1994

Ethics in Psychotherapy: The Practice of Nonsexual Dual Roles

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ETHICS IN PSYCHOTHERAPY: THE PRACTICE OF NONSEXUAL DUAL ROLES

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

DEPARTMENT OF PSYCHOLOGY

BY

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CHICAGO, ILLINOIS

MAY 1994

ACKNOWLEDGEMENTS

I would like to thank the chairman of my dissertation committee, Pat Rupert, Ph.D. for her guidance and support in the completion of this project. Her expertise and commitment to this area of research helped make this project a valuable and rewarding experience.

I would also like to thank the members of my committee, Dan Barnes, Ph.D., Linda Heath, Ph.D., and Grayson Holmbeck, Ph.D. for their useful insights and contributions. Special thanks to Dan for his steadfast support and faith throughout my graduate education. His guidance and perspectives have been extremely important to me in my personal and professional development as a psychologist. Thanks also to Grayson, my academic advisor, for his time, support, and patience in helping me to navigate through the innumerable tasks and challenges of graduate school.

I would also like to thank my friends and my family, especially my parents, Pat and Judy Aikman. Their presence, encouragement, and support of my work has helped sustain me and given me the strength and endurance to attain this goal.

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CHAPTER I

INTRODUCTION AND REVIEW OF RELATED LITERATURE

Within the field of psychology there has been a growing concern for the ethical practice of psychotherapy. Evidence of this growing concern has been manifest in numerous ways including the recent proliferation of research and literature addressing ethical responsibilities and dilemmas that frequently confront psychotherapists.

The range of ethical issues in psychotherapy receiving increased attention and recognition is quite broad. Some of the issues include, confidentiality, therapist competency, dual role relationships, conduct of colleagues, questionable or harmful interventions, termination, helping the financially stricken, billing practices, informed consent, access to records, and supervisory relationships (Pope & Vetter, 1992; Keith-Spiegel & Koocher, 1985). All of these issues are extremely relevant to the practice of psychotherapy and at some point confront most clinicians. The importance of these issues is evidenced by the fact that the APA Ethics Principles (1981, 1992) address, in some fashion, all of these issues.

Though there exist a myriad of potentially problemat-

ic ethical situations in psychotherapy, dual role relationships have received a disproportionate amount of attention and scrutiny. Dual role relationships in therapy occur when a therapist is involved in a second, significantly different relationship with a client. The second relationship is typically social, financial, professional and sometimes, sexual (Pope, 1991). The relationships do not have to exist concurrently to be dual roles. A dual role may exist when a social, financial, professional or sexual relationship precedes the therapy relationship or when a therapist becomes involved in a second relationship with a former client.

Dual Role Relationships: General Background

The Ethical Principles (APA, 1981, 1990, 1992) have consistently recognized the potential harm associated with dual role relationships and renounce this practice in situations where the psychologist's professional judgement is adversely affected and the risk of exploitation is present. The former ethics code states in Principle (6a) (APA, 1981):

> Psychologists are continually cognizant of their own needs and of their potentially influential position vis-a-vis persons such as clients, students, and subordinates. They avoid exploiting the trust and dependency of such persons.
>
> Psychologists make every effort to avoid dual relationships that could impair their professional judgment or increase the risk of exploitation. Examples of such dual relationships in-

> clude research with and treatment of employees, students, supervisees, close friends, or relatives. Sexual intimacies with clients are unethical.

The most recently revised Ethics Code (APA, 1992) advises against "multiple relationships" (Principle 1.17) with patients, students, supervises and research participants. In situations where harmful dual relationships occur and are unforeseen, the Code states that it is the responsibility of the psychologist to resolve the situation with, "due regard for the best interests of the affected person and maximal compliance with the Ethics Code." The revised Code also includes principles which specifically address the issue of bartering (Principle, 1.18), and sexual relations with students, supervisees and current and former clients (Principles 1.19, 4.05, 4.07).

The Ethics Codes (APA, 1981, 1990, 1992) have addressed dual roles/multiple relationships because the profession recognizes the importance of maintaining appropriate boundaries in the therapy relationship. The therapy relationship has established boundaries that both the therapist and client rely upon. These boundaries provide some consistency and expectation for the ways in which the therapist and client will interact. When the boundaries are significantly altered, the potential for impairing the therapy process is great (Gabbard & Pope, 1988). A second, and typically conflicting set of expectations and

interests are introduced when a dual role is established. The therapist, responding to the second role (e.g., social or sexual) risks compromising a client's best interests in order to meet his/her own needs. The therapist's judgement thus becomes less objective. Furthermore, fluid and/or unpredictable boundaries may leave a client confused about the nature of the professional relationship.

A variety of types of dual role relationships exist; however, those of a sexual nature have received considerably more attention in professional literature and research than nonsexual dual role relationships. A primary reason for this is likely that sexual relationships with clients represent the most serious form of boundary violation. The psychological impact of therapist-client intimacies on clients has been widely researched (Bouhoutsos, Holroyd, Lerman, Forer, Greenberg, 1983; Brown, 1988; Gabbard & Pope, 1988; Sonne, Meyer, Borys, & Marshall, 1985) and the research indicates that the effects are often serious and long-lasting. Another reason for the disproportionate amount of attention given to the study of sexual dual relationships is that this practice frequently results in ethics complaints and civil suits against offending therapists. Sexual dual relationships account for the majority of licensing disciplinary actions, financial losses in malpractice suits, and ethics complaints

(Pope, 1989; Ethics Committee of the APA, 1988). Furthermore, the practice of sexual relations with clients is the only dual role relationship which is legally prohibited in some states. Minnesota and Wisconsin state laws consider sexual intimacies with clients a felony with prison terms of up to 10 years and fines of up to $20,000 (1983 Wisconsin Act 434; Chapter 297 Minnesota Laws, 1985; cited in, APA, 1988).

The consensus is high among mental health professionals that the practice of sexual relations with clients is unethical and should never be condoned. Borys and Pope (1989) surveyed a group of psychologists, social workers, and psychiatrists and asked half of the respondents to indicate how frequently they had engaged in sexual relations with clients (i.e., with: no clients, few clients, some clients, most clients, all clients). The other half of the respondents were asked how ethical they believed this practice to be (i.e., never ethical, ethical under rare conditions, ethical under some conditions, ethical under most conditions, always ethical). They found that nearly all the subjects (98.3%) considered the practice, "never ethical," and most subjects (98.7%) reported that they had never engaged in sexual relations with a client. Pope, Tabachnick, and Keith-Spiegel (1988) surveyed a group of psychologists from Division 29 (Psychotherapy)

and asked them to indicate the extent to which they considered having sexual relations with clients to be good or poor practice (i.e., poor, poor under most circumstances, don't know/not sure, good under most circumstances, good). The investigators found that 97% indicated that this practice was "poor."

Established ethical standards addressing sexual relations with clients reflect the consensus among mental health professionals that this type of dual role relationship is unethical. Sexual relationships with clients are specifically and explicitly prohibited by the American Psychological Association (1981, 1992) as well as by other mental health professions including the American Psychiatric Association (1973) and the National Association of Social Workers (1980). The former Ethics Code (Principle 6a), (APA, 1981) states, "Sexual intimacies with clients are unethical," and the revised Code (Principle 4.05) states, "Psychologists do not engage in sexual intimacies with current patients or clients." Moreover, the revised Code explicitly advises against the practice of providing therapy to former sexual partners (Principle 4.06) and engaging in sexual relations with former clients (Principle 4.07).

Nonsexual dual role relationships have received significantly less professional attention and study than

sexual dual relationships. This is somewhat surprising given that the prevalence of nonsexual dual role relationships far exceeds that of sexual dual relationships (Pope, Tabachnick & Keith-Spiegel, 1987; Borys & Pope, 1989). Pope, Tabachnick and Keith-Spiegel (1987) surveyed 456 psychologists from Division 29 (Psychotherapy) and found that 1.9% of the respondents indicated that they had sexual relations with current clients and 11.1% had had relations with former clients. Borys and Pope (1989) surveyed 2,332 psychologists, psychiatrists, and social workers and found that .5% of the respondents had had sex with current clients and 3.9% had had sex with former clients. These two studies (i.e., Borys & Pope, 1989; Pope, Tabachnick, & Keith-Spiegel, 1987) also examined the prevalence of nonsexual dual role relationships. Between 10 and 45 percent of the respondents in each study indicated that they had engaged in the following nonsexual dual role behaviors: became friends with former clients, bartered for services, invited clients to a party, social event or open house, accepted an invitation to a client's special event, employed a client, and sold a product to a client.

Though the research indicates a higher prevalence of nonsexual dual relationships than sexual dual relationships, it is difficult to know the actual incidence of

either of these practices. This is likely the case because survey respondents may be reluctant to admit engaging in these behaviors because they are typically considered unethical and in some cases illegal.

There are a variety of ways in which nonsexual dual role relationships can be established between a therapist and a client. Keith-Spiegel and Koocher (1985) identified and described the following types of nonsexual dual relationships: treating close friends, family members and employees, socializing with and employing current and former clients, accepting "significant other" referrals, accepting gifts and favors and bartering for services. Unlike sexual dual roles, there is no single, striking behavior or set of behaviors that denote that a nonsexual dual role has occurred. Each nonsexual dual role situation typically involves a unique set of features/circumstances and thus it is difficult to explicitly define nonsexual dual roles and to evaluate their impact. Furthermore, Keith-Spiegel & Koocher (1985) make the point that little consensus exists among psychologists as to when a client is no longer a client, or what differentiates a close friend from an acquaintance.

Because of the inherent difficulty in defining nonsexual dual role relationships, they often create complicated clinical and ethical dilemmas for psychologists.

Unfortunately, the Ethical Principles (APA, 1981, 1992) may be only minimally helpful in guiding clinicians toward making ethical decisions in nonsexual dual role situations. The Ethical Principles addressing "multiple relationships" (Principle 1.17, APA, 1992) states:

> In many communities and situations, it may not be feasible or reasonable for psychologists to avoid social or other nonprofessional contacts with persons such as patients, clients, students, supervisees, or research participants. Psychologists must always be sensitive to the potential harmful effects of other contacts on their work and on those persons with whom they deal. A psychologist refrains from entering into or promising another personal, scientific, professional, financial, or other relationship with such persons if it appears likely that such a relationship reasonably might impair the psychologist's objectivity or otherwise interfere with the psychologist's effectively performing his or her functions as a psychologist, or might harm or exploit the other party.
>
> Likewise, whenever feasible, a psychologist refrains from taking on professional or scientific obligations when preexisting relationships would create a risk of such harm.
>
> If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist attempts to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

Principle 1.17 (APA, 1992) addressing nonsexual, multiple roles is not nearly as explicit as the Principles (APA, 1981, 1992) addressing sexual dual relationships. Sexual relations with clients are explicitly unethical and attempts made by offending psychologists to justify this

behavior are viewed as inadequate (Pope, 1991). However, Principle 1.17 (APA, 1992) implies that nonsexual dual role relationships may not always be avoidable ("it may not be feasible or reasonable for psychologists to avoid social or other nonprofessional contacts with persons such as patients...."). Furthermore, the Code seems to suggest that in exceptional circumstances dual roles might be justified and may exist without significant harm to the client or to the therapy relationship. The code states, "A psychologist refrains from entering into or promising another personal, scientific, professional, financial, or other relationship with such persons if it appears likely that such a relationship reasonably might impair the psychologist's objectivity...or might harm or exploit the other party." Nonsexual dual role situations often create complicated ethical dilemmas and therefore clinicians may look to the Ethics Code for guidance and clarification. However, the Ethics Code may be of limited usefulness in some situations as it does not definitively indicate that nonsexual dual roles are unethical and avoidable in all situations. Clinicians may therefore need to rely upon their clinical judgment, the judgment of colleagues with whom they consult, and professional ethics committees to determine how best to deal with these ethical dilemmas.

