counsellors. Subsequent research might attend specifically to the manner in which experience impacts the monitoring process – perhaps there are developmental stages as hypothesized by the researcher. As this research represents an initial description of a process that up until this point has remained ill-defined, the directions in which future studies could go is limitless. The above suggestions represent but a few possibilities.

**Practical Implications**

**Counsellor training.** In regards to counsellor training, the present research findings support several recommendations. The first relates to the counsellors’ reports
that many of them did not receive feedback regarding their ethical practices while attending an accredited counselling program. As many of the counsellors spoke of struggles and challenges regarding their day-to-day ethical practices, it is likely that such struggles were observable when they first began their counselling training. My hunch as to why they did not receive feedback in that regard is that perhaps the instructors subscribed to the notion, so prevalent in the literature, that ethical practice is predominantly concerned with resolution of ethical dilemmas. As it is hoped that results from this study helped substantiate that ethical practice includes a day-to-day component, one recommendation for counsellor training would involve helping to foster such an appreciation in beginning counsellors. Stemming from this suggestion is the recommendation that students receive feedback pertaining to the more subtle dimensions of their ethical practice.

A second recommendation for counsellor training relates to that stated above and involves clearly drawing a connection between the ethics codes and daily practice. In the follow-up interview, one of the counsellors made the comment that he would find the codes to be more useful, if in his training or at present, he had the opportunity to engage in a dialogue in which the link between daily practice and ethics codes was discussed and considered. To illustrate how such a process might be incorporated into counsellor training, consider section A.1.a (Primary Responsibility) of the ACA Code of Ethics (1995) which states, “The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients.” Considering and engaging in a discussion on the subtle and dramatic ways that one could violate this section might assist with the counsellors’ eventual monitoring of their practices in regards to this particular section. Many of the participants in the present study spoke about needing to be aware of and
monitor some particular tendency or character trait in order to stay within the confines of ethical practice. Some such examples included, "pushing my agenda," "inappropriate self-disclosure," "rescuing clients" and "wanting to be liked by clients."

Perhaps stimulating reflection on some of the traits or tendencies that represent the areas in which the beginning counsellor will have to be particularly alert in order to ensure that he or she can actualize aspects of the ethics code might also make a contribution to future monitoring of ethical practice.

A third recommendation for counsellor training is that students be presented with an ideal representation of "the self-monitoring practitioner." It seems to me that students have a template of "the empathic practitioner" or "the challenging practitioner" which can serve to provide direction in which to focus one's learning. Perhaps such a representation of self-monitoring would clarify what it means to self-monitor ethical practice and how it is accomplished. As a beginning counsellor myself, having an image of the ideal would provide me with more confidence going into the field as I would know exactly what is involved, the part that I play in maintaining the standards, and I would be better equipped to incorporate various strategies that assist with the process into my practice. Conducting this research has, in fact, served this function for me: After speaking with experienced counsellors about their self-monitoring process I have a much clearer sense of what my responsibilities are and how to go about regulating and maintaining them. I suspect that such would also be the case for other beginning counsellors if this information was disseminated in training programs. Many of the counsellors in this study spoke about "learning as you go," "trial and error," and "making mistakes." I wonder what difference having a clear sense of what monitoring ethical
practice entails before entering the counselling field might make regarding the quality of care received by consumers of mental health services.

A fourth recommendation pertains to the cues that were described as setting the process in motion. Educating counsellors on such cues and fostering their recognition of them would likely improve their future abilities to monitor their ethical practice. In the follow-up interview, one of the counsellors, when describing the shift in her reactive monitoring process that came with experience, spoke about her improving recognition of internal and external client-driven cues. In particular, she spoke about recognizing that clients do evoke feelings in her. This counsellor stated that, in her training, she was implicitly instructed that she was not to have feelings about clients thus she did not allow herself to recognize her reactions for some time. When describing this shift, the counsellor referred to a client with whom she had terminated counselling earlier than might have been in the client's best interest because she was having adverse feelings toward this particular client. She said that, at the time, she was not aware of the reason, she had not recognized the internal cue; however, in retrospect, she was confident that she terminated early because she didn't like the client. It is hoped that the above illustration of one counsellor's experience lends some support to the recommendation that students be educated and their recognition regarding counsellor, client, and other driven cues be fostered in counsellor training. The above example also demonstrates the cost in reduction in quality of care when such cues are missed.

