BOUNDARY TRANSGRESSIONS IN THERAPEUTIC RELATIONSHIPS

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(ABSTRACT)

The relationship expected to occur between a therapist and his or her clients is a fiduciary relationship, a relationship of special trust. Professional boundaries ensure that the needs of clients remain primary. However, boundary transgressions are inevitable. Unfortunately, boundary transgressions have the potential of exploiting clients. Most of what is known about boundary transgressions comes from the perspective of professionals. The literature reiterates the importance of educating the lay public about the dangers of boundary transgressions. This study experimentally examined what effect education specific to boundary transgressions has on the lay public's level of acceptance of boundary transgressions, as opposed to what effect general information about personal/family therapy has on the lay public's level of acceptance of boundary transgressions. Two hundred students from a southeastern university participated and read either general information pertaining to personal/family therapy, or specific information pertaining to boundary transgressions, prior to rating their level of acceptance of therapists transgressing boundaries with their clients. Independent sample t-tests determined there were statistical differences in mean ratings of acceptance of boundary transgressions between the groups. However, because the mean scores between the two groups were not much different, the results suggest that the lay public could benefit from a more comprehensive explanation of boundary transgressions.

DEDICATION

I would like to dedicate this thesis to my parents, Lester and Helene Rosenbloom. Thank you for your emotional and financial support throughout my educational journey. Your hard work and limitless sacrifices enabled me to attain my goals.

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TABLE OF CONTENTS

INDEX OF TABLES

INDEX OF APPENDICES

CHAPTER ONE: INTRODUCTION

Therapy helps people who are hurting and in need. People seek therapy to find lost satisfaction and meaning (Nichols & Schwartz, 2001; Pope & Vasquez, 1991). There are several distinctions between the therapeutic relationship and other types of relationships (Nerison, 1992). A deep interpersonal exchange can occur between clients and their therapists because of the highly structured encounter. This exchange is a meaningful connection that is important for the emotional well being of clients so that they feel comfortable and open to discuss personal issues with their therapist. The common goal during this meeting is alleviating clients' emotional suffering. Therapists achieve this by helping clients resolve problems. Therapists are responsible for putting personal issues aside to ensure their clients' issues are the primary focus during the therapeutic relationship. Clients, on the other hand, prepare to disclose personal information that might otherwise remain hidden (Hyman, 2002). The relationship expected to occur between a therapist and his or her clients is a fiduciary relationship. A fiduciary relationship, by law, is a relationship of special trust. In a therapeutic relationship, therapists assume special responsibilities for their clients' behavior that are not a part of everyday relationships (Gladding, Remley, & Huber, 2001; Kagle & Giebelhausen, 1994). The therapeutic relationship often involves regular contact over time with clients sharing their deepest, most profound feelings. These feelings (induced in therapists and clients) carry the potential for evoking actions that are clinically inappropriate, unhealthy, unethical, and illegal. Due to the highly charged, emotionally significant context, the potential for boundary transgressions between therapists and their clients (e.g. hugging a client after the client discloses painful memories, or a therapist disclosing his or her political views) is higher (Atkins & Stein, 1993). This is problematic because the therapeutic relationship may be compromised when therapists transgress boundaries with their clients. Boundary transgressions cause difficulties because when the line between the therapeutic relationship and clients' personal affairs is blurred, it can prevent therapy from reaching it's full potential.

Statement of the Problem

Professional boundaries are rules that establish a professional relationship as separate from other relationships (Frick, 1994). Professional boundaries ensure that the needs of clients (who are vulnerable) remain primary. Therapists set treatment boundaries with their clients

according to accepted professional standards. It is therapists' professional duty to establish and maintain appropriate treatment boundaries with their clients (Simon, 1992). Chadda and Slonim (1998) describe boundary rules ranging from subtle rules (e.g. therapists should not display family photographs in their therapy office) to more obvious rules (e.g. therapists are not to engage in sexual relations with their clients). Mental health professionals define boundaries relating to therapy differently. Such differences may be attributed to therapists' theoretical orientation, the characteristics of their clients, and the therapeutic alliance they establish (Chadda & Slonim; Simon). Boundaries are important because they provide guidelines and structure for safe and successful therapy (Chadda & Slonim; Gabbard, 1996; Pope & Vasquez, 1991). According to Ryder and Bartle (1991), boundaries "foster the growth of relationships, maintain relationships, facilitate desirable and desired functioning, and forestall objectionable relationships." Given the importance of maintaining boundaries, there is a need to examine instances in which therapists transgress boundaries.

Boundary transgressions tend to be conceptualized on a continuum ranging from boundary crossings to boundary violations. Boundary crossings (e.g. accepting an inexpensive holiday gift from a client, unintentionally encountering a client in public, or attending a client's special event) are described in the literature as deviations from commonly accepted practice that may be harmful, helpful, or benign to the therapeutic process. On the other hand, boundary violations (e.g. drinking alcohol with a client, or engaging in sexual relations with a client) depart from accepted practice and place clients, and the therapeutic process, at serious risk (Gutheil & Gabbard, 1993; Simon, 1992). According to empirical findings, sexual boundary transgressions between therapists and their clients are almost always harmful. When therapists become sexually involved with their clients, clients may experience feelings such as depression, betrayal, and low self-esteem. Thus, these relationships are commonly referred to as boundary violations. Non-sexual boundary transgressions tend to be regarded as boundary crossings. However, these boundary transgressions may be just as harmful to clients as sexual boundary transgressions. Non-sexual boundary transgressions are problematic because of their pervasiveness, inevitability, and lack of consensus among mental health professionals regarding their appropriateness. For example, a couple from a small town may need therapy and there is only one therapist within a 300 mile radius. The problem is that this couple owns the only

grocery store in the area, and the therapist is a frequent customer. Would it be ethical for the therapist to deny needed services to this couple? Is it reasonable for the therapist to treat this couple and forego food consumption? These are the sorts of questions that mental health professionals debate. In addition, subtle boundary crossings are problematic because they tend to consistently lead to more adverse boundary transgressions.

Boundary transgressions have the potential of exploiting clients and impairing therapists' professional judgment (Corey, Corey, & Callanan, 1998). As a result, the therapeutic relationship between therapists and their clients is compromised. Research concerning this topic discusses how exploited clients experience depression, feelings of betrayal, loss of self-esteem, and suicidal ideation. Thus, therapists are advised to refrain from transgressing boundaries with their clients. However, because they are inevitable, therapists should educate their clients about boundary transgressions during initial therapy sessions, and continuously address such actions when they arise. It is also helpful to let clients express their feelings pertaining to boundary transgressions (Chadda & Slonim, 1998; Corey et. al.; Plaut, 1997).

According to Butler and Gardner (2001), professional codes of ethics are "constitutional frameworks" that guide professionals in their work. Almost all the mental health professions' ethical codes stress the obligation of therapists to be cognizant of the potential harm that may result when boundaries are transgressed. The codes explicitly prohibit sexual boundary transgressions. Yet, ethical codes regarding non-sexual boundaries are general and subjective (Miller & Maier, 2002). This is because they are inevitable, pervasive, and there is a lack of consensus among mental health professionals regarding their appropriateness. For example, professionals are not in full agreement regarding the appropriateness of using first names with clients. Professional code's of ethics inability to decrease the incidences of client exploitation (caused by boundary transgressions) has resulted in state legislatures becoming increasingly involved in professionals' practices.

Most of what is known about boundary transgressions comes from the perspective of professionals. According to the literature, mental health professionals agree that therapists have an ethical obligation to ensure clients or potential clients (in other words, members of the general

public) understand what constitutes appropriate behavior during the therapeutic relationship. However, little knowledge exists regarding the lay public's perspective regarding boundary transgressions, especially non-sexual boundary transgressions, during the therapeutic relationship. If clients are knowledgeable regarding ethical practice, they are able to be vigilant and informed consumers of mental health services (Iosupovici & Luke, 2002). To the extent that therapists can anticipate clients' knowledge gaps concerning ethical issues, therapists can develop more effective ways to fulfill their obligations of informing clients about ethical issues (Claiborn, Berberoglu, Nerison, & Somberg, 1994).

Mental health professionals suggest educating the lay public regarding ethical issues that may arise during the therapeutic encounter. However, there is a paucity of information regarding the effectiveness of educating the lay public about boundary issues. There is only one study, that this investigator is aware of, that exposed potential clients to information regarding ethical behavior, such as multiple relationships, in order to determine if such information could influence potential clients' opinion about ethical behavior (Hardwick, 1999). The literature reiterates that clients' ethical beliefs may not be entirely consistent with the ethical codes that help guide therapists' behavior. Miscommunication results when clients' expectations regarding how therapists should behave differs from therapists' actual behavior. In addition, clients are more susceptible to exploitation when they are unable to understand the ethical codes of therapy (Walden, 1996).

Rationale for Study

Clients play an important role in shaping the therapeutic process and relationship. Mental health professionals agree that clients' ethical understanding is important, and that therapists must increase their understanding of clients' ethical perspectives (Claiborn et. al., 1994; Hillerbrand & Claiborn, 1988). Mental health professionals set standards of practice they believe will help protect clients' welfare and best interests. However, they tend to set these standards without the input of the lay public, who may become consumers of mental health services. When mental health professionals include the lay public's perspectives, they decrease the likelihood of harm to their clients, and increase the opportunities for positive results in therapy. In addition, taking the time to understand consumers or potential consumers

perspectives, regarding therapy, indicates to these individuals that their views are valuable (Herlihy & Corey, 1997, Walden, 1996). Mental health professionals agree on the need for more research examining the lay public's views regarding boundary transgressions. These same mental health professionals suggest the importance of educating the lay public about boundary transgressions, and how they pertain to personal/family therapy. Unfortunately, the many suggestions from these professionals to educate the lay public have not translated into much action. For example, mental health professionals suggest educating the lay public through the Internet and brochures. However, this is not common practice.

The current study is an important addition to the literature because it took the suggestions of professionals, and experimentally examined the effects of educating the lay public. Educating clients about appropriate therapist behavior helps empower clients by informing them of their rights, and ensuring they are treated respectably. In addition, because efforts directed towards informing mental health professionals about the potential dangers of boundary transgressions have not caused a decline in incidences, it may be beneficial to direct educational efforts towards the other participant in the therapeutic relationship- the consumer (Walden, 1996).

Theoretical Framework

The theoretical framework used in this study was post-positivism. The theory of post-positivism developed during the middle part of the 20th century as a modified version of positivism, when the tenets of positivism were deemed untenable. The philosophy of positivism held that observations and measurements were the core of the scientific endeavor, and were infallible. Those who believed in positivism put aside their values and beliefs (because values and beliefs cannot be observed directly), and thought the goal of science was to uncover the truth, or discern the laws of cause and effect, using the scientific method (Guba, 1990).

Post-positivism is a theory that explains that there is a true state regarding how people think, and how the universe operates, but we can never know that state completely. We can only approximate it through objective measurements. Each new piece of data about that state brings us closer to knowing that state of reality. According to this theory, all observations and measurements are fallible. Thus, obtaining multiple measurements and observations, also known

as triangulation, is important in order to approach objectivity. Unlike the theory of positivism, the theory of post-positivism assumes that people are biased due to their values and beliefs, and biases affect observations. Thus, it is important to examine beliefs and values. The saying, "there is more to seeing than meets the eye" resonates well with the theory of post-positivism (Guba, 1990; Trochim, 2002).

Post-positivists reject the idea that people are unable to understand each other because everyone comes from different experiences and cultures. Post-positivists believe that triangulating different perspectives (the perspectives of those with different experiences and cultures) helps us approach objectivity (Guba, 1990; Trochim, 2002).

The theory of post-positivism fits well with the current study. For example, the current study examined the lay public's perspectives in an effort to triangulate (or obtain multiple viewpoints) the data regarding boundary transgressions. Although there is a lot of research concerning boundary transgressions from the perspective of professionals, there are considerably fewer studies that assess the lay public's perspective. Thus, there has been little triangulation regarding the issue of boundary transgressions. As mentioned previously, triangulation helps us approach objectivity. Having different perspectives (in this case, perspectives from the lay public and therapists) provides a better idea about how things are in reality (Trochim, 2002). This study helps us better understand boundary transgressions by adding another perspective, that of the lay public.

Research Question

Is there a significant difference in the level of acceptance of boundary transgressions between participants who receive general information about personal/family therapy (General group), and those who receive specific information about boundary transgressions (Educated group)?