Most would agree that it is unrealistic and inappro-

priate to expect the Ethics Code to provide strict definitions for nonsexual dual roles and guidelines for dealing with them (Keith-Spiegel & Koocher, 1985; Ryder & Hepworth, 1990). Though this may be the case, Pope and Vetter (1992) have offered several suggestions for improving the Ethics Code so that it can more adequately serve as a resource and guide for psychologists dealing with potential nonsexual dual role relationships. First, Pope and Vetter believe that the Ethics Code should distinguish between the different types of extra-therapeutic contact that exist. "Accidental" contact refers to times when a client and therapist interact outside of therapy unexpectedly (e.g., running into a patient at the grocery market or unexpectedly seeing a client at a party). Borys and Pope (1989) defined "incidental" contact as "one-time exceptional boundary alterations initiated by the client and accepted by the therapist (e.g., inviting a therapist to a special occasion)." Accidental and incidental contact should be distinguished from dual role relationships because they all represent very different ways in which a therapist and client interact outside the therapy relationship. These different types of contacts and relationships undoubtedly affect the therapy relationship; however, the impact may be quite different depending upon what type of contact exists. Furthermore, accidental, inciden-

tal and dual roles likely differ in the extent to which they are avoidable. Therefore, in order for the Ethics Code to adequately address extra-therapeutic contact, it may be necessary to identify the various ways in which this contact occurs.

Pope and Vetter (1992) have also suggested that the Ethics Code offer more clarity and specificity in determining if and when nonsexual dual role relationships are ever therapeutically indicated or acceptable. This is important because, as mentioned above, it is not clear that nonsexual dual relationships are <u>always</u> unethical and avoidable in every circumstance (Stockman, 1990). In exceptional instances it may be possible for a clinician and client to identify and effectively negotiate accidental, incidental and dual roles in a manner which creates minimal risk to the client and to the therapy relationship.

Guidance in determining the impact and advisability of dual role relationships is apparently what clinicians need, considering the clinical and ethical dilemmas that they report facing. Pope and Vetter (1992) asked survey respondents (i.e., random sample of 1,319 APA members and fellows) to describe clinical incidents that they found ethically challenging. The second most frequently described incident involved maintaining clear and reasonable

therapeutic boundaries. Many of the incidents described by the respondents involved confusion around the definition of dual relationships. For example, Pope and Vetter reported that one respondent stated, "I have employees/supervisees who were former clients and wonder if this is a dual relationship." Pope and Vetter also found a lack of agreement pertaining to the advisability of dual role relationships. Some respondents described dual role situations which they believe are therapeutic because they provide, "role modeling, nurturing and a giving quality to therapy." Other respondents reported more negative feelings and experiences associated with the dual role situations in which they had been involved.

Another criticism Pope and Vetter (1992) have of the Ethics Code is its lack of attention to the special circumstances in which nonsexual dual relationships and incidental and accidental contacts are difficult to avoid. In particular, he identifies small, rural or isolated communities as places where it is often hard to avert these contacts and relationships. Pope and Vetter believe that the Ethics Code should acknowledge these special circumstances and should offer some guidance to psychologists working in these communities. Stockman (1990) and Pope and Vetter (1992) recognize the potential for overlapping personal and professional relationships given the

limited and confined population and the interdependency that exists within these communities. Stockman states, "Psychologists who practice in rural communities are more likely to find themselves interacting with clients on not only a therapeutic level but possibly a professional, business or personal level as well." She gives as specific examples, a client and therapist who attend the same church, a client who teaches in school the therapist's child and a client who is the ex-spouse of another current client.

Though Pope readily acknowledges that there are situations where nonsexual dual roles are difficult to avoid, he cautions against using these circumstances to justify extra-therapeutic contact that is reasonably avoidable and that may cause harm to the client and to the therapy relationship. He believes that some clinicians exaggerate the extent to which accidental and incidental contacts and dual role relationships are unavoidable (personal communication, January 14, 1993). However, he stated that this perspective awaits empirical validation as it is based primarily on his impressions of clinicians who have engaged in these practices, and not on any existing empirical data.

In sum, given the inherent complexity of defining and assessing nonsexual dual role relationships, clear and ex-

plicit prohibitions against them cannot exist as they do for sexual dual relationships. Though the Ethics Code (APA, 1992) does not provide specific guidelines for dealing with the multitude of nonsexual dual roles and accidental and incidental contacts that arise in treatment, it acknowledges the potential harm associated with these practices and advises against them. It is the responsibility of the clinician to identify and avoid these practices when they exploit the other party, impair the psychologist's objectivity, or interfere with the psychologist's effectively performing his or her functions as a psychologist (Principle 1.17, APA, 1992).

Nonsexual Dual Relationships: Empirical Findings

Although considerable empirical research exists regarding sexual dual relationships (Gabbard, 1989; Pope, 1990a; Pope, 1990b; Pope & Vetter, 1991), there is a scarcity of empirical research devoted to the study of nonsexual dual roles and the research that does exist consists solely of descriptive studies. The empirical studies have mainly surveyed clinicians' attitudes and behaviors regarding specific nonsexual dual role practices (Borys & Pope, 1989; Pope, Tabachnick & Keith-Spiegel, 1987; Pope, Tabachnick & Keith-Spiegel, 1988). For example, respondents have been asked to indicate how frequently they engage in certain dual role and incidental prac-

tices and how ethical they believe these practices to be.

In addition to the empirical literature described above, a limited amount of research also exists on a few other related aspects of nonsexual dual roles. Some of these other areas of research have examined the relationship between respondents' (therapists) personal characteristics and their reported attitudes and behaviors regarding nonsexual dual roles, and the relationship between nonsexual and sexual dual roles in therapy. A summary of the empirical literature pertaining to nonsexual dual roles follows. This summary begins with a review of the surveys which have examined clinicians' attitudes and behaviors regarding specific nonsexual dual role practices.

Attitudes and behavior. Tallman (1981; cited in Keith-Spiegel, 1985) apparently conducted the first empirical study of nonsexual dual role relationships. Thirty-eight psychologists were surveyed and approximately 33% of these respondents reported having established social relationships with at least one client. All of the respondents who reported having been involved in a social relationship with a client were male (though the survey sample consisted of an equal number of male and female respondents). The respondents indicated that the social relationships were justified because they provided addi-

tional support to clients and helped facilitate the establishment of rapport. Another noteworthy finding is that approximately one third of the female respondents indicated that they had attended "special events" in clients' lives such as weddings and Bar Mitzvahs. However, the respondents reported that these events were attended because of the special meaning they had for the clients. Attendance at these events was not described as social. The remaining third of the respondents reported that they did not engage in any contact with clients outside of therapy. Some of their reasons for this included the potential for exploiting clients and the loss of therapeutic objectivity.

In a more extensive study, Pope, Tabachnick and Keith-Spiegel (1987), sent surveys to 1,000 psychologists from Division 29. A total of 456 psychologists completed the survey which represents a 45.6% return rate. The respondents were asked questions regarding their beliefs about and compliance with various Ethical Principles (APA, 1981). The respondents were given a list of 83 different situations, that often arise between clinicians and their clients, students, supervisees, and colleagues that are potentially ethically problematic. Included in this list were various dual role situations and incidental contacts with clients. In the major portion of the study, respon-

dents were asked to rate the extent to which they engaged in the behaviors (i.e., never, rarely, sometimes, fairly often, very often) and the extent to which they considered the behaviors ethical (i.e., unquestionably not (ethical), under rare circumstances, don't know/not sure, under many circumstances, unquestionably yes). The results of this study indicated that seven of the 83 behaviors were practiced by most psychologists (i.e., 90%). These seven behaviors included, "using self-disclosure as a therapy technique, telling a client you are angry at him (her), having a client address you by your first name, addressing your client by his(her) first name, accepting a gift worth less than $5 from a client and offering or accepting a handshake from a client." Sixteen behaviors were engaged in by fewer than 10% of the respondents. Some of these behaviors included, "having sexual relations with clients, using sex surrogates, helping candidates become degreed/licensed without requisite supervised experience, borrowing money from a client, selling goods to a client, going into business with a client, getting paid to refer clients to someone, and directly soliciting a person to be a client."

For many of the 83 practices listed there was considerably more variability among the psychologists' responses. In particular, there was minimal consensus among

psychologists as to their ratings of the ethicality of nonsexual dual role relationships and incidental contacts as well as their actual involvement in these situations. The following list of nonsexual dual roles and incidental contacts indicate the percentage of respondents who said that they had engaged in the behavior at least rarely (the first percentage listed) and the percentage who said that the behavior was ethical in at least rare circumstances (the second percentage listed). These behaviors include: becoming social friends with a former client (57%, 80%), providing therapy to one of your friends (28%, 48%), accepting services from a client in lieu of fee (31%, 62%), inviting clients to an office open house (17%, 46%), accepting a client's gift worth at least $50 (22%, 80%), accepting goods (rather than money) as payment (32%, 62%), inviting clients to a party or social event (16%, 42%), asking favors (e.g., a ride home) from clients (38%, 60%), lending money to a client (25%, 48%), providing therapy to one of your employees (16%, 36%), accepting a client's invitation to a party (40%, 64%), going to a client's special event (e.g., wedding) (76%, 80%), and going into business with a former client (13%, 44%).

Pope, Tabachnick and Keith-Spiegel (1988) asked these same respondents to rate the extent to which they considered the list of 83 behaviors to be good or poor practice

(i.e., poor, poor under most circumstances, don't know/not sure, good under most circumstances, good). The authors indicated that establishing standards of good and poor practice is important because such standards do not necessarily coincide with ethical and legal standards. For instance, in some situations, a behavior might not conflict with ethical or legal standards though the practice may be considered poor. In addition, there may be unusual circumstances (e.g., confidentiality) where a psychologist may behave in a manner contrary to ethical and legal standards. Pope, Tabachnick and Keith-Spiegel found empirical evidence for this. Judgements of good and poor practice did not, in many instances, coincide with beliefs about ethical standards. Respondents reported more stringent standards for good practice than for ethical practice. For example, the practice of "limiting treatment notes to name, date and fee" was considered unethical by a smaller percent of respondents than by the number of respondents who deemed it poor practice. Ratings of good and poor practice did coincide with reports of clinicians' behavior.

Pope, Tabachnick and Keith-Spiegel (1988) found that the majority of respondents indicated that most nonsexual dual role relationships are either, "poor" or "poor under most conditions." However, it is interesting to note that

for many of the dual roles, the percentage of respondents who rated the practices as "poor" was smaller than the percentage that rated them as "poor under most conditions." This suggests that many respondents believed that dual roles with clients are not universally poor practice. Furthermore, a sizable minority said that some nonsexual dual roles are "good under most conditions." A summary of Pope, Tabachnick and Keith-Spiegel's specific findings related to dual roles follow. The first number indicates the percentage of respondents that classified the behavior as "poor under most circumstances" and the second number represents the percentage that classified the behavior as "good under most circumstances" or "good." The results were as follows; becoming social friends with a former client (51%, 14%), providing therapy to one of your friends (30%, 2%), accepting services from a client in lieu of fee (40%, 13%), inviting clients to an office open house (26%, 13%), accepting a client's gift worth at least $50 (34%, 8%), accepting goods (rather than money) as payment (41%, 14%), inviting clients to a party or social event (29%, 4%), asking favors (e.g., a ride home) from clients (47%, 5%), lending money to a client (34%, 3%), providing therapy to one of your employees (27%, 2%), accepting a client's invitation to a party (48%, 8%), going to a client's special event (e.g., wedding) (36%,

34%), going into business with a former client (31%, 6%) and going into business with a current client (10%, .4%).

Borys and Pope (1989) surveyed 4,800 psychologists, psychiatrists, and social workers to examine their attitudes and practices regarding dual role relationships, incidental contact, and social and financial involvement with clients. A total of 2,332 subjects returned completed surveys which represents a 49% return rate. Half of the respondents were asked to indicate how frequently they had engaged in eighteen different behaviors with clients (i.e., with: no clients, few clients, some clients, most clients, all clients). The other half of the respondents were asked how ethical they believed these eighteen practices to be (i.e., never ethical, ethical under rare conditions, ethical under some conditions, ethical under most conditions, always ethical).