The last implication to be addressed is in relation to the questions proposed by Welfel (1998): "What damage have I done and how can I undo or ameliorate that damage?" and "What steps should I take to ensure that I do not repeat this mistake?" As previously stated, the counsellors in this study did ask themselves questions to that effect
when they had erred and this seemed to prove helpful. Equipping counsellors-in-training with a "what to do if" intervention has a two-fold benefit. One, it normalizes ethical mistakes as a part of ethical practice (i.e., we're still human and make mistakes from time to time), which in my opinion contributes to having open conversations about refining our ethical practices. Two, it demonstrates that the damage might be lessened by taking a particular action (perhaps utilizing one of Watkins' (1983) interventions) and it makes clear that the practitioner can play a role in ensuring (i.e., monitor) that such a mistake does not occur in the future.

**Practicing counsellors.** In addition to contributing to the area of counsellor training, the present research findings have implications for existing members of the counselling profession as well. For example, one trend in participants' responses was the beneficial impact that reflecting on the totality of their ethical practice seemed to have for them. For most, this reflection generally gave rise to feelings of pride as they realized how conscientious they were. As well, the process of engaging in such a reflective and descriptive conversation about their ethical practice was said by some to initiate additional reflection (after the initial interview) and reportedly heightened their awareness of the role that they play ensuring that their practice is ethically sound. Possibly, such a routine reflection on ethical practice could be incorporated as a requirement for continued participation in the field of counselling in the same way that some professional organizations require additional training to maintain membership.

For example, to maintain membership with the BCACC one must attend a minimum of 20 hours of professional training each year and show appropriate documentation of such. Could not a requirement also be to submit documentation that one had met with a supervisor and engaged in a two-hour conversation in which their
ethical practices were reviewed? Alternatively, perhaps the BCACC could adopt the professional membership requirement of the Registered Nurses Association of British Columbia (RNABC) in which practitioners are required to complete a self-assessment form each year in which they reflect on their performance in relation to the six ethical standards of nursing practice. Such a routine reflection, either in a self-assessment form or a dialogue, would likely heighten counsellors’ awareness of their day-to-day ethical practice as well as provide an opportunity for improvement as their attention may be drawn to an area of weakness. Such an approach would be following the lead of some other Canadian provinces (e.g., Alberta and Quebec) that have implemented a more preventative professional regulatory approach that involves formally instituting consultation and practice reviews in order to monitor professionals and promote education and professional development on an ongoing basis (Pettifor & Sinclair, 1991).

Another trend in participants’ responses was observed in the follow-up interviews: the counsellors appeared to be quite interested in learning about the other counsellors’ monitoring of their ethical practice. This eagerness struck me as somewhat odd as I found it surprising that these counsellors, who were nominated as being particularly knowledgeable and conscientious, did not have a clear sense of what they should be doing to monitor their ethical practice. To me, this suggests that an exemplary model of what self-monitoring ethical practice entails is both information that experienced counsellors want and, in my opinion, should have. Ideally, such information is best presented in one’s training program; however for current members of the profession, perhaps such a portrait of “the self-monitoring practitioner” could be disseminated through professional organizations such as the BCACC. In my opinion, it seems less likely that the average counsellor would be self-monitoring their ethical
practice to the extent that perhaps they should be if they are not even aware of the
direction in which they should strive.

The last point to be made in regards to implications for current members of the
counselling profession pertains to a trend also evidenced in the follow-up interview. In
general, these participants seemed to be quite open to incorporating into their practice
what they saw another to be doing. Although most of the counsellors stated that, in
general, they did everything that was mentioned (pertaining to their work setting and
client population), some counsellors did come across one or two strategies that they did
not use and they informed the researcher that they planned to incorporate them into their
day-to-day ethical practice. For example, one counsellor said that, after receiving the
research summary, he incorporated the strategy mentioned by another counsellor to
imagine one’s client standing over one’s shoulder while writing case notes. He reported
that he found this strategy contributed to writing respectful case notes. Although one
might think that recognizing something that was missing in one’s practice might give rise
to feelings of inadequacy or defensiveness, such was not the case for most of these
participants. As previously stated, these counsellors seemed to possess both an openness
to learning what others were doing as well as a desire to refine their practices by
incorporating strategies used by others. Given the previous finding that one characteristic
that sets the “master therapists” apart from the average is that they are “voracious learners
who are open to experience and nondefensive when receiving feedback...” (Jennings &
Skovholt, 1999 p. 9) it would be of interest to explore how typical these traits, as they
pertain to ethical practice, are of counsellors in general.
Limitations of the Study