CHAPTER 2: LITERATURE REVIEW

Theoretical Background

What are boundaries? The concept of a boundary is a spatial metaphor that describes and defines a relationship with other people. Boundaries demarcate the lines where one individual stops, and others begin (Gabbard, 1996; Pope & Vasquez, 1991). The importance of helping professionals upholding boundaries dates back at least 2,200 to the Hippocratic Oath, which prohibited physicians from "…all intentional ill-doing and all seduction, and especially from the pleasures of love with women and men." Therapists tend to feel that they understand the concept of boundaries instinctively. However, using it in practice or explaining it to others is more challenging for them (Gutheil & Gabbard, 1993). Chadda and Slonim (1998) describe boundaries as "a spectrum of rules (p. 489)" ranging from subtle rules (e.g. therapists should not address clients on a first name basis) to more obvious rules (e.g. therapists should not date their clients). Chadda and Slonim report that no universal definition of a therapeutic boundary exists. The difficulty in defining treatment boundaries appears to be a function of the nature of the client, the treatment (e.g. behavioral therapy), and the status of the therapeutic alliance (Simon, 1992). For example, an optometrist may not have as much difficulty defining treatment boundaries because his or her job is associated with objectivity, and less intense interactions. Although there is sometimes disagreement about the details of boundaries, or about the conditions under which boundaries apply, no one seems to advocate therapy without boundaries (Ryder & Bartle, 1991).

Smith and Fitzpatrick (1995) conceptualize treatment boundaries as a therapeutic frame. They define this frame as a set of roles for participants in the therapeutic process. For instance, clients are expected to disclose personal information to their therapist, while therapists are to refrain from disclosing personal information. The concept of a therapeutic frame allows a therapist to be empathic and warm, while also creating a sense of safety for clients (e.g. the therapist's warmth is not a precursor to a sexual advance) (Gabbard, 1996; Smith & Fitzpatrick). According to Smith and Fitzpatrick, even though therapists are largely responsible for constructing and maintaining the therapeutic frame, clients' behaviors can influence this frame. For example, a client may feel sexually attracted to his or her therapist and decide to kiss the therapist. Even though the therapist did not initiate the action, he or she is still responsible for

dealing with the boundary transgression. Thus, the therapist should discuss the boundary transgression with the client as a therapeutic issue. It is important to note that clients' boundaries are more "forgiving and flexible" (e.g. a client can be late to a session, however, a therapist should not be late to a session). (Chadda & Slonim, 1998; Gutheil & Gabbard, 1993).

Why are boundaries important? As mentioned previously, therapy is a unique relationship between therapists and their clients in which clients' interests are the primary focus. Boundaries help to ensure that vulnerable clients won't be harmed during the therapeutic relationship. Sigmund Freud was among the first mental health professional to observe the need for structure and safety in therapy. His observations provide the foundation for current views regarding the need for boundaries. He believed that boundaries provide guidelines, and these guidelines ensure safe and successful therapy for therapists and their clients (Chadda & Slonim, 1998). Gabbard (1996) and Pope and Vasquez (1991) discuss how boundaries provide structure in a therapeutic relationship, and how structure is necessary for safe and successful therapy. "Boundaries foster the growth of relationships, maintain relationships, facilitate desirable and desired functioning, and forestall objectionable relationships (Ryder & Bartle, 1991)." Treatment boundaries define and secure the professional relationship between therapists and clients, while promoting a trusting working alliance (Simon, 1999). A feeling of safety, and belief that therapists will act in clients' best interests allows clients to develop trust in their therapist, and to openly express fears and desires without concern over negative consequences. Proper maintenance of boundaries supports clients' autonomy and independence (Smith & Fitzpatrick, 1995). Therapists are ethically, professionally, and legally responsible for establishing and maintaining treatment boundaries consistent with the provision of good clinical care (Simon).

What are boundary transgressions? Helping professionals are increasingly becoming concerned with the effects of boundary transgressions on the therapeutic process. Boundaries between clients and their therapist are regularly transgressed. Smith and Fitzpatrick (1995) suggest conceptualizing boundary transgressions on a continuum ranging from those that pose minimum risk to clients (i.e. boundary crossings), to those that put clients at risk of serious psychological harm (i.e. boundary violations). Boundary crossings, a "nonperjorative" term, describes deviations from commonly accepted practice. These deviations may be harmful or

helpful to the therapeutic process, or they may be relatively benign. Boundary violations depart from accepted practice and place clients, and the therapeutic process, at serious risk (Gutheil & Gabbard, 1993; Simon, 1992). Gutheil and Gabbard refer to a boundary crossing as a descriptive term, neither laudatory nor pejorative. They believe that the impact of a boundary crossing is determined on a case-by-case basis that takes into account the context and situation-specific factors, such as the possible harmfulness it may cause a client. On the other hand, a boundary violation represents a more harmful boundary transgression than a boundary crossing. According to Simon (1999), the disagreement expressed among therapists regarding what constitutes a boundary crossing or violation seems to be a function of the nature of the client, the type of treatment, the status of the therapeutic alliance, and the personality of the therapist, combined with his or her training and experience. At the extreme end of the continuum of behavior it is easy to differentiate between boundary crossings and boundary violations. For example, most people would agree that a therapist giving a client an itemized bill is harmless. In addition, most people would agree that it is harmful for a therapist to have sex with a client during a therapy session. However, the middle of the continuum, or the line between crossing a boundary and violating a boundary, is not always as clear (Miller & Maier, 2002).

Researchers describe many behaviors or activities as boundary transgressions. For example, Smith and Fitzpatrick (1995) describe engaging in dual relationships, physical contact (non-erotic), self-disclosure, and therapist-client sexual contact as behaviors and activities that constitute boundary crossings and boundary violations. Also, meeting after hours, appointments held outside the office, and gifts to or from the therapist are examples of boundary transgressions, according to Iosupovici and Luke (2002).

According to the literature pertaining to boundary transgressions, terms such as boundary crossings, boundary violations, dual relationships, and multiple relationships are used synonymously with the term boundary transgression. However, there is not a consensus among researchers as to what constitutes each of these terms. For example, some therapists may classify an unintentional encounter with a client (i.e. bumping into a client in a store) as a non-sexual, unintentional dual relationship. This is because even though this does not really constitute a relationship in any meaningful sense of the word, such events do occur, and have unknown

effects (Nerison, 1992). Other therapists may not even consider this a boundary crossing. Borys and Pope (1989) defined incidental events as one-time, exceptional boundary alterations initiated by the client, and accepted by the therapist. Although they believe that this does not constitute a dual relationship, it might raise questions regarding potential conflict of interest (e.g. giving the therapist a gift worth more than $50 or inviting the therapist to a special occasion). Also, some therapists would define a therapist attending a client's party as a dual relationship. Others would refer to this as action as a non-sexual boundary transgression. Plaut (1997) describes a dual relationship existing when a therapist serves two professional roles, or when the professional relationship includes certain personal elements. According to Nerison, dual relationships exist whenever a client has a relationship with his or her therapist outside the therapeutic relationship.

The term multiple relationship replaced the term dual relationship in the revised Code of Ethics (2001) for marriage and family therapists. This is because the word *multiple* can define a wide range of contacts and interactions with clients (Hill and Mamalakis, 2001). Whether a multiple relationship constitutes a boundary crossing or boundary violation is case dependent (context and situation-specific factors need to be taken into consideration). It is important to note that situations that test boundaries frequently occur, and are not always clear. In addition, an individual's training and orientation influences how a person identifies and responds to such situations (Lamb & Catanzaro, 1998).

There is general agreement among mental health professionals that boundary transgressions of a sexual nature are harmful. However, there is not a clear consensus regarding the consequences of non-sexual boundary transgressions. For the purpose of this study, boundary transgressions of a sexual nature, referred to as sexual boundary transgressions, will be considered boundary violations that are always harmful to clients, and the therapeutic relationship. On the other hand, a non-sexual boundary transgression may be considered a boundary crossing (action poses minimum risk to client), or a boundary violation, depending upon the way the action effects the client.

Sexual and non-sexual boundary transgressions. Throughout the 1980s, sexual misconduct between therapists and their clients received a great deal of attention (Herlihy &

Corey, 1997). Sexual relations are at the extreme end of the continuum regarding boundary transgressions. Such relationships are considered boundary violations. Sexual boundary transgressions do not always arise from therapists' selfishness. Many times sexual boundary transgressions occur from "a misguided effort to love a client back to health" (Gabbard, 1996, p. 314). All the major mental health professions explicitly prohibit sexual relations between therapists and their clients. In addition, state laws prohibit such behavior. The trauma that results from sexual boundary transgressions has received a great deal of attention. Empirical evidence consistently finds that such relationships are harmful to clients. As a result, there is a firm consensus regarding its inappropriateness (Hundert & Appelbaum, 1995; Welfel, 1998). However, there is ongoing debate regarding the appropriateness of such relationships between therapists and their terminated clients (Smith & Fitzpatrick, 1995).

In the 1990s, non-sexual boundary transgressions began getting more attention (Herlihy & Corey, 1997). According to the literature, non-sexual boundary transgressions are generally referred to as boundary crossings. However, how the behavior effects the client, and therapeutic relationship, ultimately determines if the behavior constitutes a boundary crossing or a boundary violation. It is apparent from highly publicized cases, rulings by licensing boards, and lawsuits, that the public is concerned about non-sexual boundary transgressions (Hundert & Appelbaum, 1995). Unfortunately, ethical codes fail to adequately address the inherent complexity of non-sexual multiple relationships. In addition, the codes fail to specify the conditions under which such relationships may be harmful, benign, or beneficial (Smith & Fitzpatrick, 1995). The codes warn therapists about engaging in multiple relationships with clients because of the harm that may ensue from these relationships. This includes therapeutically treating someone after having a prior relationship (sexual or non-sexual) with him or her (Corey et. al., 1998). Non-sexual boundary transgressions are problematic because they are pervasive, their beginning can be difficult to recognize, and they are unavoidable at times (Corey & Herlihy). Professional associations have taken these factors into account when revising ethical codes. As a result, mental health associations [e.g. the American Psychological Association's Ethical Principles of Psychology and Code of Conduct (1992)] no longer prescribe a general prohibition with respect to engaging in multiple relationships (Hill & Mamalakis, 2001). However, warnings of the dangers of multiple relationships stay in place.

The problem is that relatively little data exists in the literature regarding non-sexual boundary transgressions. Although, there are ethical guidelines regarding non-sexual boundary transgressions, these guidelines are general and subjective. Non-sexual boundary transgressions are heavily debated in the literature regarding their appropriateness. The literature discusses non-sexual boundary transgressions as problematic because they tend to consistently lead therapists down a "slippery slope" which results in sexual boundary transgressions. It is important to note that non-sexual boundary transgressions may also be problematic in and of themselves (Miller & Maier, 2002).

What are the effects of boundary transgressions? Because people perceive behaviors differently, boundary transgressions are ill advised because of their potential to cause clients distress. For example, a therapist may not perceive a gesture of caring or concern, such as a hug, as harmful. On the other hand, a client may mistake a hug as a sexual advance.

Boundary transgressions have the potential of exploiting clients and impairing therapists' professional judgment (Corey et. al., 1998). When this occurs, the therapeutic relationship between therapists and their clients is compromised. According to Plaut (1997), "…exploited clients experience feelings of betrayal of trust, depression, loss of primary relationships, and loss of self-esteem. At worst, such boundary violations result in client suicide." Corey et. al. state that counselors who engage in a dual relationship with a client might become less confrontational, challenging, and objective. Also, these therapists' clients might become inhibited during therapy sessions, censuring their disclosures as to not threaten the social relationship. Exploitative behavior by a therapist is highly disruptive because it violates the sense of trust derived from therapeutic boundaries. The tendency to exploit must be recognized, and interventions (e.g. discussing the violating action with the client and supervisor) must occur immediately. This is because such activity can adversely effect the therapeutic alliance, and the treatment process causing therapeutic impasse, exacerbation of underlying disorders, and escalating violations of treatment boundaries (Epstein & Simon, 1990). Thus, therapists need to be sensitive to the possibility of boundary transgressions (Chadda & Slonim, 1998). Boundary transgressions also cause confusion regarding the nature and goal of the therapeutic relationship. For example, clients may question whether the nature and goal is social or professional (Kaslow,

1998). In addition, boundary transgressions are damaging to the mental health profession. When therapists exploit clients, the field as a whole loses credibility. The general public loses their ability to trust therapists. Therapists are entrusted with the most intimate information. Clients hold therapists responsible for helping them correct their problems, not add to them (Reid, 1999).