The majority of the respondents reported that they had never engaged in most of these behaviors. However, a sizeable minority indicated that they had engaged in some of these behaviors with at least a few clients. Furthermore, several respondents indicated that many of the behaviors were ethical under certain conditions. Borys and Pope found that over 30% of the respondents reported engaging in the following behaviors with at least a few clients: accepted a gift worth under $10, accepted a

client's invitation to a special occasion, became friends with a client after termination, disclosed details of personal stresses to client, and provided individual therapy to a relative, friend, or lover of an ongoing client. Over 15% of the respondents reported having accepted a service or product as payment for therapy and having bought goods or services from a client. In terms of ratings of ethicality, all eighteen behaviors, with the exception of engaging in sexual behavior with a current client, were believed to be ethical under at least rare conditions by 25% of the respondents.

The findings summarized above (i.e., Borys & Pope, 1989; Pope, Tabachnick & Keith-Spiegel, 1987, 1988) in conjunction with the disproportionate number of ethics complaints involving dual role violations suggest that compliance with the Ethical Principles has been difficult for many psychologists. Even though the Ethics Code advises against dual role relationships, because they "impair professional judgment and increase the risk of exploitation" (APA, 1981), psychologists report engaging in numerous dual role relationships and incidental contacts. For example, the Code (APA, 1981) explicitly advises against treating employees, students, supervisees, close friends, and relatives, yet Pope, Tabachnick & Keith-Spiegel (1987), found that 28% of their

respondents had treated at least one of their friends, 30% had treated one of their students, and 15% had provided therapy to at least one employee. Furthermore, not only do some psychologists engage in nonsexual dual role relationships with clients, but many psychologists do not consider these practices unethical. Overall, these findings highlight the varied viewpoints that psychologists have about these practices and the apparent confusion regarding the ethicality of them.

Factors influencing attitudes and behaviors. Given the variability in clinicians' attitudes and behaviors regarding nonsexual dual roles, researchers have attempted to determine which clinicians engage in dual role relationships with clients. Toward this end, several of the surveys previously cited have examined the relationship between dual role situations and a variety of personal and demographic characteristics. Some evidence now exists that suggests that certain therapist characteristics may be associated with a greater willingness to engage in dual roles with clients.

Borys and Pope (1989) had respondents provide personal and demographic information including their gender, profession (i.e., social worker, psychiatrist, or psychologist), age, years of experience providing psychotherapy, region of residence (Northeast, Midwest, South, West or

overseas), marital status, theoretical orientation, and practice setting (private practice, group practice, outpatient clinic, and inpatient facility). This information was collected in order to examine the relationship between respondent (therapist) characteristics and therapists' reported attitudes and behaviors regarding dual roles, incidental contacts, and social/financial involvement with clients. In this study, professional dual roles were defined as simultaneously engaging in two different roles (e.g., teacher and therapist) with a client. Social and financial arrangements are two specific types of dual roles that were identified and assessed. Incidental contact was defined as, "one-time, exceptional boundary alterations initiated by the client and accepted by the therapist. Though this type of contact is not considered a dual role, it does create questions of potential conflict of interest. A summary of Borys and Popes' findings follows.

The frequency of <u>incidental</u> involvements with clients varied significantly by profession, gender, and practice setting. Psychologists, female therapists and private practitioners reported having engaged in incidental contact with clients more frequently than social workers, psychiatrists, male therapists, and therapists from other practice settings combined. <u>Social</u> contacts with clients

reportedly occurred less frequently among female therapists and psychodynamically oriented therapists than among male therapists and respondents of other theoretical orientations. The frequency of financial involvements with clients varied significantly by theoretical orientation and practice locale. Psychodynamically oriented therapists reported fewer financial involvements than humanistic and cognitively oriented therapists. Respondents who live and provide psychotherapy services in the same small town reported engaging in financial involvements with a greater proportion of clients than respondents in other practice locales. Finally, the frequency with which therapists reported engaging in professional dual roles with clients varied significantly according to theoretical orientation and therapist gender. Female therapists and dynamically oriented therapists reported engaging in professional dual roles less frequently than male therapists and therapists with other orientations.

Pope, Tabachnick and Keith-Spiegel (1987) analyzed the relationship between respondent gender and the reported frequency with which the respondents engaged in each of the 83 potentially ethically problematic situations. The results indicated that the male respondents reported engaging in the following four behaviors more frequently than the female respondents, "treating homosexuality per

se as pathological, engaging in sexual fantasy about a client, telling a client, "I'm sexually attracted to you," and directly soliciting a person to be a client." Females reported a higher frequency of, "hugging a client and having a client address you by your first name."

Pope, Tabachnick and Keith-Spiegel (1988) also examined the relationship between ratings of good and poor practice and therapist characteristics. They found that "hugging a client" was more likely to be considered "poor practice under most circumstances" by psychodynamically and behaviorally oriented psychologists. Humanistic, existential, systems, cognitive, and gestalt therapists were more likely to rate this behavior as "good under most conditions." A greater frequency of female therapists (72%) than male therapists (48.7%) rated the practice of "treating homosexuality per se as pathological" as poor. Lastly, younger psychologists (i.e., 45 years and younger) were less likely than older psychologists to rate the practice of, "helping a client file a complaint re: a colleague" as poor.

Relationship between nonsexual and sexual dual roles. Only one empirical study (Borys, 1988) has examined the relationship between sexual and nonsexual dual roles in therapy. Typically sexual and nonsexual dual roles have been studied independently. However, in a separate analy-

sis of Borys and Pope's (1989) data, Borys (1988) examined the relationship between clinicians' involvement in sexual activity with clients and the frequency with which they reported involvement in nonsexual dual roles and incidental contact. Borys found that these different types of contacts and relationships were significant predictors of whether therapists had engaged in sexual relations with clients post-treatment. Social involvement with clients was the best predictor of sexual relations with clients. Borys suggested that nonsexual boundary violations may lead to, or increase the risk of sexual involvement with clients (when the client and therapist have the same sexual orientation). In addition to the empirical evidence that Borys found for the relationship between sexual and nonsexual dual roles, other support for this relationship comes from case studies of sexualized therapy relationships. These case studies describe numerous nonsexual boundary violations (e.g., dining with clients, employing clients, allowing numerous phone calls at home from clients, socializing with clients, and sharing considerable personal information with clients) prior to the onset of sexual relations between a therapist and client (Chesler, 1972; D'Addario, 1977, cited in Borys, 1988; Robertiello, 1975). Borys (1988, p. 52) stated, "sexual involvement may often be the culmination of a more general

breakdown in the roles and boundaries which begins on a more subtle and/or nonsexual level."

Establishing the relationship between sexual and nonsexual dual roles is important. If a relationship between nonsexual and sexual relationships could be established, there would likely be increased attention given to the often neglected topic of nonsexual dual role relationships. Furthermore, Borys (1988) suggested that the establishment of this relationship could positively influence the direction and course of research on dual relationships. She points out that the current research on nonsexual dual roles has been limited in scope. It has mostly examined the prevalence of nonsexual dual roles and has not acknowledged or explored the development or evolution of dual roles within the context of the therapy relationship. Borys suggests that what is needed is a "greater appreciation of the therapy relationship as a complex, integrated system of interrelated behaviors, norms, and relationships, much like the family system" (Borys, 1988, p. 54).

As reviewed above, the majority of the empirical research on nonsexual dual role relationships has been devoted to the compilation of descriptive data concerning the prevalence of these practices as well as some limited exploration of factors associated with these practices. A

minimal amount of research exists which goes beyond this basic descriptive data. Therefore it is appropriate for research to begin to examine more closely specific types of nonsexual dual roles. This would help to develop a more indepth, thorough understanding of nonsexual dual role practices between clients and therapists.

Present Study and Hypotheses

This study examines social, nonsexual relationships with former clients. This dual role was selected for investigation for several reasons. First, studies indicate a widespread prevalence of this practice. Borys and Pope (1989) found that 31% of their survey respondents (i.e., social workers, psychologists and psychiatrists) indicated that they had formed a friendship relationship with at least one former client and fifty-seven percent of the psychologists that Pope, Tabachnick and Keith-Spiegel (1987) surveyed reported having engaged in this same practice. A second reason for examining this particular dual role is that in addition to the high prevalence of this practice, there exists considerable variability in attitudes among clinicians in regard to the ethicality and advisability of this practice. Clinicians as a group do not seem to agree on whether this practice is ethical, or whether is it a harmful or beneficial practice. For example, Borys and Pope (1989) asked psychologists to

indicate how ethical it is to become friends with a client after termination. They found that approximately 14% said it was "never ethical," 38% said it was "ethical under rare conditions," 32% said it was "ethical under some conditions," 10% indicated that it was "ethical under most conditions," and 2% said that it was "always ethical." Pope, Tabachnick and Keith-Spiegel (1987) asked psychologists to indicate the extent to which they viewed, "becoming social friends with a former client" as good or poor practice. They found that approximately 21% of their respondents rated the practice as "poor," 51% rated it as "poor under most conditions," and approximately 14% rated the practice as, "good," or "good under most conditions." Another interesting finding was that another 13% of the respondents indicated that they were not sure whether this was a good or poor practice. All of these findings indicate that clinicians may lack information/knowledge regarding the impact and advisability of establishing non-sexual, social relationships with former clients. Clinicians could likely benefit from the knowledge gleaned from a more thorough investigation of this practice. This would hopefully illuminate and address some of the dilemmas surrounding the establishment of social relationships with former clients and may offer some guidance and direction in dealing with these situations.

The present study surveyed a randomly selected group of clinicians from the American Psychological Association membership list. The survey used in this study consisted mostly of Likert scale items and these items were examined quantitatively to provide a variety of descriptive data related to the practice of friendship relationships between therapists and former clients. There were three primary and specific purposes of this study. First, the survey examined the relationship between personal and demographic therapist variables and clinicians' willingness to engage in friendship relationships with former clients. Second, the study examined the relationship between clinicians' willingness to engage in friendships with former clients and the frequency in which they engage in a variety of other dual role practices and incidental contacts. Lastly, this study attempts to identify factors which impact clinicians' decisions to enter into friendship relationships with former clients. These three primary areas of investigation and the associated hypotheses are outlined and more fully described below.

Personal and demographic therapist variables. One purpose of this study was to determine whether clinicians who report having engaged in friendship relationships with former clients differ from those clinicians who have not on a variety of personal and demographic characteristics.

The following personal and demographic information was gathered from survey respondents: therapist gender, age, race, degree, years of experience providing psychotherapy, locale of clinical setting (solo private practice, group private practice, inpatient facility, outpatient clinic, university counseling center), geographic practice setting (urban, suburban, rural community/small town), theoretical orientation, and marital status.

As mentioned previously, only one empirical study (Tallman, 1981; cited in Keith-Spiegel, 1985) has examined the relationship between therapists' characteristics and therapists' willingness to engage in friendship/social relationships with former clients. As reviewed above, there are research studies which have examined the relationship between therapists' characteristics and therapists' willingness to engage in dual roles, incidental contact, and social and financial relationships with clients (Borys & Pope, 1989; Pope, Tabachnick & Keith-Spiegel, 1987; Pope, Tabachnick, & Keith-Spiegel, 1988). However, these studies do not provide information <u>specific</u> to the relationship between therapists' characteristics and therapists' reported participation in friendship relationships with former clients. Because of the limited number of empirical studies related specifically to friendship relationships with former clients, the bases for the

following hypotheses are derived largely from the findings of studies which have examined therapists' characteristics and their involvement in a more general categories of sexual and nonsexual dual role relationships with clients.

Hypothesis 1. A greater number of male than female respondents (therapists) will report having engaged in friendship relationships with former clients.