The results of this study and subsequent implications should be considered in relation to the following five limitations. The first limitation pertains to the composition of the participant sample which may limit, what has been termed by Guba (1981; in Krefting, 1991), the transferability of research findings to counsellors in general. Krefting (1991) states that “a key factor in the transferability of the data...is the representativeness of the informants for that particular group” (p. 220). Although this group did show some variation along some dimensions (e.g., theoretical orientations and work settings), for the most part, they were likely more homogeneous of a group than might be representative of counsellors in general. Three additional factors may also limit the transferability of research findings to counsellors in general.

The first factor is that participants’ descriptions might only be representative of the manner in which graduates from the UBC Master’s program self-monitor their ethical practice. However, given the unexpected finding that many participants stated that they had received minimal to zero feedback on their ethical practice it seemed that their training had little effect on the development of their monitoring of ethical practice. A second characteristic of this sample that may limit the transferability of findings to counsellors in general stems from the fact that those who contacted the researcher after receiving the initial letter, and were thus willing to discuss monitoring ethical practice, might be characteristically different from those who were unwilling to have such a conversation on their ethical practice. And lastly, as these counsellors were nominated, based on a former professor’s perception of their suitability, they may be more knowledgeable and conscientious concerning ethical practice than are the general population of counsellors. Although the present description of the self-monitoring
process may not be transferable to counsellors in general, the central intention in conducting this research was to begin, rather than conclude, the process of defining an essential aspect of ethical practice. Therefore, despite the limitations pertaining to transferability, current findings contribute to what is hoped to be an ongoing area of future investigation.

A second possible limitation is linked to the relatively stable finding in the literature that practitioners report doing less than they know that they should regarding ethical practice (Bernard & Jara, 1986; Smith et al, 1991; Welfel & Lipsitz, 1984; Wilkins et al, 1990). Considering the stability of this finding, it is possible that the description of the monitoring process might more closely resemble the ideal, or what practitioners think that they should be doing, rather than what they actually are doing. My supposition, based on the participants' reports and my intuitive sense when conducting the interviews, is that, excluding the occasional "bad day," the counsellors were describing what they do as they best as they could articulate it. However, even if the description is somewhat inflated, in light of the fact that the self-monitoring process, as it relates to ethical practice, has not yet been articulated, a description of the ideal is still be a significant contribution to the literature in this area.

A third limitation pertains to the possibility that the attained description was somewhat superficial or simplistic, which could be a function of one or both of the following factors. Although five of the counsellors said that they had considered the role that they played in monitoring their practices prior to being contacted by the researcher, it was my sense that this interview represented the first time that these counsellors had reflected to this extent or described to another their overall sense of what constituted ethical practice and subsequent monitoring strategies. The second factor that may have
led to a superficial description relates to the all-encompassing nature of the research question, which asked participants to describe the totality of their ethical practice. With a topic as complex as ethics, it may be unrealistic to ask counsellors their ethical beliefs, practices, and monitoring strategies in one interview. Considered together, these two factors suggest that the description of the monitoring process and the various components presented in this study may be best considered as an outline or initial sketch of the monitoring process. However, despite this limitation, several unexpected regularities in participants’ descriptions of the self-monitoring process did emerge. For example, all of the participants mentioned both reactive and proactive monitoring strategies and each counsellor spoke of the evolution and development of the monitoring process. As a means of possibly attaining a more complex, and extensive description of the monitoring process future researchers might attend to a particular aspect of ethical practice (i.e., not the totality) and/or employ a research design in which participants engaged in several discussions or kept journals in which they regularly recorded something pertaining to self-monitoring.