Kitchener (1988) explains why she thinks dual relationships are problematic. She believes that the potential for harm increases as the incompatibility of expectations increases between roles. For example, it is not unusual or inappropriate for a client to call his or her friend at home to discuss bothersome thoughts. However, it is inappropriate for a client to call his or her therapist at home to discuss such thoughts. If a client works with a therapist, who happens to be his or her friend, the client may become confused regarding the appropriateness of calling his or her therapist/friend at home. The potential for loss of objectivity and divided loyalties increases as the obligations associated with different roles diverge. She also explains that as the difference in power and prestige between the therapist's and client's role increases, the possibility of exploitation increases. Lastly, Kitchener suggests that as the risks of harm increase, ethical prohibitions about engaging in dual relationships should also increase.

Subtle boundary crossings (e.g. self-disclosure or using a client's first name) tend to lead to more adverse boundary violations (e.g.. sexual contact with a client). Strasburger, Jorgenson, and Sutherland (1992) explain that the slippery slope of boundary violations "may be ventured upon first in the form of small, relatively inconsequential actions by the therapist such as scheduling a 'favored' patient for the last appointment of the day, having excessive telephone conversations with the patient, and becoming lax with fees (p. 547)." Therapists then tend to proceed through a gradual blurring of boundaries. This may cause the structure essential to therapy to deteriorate, ceasing to be a viable process for personal growth and change. Thus, therapists are advised to refrain from starting down the "slippery slope" by avoiding boundary crossings. Gabbard (1996) explains that self-disclosure is often the first boundary crossed, and soon the therapist finds him or herself engaging in an informal, friendly style of interaction that is not associated with the client's treatment goals. When there is no immediate disaster after crossing one boundary, the therapist may then begin to feel that other boundary crossings will be

just as safe. As a result, the therapist develops a false sense of security. This leads to a progressive slide down the "slippery slope." However, under the right circumstances, touch, personal disclosure, social activity, a personal favor, or acceptance of a gift may be harmless, and provide a level of support and modeling that may be beneficial to the client. A gift from a client, in whose culture this is a common occurrence, may mean something different than a gift from a client who expresses personal feelings for the therapist (Plaut, 1997). However, Chadda and Slonim (1998) recommend that a therapist not accept gifts or services from clients. Instead, therapists should explore with their client(s) the meaning of the gift or service to keep the boundary.

What professional organizations say about boundary transgressions. Codes of ethics provide a constitutional framework for the practice of one's profession. They are intended to provide guidance and rules when a professional finds him or herself in a high-risk situation. However, they do not account for every complex situation that may arise during the therapeutic relationship (Butler & Gardner, 2001). Professional codes of ethics tend to elaborate general rules that offer little guidance in specific situations. Mental health professionals' codes of ethics explicitly prohibit therapists from engaging in sexual relations with their clients. However, it is hard for mental health professionals and regulators to articulate the rules governing non-sexual aspects of the therapeutic relationship because the literature regarding this topic is scarce, and not always helpful (Hundert & Appelbaum, 1995). Almost all the mental health professionals' ethical codes stress the obligation of therapists to remain mindful of the potential harm that may result when boundaries are transgressed. Being aware of one's professional ethical codes will allow for the realization that non-sexual boundary transgressions are neither always unethical, nor always avoidable. This will help therapists be better prepared to make choices about multiple relationships that attend to the needs of their clients (Zur, 2002). For example, according to the American Association of Marriage and Family Therapist (AAMFT) Code of Ethics (2001) Section 1.3, regarding multiple relationships, "[s]uch relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family." The AAMFT Code of Ethics advises therapists to make every effort to avoid multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. The Codes state that when the risk of impairment or exploitation exists due to

conditions or multiple roles, therapists need to take precautions. In addition, the AAMFT Code of Ethics states that sexual intimacy with a client is prohibited for two years after termination. Even after the two years, the burden rests with therapists to demonstrate no exploitation took place (Herlihy & Corey, 1997). However, mental health professionals debate the appropriateness of sexual relations between therapists and their terminated clients after the two years (Smith & Fitzpatrick, 1995).

According to Kaplan and Culkin (1995), the most common ethical violation that counselors commit is engaging in multiple relationships. They believe that ethical codes are set up not to prevent what will happen, but to prevent what might happen. They believe it is selfish for counselors to engage in such relationships because it may cause great psychological damage. They believe that this is the reason that Section IJ of the International Association of Marriage and Family Counselors (IAMFC) ethical code states that members must not engage in multiple relationships or engage in sex with any current or former client, or family member, to whom they provided professional services. Judy Ritterman, one of the members of the IAMFC ethics committee, describes therapists who become too emotionally attached to a family, during a therapeutic relationship, as useless. This is because the therapist becomes a part of a system that helps to perpetuate things as they are, rather than acting as a change agent (Kaplan & Culkin).

The American Psychological Association (APA) Ethics Code Draft Published for Comment (2001), Section 3.05 states that psychologists need to avoid entering into multiple relationships if such a relationship could "reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness…with whom the professional relationship exists." The National Association of Social Workers (NASW) Code of Ethics (1999), Standard 1.06c states that "social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client…. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business…)." In addition, the American Counseling Association (ACA) Code of Ethics and Standards for Practice (1996), Section A.6.a states that "[c]ounselors make every effort to avoid dual relationships with clients that could impair professional judgment or

increase the risk of harm to clients (examples of such relationships include, but are not limited to, familial, social, financial, business, or close personal relationships with clients)."

Therapists who belong to professional organizations may be reprimanded, suspended, or expelled for violating ethical codes pertaining to boundary transgressions (Jorgenson, Hirsch, & Wahl, 1997; Plaut, 1997). According to Jorgenson et. al., these remedies may seem harsh to professionals, yet they do not address the harm suffered by the client, or minimize the chance that the perpetrator will repeat the behavior with another client. Professional organizations can only revoke membership. In addition, not all professionals belong to a professional organization. Thus, members of the lay public (e.g. victims of therapists' exploitation, and their advocates) often exert pressure on state licensing boards, legislators, and the court system to ensure perpetrators are held accountable for their actions, and punished appropriately. This has resulted in civil and criminal statues that address therapists' misconduct. Unfortunately, these statutes tend to only address behaviors that sexually exploit clients. Unless educational efforts regarding multiple relationships are more effective however, legislatures will increasingly become more involved (Appelbaum, 1990; Simon, 1999).

State licensing organizations and legislation. Licensing boards have certain regulatory and disciplinary authority granted by state statutes. Licensing acts regulate a profession, protect the public from harm, and create minimum standards of conduct for a profession (Bernstein & Hartsell, 2000).

According to the law, the therapist-client relationship is fiducial. Roy v. Hartogs (1975) was a landmark case in which the court explicitly stated that a psychotherapist is a fiduciary to his or her client (Jorgenson, Randles, & Strasburger, 1991). Therapists must comply with existing law, and the law takes precedent over a professional's code of ethics. Thus, therapists should be aware of applicable laws and case law precedents to decrease their risk of liability if sued for malpractice. It is also important to note that the laws vary from state to state.

Before the case of Roy v. Hartog (1975), the legal system overlooked malpractice suits claiming sexual misconduct. Previously, the legal system believed these types of claims arose

from the sexual fantasies of mentally unbalanced women. Sexual misconduct continues to be a common malpractice action in the mental health profession. According to Kaslow (1998), it is probably the grounds for the greatest number of ethics and malpractice charges against therapists in America. The problem is that statutory definitions of sexual misconduct vary from state to state, and these definitions cannot encompass the wide variety of sexual activities that constitute the abuse of clients by therapists. On a positive note, more states are enacting legislation that provides civil and criminal remedies for clients who have been sexually abused by therapists. In Rhode Island, licensed mental health professionals formed a task force in response to the findings of a survey that indicated the underreporting of sexual misconduct violations. As a result of the task force's effort, a mandatory reporting law was passed, a victim support group was established, and literature is now available to the public pertaining to identifying and reporting unethical therapist conduct (Parsons & Wincze, 1995).

States provide criminal sanctions (usually a felony that may carry prison sentences and fines) against therapists who sexually exploit clients (e.g. AK, AZ, CA, CT, CO, DE, FL, GA, IA, ID, KS, ME, MI, MN, MS, ND, NH, NM, SD, TX, UT, WA,WI,). In addition, a client's consent to a sexual relationship is not allowed as a defense. According to most mental health professional organizations, sexual relations with a client may be considered after two years. However, some states (e.g. FL, CA, CO) prohibit sexual relations between a therapist and client forever. These states tend to believe that once a person becomes a therapist's client, he or she is always a client. One reason is because clients tend to resume therapy after initially terminating such services. Reporting statutes require therapists to report to state authorities any sexual relations, between a therapist and his or her client, they become aware of (including past or current sexual relations). Wisconsin was the first state to require therapists who suspect previous sexual involvement, between therapists and their clients, to ask clients for permission to report the case, with clients' names allowed to remain anonymous. Therapists in California who become aware of such a relationship are obligated to give clients the state procedures delineating their rights as clients, and must discuss the matter with these clients. In Minnesota, therapists are required to report the names of therapists presumed to have sexually violated their clients, even if a violated client does not want to report the incident (Gutheil & Weisstub, 1996).

The first known civil action concerning a therapist's improprieties with a client was in 1961, the case of Landau v. Werner. In this case, a psychiatrist was found negligent for pursuing a social relationship with his client immediately following termination (Coleman, 1989; Jorgenson et. al., 1991). Civil statutes proscribe therapist misconduct. Civil laws relate to the obligations that citizens have to one another. Criminal statutes govern therapist-client exploitation. Criminal laws require certain behaviors of citizens and prohibit others (Herlihy & Corey, 1997; Simon, 1999). Civil statutes define boundary transgressions and provide means for clients to recover monetary damages from professionals found guilty of violating statutes that are intended to protect clients. They provide compensation for damages suffered by clients after a breach of duty, negligence, or malpractice has occurred. Criminal statutes allow states to prosecute professionals who risk the welfare of individuals. Prevention of harm is the focus of criminal statutes. All states report adverse malpractice outcomes and actions following complaints before registration boards to a National Practitioner Databank. This is a centralized registry that receives reports concerning legal and disciplinary actions. Hiring agencies are required to check with this registry (Gutheil & Weisstub, 1996).

In any state, a client may sue his or her therapist for malpractice if the therapist fails to maintain the standards of the profession (e.g. practice therapy while in a conflict of interest). (Evans & Hearn, 1997). Insurance companies tend to include provisions in malpractice policies they sell to therapists in order to limit the amount of money they have to pay clients when an insured professional engages in harmful behaviors (Jorgenson et. al., 1997). The laws regarding boundary transgressions typically include no statue of limitation for bringing a complaint against a therapist, protection from civil liability to any individual acting in good faith, and clients' confidentiality is maintained in public reports of any proceedings. For example, California and Minnesota's statutes restrict defendants from introducing evidence regarding the plaintiff's sexual history unless the Court deems it relevant (Appelbaum, 1990). In addition, criminalization of boundary transgressions provide a measure of control over those who are practicing legally, but are not held accountable under a licensing board (Plaut, 1997).

Previous Research

Research from the perspective of professionals. Borys and Pope (1989) randomly selected members from the American Psychological Association, the American Psychiatric Association, and the National Association of Social Workers to participate in their study. They had 1108 participants rate the degree to which they believed a variety of boundary transgressions were ethical, and 1021 participants rated how often they engaged in these boundary transgressions. These investigators were among the first to investigate non-sexual boundary transgressions. Participants completed surveys that examined attitudes and practices regarding dual professional roles, social involvement, financial involvement, and incidental involvement. They found no difference between psychologists, psychiatrists, and social workers in frequency of providing therapy to a relative, friend, or current employee. In addition, there was no significant difference between professions with respect to having social or financial involvement with clients, or sexual intimacies with clients before or after termination. At the time the study was conducted, the ethical standards of psychologists explicitly prohibited non-sexual "dual relationships" (APA, 1981). Although, psychiatrists viewed these types of relationships as less ethical than psychologists and social workers, they engaged in these types of relationships with the same frequency as psychologists and social workers. The majority of participants rated sexual activity with a client before termination (98.3%), selling a product to a client (70.8%), sexual activity with a client after termination (68.4%), inviting a client to a personal party or social event (63.5%), and providing therapy to an employee (57.9%), as never ethical. Behaviors in which the therapist assumed two roles (except providing individual treatment to the significant other of a client), behaviors involving sexualized relationships, and behaviors involving extra fee financial arrangements were rated as less ethical than behaviors involving incidental involvement, social involvement, and special fee arrangements. Borys and Pope found that a majority of subjects accepted a gift worth less than $10 (85.2%), and provided concurrent individual therapy to a client's significant other with at least one client (61.2%). Whereas few participants admitted being sexually intimate with a current client, many admitted transgressing non-sexual boundaries. Borys and Pope's investigation focused on psychotherapy with adults. They stated that an attempt to obtain a national, representative random sample of marriage and family counselors proved "futile" because such counselors did not have a well-organized

national association with a membership list during the time of this study. In addition, many states prohibited disclosure of licensed marriage and family counselors' names and addresses.