A greater number of male than female respondents are expected to report engaging in this practice because the existing literature indicates that a disproportionate number of male therapists are perpetrators of both sexual (Borys & Pope, 1989; Gechtman & Bouhoutsos, 1985; Holroyd & Brodsky, 1977) and nonsexual (Borys & Pope, 1989; Tallman, 1981, cited in Keith-Spiegel, 1985) dual role relationships with clients.

Hypothesis 2. Respondents endorsing a psychodynamic theoretical orientation will report engaging in friendship relationships with former clients less frequently than clinicians who ascribe to other theoretical orientations.

Borys and Pope (1989) found a significant relationship between respondents' theoretical orientation and the frequency with which they reported engaging in social, financial and dual role relationships with clients. Respondents endorsing a psychodynamic theoretical orientation reported engaging in fewer relationships of these

sort than respondents of other orientations. It is likely that psychodynamically-oriented therapists are more acutely aware of maintaining appropriate boundaries in the therapy relationship and may be more sensitive to the negative impact of boundary violations.

Hypothesis 3. Respondents who live and work in the same small or rural community will report engaging in friendship relationships with former clients more frequently than respondents who live or work in suburban or urban communities.

Stockman (1990) and Pope and Vetter (1992) have acknowledged that clinicians who live and work in the same small or rural community, often find it difficult to avert overlapping personal and professional relationships with clients. Borys and Pope (1989) found empirical evidence which suggests that clinicians in these practice locales view social, financial and dual relationships with clients as more ethical than clinicians in other practice locales (e.g., those working or living in urban or suburban areas). Furthermore, respondents from rural communities reported engaging more frequently in financial dual relationships with their clients than other clinicians.

A number of additional therapist characteristics were examined in this study in an exploratory manner. No particular hypotheses were offered for the existence of a

relationship between involvement in friendship relationships with former clients and clinicians's race, marital status, age, degree, years of experience, and the type of clinical setting in which the therapist works. These therapist characteristics were evaluated in an exploratory manner because of a lack of existing literature and research suggesting a relationship between these variables and clinicians' involvement in nonsexual dual role relationships.

Involvement in other dual roles. A second purpose of this study was to examine the relationship between clinicians' involvement in friendship relationships with former clients and their involvement in other dual role relationships. Clinicians' who report having established friendships were compared with those who have not in regard to their participation in various professional, social, and financial dual roles and incidental contacts with current and former clients. All survey respondents were asked to indicate the proportion of clients (i.e., Most Clients, Some Clients, Few Clients, 1 or 2 Clients, No Clients) with whom they have engaged in the various dual roles and incidental contacts.

Hypothesis 4. Clinicians who report having engaged in friendship relationships with former clients will report a greater frequency of involvement in other dual

roles than clinicians who deny having established friendships with former clients.

The basis for this prediction comes from Borys' (1988) study which examined the relationship between sexual and nonsexual dual role relationships between therapists and clients. Borys found that the clinicians who reported having had sexual relations with former clients, had also engaged in a variety of financial, social, incidental and nonsexual dual roles with clients. Borys concluded that, "sexual involvement may often be the culmination of a more general breakdown in the roles and boundaries which begins on a more subtle and/or nonsexual level." This suggests that fluid boundaries likely exist prior to the establishment of sexual relations with clients post-treatment. In other words, the pattern of interaction between the client and therapist involving loose and inappropriate boundaries seemingly begins prior to the termination of treatment and likely facilitates the establishment of a sexual relationship. A similar situation may occur when therapists engage in social, friendship relationships with clients following the termination of treatment. It is likely that nonsexual dual roles may have existed throughout the therapy relationship.

External factors influencing clinicians' decisions to enter into friendship relationships with former clients. Previous literature (Borys & Pope, 1989; Pope, Tabachnick & Keith-Spiegel, 1987) clearly indicates that a large number of therapists have established friendship relationships with their former clients. However, the majority of these therapists have established these relationships with only a "few clients" (Borys & Pope, 1989) or only on "rare" occasions (Pope, Tabachnick & Keith-Spiegel, 1987). This suggests that although many therapists have engaged in this practice at some point, it is reportedly not a typical or routine practice. The exclusivity of this practice suggests that there may be limited and/or specific circumstances under which therapists decide to engage in friendship relationships with former clients.

A third purpose of this study was to gather information that can help to elucidate the factors related to clinicians' decisions to enter into friendship relationships with former clients. Three different approaches were used to gather these data. First, an experimental approach was used to assess the impact of particular therapeutic circumstances on clinicians' willingness to engage in friendship relationships with former clients. All respondents were asked to respond to a vignette depicting a clinical situation where the possibility of

having lunch and establishing a friendship relationship with a former client arises. Respondents were asked to image themselves in the situation and to indicate how likely they would be to enter into the friendship relationship (i.e., Extremely Likely, Very Likely, Likely, Unlikely, Very Unlikely, Extremely Unlikely) and how ethical it would be to establish the friendship. Respondents were also asked to indicate their willingness to have lunch with the former client depicted in the vignette. The impact of three variables was assessed in terms of clinicians response to these three questions. Two factors were manipulated in each vignette including; the concordance or discordance of the sex of the client and therapist (same-sex client versus opposite-sex client) and the amount of time that elapsed between the termination of treatment and the initiation of the friendship (one week versus two years). A third nonmanipulated factor, clinicians' history of establishing friendship relationships with former clients, was also examined. Those who have established friendships were compared with those who have not on their responses to the three vignette questions.

All circumstances in each clinical situation were kept constant except for the manipulated variables. There were a total of four vignettes and each respondent random-

ly received one of the four vignettes. No specific hypotheses were made regarding the impact of the three factors on clinicians' willingness to have lunch or to enter into a friendship relationship with the former client depicted in the vignettes. Furthermore, no hypotheses were made for the ratings of how ethical it would be to consider a friendship relationship with the former client. The factors were evaluated in an exploratory manner due to a lack of existing research which has established a relationship between therapeutic circumstances and clinicians' attitudes and behaviors related to nonsexual dual roles.

The second approach for gathering information to illuminate clinicians' decisions to enter into friendship relationships was directed to the respondents who report that they have <u>not</u> engaged in friendship relationships with former clients. These respondents were asked to indicate by selecting one of four different options, why they have not established a friendship relationship with a former client. The options include; 1) I believe that this practice is unethical, 2) I believe it is poor practice, 3) I believe this practice is okay in certain circumstances but these circumstances have not arisen with any of my clients, and 4) Other. These respondents were also asked if they would consider establishing a friend-

ship relationship with a former client under any circumstances. For those who indicated that they would, they were also asked to describe in an open-ended format, the specific circumstances under which they would consider establishing the relationship. These data were examined in a descriptive manner and no specific hypotheses were made.

The third approach for assessing the factors which influence clinicians' decisions to enter into friendship relationships with former clients was directed to those respondents who indicate that they have established friendship relationships with former clients. These respondents were asked to respond to a series of questions about one particular friendship relationship that they have established with a former client. They were asked to select the former client with whom they felt they established the "most significant" friendship relationship and to answer the questions with this particular relationship in mind. Respondents were asked to provide the following information: the point at which the friendship was established (i.e., before treatment began, during treatment, or following the termination of treatment), the type and duration of the treatment, the treatment setting, the quality of the friendship relationship, the gender, and age of the client, and the number of clients that the

therapist has established this type of relationship with following treatment. Lastly, these respondents were asked to describe, in an open-ended format, the factors that were most influential in their decision to establish the friendship relationship. These data were assessed to determine whether there are variables (e.g., certain client characteristics, and treatment circumstances) that are consistently associated with the establishment of these relationships. Due to the lack of existing data to support specific hypotheses, these data were evaluated in an exploratory manner.

CHAPTER II

METHOD

Participants

Participants in this study were randomly selected from a list of American Psychological Association (APA) members. The American Psychological Association's Office of Demographic, Employment and Educational Research provided a computer-generated random sample. This office uses a computer program which generates a series of random numbers which are used to select the ordinal position of each member to be sampled from the membership list. Based on this selection process, mailing labels are then produced.

In this study, the sample from which a random selection was made consisted of licensed, doctoral level clinical and counseling psychologists working primarily in clinical settings. The sample also consisted of clinicians who provide psychotherapy services predominately to adult clients. The dual role situations examined in this study are relevant to the practice of therapy with adult clients and in most cases are not applicable to working with children. Therefore, APA members who identify themselves as working primarily or exclusively with children were not included in the sampling.

Surveys and cover letters were sent to six hundred selected members of the APA. Three hundred and twenty-two of the six hundred surveys were completed and returned by the respondents. This represents a return rate of 54%. Demographic characteristics of respondents are summarized in Table 1. Of the 322 respondents, 39% were female (n= 126) and 61% were male (n= 196). The average age of the respondents was 48.5 years and the ages ranged from 31 to 80. The majority of the respondents were caucasian (97%) and most of them were married (79%). As requested in the selection process, most respondents were licensed (99%), doctoral-level (Ph.D.= 88%, Psy.D.= 6%, Ed.D.= 6%) clinicians. These clinicians reported a considerable range in years of experience providing psychotherapy services (range= 2 to 50 years). The average amount of experience was 14.5 years. The majority of the clinicians (93%) reported that they were currently providing therapy services to adult clients. The remaining seven percent (n= 22) indicated that they were not providing therapy services currently; however, 86% of these respondents (n= 19) have provided treatment to adults in the past five years.

Materials

A two-page (front and back of each page) survey (see Appendix A) and a cover letter (see Appendix B) were sent to each of the respondents. The survey was constructed

Table 1

Demographic Characteristics of Respondents

	n	Percent
Sex		
Female	126	39%
Male	196	61%
Race		
Cauc	312	97%
A-A	1	< 1%
Latino	4	1%
Asian	3	1%
Mixed	1	< 1%
Not Known	1	< 1%
Marital		
Married	254	79%
Sep/Div	31	10%
Single	23	7%
Cohab	9	3%
Widow	5	2%
Degree		
Ph.D.	284	88%
Psy.D.	19	6%
Ed.D.	19	6%
Specialty		
Clinical	231	72%
Counseling	64	20%
Other	19	6%
Not Known	8	2%
Licensed		
Yes	320	99%
No	2	1%

Table 1 (cont).

	n	Percent
Prov Rx Curr		
Yes	300	93%
No	22	7%
Orientation		
Behavior	13	4%
Cognitive	81	25%
Cogn/Behav	13	4%
Exist/Hum	22	7%
Feminist	3	1%
Gestalt	3	1%
Dynamic/Analytic	128	40%
Systems	11	3%
Eclectic	33	10%
Other	14	4%
Not Known	1	< 1%
Rx Setting		
Private Practice	152	47%
Grp Practice	71	22%
Counseling Center	11	3%
Outpatient Clinic	49	15%
Inpatient	18	6%
Other	21	7%
Geo Work Loc		
Urban	132	41%
Suburban	122	38%
Rural/Small Town	68	21%
Live also rural/small town		
Yes	57	84%
No	11	16%

Note. Percentages may not add up to 100% exactly because of rounding.
Key: Prov Rx Curr= Providing treatment currently
Geo Work Loc= Geographic work location

specifically for use in the present study and was composed of four Sections, as described below.

Section I. The first section of the survey requested demographic information including respondent gender, age, highest degree held, area of specialty, race, years of experience providing psychotherapy, practice setting and locale, theoretical orientation, and marital status.

Section II. The second Section of the survey asked clinicians about their involvement in 21 dual roles and incidental contacts. The survey respondents were asked to indicate the proportion of their clients (i.e., Most Clients, Some Clients, Few Clients, 1 or 2 Clients, No Clients) with whom they had engaged in these various dual roles and incidental contacts. These 21 dual role situations were drawn from items used in a previously cited study by Pope, Tabachnick, and Keith-Spiegel (1987). These authors developed a list of 83 dual roles and incidental contacts. A subset of 21 of these 83 items was chosen for the current survey. Items were selected that represented a range of dual role situations which occur in clinical settings.