The fourth limitation pertains to the raw data being filtered through the lens of the researcher. This limitation relates to the previous discussion on the consistency of research findings. It is possible that, if presented with the same information, another individual may have conceptualized the monitoring process differently. While conducting the follow-up interviews, I was initially quite pleased to hear participants make comments such as, “That’s not the words I’d use but that’s what it is” or “You’ve given it a language.” However, these comments lingered such that I subsequently found myself wondering, “How might the language (literal and figurative) of another have effected the research findings and ensuing description of the monitoring process?” In recognition of
this limitation, it is hoped that the understandings, descriptions, and conceptions as presented by the researcher will at the least contribute to this area by providing an initial articulation from which future researchers can challenge, redefine, or clarify the present description of the self-monitoring process as it pertains to ethical practices.

A final factor that may limit research findings involves the manner in which the process of self-monitoring ethical practice was conceptualized by the researcher in relation to Kitchener's (1984) model of ethical justification. Prior to beginning this study it was thought that the self-monitoring process might be best understood in relation to the critical-evaluative level as the process was thought to involve a purposeful, thoughtful consideration and evaluation of the implications of behavior and decisions in relation to the ethics codes and principles. During the interview process, however, several participants made some mention of the difficulty of articulating the process describing it as "automatic," "a habit," or something that "just happens." These statements seem characteristic of the intuitive level of Kitchener's model. The design of this study, a retrospective verbal report of what one does, was not conducive to gaining an understanding of the elements of the process that were more intuitive in nature. Therefore, the description of the process as presented in these findings may be more heavily weighted toward the critical-evaluative level of the self-monitoring process than is perhaps accurate.

**Conclusion**

Although the descriptions and conceptualizations of the self-monitoring process presented in this paper are best considered with the above limitations in mind, present findings do provide an initial first look at a process that is considered within the literature to be essential to ethical practice (Pettifor, 1996; Pope et al., 1987; Van Hoose & Kottler,
Up until now the extent to which practitioners are familiar with this term, and the manner in which the process is engaged in, if at all, has not been documented. As the counselling profession relies so heavily on the individual’s ability to self-monitor and regulate his or her own day-to-day ethical practice it is hoped that the present inquiry into this topic area, the description and articulation of the process and the consideration of the implications of research findings, will potentially impact upon the knowledge and practice in this area in the following ways. One, articulation of the monitoring process might assist in further reducing the risk of ethical transgressions and harm to clients. Two, descriptions of the process might contribute to the development of means by which to teach, enhance, and regulate that individual practitioners are, on a day-to-day basis, practicing within the boundaries of ethical practice as defined by the counselling profession. Three, present findings illuminate the complexities involved in both the day-to-day component of ethical practice and the process of self-monitoring. Four, current findings make a contribution to the limited existing knowledge in the area of application of ethics into practice. And lastly, it is hoped that results attained in the present study encourage future authors to investigate and expand – either in terms of theory, research, or practice – what is known about the application of ethics into practice.
REFERENCES


Canadian Guidance and Counselling Association (1989), Guidelines for Ethical Behavior.


APPENDIX B

Initial Contact Letter to Counselling Psychology Professors

Dear Professor,

I am a Counselling Psychology Masters student at the University of British Columbia and am conducting thesis research on counsellors’ self-monitoring of their ethics of practice. My research will involve interviewing counsellors about their experience engaging in this activity and the qualitative methodology I am using requires that I solicit nominations of former counselling psychology masters students. I am requesting your assistance in nominating former students that you think would be comfortable engaging in a candid interview on the topic of self-monitoring ethical practice.

Within the literature the activity of self-monitoring is frequently regarded as essential to ethical practice. However, there has been no research on counsellors’ awareness of the term, what it means to self-monitor, or how often or in how many ways individuals engage in the process. I plan to use the interviews with recent graduates in hopes of contributing to our knowledge in this area.

The participants that I hope to recruit, and whom I would ask you to nominate, would be graduates of the Counselling Psychology Masters program who meet the following criteria:

1. at least two years post-graduation counselling experience
2. basic familiarity with the formal ethical codes and standards of practice of the counselling profession
3. self-reflective
4. residents of the Lower Mainland or Fraser Valley
APPENDIX C

Initial Contact Letter to Participants

Dear (name of nominated counsellor),

I was recently contacted by Tara Stoll, one of our Counselling Psychology Masters students, who asked me to recommend former students to be interviewed for her thesis research. The title of her project is Counsellor's Self-Monitoring of Day-to-Day Ethical Practice. Tara is interested in speaking with former students that I, and other professors, believe to be good candidates to speak on this topic. As I know you to be self-reflective and aware of the ethical codes and standards of the counselling profession, I thought that you would be an excellent candidate.