Pope, Tabachnick, and Keith-Spiegel (1988) randomly selected members of the American Psychological Association (APA) Division 29 (Psychotherapy) to rate the degree to which they considered 83 behaviors to constitute good or poor practice. From their sample of 456 psychologists, they found that therapists maintain stricter standards for judging whether a behavior constituted good or poor practice than for judging whether it was ethical or unethical. With respect to boundary issues, the majority of participants rated sexual involvement with a former clients (66.7%), providing therapy to friends or employees (64.7%), giving a gift worth at least $50 to clients (78.9%), selling goods to clients (75.2%), and inviting clients to a party or social event (61.4%), as representing poor practice. In addition, 97.4% of participants rated engaging in sexual contact with clients, and 96.7% of participants rated engaging in erotic activity with clients as representing poor practice. Lastly, the results show that participants are not sure if it is considered good practice to send holiday greeting cards to their clients (26.5%), accept a gift worth less than $5 from clients (21.3%), and attend clients' special event (e.g. wedding) (20.0%).

Pope and Vetter (1991) determined the number of female clients that psychologists treated who were sexually intimate with a therapist prior to termination, and how many of these females suffered harm as a result. Psychologists were randomly selected from the membership directory of the American Psychological Association (1989). Almost half (n=323) of the 647 participants reported assessing or treating at least one client who had been sexually intimate with a prior therapist (958 sexual intimacy cases reported). According to the results, harm (e.g. attempted suicide, committed suicide, and hospitalization) occurred in at least 80% of instances in which therapists engaged in sexual activity with a client after termination. Because so many psychologists reported treating clients who were sexually intimate with a prior therapist, and because such boundary transgressions are harmful, therapists need to be prepared to render appropriate treatment if they determine their client was exploited in such a manner. In addition, the investigators concluded that the matter of therapist-client sexual relations requires urgent

attention because of the frequency of incidences, and the harm that results from these transgressions.

Pope and Vetter (1992) randomly selected members of the American Psychological Association (APA) to describe an incident they found ethically challenging or troubling, or describe a challenging or troubling incident a colleague faced. They obtained responses from 679 psychologists describing 703 incidents. The second most frequently described incidents included maintaining clear, reasonable, and therapeutic boundaries around the professional relationship with a client. Participants reported difficulty in knowing what constitutes a "dual relationship," or conflict of interest. According to Pope and Vetter, the results from this study suggest that ethical codes need to define non-sexual boundary transgressions more clearly. The ethical codes must also clearly and realistically address situations that occur when practicing in small communities. This is because 41 of the incidents involved small, rural, and other remote locales. Lastly, the investigators discussed how the results indicate that the ethical codes should distinguish between "dual relationships" and accidental or incidental extratherapeutic contacts (e.g., unexpectedly encountering a client at a mall). It is also worth noting that 4% of the challenging or troubling incidents concerned sexual issues.

According to Malley, Gallagher, and Brown (1992), one of the most difficult ethical problems to resolve in university and college counseling centers is the issue of multiple relationships. Using the Delphi technique, 28 university or college counseling center directors throughout the country identified dilemmas they experienced, or knew others experienced, in their daily practice. They were also asked which ethical problems were the most difficult to resolve. Participants expressed concern about counselors who encourage dependency in their clients, become emotionally involved with clients, fail to recognize when they are using the therapeutic relationship to meet their own needs, and confuse advocacy of their own social issues with counseling. These behaviors are problematic because such unethical behavior may damage the therapeutic relationship, and these behaviors may be precursors to sexual intimacy. The investigators conclude that because multiple relationships have adverse effects on clients, and the therapeutic relationship, this issue needs to be addressed during therapists' training.

Strom-Gottfried's (1999) study showed that 56.1% of ethical complaints against social workers involved some form of boundary transgression. Strom-Gottfried reviewed 894 ethics complaints submitted for adjudication with the National Association of Social Workers (NASW), over an 11-year period. In findings of misconduct, the actions were recorded in one or more of 66 categories of unethical behavior. Fourteen of these categories represented boundary violations. One hundred forty-seven cases (29.1% of all cases that went to hearing) resulted in findings of some type of boundary violation. One hundred and seven of the cases (72.7%) involved some form of sexual violation, 62 (52.3%) constituted "dual relationships" (e.g. sharing a holiday meal with a client, attending a party with one's client, etc.), and 70 (47.6%) regarded "other" boundary violations such as providing clients with illegal substances. Because of such a high number of complaints pertaining to boundary transgressions, Strom-Gottfried reiterates the importance of supervision, therapists being aware of their actions, and enhanced education pertaining to boundary transgressions.

Epstein and Simon (1990) devised the Exploitation Index. This index warns therapists that they may be in danger of transgressing boundaries with a client. The Exploitation Index was derived from actual examples of exploitive behavior found in published case reports, forensic records from cases involving litigation against psychiatrists and other mental health professionals, and personal clinical observations. The examples were formulated into questions that clinicians can ask themselves, and then answer concretely based on frequency of occurrences. Epstein and Simon administered their Exploitation Index to 532 psychiatrists and found that 43% of participants reported one or more of the questions on the Exploitation Index altered them to the possibility that they may transgress a boundary with a client. They also found that 29% of participants reported that the questionnaire motivated them to make specific changes in future treatment practices to guard against any boundary transgression that may arise.

Parsons and Wincze (1995) mailed 678 surveys to licensed psychologists, psychiatrists, social workers, marriage and family therapists, and mental health counselors, in the state of Rhode Island. The surveys asked participants if they had treated or evaluated clients who had been sexually involved with a previous therapist between 1989 and 1991. Parsons and Wincze compared their results to the number of violations reported to licensing boards and professional

society ethics committees. They found that there are many sexual misconduct violations that are not reported to licensing boards or professional society ethics committees. This study supports the findings of previous studies that examined the issue of sexual boundary transgressions. Results from previous studies resulted in licensed therapists forming a task force to improve the reporting of offenses, and to enact legislation that would give victimized clients the message that sexual misconduct during the therapeutic relationship is wrong, and therapists who engage in such behavior should be identified, helped, and punished. In 1994, as a result of the task force's effort, a mandatory reporting law was passed. Also, a victim support group was established. Lastly, due to the results of investigations such as Parson and Wincze's, literature is now available to the public pertaining to identifying and reporting unethical therapist conduct (Parsons & Wincze).

Nickell, Hecker, Ray, and Bercik's (1995) is an important study because very few studies include the perspectives of marriage and family therapists (MFTs). Nickell et. al.'s, research included 189 MFTs. These investigators were interested in assessing MFTs' ethical beliefs, practices, training, and influences on decisions regarding sexual attraction to clients. They randomly selected Clinical Members of the American Association of Marriage and Family Therapy (AAMFT). Nickell et. al. found that 55.1% of participants reported their graduate programs provided little or no training on the topic of sexual attraction to clients, while 25.4% reported "much coverage" on this topic. Similar percentages were found regarding the amount of educational coverage pertaining to sexual attraction to clients during clinical supervision and training. For example, 47.3% of respondents reported little or no coverage of sexual attraction during clinical supervision, while 29.1% reported "much" coverage. According to Nickell et. al., therapists have more divergent opinions on things that aren't specifically illegal or labeled unethical. Surprisingly, therapists who report more training on decision making about sexual attraction to clients did not report more effective handling of, or less discomfort with the issue. The investigators also examined other influences in the decision making of MFTs about sexual attraction to clients because their findings indicate that training programs do not effectively teach therapists how to handle feelings of sexual attraction to clients. The other influences included internship experiences (28% rated this as a "good-to-excellent" influence), state and federal laws making sexual involvement with clients a felony (51% rated these as "good-to-excellent"

influences), independent readings (63% rated this as a "good-to-excellent" influence), continuing education programs (41% rated this as a "good-to-excellent" influence), informally networking with colleagues (65% rated this as a "good-to-excellent" influence), and the AAMFT code of ethics (74% rated this as a "good-to-excellent" influence). Overall, this study shows that therapists do experience sexual attraction to clients. However, it is important to note that none of the participants reported engaging in sexual relations with clients within the past two years. This may be due to the laws forbidding sexual involvement between therapists and their clients, or due to the publicity regarding this issue. According to Nickell et. al., MFTs tend to see more couples and families than individual oriented therapists. As a result, they are not afforded as many intimate opportunities with clients. Because of the lack of accepted guidelines in the profession for appropriate responses to feelings of sexual attraction to clients, training regarding this issue is highly suggested.

Brock and Coufal (1994) also randomly sampled Clinical Members of AAMFT. The researchers disseminated a survey to determine MFTs compliance with the AAMFT Ethics Code and their attitudes towards its principles. Brock and Coufal's study included 540 participants. Pope, Tabachnick, and Keith-Spiegel's (1987) survey was used. This survey was originally developed for psychologists to assess their self-reported behavior and attitudes. The investigators adapted this survey for the use of marriage and family therapists. The findings of Brock and Coufal's study were compared with Pope et. al.'s findings. Participants rated on a 5-point scale whether they engaged in specific behaviors, and their beliefs regarding the ethical appropriateness of the specific behaviors. Overall, the results indicate that between 71% and 100% of participants rarely or never behave contrary to the Ethics Code. In addition, between 78% and 90% of the participants support the Ethics Code by reporting the items from the survey were either absolutely unethical, or ethical only in rare circumstances. In general, participants' behavior was generally congruent with their attitudes. Twenty of the variables from the survey were associated with "dual relationships" (e.g. sexual and non-sexual boundary transgressions). Twelve percent of the sample reported attitudes more liberal than their behavior. However, 88% of participants reported that they rarely or never engaged in "dual relationship" behavior, and they considered these relationships absolutely unethical, or ethical only under rare circumstances. According to Brock and Coufal, marriage and family therapists are very unlikely

to transgress sexual boundaries with their clients. In their research, only 1.7% of participants reported that they engaged in sexual activity with a client. Research in the 1970s and 1980s addressed this behavior and found other groups of mental health professionals reported higher rates. The investigators suggest that this lower rate may exist because there tends to be other people present in the therapy room during marriage and family therapy. This reduces the opportunity for sexual boundary violations. Over 75% of participants read the AAMFT Ethics Code, and believed themselves either as ethical, or more ethical than their colleagues. Although MFTs believe they are ethical, or more ethical than their colleagues, they reported engaging more frequently, than psychologists, in behaviors the AAMFT Ethics Code prohibits or warns against. On the other hand, with respect to attitudes, the psychologists reported more acceptance of behaviors prohibited or warned against. It is important to note that this study was conducted when the 1988 Ethics Code was in effect.

The studies described above are only a few examples of research regarding boundary transgressions from the perspective of professionals. Most of the research assessing professionals' perspectives shows that professionals tend to agree that sexual boundary transgressions are inappropriate. However, these same professionals have more divergent opinions regarding the appropriateness of non-sexual boundary transgressions.

Research from the perspective of the lay public. Ramsdell and Ramsdell (1993) believed they were the first investigators to ask clients to report the nature of their social and physical contact with their counselor, and to solicit clients' views regarding such contact. Ramsdell and Ramsdell randomly surveyed 67 former clients of a large metropolitan counseling center, in a systematic fashion. Participants assessed the frequency with which they experienced 21 specific forms of client-counselor contact during therapy, and their opinions regarding whether the contact was beneficial or detrimental to therapy. Eight of these behaviors regarded physical contact such as shaking hands, hugging, and kissing on the cheek. Thirteen of these behaviors regarded social contact such as sharing a meal, dating, and addressing a counselor by first name. If a specific behavior did not occur during their therapeutic experience, they were asked to rate how they think each behavior would affect their therapy if it did occur. The majority of participants rated only three non-sexual boundary transgressions as beneficial in therapy. These

include, counselor self-disclosure, a counselor visiting his or her client in the hospital, and a counselor addressing his or her client on a first name basis. The investigators also found that client-counselor dating; going to bars, nightclubs, or dances; counselors giving clients a gift; and counselors visiting a client's home as very detrimental. There was considerable variation in the participants' ratings, however. For instance, the results show that 46.2% of participants believed sharing a meal with their counselor has no effect on therapy, while 43.1% rated this behavior as likely to be "somewhat or very detrimental," and 10.7% rated this action to be "somewhat or very beneficial." The majority of participants also rated attending a movie, play, concert, or sporting event with one's therapist as detrimental. According to Ramsdell and Ramsdell, the greatest uniformity was found regarding opinions concerning sexual contact. Over 90% of participants viewed this behavior as very detrimental. The variance in clients' evaluation of many behaviors suggests the complexity of attempting to define a uniform code of conduct for all counselors, with all clients.