The final list of 21 items consisted of four general categories of dual role practices (i.e., social, financial, and professional dual roles and incidental contacts). Borys and Pope (1989) defined incidental contacts as, "one-

time, exceptional boundary alterations initiated by the client and accepted by the therapist." Though these contacts do not necessarily constitute dual relationships, they may promote conflicts of interest. Professional dual roles refer to the type of practices that the APA (1981) Ethical Guidelines address (e.g., simultaneously serving as teacher and therapist). The four general categories (i.e., social, financial, professional dual roles and incidental contacts) were determined by Borys and Pope (1989) in a factor analysis.

Section III. In the third Section of the survey, each respondent was presented with a clinical vignette depicting a situation where the possibility of having lunch and establishing a social relationship with a former client arises. Respondents were asked to indicate how likely they would be, in the situation depicted, to have lunch with the former client, and to enter into a friendship relationship with the client (i.e., Extremely Likely, Very Likely, Likely, Unlikely, Very Unlikely, Extremely Unlikely). Respondents were also asked how ethical it would be to establish a friendship relationship under the depicted conditions.

Two factors were manipulated in each vignette: the concordance or discordance of the sex of the client and therapist (same-sex client versus opposite-sex client) and

the amount of time that elapsed between the termination of treatment and the initiation of the friendship (one week versus two years). The impact of a third factor, clinicians' history of establishing friendship relationships with former clients, was also examined. Those who have established friendships were compared with those who have not on their responses to the three vignette questions. All circumstances involved in each clinical vignette remained constant except for the manipulated variables. There were a total of four different vignettes and an equal number of each version (i.e., 150) were used and distributed. Respondents randomly received one of the four vignette versions. A sample vignette follows.

> You treated an opposite-sex (same-sex) client in individual therapy. Treatment was terminated because the goals of therapy were successfully reached. The client was a fairly high functioning person who was bright and engaging. You enjoyed working with this client and you felt that you had several things in common. Two years (one week) following the termination of treatment you accidentally encounter the former client at the movie theater. The two of you talk and the client asks you to have lunch the following week.

Section IV. The fourth Section of the survey is divided into Parts A and B. Respondents were asked whether they had ever established a friendship relationship with a former client. Friendship was defined as, "ongoing, nonaccidental, social, nonsexual contact." Part A was completed by the respondents who indicated that they had not

established a friendship relationship with a former client. These respondents were asked to indicate why they have not engaged in this practice. The options included; 1) I believe that this practice is unethical, 2) I believe it is poor practice, 3) I believe this practice is okay in certain circumstances but these circumstances have not arisen with any of my clients, and 4) Other. These respondents were also asked whether they would consider establishing a friendship relationship under any circumstances. Those who would consider engaging in this practice were asked to describe in an open-ended format, the circumstances under which they would establish the friendship. Part B was completed by respondents who <u>have</u> established a friendship relationship with a former client. They were asked to consider the "most significant" friendship that they have established with a former client and to answer a series of questions about this relationship. Respondents were asked to provide the following information: the point at which the friendship was established (i.e., before treatment began, during treatment, or following the termination of treatment), the type and duration of the treatment, the treatment setting, the quality of the friendship relationship, the gender, and age of the client, and the number of clients that the therapist has established this type of relationship with following treatment. These data were

used to determine whether there are variables (e.g., certain client characteristics, and treatment factors) that are consistently associated with the establishment of these relationships and therefore may be significant in clinicians' decisions to establish friendship relationships.

Procedure

Construction of the survey. Prior to the dispersement of the surveys used in this study, a small pilot study was conducted. Twenty-five surveys were distributed to licensed, doctoral level clinical psychologists, all of whom were known to the writer. The respondents were asked to complete the survey and to provide feedback regarding the readability, clarity and amount of time it took them to complete the survey. Based upon the feedback received, some modifications to the survey were made.

Conducting the survey. Each of the 600 subjects was sent an envelope containing the following materials; a cover letter describing the study and the instructions for completing the survey, the two-page survey form, and a prepaid and pre-addressed return envelope for the completed survey. The subjects randomly received one of the four different versions of the survey. One hundred and fifty subjects received each version. Mailing labels were provided by the American Psychological Association's Office of Demographic, Employment and Educational Research. The

surveys were distributed in June, 1993 and the majority of the surveys were returned within four weeks of their dissemination. A reminder postcard was sent to the 600 survey recipients two weeks following the initial mailing of the surveys.

Confidentiality of the respondents' surveys was provided in the following ways. First, each respondent was instructed to complete the survey and return it without indicating his/her name or address on the survey or the envelope. Second, no coding system to identify the subjects was used and the return envelopes were destroyed.

CHAPTER III

RESULTS

The primary purpose of this study was to gather information about the practice of establishing friendship relationships between therapists and their former clients. More specifically, three primary areas were investigated. First, this study sought to determine whether clinicians who report having engaged in friendship relationships with former clients differ on personal and demographic variables from those clinicians who report that they have not established these social relationships. Second, these two groups of clinicians were compared in terms of the frequency in which they report having engaged in a variety of other dual role practices and incidental contacts. Thirdly, factors which impact clinicians' decisions to enter, or not to enter into friendship relationships with former clients were identified and assessed. These three areas of investigation and the associated empirical analyses are described below.

Personal And Demographic Therapist Variables

Of the 322 clinicians responding to the survey, 76 indicated that they had established a friendship relationship with a former client. Friendship was defined in this

study as, "ongoing, nonaccidental, social, nonsexual contact." Those who reported having engaged in a friendship relationship represent 23.6% of the respondents.

Chi-square analyses and *t*-tests were used to determine whether the two groups of clinicians (i.e., those who have established a friendship relationship with a former client (Friendship), and those who have not (No Friendship), differed significantly on the demographic variables. In regard to the categorical demographic variables, three hypotheses were made. The first hypothesis stated that a greater number of male than female respondents would report having engaged in social relationships with former clients. There was no support for this first hypothesis as no significant difference was found between the 'Friendship' and 'No Friendship' Groups on the gender variable, $\chi^2(1)= .00492$, $p=.944$.

The second hypothesis stated that respondents endorsing a psychodynamic theoretical orientation would report engaging in social relationships with former clients less frequently than clinicians who ascribe to other theoretical orientations. Two chi-square analyses were computed to test this hypothesis. In the first analysis, subjects endorsing a psychodynamic orientation were compared to the remaining subjects (i.e., those endorsing all other orientations). This analysis revealed a lack of support for the

hypothesis, $\chi^2(1)= 1.953$, $p=.162$. A second chi-square analysis was computed comparing psychodynamic clinicians only to clinicians who ascribed to an existential/humanistic orientation. Results of this analysis lend some support to the hypothesis, $\chi^2(1)= 7.052$, $p=.007$. These results suggest that psychodynamic clinicians are significantly less likely to establish friendship relationships with former clients than clinicians who ascribe to an existential/humanistic perspective. Forty-five percent of the clinicians endorsing a humanistic/existential orientation reported having established a friendship relationship with a former client, whereas only 19% of the clinicians ascribing to a psychodynamic orientation reported having had a friendship relationship. The chi-square matrix is presented in Table 2.

The third hypothesis stated that respondents who live and work in the same small or rural community should report engaging in friendship relationships with former clients more frequently than respondents who do not live and work in this type of community (which includes those respondents who live or work in suburban or urban communities and those who work in a rural or small community but do not also live there). The chi-square analysis supported this hypothesis, $\chi^2(1)= 5.067$, $p=.024$. Respondents who live and work in the same small town or rural area more frequently reported

Table 2

Relationship Between Theoretical Orientation and Clinician Membership

	Humanistic/Exist	Psychodynamic
Friendship	10 45.5%	25 19.5%
No Friendship	12 54.5%	103 80.5%
Column Total:	22	128

engaging in friendship relationships with former clients. Thirty-five percent of the respondents who live and work in a small town/rural area reported having established a friendship relationship, whereas only 21% of the remaining clinicians (i.e., those not living and working in a small or rural area) reported having engaged in this practice. Table 3 presents the chi-square matrix.

No significant differences were found between the two groups of clinicians on the remaining categorical demographic variables of race, marital status, degree, specialty, and practice setting. These chi-square analyses were conducted for exploratory purposes as no specific hypotheses were made.

The *t*-test was used to determine whether the two groups of clinicians (Friendship and No Friendship) differ significantly on the following demographic variables: age, years of experience, and number of adult clients treated in therapy in the past two years. No specific hypotheses were made regarding the difference between the two clinician groups on these variables. Results of the *t*-tests found a significant difference between the two groups on age, $t(320) = 2.58$, $p=.01$, and years of experience, $t(320) = 3.07$, $p=.002$. Clinicians who reported engaging in friendship relationships with former clients were significantly older (Friendship, $M= 51.1$, $SD= 10.1$; No Friendship, $M=$

Table 3

Relationship Between Geographic Setting and Clinician Membership

	Live and Work in Small/Rural Area	
	Yes	No
Friendship	20 35.1%	56 21.1%
No Friendship	37 65%	209 78.9%
Column Total:	57	265

47.7, SD= 10.1) and had more years of experience (Friendship, M= 17.5, SD= 8.8; No Friendship, M= 14.2, SD= 8.3). There was no significant difference between the two groups in regard to the number of clients treated in the past two years. Table 4 presents a summary of these t-test findings.

Involvement In Other Dual Roles

The second Section of the survey asked clinicians about the frequency of their involvement in 21 therapeutic dual roles and incidental contacts. Respondents indicated the proportion of their clients (i.e., Most Clients, Some Clients, Few Clients, 1 or 2 Clients, No Clients) with whom they had engaged in these various dual roles and incidental contacts. Each respondent received a total score which was the compilation of his/her 21 individual item scores. A t-test was used to compare the scores of clinicians who reported having engaged in friendship relationships (Friendship) to the scores of those who denied this practice (No Friendship). It was hypothesized that clinicians who reported having engaged in friendship relationships with former clients would report a greater frequency of involvement in the 21 dual roles and incidental contacts than the clinicians who denied having established friendship relationships with former clients. Support for this hypothesis was found, $t(82.96) = 7.06$, $p<.0001$. Clinicians who re-

Table 4

Means for Two Clinician Groups for Age, Years of Experience, and Number of Clients Treated in Past Two Years

Demographic Variable	M	SD
Age		
Friendship	51.13*	10.11
No Friendship	47.72	10.05
Yrs Exp		
Friendship	17.54**	8.82
No Friendship	14.15	8.28
Treat 2 Yrs		
Friendship	114.92	97.58
No Friendship	111.58	115.00

*p = .01

**p = .002

Key: Yrs Exp= Years of experience providing psychotherapy services (post-licensure/certification).
Treat 2 Yrs= Number of adult clients treated in therapy in the past two years.

ported friendship relationships were significantly more likely to engage in these dual role behaviors and incidental contacts than those who denied this practice (Friendship, M= 30.6, SD= 5.8; No Friendship, M= 25.6, SD= 3.2).

To further assess the difference between the two groups of clinicians, the 21 dual role situations were categorized into four groups, 1) incidental contact, 2) social dual roles, 3) financial dual roles, and 4) professional dual roles. This categorization was used to determine whether a pattern exists in terms of the type of dual role practices in which clinicians who have established friendship relationships with former clients tend to engage. A t-test was used to determine whether the two groups of clinicians differed significantly in terms of the frequency of their involvement in each of these categories of practices.