When meeting with Tara only your first name was disclosed thus, at this point, she is unaware of your complete identity. This letter was addressed and mailed by the department receptionist. Your full identity will be known to the researcher only if you decide to participate in the study and contact Tara.

Participation in this study would involve approximately one hour of your time, plus a half hour follow-up interview. All of the information that you share will be kept confidential and, were you to participate, you would be free to disengage from the interview at any point. The purpose of the interview is to attain a description of the unique way that you self-monitor your ethical practice. In appreciation of your participation upon completion of the study Tara will offer you a tool, in the form of a questionnaire, that may further contribute to your self-monitoring practices.

If you have at least two years one-to-one counselling experience post graduation, are familiar with the ethical codes and standards of the profession, are open to discussing the
APPENDIX E

Orienting Statement

Before beginning the interview I'd like to ask you to think back to your practitioner experience in the counselling psychology program when, as a beginning counsellor, you were monitored by your professors, your classmates, and later by your practicum supervisor. Although each student's experience is unique, the feedback that you received from these individuals likely focussed on both your counselling skills (e.g., empathic responses) and on your ethics of practice. In terms of your ethics of practice, you may have received feedback concerning common procedural standards such as attaining written permission to speak with another professional about your client or something pertaining to the limits of confidentiality.

Other times, you may have received feedback about your ethics of practice that were perhaps along more subtle lines. For example, you may have received feedback about aspects of the counselling relationship pertaining to such things as the role of your needs and values in the session; the rights and welfare of your client; diversity issues; or the boundaries of the therapeutic relationship. Or, you may have received comments that pertained to your professional responsibility such as practicing within the boundaries of competence (as best as a student can), or the possible influence of your personal experiences, problems or conflicts in the counselling session.

Can you recall such experiences? As you progressed in the program from clinic to practicum the level of external monitoring that you received decreased as you developed the ability to regulate and monitor yourself in regards to both the obvious and the more subtle ethics of practice.
At this point little is known about counsellors’ private experiences with monitoring or regulating their counselling practice in regards to ethics. Thus the purpose of my research is to discover the various ways in which counsellors engage in some sort of monitoring process. There is no “correct” description of this process as what may be effective for one counsellor may not work for another. I am interested in learning, in as much detail as possible, about the manner in which you self-monitor your day-to-day ethical practice, however you chose to define that process. I am also interested in learning more about the particular areas in which you self-monitor.

Throughout the interview I might ask you for more information or clarification in order to ensure that I understand your experience. However, if you become uncomfortable or do not want to answer a question let me remind you that you can pass on that question or disengage from the interview at any time. Do you have any questions before we begin? If not, please take the time that you need for reflection.

You might find it helpful to think back to a typical week in your counselling practice and see if that brings to mind

-- any moments that you were aware of the ethical dimensions or aspects of your practice....

-- your way of self-monitoring that you were being consistent with the ethical codes and standards of practice....

The specific question that I’d like you to answer, when you feel ready, is: WHAT ARE THE WAYS THAT YOU SELF MONITOR YOUR ETHICS OF PRACTICE? When you are ready please begin describing how you think that this happens for you.
APPENDIX F

Specific Questions That Followed Initial Interview

1) What is your personal sense of what constitutes ethical practice? What role do the formal ethical codes and standards of practice play regarding the dimensions along which you self-monitor? Are there other criteria along which you monitor yourself in regards to ethical practice?

2) Prior to being contacted by me and participating in this interview had you given the activity of self-monitoring much thought. If you had, how frequently do you think about it? In what ways? Can you give me an example?

3) What sets the self-monitoring process in motion for you? Is there typically something that occurs that initiates your engagement in this process?

4) How often do you typically engage in the activity of self-monitoring?

5) During the interview how closely did your description reflect what you actually do as opposed to what you think that you should do or what you would like to ideally do?

6) Is there anything else that you would like to add that has come to mind as we’ve talked?