Hillerbrand and Claiborn (1988) found that clients did not demonstrate superior ethical knowledge compared to non-clients. Their study sampled 77 undergraduate students from educational psychology classes. The students were from a large midwestern state university. They completed a questionnaire concerning their knowledge of ethical issues. The questionnaire was based on ethical principles of the American Psychological Association (1981), the American Association for Counseling and Development (1981), the National Association of Social Workers (1979), and other literature discussing ethical practices. One of the seven items answered correctly by at least 90% of the subjects asked if it is unethical for therapists to have sexual contact with their clients. This was answered correctly by 99% of participants. Results indicate that participants seem to accurately understand ethical issues on a general level, but they have less accurate knowledge about specific situations regarding ethical issues. For example, the participants knew sexual contact between counselors and their clients are wrong, but were less certain about social interactions of a non-sexual nature. Thus, Hillerbrand and Claiborn advise counselors to refrain from assuming that general knowledge of an issue represents complete understanding of that issue, including those concrete applications most relevant to clients, such as the prohibition of therapists having social interactions with their clients. With respect to assessing ethical knowledge, they suggest using free response items. They believe this would

have the benefit of showing how participants organize and use their knowledge. However, it is important to note that their sample consisted of college students from a major liberal arts university with numerous professional schools. Thus, according to the investigators, the participants might have some familiarity with ethics in business, education, the professions, and personal relationships. This might have made the baseline ethical knowledge of non-clients high enough to obscure what knowledge, if any, clients gained as a result of their therapeutic experience.

Nerison (1992) assessed how clients (former and current), and potential clients, rate the ethicality of different types of boundary transgressions. Nerison surveyed women who attended the Association for Women in Psychology (AWP) 1991 national conference. She obtained 259 usable surveys from these women. N erison also surveyed women and men from a Presbyterian Church in Iowa. She received 29 usable surveys from these church attendees. Overall, the majority of participants were women. Nerison reworded items from Borys's (1988) study (which assessed therapists' views on boundary transgressions), to obtain the perspective of clients and potential clients. Participants described their attitude by rating on a 5-point scale the acceptability of boundary transgressions between therapists and their clients. Participants' ratings tended to correspond to the ethical guideline of psychologists, and to therapists' rating from Borys and Pope's (1989) research. Of the 22 survey items, 82% received mean ratings indicating that the therapist's behavior was never, rarely, or only sometimes acceptable. The majority of her participants rated 36% of the items as never acceptable. These included sexual relationships between therapists and their current and former clients, therapists employing their clients, therapists accepting expensive gifts, therapists providing therapy to current students, therapists and their clients dining together following a therapy session, and other therapist–initiated social engagements. Accepting a client's handshake, accepting a hug from a client, and accepting a gift worth less than $10 was rated as the most acceptable. Nerison concludes that the area of non-sexual "dual relationships" needs further investigation. She describes how her study, along with other studies, suggests these relationships occur more often then sexual relationships, often with damaging consequences. According to her results, current and former clients, as opposed to non-clients, tend to be more aware of the problems associated with engaging in

multiple relationships. However, her subjects consisted of therapists, which might have confounded her findings.

Walden (1996) used a computer-generated random digit dialing list to randomly select adults in the state of Ohio. She did this so that she could assess the lay public's overall knowledge of ethical counselor behavior, as well as the lay public's knowledge of eight specific areas of counseling ethics (e.g. sexual and non-sexual boundary transgressions). Her sample consisted of 400 adults. Participants rated their beliefs regarding the ethicality of eight vignettes on a 5-point scale. Walden found what Hillerbrand and Claiborn's (1988) research found; clients are somewhat knowledgeable about general ethical issues, but less knowledgeable about specific issues. According to Walden's study, clients or former clients did not score significantly higher than non-clients. Thus, knowledge of ethical standards may result from sources other than from counselors, or counselors are not very effective in instructing clients about ethical issues. One of the vignettes from Walden's study pertained to "dual relationships." This vignette was about a counselor who conducted business and social relationships with clients. The mean score for this item was 3.20 (on the five-point scale, 3 represents "neutral, I don't know if it is ethical or unethical"). Walden believes it is a matter of concern that her study found participants uncertain regarding the ethicality of a non-sexual boundary transgression. Another item in her study pertained to sexual "dual relationships." This vignette described a sexual boundary transgression between a counselor and a former client one-year following the termination of the counseling relationship. The counseling relationship was terminated because the counselor was sexually attracted to the client. The scenario in the vignette is considered unethical according to the American Counseling Association's Ethics Committee. The mean score for all participants for this vignette was 3.07. According to the literature, there tends to be a discrepancy between the appropriateness of sexual relationships with current clients versus former clients. According to Walden, mental health professionals are not in agreement about the ethicality of relationships between counselors and former clients. Thus, Walden is not surprised that participants in her study were uncertain about the appropriateness of counselors' behavior. In conclusion, because Walden's overall findings were that the lay public was uncertain regarding the ethicality of the eight areas of ethical counselor behavior, she suggests public education regarding ethical standards in counseling. She believes it is important to obtain the perspectives of the lay public

because "those individuals who are at greater risk of harm from unethical practices may provide an important perspective in future research. The inclusion of representatives of the general public may help to further protect the interests and well-being of those served by the counseling profession (p. 167)."

Claiborn et. al. (1994) asked adult clients and non-clients to judge the ethical appropriateness of 60 therapist practices. They also asked clients to indicate how often these behaviors occurred during their therapy experience. Ninety-six adults participated. The questionnaire used was modeled after Pope et. al.'s (1987) survey developed for therapists. Participants rated on a 5-point scale the ethical appropriateness of particular therapist practices. With respect to items pertaining to multiple relationships, in which the majority of the items referred to ethically inappropriate practices, participants' judgments corresponded closely to therapists' judgments, as reported by Borys and Pope (1989), and to clients' judgment, as reported by Nerison (1992). Thus, participants demonstrate a general understanding of "dual relationship" issues, despite the fact that subjects in this study had no training in professional ethics, and many of them had no experience as clients in therapy. Claiborn et. al.'s findings are similar to Hillerbrand and Claiborn's (1988) finding that adults display an accurate understanding of ethical principles, but confusions about specific applications of the principles. This study improved upon previous research because the participants in this study had no training in professional ethics, and many of them had no experience as clients in therapy. Of the practices judged clearly inappropriate, only the therapist knowing the client prior to the beginning of therapy was reported with any frequency (i.e. 22% of females reported that this occurred while they were clients in therapy). Claiborn et. al.'s overall results suggest that clients may have ethical beliefs that are not entirely consistent with mental health professionals' codes of ethics. Thus, Claiborn et. al. suggests that therapists avoid making assumptions about the clients' level of ethical knowledge, and should consider ways to discuss and clarify such issues with clients when they initially seek therapeutic services.

Hardwick (1999) found that exposure to ethical training results in potential clients viewing ethical behavior more similarly to the way mental health professionals view such behavior. Hardwick disseminated surveys to 42 participants from the lay public (mean age of

28.8 years). In addition, 21 mental health professionals completed the survey. The surveys contained vignettes representing realistic ethical dilemmas, including the issue of multiple relationships. Participants were then exposed to information regarding ethics in the field of psychology and the surveys were again disseminated to the 42 participants from the lay public. The results indicate that exposure to ethical training generally shifted the participants' responses to be more similar to the responses of mental health professionals (Hardwick).

Overall, most of the research indicates that the lay public understands general ethical principles of boundary transgressions, but have trouble applying these principles to situations that may arise during a therapy session. In addition, the lay public also seems to agree that sexual boundary transgressions are inappropriate, yet they are not able to reach a consensus regarding the appropriateness of non-sexual boundary transgressions.

CHAPTER 3: METHODS

The purpose of this study was to determine what effect education specific to boundary transgressions has on the lay public's level of acceptance of boundary transgressions, as opposed to what effect general information about personal/family therapy has on the lay public's level of acceptance of boundary transgressions. Participants from three undergraduate courses at a southeastern U.S. university rated their level of acceptance of therapists transgressing boundaries with their clients after reading either general information about personal/family therapy, or specific information pertaining to boundary transgressions in therapy.

RESEARCH QUESTION: Is there a significant difference in the level of acceptance of boundary transgressions between participants who receive general information about personal/family therapy (General group), and those who receive specific information about boundary transgressions (Educated group)?

HYPOTHESIS: Participants who are specifically informed about boundary transgressions will have a lower level of acceptance of therapists transgressing boundaries with their clients compared to those who read general information about personal/family therapy.

Procedures

Survey development. The investigator was primarily interested in assessing the lay public's level of acceptance of boundary transgressions. Thus, the investigator created 12 vignettes for participants to rate, on a scale of one to five (with one being "completely acceptable," and five being "completely unacceptable"), their level of acceptance of therapists transgressing client initiated boundary transgressions (ranging from minimal to major transgressions).

After obtaining suggestions from the thesis chair, pronouns replaced gender neutral names used in the vignettes to guard against a possible gender bias, and a 13th question regarding an appropriate request therapists should comply with was created to provide a non-violation anchor to the score. After proposing the idea of studying the lay public's level of acceptance of therapists transgressing boundaries, the thesis committee suggested developing two surveys (See

Appendix B and C) with the same 13 vignettes. Thus, the investigator created two surveys containing the same 13 vignettes, with different introductory information. One survey briefly explains personal/family therapy in general (See Appendix B), and the other survey briefly explains boundary transgression relating to personal/family therapy (See Appendix C). The boundary transgressions from the vignettes ranged from boundary crossings of a non-sexual nature to boundary violations of a sexual nature. Thus, the purpose of this study was to determine if participants who read information pertaining to boundary transgressions had a significantly lower level of acceptance of boundary transgressions, as opposed to those who read general information about personal/family therapy.

Reliability. The investigator created the vignettes. Thus, there was no evidence of reliability. To determine evidence of reliability, the investigator conducted a test-retest reliability study by distributing the study twice (a week apart) to willing individuals. Participants completed a test-retest reliability survey that contained the same 13 vignettes the student participants rated. The test-retest reliability survey did not contain a description of personal/family therapy in general, or specific information about boundary transgressions. The stability of their scores were assessed using a correlation coefficient.

Seventeen individuals participated in this study of reliability. Results showed that the vignettes were reliable (See Table 3.1). Thus, participants' scores for answering the same 13 vignettes seemed to remain stable from one week to the next.

Table 3.1

Test-Retest Reliability Study

Question Situation	Reliability
#1 you think it would be more comfortable to use first names	.91
#2 you see your therapist in the mall	.89
#3 your car won't start so you ask to borrow bus money	.87
#4 you give your therapist a gift	.87
#5 you send your therapist a holiday card	.91
#6 you seek therapy with your romantic partner's relative	.80
#7 you ask your therapist to visit you in the hospital	.67
#8 you offer your therapist an extra ticket	.74
#9 you offer to buy coffee and a doughnut	.90
#10 you tell your therapist you find them sexually attractive	.68
#11 you tell your former therapist you want to date someone	.69
#12 you ask your therapist to dance at a club	.83
#13 you ask your therapist for an itemized bill to submit to insurance	.75

Participants

This was a sample of convenience, consisting of students enrolled in undergraduate courses in the Human Development Department during the spring semester of 2003. Students from three undergraduate classes at a southeastern university participated during their regular class period.

Sample demographics. Participants were asked to indicate their gender, age, major, year in school, and if they had ever been in personal/family therapy. Two hundred students participated. Because the investigator wanted to acquire the viewpoints of those uninfluenced by having participated in personal/family therapy, 57 students were eliminated because they indicated that they received personal/family therapy. Thus, the responses of 143 students [27 males (18.9%) and 116 females (81.1%)] were analyzed. However, for nine of the questions, there were only responses from 142 students because missing data was excluded from the analysis. The mean age of participants was 19.89. Participants identified themselves as

majoring in a variety of fields offered by the university, or indicated that that they did not yet choose a major. First through fifth year students volunteered to participate in the study.

Sample recruitment. The investigator's thesis chair sent an e-mail to faculty (teaching classes open to all students, at a large southeastern U.S. university) requesting their assistance in recruiting subjects. Two professors responded with interest. These professors were given a description of the research and its purpose. One professor requested that the investigator send a letter introducing herself [the investigator] and the study's purpose so that the professor could e-mail a letter to her class explaining the investigator's presence. The investigator complied with this request. A date to conduct the research was set after the Institutional Review Board read and accepted a brief description of the study, and the Informed Consent Form (See Appendix A). After conducting the study in the two classes, a third professor offered the investigator the opportunity to conduct the study during her [professor's] class period. Thus, participants were from three large, general education courses (open to all undergraduate students enrolled at the university).