The questions relevant to each category are listed in Table 5. The four categories used in this study were identified in a factor analysis completed by Borys and Pope (1989). However, not all of the 21 items were categorized and used in the current t-test analyses because some of these items were not included in the original Borys and Pope factor analysis. Furthermore, some of the items used in the Borys and Pope study were not included in the current survey. Therefore, the categories do not replicate

Table 5

Categories of Dual Roles and Incidental Contacts

I	Incidental Contacts
1.	Accepted a client's invitation to a special occasion (e.g., wedding, graduation, funeral).
2.	Accepted a gift from a client worth over $50.
II	Social Dual Roles
1.	Disclosed details of personal distress to a client.
2.	Invited a client to a personal party or social event.
3.	Engaged in sexual activity with a client after termination.
4.	Went out to eat with a client.
III	Financial Dual Roles
1.	Accepted a service or product from a client in lieu of a fee.
2.	Sold a service/product to a client.
IV	Professional Dual Roles
1.	Provided therapy to a then-current student or supervisee.
2.	Provided individual therapy to relative or friend of ongoing client.

exactly the categories used by Borys and Pope.

No specific hypotheses about clinicians involvement in these categories of practices were made. Results of the analyses determined that the clinicians who reported friendships relationships with former clients, engaged more frequently in social, $t(93.59) = 4.73$, $p < .0001$, financial, $t(85.6) = 4.31$, $p < .0001$, and professional dual roles, $t(103.67) = 4.78$, $p < .0001$, and incidental contacts, $t(90.14) = 4.46$, $p < .0001$, than the clinicians who denied having engaged in friendship relationships. The means and standard deviations for the two groups of clinicians on each of the four categories of practices are listed in Table 6.

External Factors Influencing Clinicians' Decisions to Enter Into Friendship Relationships With Former Clients

The third and forth Sections of the survey were designed to help elucidate factors which influence clinicians' decisions to enter, or not to enter into friendship relationships with former clients. In Section three, respondents were presented with a vignette and asked to respond to three questions related to the vignette. Respondents were asked, how likely they would be first, to have lunch, and second, to establish a friendship relationship with the client depicted in the vignette. The third question asked how ethical it would be to establish a

Table 6

Means for Two Clinician Groups on Dual Role Practices and Incidental Contacts

	M	SD
Incidental Contacts		
Friendship	3.01*	1.12
No Friendship	2.41	.66
Social Dual Roles		
Friendship	5.57*	1.48
No Friendship	4.71	.95
Financial Dual Roles		
Friendship	2.59*	.83
No Friendship	2.15	.46
Professional Dual Roles		
Friendship	4.03*	1.37
No Friendship	3.20	1.11

*$p < .0001$

friendship relationship with the client. A six-point Likert scale was provided for each question. Two variables were manipulated in the vignette including the amount of time that elapsed between the termination of treatment and the potential extratherapeutic contact (one week versus two years) and the concordance or discordance of the sex of the client and therapist (same-sex client versus opposite-sex client). The two manipulated factors, in addition to clinicians' history of establishing (or not establishing) friendship relationships, were assessed in terms of their impact on clinicians' responses to the three vignette questions. No hypotheses were made regarding the impact of these three factors.

The pattern of results for the 2 (client gender) X 2 (time elapsed) X 2 (history of past friendship with client) analysis of variance (ANOVA) was identical across each of the three vignette questions. More specifically, the results revealed no significant two or three-way interactions; however, a main effect was evident for each of the three factors across the three vignette questions. First, in terms of the gender main effect, respondents indicated that they would be more likely to have lunch with a former client, $F(1)= 13.15$, $p<.0001$, to establish a friendship relationship, $F(1)= 5.04$, $p=.025$, and to view the friendship as more ethical, $F(1)= 3.82$, $p=.049$, when the client

is of the same sex as the respondent. Table 7 presents the means for the gender variable across the lunch, friendship and ethics questions.

Second, in terms of the time elapsed main effect, respondents also indicated that when a longer period of time has elapsed following treatment (i.e., two years), they would be significantly more likely to have lunch with the former client, $F(1)= 26.81$, $p<.0001$, to establish a friendship relationship, $F(1)= 10.92$, $p=.001$, and to view the friendship as more ethical, $F(1)= 12.57$, $p< .0001$. Table 8 presents the means for the time elapsed variable across the three vignette questions. Lastly, respondents who reported having established a friendship relationship, indicated a greater likelihood of having lunch with a former client, $F(1)= 29.10$, $p<.0001$, establishing a friendship relationship, $F(1)= 40.44$, $p<.0001$, and were more inclined to perceive the friendship as an ethical practice, $F(1)= 32.60$, $p<.0001$. Table 9 presents the means for the history of friendship variable across the vignette questions.

Section IV of the survey was designed to provide further information about the factors which impact or influence clinicians' decisions to enter or not to enter into social relationships with former clients. The first question in this Section asked respondents if they had ever

Table 7

Means for the Gender Variable Across the Lunch, Friendship, and Ethics Questions

	Same-Sex	Opposite-Sex
Lunch	M= 2.28	1.86
	n= 161	157
Friendship	M= 1.96	1.74
	n= 161	157
Ethics	M= 2.80	2.53
	n= 161	156

Note. Response set: Lunch and Friendship Questions, 1= Extremely Unlikely, 2= Very Unlikely, 3= Unlikely, 4= Likely, 5= Very Likely, 6= Extremely Likely. Ethics Question, 1= Definitely Not Ethical, 6= Definitely Ethical.

Table 8

Means for the Time Elapsed Variable Across the Lunch, Friendship, and Ethics Questions

	One Week	Two Years
Lunch	*M*= 1.73	2.41
	n= 158	160
Friendship	*M*= 1.65	2.06
	n= 158	160
Ethics	*M*= 2.37	2.96
	n= 158	159

Note. Response set: Lunch and Friendship Questions, 1= Extremely Unlikely, 2= Very Unlikely, 3= Unlikely, 4= Likely, 5= Very Likely, 6= Extremely Likely. Ethics Question, 1= Definitely Not Ethical, 6= Definitely Ethical.

Table 9

Means for the History of Friendship Variable Across the Lunch, Friendship, and Ethics Questions

	Friendship	No Friendship
Lunch	M= 2.71	1.87
	n= 76	242
Friendship	M= 2.46	1.66
	n= 76	242
Ethics	M= 3.42	2.42
	n= 76	241

Note. Response set: Lunch and Friendship Questions, 1= Extremely Unlikely, 2= Very Unlikely, 3= Unlikely, 4= Likely, 5= Very Likely, 6= Extremely Likely. Ethics Question, 1= Definitely Not Ethical, 6= Definitely Ethical.

established a friendship relationship with a former client. Friendship was defined as, "ongoing, nonaccidental, social, nonsexual contact." Of the 322 respondents, 246 (76.4%)indicated that they had not established a friendship relationship and 69 (21.4%) respondents indicated that they had engaged in this practice. In addition, seven respondents initially indicated that they had not established a friendship relationship. However, these seven respondents later indicated that they had engaged in this practice as they described a particular friendship relationship that they had established in response to questions in a later part of the survey. Given that they described a friendship relationship, it was assumed that they had incorrectly indicated that they had not engaged in this practice. Therefore, it appeared that a total of 76 respondents (23.6%) had established friendship relationships with former clients.

Section IV of the survey was then divided into two parts, Part A and Part B. Part A was completed by only the respondents who indicated that they had not established a friendship relationship with a former client, and Part B was completed by those who reported they had engaged in this practice.

In Part A respondents were asked to select the statement (four were provided) that best describes why they have not established a friendship relationship with a former

client. The four choices and the percentage of the respondents endorsing each one follows, 1) I believe that this practice is unethical (23.8%), 2) I believe it is poor practice (50.8%), 3) I believe this practice is okay in certain circumstances but these circumstances have not arisen with any of my clients (19.7%), and 4) Other (6%).

The second question in Part A asked respondents whether they would consider establishing a friendship relationship with a former client under any circumstances. Nearly half of the respondents (n= 118, 48.8%) indicated that they would, and the remaining subjects (n= 124, 51.2%) reported that they would not engage in this practice under any circumstances. Respondents who indicated that they would consider establishing a friendship relationship, were asked to briefly describe in an open-ended format, the circumstances under which they would consider this practice. In an attempt to summarize the open-ended response data, the circumstances identified by these respondents were divided into nine categories, representing the most salient circumstances identified by the respondents. The nine categories along with some response examples follow: 1) the amount of time elapsed between the termination of treatment and the initiation of the relationship (e.g., "two to three years past treatment") 2) external/situational factors (e.g., "friendship arises from other context, membership in orga-

nization, children of both people develop friendship at school"), 3) treatment factors (e.g., "treatment was brief"), 4) client characteristics (e.g., "client is high functioning, has good boundaries"), 5) the potential for a constructive, nonharmful relationship (e.g., "if it would provide an opportunity for a healthy, productive friendship for both"), 6) mutuality of feelings, interests, values (e.g., "many values, beliefs, attitudes in common"), 7) understanding that treatment will not resume with therapist (e.g., "patient understood that treatment wouldn't resume with me"), 8) client is a therapist/colleague/in same profession, (e.g., "former client became a professional colleague"), and 9) catch-all category (all other responses).

All of the responses were read and independently coded by the investigator and another graduate student in clinical psychology. The interrater reliability (percent agreement) was determined to be 93% for these responses. For the responses where there was not initial agreement as to the category in which they should be placed, the two coders discussed these responses until a consensus was reached.

Although 118 respondents indicated that they would consider establishing a friendship relationship, only 107 subjects completed the open-ended question. The data reported below summarize the responses of these 107 subjects. The average number of circumstances identified by the re-

spondents was 1.99. The mode was two and the range was zero to six. Table 10 presents a summary of the frequencies and percentages of respondents endorsing each of the nine categories of circumstances. As can be seen in Table 10, three factors (or circumstances) were identified by a large number of the respondents. These three factors include, 1) the amount of time elapsed between the termination of treatment and the initiation of the friendship (n= 46, 43%), 2) external/situation factors (n= 31, 29%), and 3) treatment factors (n= 25, 23.4%).

In addition to identifying and analyzing the nine factors, several respondents spontaneously indicated in some fashion, the need for caution in engaging in friendship relationships with former clients. Because of the spontaneity and the frequency in which these 'caution' remarks were made, a tally was made of these remarks. A sizeable minority (n= 20, 18.7%) of the respondents identified circumstances and also made some specific reference to the need for caution in the practice of establishing friendship relationships. Another group of respondents (n= 7, 7%), did not specifically answer the open-ended question. They described in some manner, the need for caution in establishing friendships, but did not identify specific circumstances for establishing a friendship. Respondents who reported having established a friendship relationship

Table 10

Circumstances Impacting Respondents Consideration to Enter Into a Friendship Relationship with a Former Client

Circumstance	n	Percent
1 Time Elapsed	46	43%
2 External/situational	31	29%
3 Treatment Factors	25	23.4%
4 Client Characteristics	19	17.8%
5 Potential Positive Rel.	14	13%
6 Mutuality of feelings, interests	10	9%
7 No Resume with Therapist	18	16.8%
8 Client in Prof.	19	17.8%
9 Catch-all	18	16.8%

N= 107

with a former client were instructed to complete Part B of Section IV. The respondents were asked to select the "most significant friendship relationship" that they established with a client and to answer several questions about this relationship. A total of 76 respondents provided information in this section. Some data are missing and therefore the frequencies do not consistently equal 76.

The majority of the respondents (n= 64, 86.5%) indicated that the friendship relationship was initiated following the termination of treatment. Only a small number stated that the relationship began prior to treatment (n= 4, 5%), or during treatment (n= 6, 8%). Those who initiated the relationship after treatment were asked to indicate the exact amount of time that elapsed between the termination of treatment and the initiation of the relationship. Only 42 (of 64) respondents specifically provided this information. These respondents indicated considerable variability in the amount of time that had elapsed. The length of time that clinicians waited before establishing the friendship ranged from one month to twelve years. The majority of respondents (n= 23, 54.8%) reported that the friendship was initiated within one year of treatment, though the average amount of time that elapsed was 23.5 months. Table 11 provides a summary of these data.