Survey administration. The investigator spent a few hours on the university's campus conducting the research in three undergraduate level courses. In each class, the students were handed an Informed Consent Form (See Appendix A) to read after the investigator briefly introduced herself, and her study. The investigator reviewed the Informed Consent Form (See Appendix A) with the students. Students interested in participating gave the investigator his or her signed consent to participate in this study. These participants were then randomly handed one of two surveys (See Appendix B and C) to complete. Throughout the data collection process, the investigator offered to answer any questions regarding the research. The data collection process took approximately 20 minutes.

CHAPTER 4: RESULTS

The purpose of this study was to determine what effect education specific to boundary transgressions has on the lay public's level of acceptance of boundary transgressions, as opposed to what effect general information about personal/family therapy has on the lay public's level of acceptance of boundary transgressions.

Independent sample t-tests were conducted to determine if there were statistically significant differences in mean ratings of acceptance of boundary transgressions between the group that received general information about personal/family therapy (General Group) and the group that received specific information about boundary transgressions (Educated Group). T-tests were computed for each answer to compare the means between the two groups, and to compare the means of the total scores. The level of significance for all tests was set at $p < .05$. Results of the t-tests showed a significant difference between the two groups for three questions (See Table 4.1). For question one, the Educated Group (M=1.763) rated this vignette significantly higher, or as a less acceptable action for a therapist to take, than the General Group (M = 1.508) (t = -2.048, df= 140, p= .042). A statistically significant difference was also found between the two groups for question 7. In this case, the mean for the Educated Group was 2.104, and the mean for the General Group was 1.742 (t = -2.671, df = 141, p= .008). Thus, the educated group believed it was less acceptable for the therapist in this scenario to transgress a boundary. For question 10, the mean for the Educated Group was 4.312, and the mean for the General Group was 3.900 (t=-2.271, df=140, p= .025). While these three questions were significant, the difference between the mean scores for the two groups were relatively small.

The means for the total scores differed significantly between the General Group and the Educated Group. The group that received specific information about boundary transgressions rated therapists engaging in boundary transgressions as more unacceptable (mean = 38.2067) than did the group that received general information about personal/family therapy (mean = 35.7923) (t= -2.048, df= 138, p=.042).

Table 4.1

Results of t-tests

Question Situation	Mean for General Group	Mean for Educated Group	t-statistic	df	Significance (p)
#1 you think it would be more comfortable to use first names	1.508 (.6933)** (Range 1-3) N=66	1.763 (.7809) (Range 1-4) N=76	-2.048	140	.042*
#2 you see your therapist in the mall	2.667 (.9337) (Range 1-5) N=66	2.829 (.9985) (Range 1-5) N=76	-.995	140	.321
#3 your car won't start so you ask to borrow bus money	2.258 (.9657) (Range 1-5) N=66	2.250 (.8813) (Range 1-5) N=76	.049	140	.961
#4 you give your therapist a gift	2.803 (1.3035) (Range 1-5) N=66	2.855 (1.2405) (Range 1-5) N=76	-.244	140	.807
#5 you send your therapist a holiday card	2.076 (.9167) (Range 1-4) N=66	2.112 (.8587) (Range 1-4) N=76	-.242	140	.809
#6 you seek therapy with your romantic partner's relative	3.598 (.9892) (Range 1-5) N=66	3.844 (.8594) (Range 1-5) N=77	-1.589	141	.114
#7 you ask your therapist to visit you in the hospital	1.742 (.7298) (Range 1-4) N=66	2.104 (.8673) (Range 1-4) N=77	-2.671	141	.008*
#8 you offer your therapist an extra ticket	2.955 (1.1426) (Range 1-5) N=66	3.234 (1.0748) (Range 1-5) N=77	-1.504	141	.135
#9 you offer to buy coffee and a doughnut	3.061 (1.0652) (Range 1-5) N=66	3.130 (1.0803) (Range 1-5) N=77	-.385	141	.701
#10 you tell your therapist you find them sexually attractive	3.900 (1.1699) (Range 1-5) N=65	4.312 (.9902) (Range 1-5) N=77	-2.271	140	.025*
#11 you tell your former therapist you want to date someone	3.646 (1.0373) (Range 1-5) N=65	3.714 (1.1905) (Range 1-5) N=77	-.360	140	.719
#12 you ask your therapist to dance at a club	3.862(1.0136) (Range 2-5) N=65	4.026 (.9997) (Range 1-5) N=77	-.970	140	.334
#13 you ask your therapist for an itemized bill to submit to insurance	1.677 (.8498) (Range 1-5) N=65	1.766 (.9017) (Range 1-4) N=77	-.604	140	.547
Total Score	35.7923 (7.06) (Range 18-51) N=65	38.2067(6.87) (Range 21-50) N=75	-2.048	138	.042*

*p< .05

** value in parentheses is standard deviation

CHAPTER 5: DISCUSSION

There is little knowledge regarding the lay public's perspective of boundary transgressions. This study examined the effects of education on people's perceptions of boundary transgressions. This was accomplished by determining if there were significant differences in the level of acceptance of boundary transgressions between those who received general information about personal/family therapy (General Group), and those who received specific information about boundary transgressions (Educated Group).

Although the results show significant statistical differences between the two groups (Educated Group and General Group) only for questions 1,7, and 10 (See Table 5.1), there was a significant difference between the means of the two groups for the total score. However, the difference between the mean scores for the two groups was small. Thus, while education relating specifically to boundary transgressions had some influence over participants' level of acceptance of boundary transgressions, that influence was relatively small. Some findings were unexpected and merit further discussion.

The researcher asked question 1 (See Table 5.1) under the assumption that participants would rate this boundary transgression as a completely acceptable action because other studies indicate that therapists and the lay public rate this type of situation as a harmless boundary transgression. For example, Ramsdell and Ramsdell's (1993) study found that former clients judged counselors addressing clients by their first names as beneficial. However, it is interesting to note that those educated with specific information regarding boundary transgressions rated this vignette significantly less acceptable than the group that received general information about personal/family therapy. While some investigators, such as Epstein and Simon (1990), believe that permitting or encouraging use of first names between a therapist and his or her clients is a form of false advertising in which a professional relationship is misrepresented as a social friendship, others believe that permitting or encouraging use of first names is benign or even beneficial. Lastly, Chadda and Slonim (1998) state that usage of first names must be carefully and thoughtfully considered as it "may promote a false sense of collegiality and pseudoegalitarianism (p. 491)."

During the reliability study, some of the participants commented that although question 7 (which asked participants to rate their level of acceptance of a therapist visiting his or her client in the hospital) (see Table 5.1) may be against ethical codes, they believed that such transgressions would be acceptable due to the circumstances. One participant stated that if she found herself in such a situation, she would like her therapist to comply with her request, even though the action transgresses a boundary. Other investigators, such as Ramsdell and Ramsdell (1993), also found that former clients rated therapists visiting their clients in the hospital as beneficial.

Two questions (i.e. 10 and 12) were rated, on average, as mostly unacceptable by those in the Educated Group and General Group. These two questions pertained to situations regarding sexual boundary transgressions. According to the majority of the literature, and other studies investigating this issue, therapists and the lay public also rate sexual boundary transgressions as mostly or completely unacceptable. Even though most participants found question 10 mostly unacceptable, there was a statistically significant difference between the groups. Thus, education resulted in participants rating this activity as less acceptable. Nickell et. al. (1995) found that although the marriage and family therapists who participated in their study understood that sexual contact with clients is ethically wrong, and none reported engaging in sexual intimacy with clients, there is a lack of consensus for appropriate responses to feelings of sexual attraction to clients. Because Nickell et. al.'s study indicates variance among professionals regarding appropriate responses to feelings of sexual attraction to clients, the investigator of the current study will assume that the lay public is also not able to come to a general consensus regarding the appropriateness of such responses. Thus, the specific education regarding boundary transgressions might have resulted in participants choosing a more conservative response.

Participants also rated many of the questions as "maybe acceptable/maybe unacceptable." This is consistent with the findings of Claiborn et. al. (1994) and Hillerbrand and Claiborn (1988). They found that adults display an accurate understanding of ethical principles, but confusion about specific applications of the principles. The literature discusses how multiple relationships are inherently complex and heavily debated. Since professionals are not able to agree about the appropriateness of these types of actions, it makes sense to the investigator of

this study that the lay public would not be able to rate if such relationships should be considered more or less acceptable.

As previously mentioned, even though questions 1, 7, and 10 were statistically significant, the difference between the Educated Group and the General Group were relatively small. The reason that the three questions mentioned above might have been significant is because a liberal response might seem harmless, but those who read specific information pertaining to boundary transgression might have answered these questions with more caution. Appropriate behavior, in the three situations presented in these questions, is unclear to both mental health professionals and the lay public. Only participants specifically warned of the dangers of boundary transgressions (Educated Group) would be able to recognize these situations as improper.

Although the statistical tests found that participants exposed to education specific to boundary transgressions might have attributed to participants rating boundary transgressions, during the therapeutic relationship, as less acceptable, overall the two groups seem more accepting of boundary transgressions than the investigator expected. The mean scores between the two groups did not differ much. This might have been due to either the quantity or quality of the educational information provided.

Table 5.1

Results of t-tests

Question Situation	Mean for General Group	Mean for Educated Group	t-statistic	df	Significance (p)
#1 you think it would be more comfortable to use first names	1.508 (.6933)** (Range 1-3) N=66	1.763 (.7809) (Range 1-4) N=76	-2.048	140	.042*
#7 you ask your therapist to visit you in the hospital	1.742 (.7298) (Range 1-4) N=66	2.104 (.8673) (Range 1-4) N=77	-2.671	141	.008
#10 you tell your therapist you find them sexually attractive	3.900 (1.1699) (Range 1-5) N=65	4.312 (.9902) (Range 1-5) N=77	-2.271	140	.025
Total Score	35.7923 (7.06) (Range 18-51) N=65	38.2067 (6.87) (Range 21-50) N=75	-2.048	138	.042

*p<.05

** value in parentheses is standard deviation

Providing participants with specific information about boundary transgressions, in this study, did not appear to make a great deal of difference regarding the level of acceptance of boundary transgressions even though the literature suggests the importance of educating the lay public regarding boundary transgressions during therapy. The investigator was surprised at how accepting the participants were of the various boundary transgressions in the vignettes. Thus, it was assumed that because the students were so accepting of boundary transgressions in general, participants in this study did not have any effective type of ethic's training (for example, a class that explicitly discussed boundary transgressions during therapy). The survey, which was administered to undergraduate students during their class period, was also distributed to marriage and family therapist interns who completed a course in ethics, which explicitly discussed boundary transgressions. This was done to determine whether there would be a difference between therapist interns explicitly educated about boundary transgressions (Therapist Intern Group), participants who received general information about personal/family therapy (General Group), and participants who received specific information about boundary transgressions (Educated Group). One-way ANOVAs were conducted to determine if the mean scores for the

three groups (General Group, Educated Group, and Therapist Intern Group) differed significantly.

Results for Further Analysis

There were statistically significant differences for several items:

Table 5.2

Results of ANOVAs

Question Situation	df	F	Significance (p)
#1 you think it would be more comfortable to use first names	2, 153	2.593	.078
#2 you see your therapist in the mall	2, 153	11.185	<.001*
#3 your car won't start so you ask to borrow bus money	2, 153	5.029	.008*
#4 you give your therapist a gift	2, 153	8.071	<.001*
#5 you send your therapist a holiday card	2, 153	7.546	.001*
#6 you seek therapy with your romantic partner's relative	2, 154	1.137	.323
#7 you ask your therapist to visit you in the hospital	2, 154	9.399	<.001*
#8 you offer your therapist an extra ticket	2, 154	17.125	<.001*
#9 you offer to buy coffee and a doughnut	2, 154	12.468	<.001*
#10 you tell your therapist you find them sexually attractive	2, 153	4.741	.010*
#11 you tell your former therapist you want to date someone	2, 153	7.232	.001*
#12 you ask your therapist to dance at a club	2, 153	5.041	.008*
#13 you ask your therapist for an itemized bill to submit to insurance	2, 153	1.328	.268
Total Score	2, 151	17.036	<.001*

*p<.05

In addition, there is a significant difference between the total scores of the three groups.

Post Hoc tests were performed for all questions when the ANOVA indicated significant differences between groups. For questions in which the three groups met the assumption of homogeneity of variance (questions 2, 4, 5, 7, 9), a Least Significant Difference (LSD) test was performed. For questions in which the assumption of homogeneity of variance was not met (questions 3,8, 10, 11, 12, and the total score), a Dunnett test was used.