Several respondents (n= 22) did not respond to the

Table 11

Amount of Time that Elapsed between the Termination of Treatment and the Initiation of the Friendship Relationship

	Frequency	Percent
1 to 6 months	12	28.6%
6 to 12 months	11	26.2%
12 to 24 months	7	16.7%
24 to 36 months	6	14.3%
Greater than 36 months	6	14.3%

M= 23.5 months, Mode= 6 months, Range= 1 to 12 years
Percentages may not add up to 100% exactly because of rounding.

question about the amount of time that had elapsed in the manner intended. These respondents simply checked one of the three response categories provided (i.e., years, months, weeks), instead of specifically giving a numerical value indicating a precise amount of time. Four of these subjects checked "weeks", suggesting that the relationship was initiated in less than one month following treatment. Thirteen subjects checked "months" (suggesting less than one year). The remaining five subjects checked "years" suggesting that the relationship was not initiated until at least one year had past following treatment.

Respondents were asked to provide a variety of information pertaining to the client's treatment including, the duration of the treatment, the modality, the treatment approach/orientation, and the treatment setting. Results indicated a considerable range in the amount of time that these clients were in therapy (range= 1 month to 9 years) however, most clients (n= 55, 81%) were in treatment for less than two years. The average duration of treatment was 19 months. Table 12 summarizes these data. In terms of the treatment modality, the majority of clients were treated in individual therapy (n= 65, 86.7%) though a few clients were also treated in group (n= 4, 5%) and couples (n= 3, 4%) therapies. The remaining clients (n= 3, 4%) were treated in more than one treatment modality (e..g, individ-

Table 12

Duration of Time that Clients Spent in Treatment

	Frequency	Percent
1 to 6 months	18	26.5%
6 to 12 months	22	32.4%
12 to 24 months	15	22.1%
24 to 36 months	6	9%
36 to 48 months	3	4%
Greater than 48 months	4	6%

N= 68, M= 19.5 months, Mode= 12 months, Range= 1 month to 9 years.

ual and group therapy). Most of the these client were treated in a private practice setting (n= 55, 75.3%) or an outpatient clinic (n= 10, 13.7%). Respondents indicated a variety of treatment approaches with these clients though psychodynamic (n= 20, 27.4%), cognitive (n= 22, 30.1%), and existential/humanistic (n= 11, 15.1%) orientations were most frequently reported. Table 13 presents a summary of the orientation data.

Some personal information about the clients was obtained. Half of the respondents indicated that they had established a friendship with a female client (n= 36, 50%) and 43% (n= 31) established a relationship with a male client. The remaining respondents (n= 5, 7%) indicated that they had established a friendship relationship with both a female and male client. For some of these respondents, they seemed to be referring to establishing a friendship relationship with a couple, from couples therapy. Other respondents, however, did not follow the instructions as they described more than one friendship relationship throughout Part B (i.e., one with a female client and one with a male client). Most clients were the same age (within 5 years) as the therapist (n= 34, 46.6%) or were younger (n= 27, 37%) than the therapist. Only a few clients (n= 12, 16.4%) were older than the therapist.

The respondents were asked to rate their global im-

Table 13

Treatment Orientation/Approach Used with Friendship Clients

	Frequency	Percent
Behavioral	5	7%
Cognitive	22	30.1%
Existential/Humanistic	11	15.1%
Feminist	2	3%
Hypnosis	2	3%
Psychodynamic/Analytic	20	27.4%
Systems	2	3%
Eclectic/Integrative	4	5%
Other	5	7%

N= 73
Note. Percentages may not add up to 100% exactly because of rounding.

pression of the quality of the friendship relationship. A five-point Likert scale was provided: (1= Not At All Positive, 2= Slightly Positive, 3= Positive, 4= Very Positive, 5= Extremely Positive). Table 14 presents a summary of these data. Generally, respondents indicated good feelings about these friendship relationships as the average rating was between Positive and Very Positive ($\underline{M}$= 3.5).

Respondents were also asked the number of clients that they had established a friendship relationship with and the percentage of their total clients that this number represents. Results indicated a considerable range in the number of clients with whom respondents had established a friendship relationship (range 1-50), however, the majority of the respondents ($\underline{n}$= 55, 86%) indicated that the number of clients with whom they have established a friendship represented less than one percent of their total clients. Furthermore, most respondents ($\underline{n}$= 52, 78%) reported only having established either one or two friendship relationships. See Table 15 for a summary of these data.

The last question in Part B asks respondents to briefly describe, in an open-ended format, the factors that were most influential in their decision to establish the friendship relationship. These data were summarized and ten categories of factors were identified. Though many of these categories duplicate those identified by the clini-

Table 14

Respondents' Ratings of Quality of Friendship Relationships

Likert Scale Ratings	Frequency	Percent
Not At All Positive (1)	2	3%
Slightly Positive (2)	4	5%
Positive (3)	34	46%
Very Positive (4)	24	32.4%
Extremely Positive (5)	10	13.5%

N= 74, M= 3.5, Mode= 3 (Positive), Range 1-5
Note. Percentages may not add up to 100% exactly because of rounding.

Table 15

Number of Clients with Whom Clinicians Have Established Friendship Relationships

Number of Clients	Frequency	Percent
1	29	43.3%
2	23	34.3%
3	4	6%
4	3	4%
5	2	3%
6	2	3%
8	1	1%
10	1	1%
12	1	1%
50	1	1%

N= 67, M= 3, Mode= 1, Range 1-50
Note. Percentages may not add up to 100% exactly because of rounding.

cians who had not established friendships, the ten categories are not identical. These ten categories include, 1) the amount of time that elapsed between the termination oftreatment and the initiation of the relationship, 2) external/situational factors, 3) treatment factors, 4) client characteristics, 5) therapists' needs and feelings (e.g., "probably motivated out of my guilt for moving across the country"), 6) the potential for a constructive, nonharmful relationship, 7) mutuality of client's and therapist's feelings, interests, and/or values, 8) client is a therapist/colleague/in same profession, 9) understanding that treatment will not resume with therapist, and 10) catch-all category.

All of these open-ended responses were again read and independently coded by the investigator and another graduate student in clinical psychology. The interrater reliability (percent agreement) was determined to be 94%. For the responses where there was not initial agreement as to the category in which they should be placed, the two coders discussed these responses until a consensus was reached.

Although 76 respondents indicated that they have established a friendship relationship, only 73 respondents completed the open-ended question. The average number of factors identified by the respondents was two. The mode was two and the range was zero to six. Refer to Table 16

Table 16

Factors Influencing Clinicians Decision to Establish a Friendship Relationship with a Former Client

	Circumstance	n	Percent
1	Time Elapsed	1	1%
2	External/situational	19	26%
3	Treatment Factors	13	17.8%
4	Client Characteristics	28	38.4%
5	Therapist needs/feelings	7	10%
6	Potential Positive Rel.	6	8%
7	Mutuality of feelings, interests	24	32.9%
8	Client is colleague or in profession	16	22%
9	No Resume with Therapist	2	3%
10	Catch-all	8	11%

N = 73

for a summary of the frequency in which respondents endorsed each of the ten categories of factors. The following four factors were identified by the largest amount of respondents; External/situational factors (n= 19, 26%), Client characteristic (n= 28, 38%), Mutuality of feelings, interests, and values (n= 24, 32%), and Client is colleague or in same profession (n= 16, 22%).

In addition to identifying the ten categories of factors, several respondents provided additional information about their experiences in establishing friendships with former clients. These data were summarized and grouped into two categories. Some respondents (n= 12, 16.4%) acknowledged the need for caution when establishing these relationships or mentioned the limitedness of the friendships they had established. Other respondents (n= 7, 9.5%) acknowledged that the relationship did not work well and therefore indicated some hesitancy in establishing these relationships in the future.

CHAPTER IV

DISCUSSION

The purpose of this study was to investigate the practice of establishing friendship relationships with former therapy clients. Friendship was defined in the survey as, "ongoing, nonaccidental, social, nonsexual, contact." Of the 322 clinicians responding to the survey, 76 (23.6%) indicated that they had established a friendship relationship with a former client. The prevalence rate found in this study is lower than the prevalence rates found in other studies. Pope, Tabachnick and Keith-Spiegel (1987) asked a randomly selected group of psychologists from Division 29 of the American Psychological Association, the extent to which they had engaged in a variety of therapeutic practices (Never, Rarely, Sometimes, Fairly Often, Very Often) including the practice of, "becoming social friends with a former client." Fifty-seven percent of the respondents indicated a response other than "Never," suggesting that these respondents had engaged in this practice on at least one occasion. Borys and Pope (1989) asked respondents (i.e., 2,130 psychiatrists, psychologists, and social workers) to indicate the proportion of clients (No Clients, Few Clients, Some Clients, Most Clients, and All Clients)

with whom they had engaged in various therapeutic behaviors including, "becoming friends with a client after termination." Borys and Pope found that thirty percent of the respondents had established a friendship with at least a "Few clients."

The lower prevalence rate found in the current study may be due in part to the way in which "friendship" was defined. In this study, friendship was specifically and more stringently defined than in the other studies. In the Borys and Pope (1989) and the Pope, Tabachnick and Keith-Spiegel (1987) articles, no attempt at specifically defining friendship was made. Respondents were simply asked if they had established a friendship relationship. They were expected to interpret the meaning of friendship. Given the restrictiveness of the definition in the current study, fewer respondents could likely endorse this practice. This suggests that "friendship" can be interpreted and defined in different ways and that the way it is defined (or <u>if</u> it is defined), may effect the frequency in which clinicians report engaging in this behavior.

The inconsistency in prevalence rates may also be accounted for in part, by the dissimilar response categories across the three studies (i.e., current study, Borys & Pope, 1989, Pope, Tabachnick & Keith-Spiegel, 1987). Though the therapeutic practice (i.e., establishing a

friendship with a former client) was described in a similar manner in the Borys and Pope study (i.e., becoming friends with a client after termination) and the Pope, Tabachnick and Keith-Spiegel study (i.e., becoming social friends with a former client), the response categories were quite different. Borys and Pope asked respondents to indicate the proportion of clients with whom they had established friendship relationships (No Clients, Few Client, Some Clients, Most Clients, and All Clients), whereas Pope, Tabachnick and Keith-Spiegel asked respondents the extent to which they had engaged in this practice (Never, Rarely, Sometimes, Fairly Often, Very Often). Given that the response options were not consistent, and may have been interpreted by respondents in dissimilar ways, it is not surprising that the prevalency rates differed in these two studies. Furthermore, the response options in the current study were different than in either of these two studies. In the current study, respondents were asked if they had, "ever established a friendship relationship with a former client." Friendship was then described as, "ongoing, nonaccidental, social, nonsexual contact." Respondent were given a forced "Yes or No" choice option.

It is also possible that the relatively smaller prevalence rate found in this study could be a result in part of a sampling bias. The survey used in this study, in con-

trast to the Pope, Tabachnick and Keith-Spiegel (1987) and Borys and Pope (1989) surveys, asked primarily about friendship relationships with former clients. The intent of the survey was obvious as the survey was clearly geared toward gathering information about this practice. In the other two studies, a range of dual role practices were examined. Therefore in the current study, clinicians who had established friendship relationships and were concerned about revealing this particular information may not have returned the survey. This would suggest then that the prevalence rate found in this study was somewhat deflated.

Given the differences in the ways these three studies defined the therapeutic practice of establishing friendship relationships, the differences in the response options offered, and the potential sample bias, it is difficult to compare prevalence rates across these studies. However, these studies do suggest that a significant minority of clinicians (i.e., at least 20%) have ongoing, social contact with clients following the termination of treatment. Because of the relatively high prevalence of friendship relationships between therapists and their former clients and the potential harm associated with it, it seems important to understand this practice and the motivations clinicians have for establishing these relationships. The present results offer some insight in this regard.