For questions 2, 4, 5, 8, 9, 10, 11, 12, and the total score (See Table 5.2), the results showed that the therapist interns responded to the survey significantly differently than the other two groups. For these questions however, no significant difference was found to exist between the General Group and the Educated Group. On question 3 (See Table 5.2), Post Hoc Tests found no significant differences between the three groups, most likely because the assumption of homogeneity of variance was not met, and the more conservative Dunnett Test was used to compare group means pair-wise. For question 7 (See Table 5.2), all three groups were found to be significantly different than each other.

Table 5.3

Results of Post Hoc Tests

Question Situation	Mean of General Group (1)	Mean of Educated Group (2)	Mean of Therapist Intern Group (3)	Differences*
#2 you see your therapist in the mall	2.667	2.829	4.083	(1,3)(2,3)
#3 your car won't start so you ask to borrow bus money	2.258	2.250	3.167	
#4 you give your therapist a gift	2.803	2.855	4.333	(1,3)(2,3)
#5 you send your therapist a holiday card	2.076	2.112	3.167	(1,3)(2,3)
#7 you ask your therapist to visit you in the hospital	1.742	2.104	2.833	(1,2)(1,3)(2,3)
#8 you offer your therapist an extra ticket	2.955	3.234	4.917	(1,3)(2,3)
#9 you offer to buy coffee and a doughnut	3.061	3.130	4.667	(1,3)(2,3)
#10 you tell your therapist you find them sexually attractive	3.900	4.312	4.750	(1,3)(2,3)
#11 you tell your former therapist you want to date someone	3.646	3.714	4.917	(1,3)(2,3)
#12 you ask your therapist to dance at a club	3.862	4.026	4.833	(1,3)(2,3)
Total Score	35.7923	38.2067	48.0833	(1,3)(2,3)

*Figures in parentheses indicate which groups (General=1, Educated=2, Therapist Interns=3) differ significantly from one another at the $p<.05$ level.

Discussion for Further Analysis

Overall, the results show that therapist interns rated boundary transgressions as significantly less acceptable than the General Group and the Educated Group. However, no significant difference exists between the General group and the Educated group except for question 7 (See Table 5.2). This is perhaps due to the brevity of the information provided to the participants pertaining to boundary transgressions during therapy.

Implications for Clinical Practice

Educating the lay public. The results suggest that the lay public (the Educated Group and the General Group), regardless of the education received, found most of the boundary transgressions described in the vignettes acceptable. Educating the lay public by providing them with specific information about boundary transgressions had some effect, but the effect was relatively small and did not seem to follow any specific pattern. The results of the same survey when it was presented to a group of therapist interns were vastly different than either of the lay groups (Educated Group and General Group). The therapist interns found the situations presented in the survey as less acceptable than the lay groups. The investigator of this study believes the training that the therapist interns received in their education influenced the answers given on the survey. However, the brief information provided to the Educated Group and General Group had little influence on their responses. While the difference in scores between the lay groups and the Therapist Intern Group could have a variety of explanations (e.g. age or education level), it is possible that a more comprehensive explanation of boundary transgressions (which therapist interns received) could result in the lay public responding similarly to the therapist interns. Perhaps if the information was provided with a verbal explanation, the results would have been different. It is likely that the participants may not have read or understood the introductory education (general information about personal/family therapy or specific information pertaining to boundary transgressions) provided to them.

The literature pertaining to boundary transgressions reiterates the importance of educating the lay public. For example, Somer and Saadon (1995) suggest disseminating information pertaining to boundary transgressions during therapy, and potential legal action clients may take against therapists who transgress boundaries. They discuss distributing this information to clients via the Internet and brochures, before or during clients' initial therapy session. Layman and McNamara (1997) believe that this action might help deter therapists from engaging in unethical and unlawful behavior. Somer and Saadon also explain that clients should be taught subtle signs indicating that boundary transgressions are about to occur, or have already occurred. Lastly, they suggest providing clients advice on how to discuss this issue with their therapist if they are alerted to such subtle signs.

Educating mental health professionals. According to Valentick and Gripton (1992), much more effort has gone into drafting professional codes of ethics than into educating practitioners about the codes, and how to avoid unethical conduct. However, more needs to be done to educate professionals for ethical practice. The literature discusses how mental health professionals recommend providing more information in undergraduate, graduate, and continuing education programs regarding boundary transgressions.

Including the lay public's perspective. Mental health professionals create standards believed to protect clients' welfare and best interest, yet they tend to do this without the input or presence of the consumers of mental health services. Including clients' perspectives in ethics can empower clients because it indicates to them that they have an important voice. Including clients' viewpoints also fits well with current therapy models. For example, brief and solution-focused therapies emphasize collaboration between therapists and their clients. Clients determine their goals, and therapists help them reach these goals by drawing upon the clients' successes and strengths. Thus, it makes sense to extend this way of thinking into the arena of ethics. To truly respect clients, and work within their frame of reference, their views regarding ethics must be examined (Walden, 1996).

According to Walden (1996) including clients' perspective is also considered culturally appropriate. For example, in some cultures, clients show their appreciation for their therapist's good work by giving gifts. In the United States, therapists may have strict beliefs and policies that do not allow them to accept such gifts. Without exchanging viewpoints about such beliefs, misunderstanding may occur. For example, clients may be offended if they give their therapist a gift, as a way to thank the therapist for his or her help, and the therapist refuses to accept the gift due to his or her beliefs regarding non-sexual boundary transgressions. In addition, without exchanging viewpoints, therapists may not understand the reasons behind their clients' action.

Boundary transgressions and marriage and family therapy. Because marriage and family therapists frequently work with couples and families, they must guard against engaging in multiple relationships because having a prior personal or professional relationship with one family member or spouse may compromise the neutrality of the therapist. Boundary

transgressions, in the context of couples or family therapy, are harmful because such transgressions have the potential to create inappropriate alliances (Herlihy & Corey, 1997; Kaslow, 1998). For example, imagine a therapist working with a couple, and the therapist previously dated the male in the relationship. The relationship ended on "a bad note." Thus, the therapist was easily able to empathize with the female's complaints about her male partner.

In the context of marriage and family therapy, one individual may attempt to seductively manipulate the therapist in order to undermine the therapeutic alliance. In this situation, the client may attempt to gain the therapist's allegiance against his or her spouse or other family members. Examples of this seduction may include actions such as winks, smiles, or the denigration of other family members in the therapy session (Edelwich & Brodsky, 1991).

Marriage and family therapy is a relatively new field. As a result, there is a paucity of research concerning marriage and family therapists' views regarding boundary transgressions. Nickell et. al. (1995) surveyed marriage and family therapists and found no admissions of sexual contact with clients. They conclude that this may be due to a real decrease in incidences, or a greater reluctance of professionals to admit such behavior. These investigators also found that the majority of their participants reported little or no training on issues relating to sexual attraction to clients. Because the therapist interns surveyed in the current study rated boundary transgressions as less acceptable than the lay public, who read specific information pertaining to boundary transgressions, it may be that the specific marriage and family therapy program surveyed did an effective job of educating practitioners. It would be important to survey therapist interns from other programs before drawing any type of definite conclusion regarding the results of this study.

As mentioned previously, the code of ethics for marriage and family therapists do not provide clear guidelines for negotiating multiple relationships. According to Hill and Mamalakis (2001), simple and clear guidelines would not even be able to capture the complexity of such relationship issues in certain settings, such as in religious communities. This is important to note because marriage and family therapists report the most religious involvement of all the mental health specialists (Bergin & Jensen, 1990). Further empirical investigation may help those in the

field of marriage and family therapy make appropriate choices relating to boundary transgressions during therapy.

Limitations

The similarity of the results between the Educated Group and the General Group may be due in part to some of the limitations of this study. The participants sampled were not a random, cross-section of the population. They were college students from the same university, between the ages of 18 and 23. This limits the study to only a specific range of age, education, and to a lesser degree economic background. Thus, college students do not necessarily represent the lay public.

The administration of the survey also created some limitations. The education provided to the Educated Group was very brief and not accompanied by any type of verbal explanation. There was also no way of knowing if the participants read the education, or simply filled out the survey as quickly as possible.

This was a quantitative study. Perhaps qualitative data (e.g. asking participants to explain how they decided to rate each question) would provide richer data.

Due to the limitations described above, the results of this study need to be carefully interpreted.

Future Research

Because this was an exploratory study, additional research will help professionals learn more about boundary transgressions from the lay public's perspective. The vast difference found between the responses of the lay public (Educated Group and General Group) and the Therapist Intern Group, in the Further Analysis section of this study, may indicate that the education provided to the General Group and Educated Group was not very effective. Future research could investigate effective ways to educate consumers.

The two groups (Educated Group and General Group) were provided with some type of educational information. However, researchers may want to compare the responses of those who do not receive any type of educational information with the responses of those who receive specific information about boundary transgressions, and those who receive general information about therapy. In addition, it would be interesting to compare the responses of those in the Educated Group and General Group to the responses of those who received therapy (participants who indicated they received personal/family therapy in the past were eliminated from the data analysis). This type of comparison would help to determine if therapists are informally educating their clients about the dangers of boundary transgressions.

The vignettes in the current study imply that therapy occurred in the context of individual therapy. However, the same situations arise in the context of couples and family therapy. Few studies that examine boundary transgressions pertaining to marriage and family therapy exist. The available literature tends to acquire the viewpoints of psychiatrists, psychologists, and social workers. However, marriage and family therapists are not immune to boundary transgressions. Thus, it would be interesting to examine the lay public's level of acceptance of boundary transgressions occurring in the context of couples or family therapy. Researchers may consider comparing the lay public's level of acceptance of boundary transgressions when such transgressions occur in the context of couples or family therapy, as opposed to in the context of individual therapy.

Conclusion

Most of the literature pertaining to boundary transgressions assesses professionals' points of view. However, this study assessed the perspectives of the lay public. Although therapists are ultimately responsible for ensuring their clients are not exploited during the therapeutic relationship, it is also beneficial for clients to understand the potential harm that may result from boundary transgressions. When clients are aware of the dangers boundary transgressions may cause, they may be less likely to tolerate such transgressions. It was promising to learn from the further analysis that the therapist interns, who rated the boundary transgressions less acceptable than the Educated Group or General Group, grasp what types of relations are appropriate with clients. According to the literature, educating the lay public about the potential adverse

consequences of boundary transgressions is crucial. However, the challenge may be in finding exactly what type of information would help lower the lay public's level of acceptance to boundary transgressions, and how to effectively disseminate this information.

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APPENDIX A

Participant Informed Consent

Title of the Study: Boundary Transgressions in Therapeutic Relationships

Investigator: Staci J. Rosenbloom, master's student in the Marriage and Family Therapy Program at Virginia Polytechnic Institute and State University, will conduct this study.

I. Purpose of this Research

To assess people's view of therapists' behavior.

II. Procedures

As a participant in this study, you will read some information pertaining to personal/family therapy (located in the box labeled "Personal/Family Therapy"), and then complete the survey consisting of 13 vignettes, below the box. You will rate how acceptable it would be for a personal/family therapist to engage in the behaviors described in the vignettes. The rating scale ranges from 1 to 5, with 1 being completely acceptable, and 5 being completely unacceptable. This survey should take no longer than 20 minutes to complete.

III. Risks and Benefits of this Project

Because you will only be asked to fill out a survey, no risks are anticipated. Your participation will give researchers a better understanding of what people believe to be responsible, professional behavior. If requested, the investigator will mail you the results of this study

IV. Anonymity and Confidentiality

Your responses will be confidential. The only information linking you as a participant in this project is the Informed Consent Form [this form], which will be kept separate from the survey. The survey will not ask you to indicate your name. Only the investigator, and her advisor, will have access to the surveys. Upon completion of this study, the surveys will be destroyed.

V. Compensation

No compensation is offered for participation, except for the researcher's appreciation for your time.

VI. Freedom to Withdraw

If at any time you choose to not continue your participation in this study, you have the right to withdraw your consent, and not participate. If at any time you do not feel comfortable responding to a scenario, you have the right to leave it blank.

VII. Approval of Research

This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University and by the Department of Human Development.

VIII. Participant's Responsibility

You will voluntarily agree to participate in this study. As a result of participation, you will read the information pertaining to personal/family therapy and rate how acceptable it would be for a personal/family therapist to engage in the behaviors described in the vignettes

Should you have any questions about this research or its conduct, you may contact:

Staci J. Rosenbloom
Investigator (703) 538-8470

Eric E. McCollum
Faculty Advisor (703) 538-8463

David Moore
Chair, IRB
Research Division (540) 231-4991

IX. Participant's Permission

I, _____ am at least 18 years of age, and have read
(Print full name)
and understand the Participant Informed Consent Form and conditions regarding this project. I voluntarily give my consent to participate in Staci J. Rosenbloom's project.

If I participate, I may withdraw at any time without penalty.

_____ _____
Participant's Signature Date

APPENDIX B

General Information Regarding Personal/Family Therapy

1) How old are you? ___ years

2) What Is your major? _____

3) What is your gender?

Male ___ Female ___

4) What year are you in school? (Circle one)

Fresh Soph Junior Senior

5) Have you ever been in personal/family

therapy before?

Yes ____ No ___

Personal/Family Therapy

Therapy holds out the promise of helping people who are hurting and in need. Therapists help clients resolve issues that are very personal in nature. Therapists assist clients by gathering information, analyzing scenarios, and offering alternative solutions to problems. Therapists also help clients reach decisions by themselves. Therapy allows clients to become aware of aspects of themselves that were previously unconscious. The therapeutic process enables clients to lead healthier and more satisfying lives.

After reading the above description of the personal/family therapeutic relationship, please read each of the following vignettes. After each vignette, there is a scale that asks you to indicate how acceptable you think it would be for a therapist to engage in the action described in the vignette. **Please CIRCLE your answer.**

1). You and your therapist have been calling each other by your last names since you began therapy. As you begin to talk about some more painful things from your past, you think it would be more comfortable for you if you and your therapist used first names. You ask your therapist to call you by your first name and ask your therapist to do the same. How acceptable would it be for your therapist to agree to your request?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
1	2	3	4	5

Please go to next page . . ..

2). You see your therapist at the mall. You've had a great week and go over to tell your therapist how well things have been going. Then you ask about the week your therapist had. How acceptable would it be for your therapist to tell you about life events that transpired over the past week?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
1	2	3	4	5

3). You leave your therapist's office after your weekly session to find that your car won't start. You call AAA but they can't come for 3 hours or more. You then realize that you don't have any money for the bus and that you are going to miss an important class. Just as you are wondering what to do, your therapist comes to the parking lot. You ask your therapist to loan you money for the bus. How acceptable would it be for your therapist to loan you money?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
1	2	3	4	5

4). Your therapist has been very helpful to you in solving problems that were really bothering you. As a token of gratitude, you bring a $10 gift certificate to your final session to give to your therapist. How acceptable would it be for your therapist to accept your gift?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
1	2	3	4	5

5). You decide to send your therapist a holiday card in December. How acceptable would it be for your therapist to send you a holiday card in response?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
1	2	3	4	5

6). Your doctor recommends that you seek therapy. The therapist the doctor recommends happens to be a distant relative of the person with whom you are in a serious relationship. When you call to make a first appointment, you tell the therapist- who happens to be one of the only therapists in the area who is accepting new clients- that your romantic partner is the therapist's relative. How acceptable would it be for the therapist to accept you as a client under these circumstances?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
1	2	3	4	5

Please go to next page . . ..

7). You are injured in a car accident and have to stay in the hospital for several days. You call your therapist and ask your therapist to come to the hospital to visit you since the accident was traumatic and your doctor has given you bad news about your recovery. How acceptable would it be for your therapist to visit you in the hospital?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
1	2	3	4	5

8). Your therapist is a huge Redskins fan, and has been on the waiting list for tickets for years. You have season tickets. The friend you go to the games with can't attend one game so you have an extra ticket. You offer the therapist the extra ticket and mention that the therapist can sit in the friend's seat next to you or a few rows back where you know some people won't be making the game. How acceptable would it be for your therapist to accept the ticket?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
1	2	3	4	5

9). After a "break through" session with your therapist, you both are excited about the progress you have made. You want to show your appreciation for your therapist's help and offer to buy coffee and a doughnut for both of you at the coffee shop across the street. How acceptable would it be for your therapist to accept this gesture of thanks?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
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10). You have been finding yourself thinking how sexually attractive your therapist is, and decide to discuss this feeling in one of your sessions. How acceptable would it be for your therapist to tell you that they find you sexually attractive as well- if this were the truth- but that it would not be right for either of you to act on those feelings?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
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Please go on to the next page . . . .

11). A romantic partner was being abusive toward you and you sought therapy to figure out what to do. You decided to end the relationship and then ended therapy. You run into your former therapist at the gym one day and your therapist asks how things are going. You say that you are really relieved to be out of the relationship but that you'd really like to go out on a date with someone. You've been feeling lonely. How acceptable would it be for your former therapist to ask you out on a date?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
1	2	3	4	5

12). You are at a dance club with friends when you see your therapist. A slow song comes on and you ask your therapist to dance. How acceptable would it be for your therapist to dance with you?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
1	2	3	4	5

13). You just find out after attending 5 sessions of therapy that your insurance company will cover your sessions. However, you need to ask your therapist for an itemized bill to submit to the insurance company. How acceptable would it be for your therapist to comply with your request?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
1	2	3	4	5

That's it. Thanks!

APPENDIX C

Specific Information Regarding Boundary Transgressions

1) How old are you? ___ years

2) What Is your major? _____

3) What is your gender?

Male ___ Female ___

4) What year are you in school? (Circle one)

Fresh Soph Junior Senior

5) Have you ever been in personal/family

therapy before?

Yes ___ No ___

Personal/Family Therapy

It is a therapist's ethical, professional, and legal duty to establish and maintain clear treatment boundaries with clients. The client's needs must be the primary consideration in therapy. A therapist is to remain neutral and refrain from interfering in clients' personal affairs that are not part of the therapeutic agenda. Ethical codes of almost all the mental health professions prohibit or warn of the dangers of relationships involving boundary transgressions (the therapist and client becoming involved in kind of non-therapy relationship with one another) because they have the potential of impairing the therapist's professional judgment and thereby exploiting clients.

After reading the above description of the personal/family therapeutic relationship, please read each of the following vignettes. After each vignette, there is a scale that asks you to indicate how acceptable you think it would be for a therapist to engage in the action described in the vignette. **Please CIRCLE your answer.**

1). You and your therapist have been calling each other by your last names since you began therapy. As you begin to talk about some more painful things from your past, you think it would be more comfortable for you if you and your therapist used first names. You ask your therapist to call you by your first name and ask your therapist to do the same. How acceptable would it be for your therapist to agree to your request?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
1	2	3	4	5

Please continue to the next page . . . .

2). You see your therapist at the mall. You've had a great week and go over to tell your therapist how well things have been going. Then you ask about the week your therapist had. How acceptable would it be for your therapist to tell you about life events that transpired over the past week?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
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3). You leave your therapist's office after your weekly session to find that your car won't start. You call AAA but they can't come for 3 hours or more. You then realize that you don't have any money for the bus and that you are going to miss an important class. Just as you are wondering what to do, your therapist comes to the parking lot. You ask your therapist to loan you money for the bus. How acceptable would it be for your therapist to loan you money?

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4). Your therapist has been very helpful to you in solving problems that were really bothering you. As a token of gratitude, you bring a $10 gift certificate to your final session to give to your therapist. How acceptable would it be for your therapist to accept your gift?

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6). Your doctor recommends that you seek therapy. The therapist the doctor recommends happens to be a distant relative of the person with whom you are in a serious relationship. When you call to make a first appointment, you tell the therapist- who happens to be one of the only therapists in the area who is accepting new clients- that your romantic partner is the therapist's relative. How acceptable would it be for the therapist to accept you as a client under these circumstances?

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7). You are injured in a car accident and have to stay in the hospital for several days. You call your therapist and ask your therapist to come to the hospital to visit you since the accident was traumatic and your doctor has given you bad news about your recovery. How acceptable would it be for your therapist to visit you in the hospital?

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8). Your therapist is a huge Redskins fan, and has been on the waiting list for tickets for years. You have season tickets. The friend you go to the games with can't attend one game so you have an extra ticket. You offer the therapist the extra ticket and mention that the therapist can sit in the friend's seat next to you or a few rows back where you know some people won't be making the game. How acceptable would it be for your therapist to accept the ticket?

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10). You have been finding yourself thinking how sexually attractive your therapist is, and decide to discuss this feeling in one of your sessions. How acceptable would it be for your therapist to tell you that they find you sexually attractive as well- if this were the truth- but that it would not be right for either of you to act on those feelings?

Completely Acceptable	Mostly Acceptable	Maybe Acceptable/ Maybe Unacceptable	Mostly Unacceptable	Completely Unacceptable
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1	2	3	4	5

That's it. Thanks!

VITA
Staci Rosenbloom

Contact Information:

E-mail: srosenbl@vt.edu

Education:

Virginia Polytechnic Institute and State University, Falls Church, Virginia
Master of Science in Human Development, Marriage and Family Therapy Program

University of Florida, Gainesville, Florida
Bachelor of Science in Psychology, with Highest Honors, December 1998

Therapy/Professional Experience:

Intake Coordinator, Northern Virginia Family Service - Conduct intakes with potential clients over the phone; schedule appointments; provide information/referrals to callers'; verify clients' insurance benefits; coordinate services with EAP companies; and complete monthly statistical reports (August, 2003 – Present)

Therapist Intern, Chaplain Family Life Ministry & Training Center (Fort Belvoir) – Conducted therapy sessions with individuals, couples, and families in the military community regarding issues relating to depression, anxiety, communication problems, school problems, domestic violence, and spiritual issues; received feedback of my taped therapy sessions from Chaplain and Pastoral team (October, 2002 – June, 2003).

Assistant Clinic Support, The Center for Family Services – Conducted intake interviews with potential clients; provided information/referrals to callers; assisted interns with paperwork and file upkeep; assisted with billing; and assisted in day-to-day managing of a family therapy agency. (August, 2000 – June, 2003)

Therapist Intern, The Center for Family Services **–** Conducted therapy sessions with individuals, couples, and families regarding issues relating to substance abuse, suicide, depression, anxiety, communication problems, school problems, and behavioral problems; observed behind a one-way mirror by a licensed Marriage and Family Therapist. (September, 2001 – May, 2003)

In-home Service Mentor, Inova Kellar Center – Spent time with a nineteen year old female out in the community; helped female increase self-esteem and engage in socially appropriate behavior; completed case notes and monthly reports. (August, 2001 – August, 2002)

Counseling/Professional Experience (Continued):

Children's Case Manager, The Sexual and Physical Abuse Resource Center (SPARC) – Planned and facilitated child/teen enrollment in school; planned and facilitated support groups; maintained various statistics regarding demographics and levels of knowledge relating to domestic violence; ensured children's/teens' assessments, safety plans, and other forms were completed timely; completed initial risk assessments within the first 24 hours of arrival (on an on-call basis); and identified children/teens who may have been victims of physical, sexual, and/or emotional abuse. (October, 1999 – June, 2000)

Violence Prevention, The Sexual and Physical Abuse Resource Center (SPARC) – Trained to present "Second Step" violence prevention curriculum to Preschoolers through Fifth Graders; present "Second Step" curriculum to Preschoolers weekly; presented information about domestic violence to middle school students at the March of Dime's "Chain Reaction" eleventh annual Student Health Conference; presented information about abuse and safety to students in Kindergarten through Fourth Grade; presented information about abuse and assertiveness to Fifth Graders; presented information about sexual abuse and sexual harassment to Fifth Graders; presented information, at a family visitation center, on how domestic violence effects children (February, 2000 – June, 2000)

Child Advocate, The Sexual and Physical Abuse Resource Center (SPARC) – Planned and facilitated support groups for children/teens who were living, or lived in a home where domestic violence occurred; educated survivors of domestic violence in support groups about the effects of domestic violence on children/teens; conducted initial risk assessments for children/teens in the shelter within 24 hours of arrival (on an on-call basis), and prepared recommendations based upon assessments' results as requested by the State of Florida's Department of Children and Families; and identified children/teens who may have been victims of sexual, physical, and/or emotional abuse. (June, 1999 – October, 1999)

Client Service Representative, The Sexual and Physical Abuse Resource Center (SPARC) – Answered the 24 hour toll free hotline; provided information/referrals; crisis counseling; and shelter screenings. Helped staff with safety planning; establishment of weekly goals; and intake and departure interviews with clients. Provided general shelter assistance. (February, 1999 – June, 1999)

Honors:

- Outstanding Student Honor Society for Graduate Studies
- Golden Key National Honor Society
- Gamma Sigma Alpha Greek Academic Honor Society
- Phi Kappa Phi Honor Society
- University of Florida President's Honor Roll
- University of Florida Dean's List
- Gamma Sigma Alpha Scholarship Achievement Award
- Phi Mu Sorority Scholarship Charm (recognition for 4.0 grade point average)
- Phi Mu Sorority Certificate of Academic Achievement
- Phi Mu Sorority Carnation Sister Award

Membership:

AAMFT Member (September, 2001 – Present)