Personal And Demographic Therapist Variables

One of the primary purposes of this study was to determine whether clinicians who report having engaged in friendship relationships with former clients differed on personal and demographic variables from those clinicians who report that they have not established friendship relationships. The first hypothesis related to personal and demographic characteristics was not supported. Male respondents did not report engaging in friendship relationships with former clients significantly more frequently than female respondents. Though past research has generally found that male clinicians are more likely to engage in nonsexual and sexual dual roles (Borys & Pope, 1989; Gechtman & Bouhoutsos, 1985), this pattern may not exist when considering specific types of nonsexual dual roles. For example, Borys and Pope (1989) found that male clinicians reported engaging more frequently in a group of behaviors categorized as social dual roles. However, specific social dual roles were not extracted from this group of behaviors and examined independently. So, whereas male clinicians may engage in some nonsexual dual role practices more frequently than female clinicians, there may not be a significant difference between the sexes for other nonsexual dual roles. This suggests that more accurate information related to the impact of personal and demo-

graphic variables on clinicians' willingness to engage in dual roles may be gleaned when specific types of dual roles are investigated.

There was partial support for the second hypothesis which stated that respondents endorsing a psychodynamic orientation should report engaging in social relationships with former clients less frequently than clinicians who ascribe to other theoretical orientations. Although psychodynamic clinicians did not differ from clinicians endorsing all other orientations, a significant difference did emerge when psychodynamic clinicians were compared only to those endorsing an existential/humanistic orientation. This finding suggests that psychodynamic clinicians may have more conservative/restrictive ideas about therapeutic boundaries post-treatment than clinicians who ascribe to an existential/humanistic orientation. Borys and Pope (1989) found a similar difference between these two groups of clinicians. They found that psychodynamic clinicians reported fewer financial dual roles than clinicians who ascribed to an existential or humanistic orientation. Furthermore, they found that psychodynamic clinicians engage less frequently in professional dual roles and social contacts with clients when compared with respondents ascribing to all other theoretical orientations.

It is likely that psychodynamic clinicians reported

fewer friendship relationships because of their theoretical formulation of the therapy relationship. Psychodynamic clinicians recognize the salience of the transference and strive to minimize interfere with its development. These clinicians tend to believe that the transference does not disappear with the termination of treatment. Therefore, they are likely to be more cautious about altering the boundaries of the relationship during as well as following treatment. Existential/humanistic clinicians on the other hand, tend to endorse a non-role-bound conceptualization of the therapy relationship. Therefore friendship relationships may develop as a result of the equal status of the therapist and client.

The third hypothesis was supported which stated that, respondents who work and live in the same small or rural community should report engaging in social relationships with former clients more frequently than respondents who do not work and live in this type of community. These findings are consistent with previous research. Borys and Pope (1989) found that clinicians from small rural communities have different attitudes and ideas about the ethicality of dual role behaviors and in some circumstances, are more willing to establish dual roles than clinicians who work and live in other settings. These authors found that clinicians who work and live in small/rural communities,

rated social, financial, and professional dual roles as more ethical than clinicians in other practice locales. Furthermore, respondents from these communities reported having engaged more frequently in financial dual roles than other clinicians. Stockman (1990) suggested that the limited and confined population and the interdependency that exists within these communities, make some dual roles unavoidable. She stated that therapists may often be confronted with situations where they are required to interact with clients on a variety of levels (i.e., personal, business, and/or professional).

Results from the current study as well as previous research suggest that psychologists in rural settings may benefit from additional information and guidance in dealing with dual roles. For example, helping clinicians to effectively negotiate dual roles in a manner which creates minimal risk to the client and the therapy relationship is paramount. Furthermore, guidance and instruction in helping clinicians to distinguish circumstances where dual roles are unavoidable from those circumstances where they may be reasonably averted is also important.

Clinicians who reported having established friendship relationships differed from those who have not on additional personal and demographic variables. Results found that clinicians who reported friendship relationships were sig-

nificantly older and had more years of experience than the clinicians who denied engaging in this practice. Although there was a statistically significant difference between the two clinician groups, the differences may not be clinically meaningful. The difference between the two groups on the age variable was only 3.3 years (i.e., 47.8 years versus 51 years) and on the years of experience variable was also 3.3 years (i.e., 17.5 years versus 14.2 years). Furthermore, Borys and Pope (1989) did not find age or years of experience as variables relevant to clinicians' attitudes or behaviors regarding dual role practices. Therefore, given the relatively small difference between the clinician groups on the age and experience variables, and the lack of previous research that supports the findings in this study, these results should be interpreted cautiously.

No significant results were found between the two clinician groups on the following personal/demographic variables; race, marital status, degree, specialty, practice setting, and number of adult clients treated in the past two years. However, it is difficult to draw conclusions about these nonsignificant results because of the lack of variability within some of these variables. For example, 97% of the clinicians were caucasian, 79% of them were married, 88% had a Ph.D. degree and 72% were clinical

psychologists. The nonsignificant findings regarding the number of adult clients treated in the past two years suggests that clinicians who have established friendships do not engage in this behavior solely because they have seen more clients and therefore opportunities for this type of relationship have arisen more frequently.

Involvement In Other Dual Roles

In the second Section of the survey respondents indicated the proportion of their clients (i.e., Most Clients, Some Clients, Few Clients, 1 or 2 Clients, No Clients) with whom they had engaged in 21 various dual roles and incidental contacts. Results indicated that clinicians who reported having engaged in friendship relationships with former clients reported a greater frequency of involvement in these other dual role practices and incidental contacts than the clinicians who denied having established friendship relationships with former clients. These results suggest that clinicians who have had friendships generally have more fluid boundaries as the friendship relationships do not represent isolated incidents of loose or inappropriate therapeutic boundaries.

These findings lend some support to Borys's (1988) conclusions about the development of dual roles between clients and therapists. Borys found that the clinicians who reported having had sexual relations with former cli-

ents had also engaged in a variety of nonsexual dual roles with clients. She concluded that nonsexual dual roles likely occur prior to the termination of treatment and the onset of sexual relations. The pattern of loose and inappropriate boundaries that likely existed throughout treatment therefore facilitate the establishment of the sexual relationship. A similar pattern may have existed among the clinicians in this study (who reported engaging in friendship relationships) and their clients. Given that these clinicians as a group reported engaging in a variety of dual roles and incidental contacts, fluid boundaries may have occurred between the client and therapist throughout their relationship. If so, the friendship relationship would be a natural extension or outcome of this pattern of interaction.

To further assess the difference between the two groups of clinicians, the 21 dual role situations were categorized into four groups, 1) incidental contact, 2) social dual roles, 3) financial dual roles, and 4) professional dual roles. This categorization was used to determine whether a pattern existed in terms of the type of dual role practices in which clinicians, who have established social relationships with former clients, tend to engage. Results of the analyses determined that the clinicians who reported friendships relationships with former clients,

engaged more frequently in social, financial, and professional dual roles, and incidental contacts than the clinicians who denied having engaged in friendship relationships. This suggests that no particular pattern exists in terms of the type of extratherapeutic contact in which these clinicians tend to engage. Their general style seems to involve more open and permissive boundaries with current and former clients and therefore their interactions with clients may involve any number of social, financial, and professional dual roles and incidental contacts.

External Factors Influencing Clinicians' Decisions to Enter Into Friendship Relationships With Former Clients

The third and fourth Sections of the survey were designed to help identify and elucidate factors which influence clinicians' decisions to enter, or not to enter, into friendship relationships with former clients.

Results of Section III of the survey found a main effect for each of the three factors (i.e., the concordance or discordance of the sex of the client and therapist, the amount of time elapsed between the termination of treatment and the initiation of the extratherapeutic contact and clinicians' history of establishing friendship relationships) across the three vignette questions. The results suggest that these three variables were relevant factors influencing clinicians' decisions to establish extrathera-

peutic contact (i.e, having lunch and establishing a friendship relationship). Furthermore, the variables impacted clinicians' judgments about the ethicality of establishing friendship relationships with former clients.

It is important to note that although main effects were found for each of the three variables across the vignette questions, respondents overall indicated significant hesitancy to engage in extratherapeutic contact. Furthermore, friendships were not generally perceived as ethical under either manipulated condition. For example, when the client was described as the same sex as the therapist, the average rating of all clinicians in regard to their likelihood of establishing a friendship was only 1.96 (1= Extremely Unlikely and 2= Very Unlikely). A similarly low rating (2.06) was found when two years had elapsed following treatment.

Because of the overall hesitancy that clinicians indicated in response to the vignette questions, the main effects should be interpreted with some caution. Though the three variables were relevant factors influencing clinicians' ratings of the vignette questions, these factors clearly did not impact clinicians ratings to the point that the extratherapeutic contacts were perceived as ethical or to the point where clinicians were readily willing to engage in these practices. Therefore, the factors should

be interpreted and understood primarily in terms of their relative impact on clinicians' ratings of the vignette questions.

Results indicated that respondents were less hesitant to have lunch, to establish a friendship relationship with a former client and were less likely to view the friendship as ethically problematic when the client and therapist were of the same sex. The concordance/discordance of the sex of the client and therapist was likely a relevant and influential factor in these judgements because of the potential threat of sexual relations developing from the therapeutic relationship or the perception of a sexual relationship. Given the fairly recent proliferation of literature addressing the negative effects of sexual relationships with clients, as well as the legal and ethical implications of such behavior, clinicians in this study were likely sensitive in part to demand characteristics. They may have felt compelled to respond in a manner that was consistent with ethical and legal standards.

Results also revealed that when a longer period of time has elapsed following treatment (i.e., two years versus one week), respondents would be significantly less hesitant to have lunch with a former client, to establish a friendship relationship, and were less likely to view the friendship as ethically problematic. This suggests that

when a longer period of time has elapsed, respondents may feel that there is less of a risk of harming the former client and contaminating the previous therapeutic treatment. Therefore, when the opportunity arises for clinicians to engage in extratherapeutic contact, they may consider the amount of time that has elapsed since treatment ended, before engaging in this behavior.

The notion that the amount of time that has elapsed is important in making decisions about post-treatment relationships may have emanated from the Ethical Principles (1992) which address post-treatment sexual relationships with clients. The revised Code explicitly prohibits sexual relations with clients within two years following the termination of treatment. It is likely that the clinicians in this study may have applied the same type of standard or guideline put forth in the Ethical Principles which acknowledges the relevance and importance of the amount of time that has elapsed between the termination of treatment and the initiation of nontherapeutic contact with former clients.

Results found that respondents who reported a history of establishing friendship relationships indicated a greater likelihood of having lunch with a former client and establishing a friendship relationship. In addition, these respondents were more likely to view the practice of estab-

lishing friendship relationships with former clients as more ethical. This suggests that clinicians who establish friendship relationships may be generally more willing to engage in extratherapeutic contact than those who have not had friendship relationships. Therefore, therapists' history of establishing friendship relationships may be a good predictor of future behavior. These findings are consistent with the results and conclusions from Section II of the survey. It appears that clinicians who have established friendship relationships generally have more fluid boundaries and therefore may engage current and former client in a variety of types of extratherapeutic contact.

In Part A of Section IV, respondents were asked to select the statement which best described the reason they had not established a friendship relationship with a former client. The majority of the respondents indicated that they felt that it was "poor practice." The remaining respondents felt that it was "unethical" or, "okay in certain circumstances but these circumstances have not arisen with any of my clients". Only a few respondents indicated some "other" reason. These results suggest that the primary reason that clinicians do not establish friendship relationships is because they consider it poor practice rather than because they deem it unethical. This finding is consistent with other research which has also

found that standards of good practice do not necessarily coincide with ethical and legal standards. Pope, Tabachnick and Keith-Spiegel (1988) found that respondents reported more stringent standards for good practice than for ethical practice when evaluating 83 different therapeutic practices including several sexual and nonsexual dual roles. A practice may be ethical, but still considered poor practice. Thus it may be important to go beyond ethical standards to establish good standards of practice that can be used as guidelines for clinicians in relation to extratherapeutic contact with former clients.

In addition to the 76 respondents who reported that they had established a friendship relationship, several more respondents (n= 118) who had not engaged in this practice indicated that they would not rule out the possibility of this practice. These clinicians could imagine circumstances in which they might establish a friendship relationship. This suggests that these respondents do not perceive the practice as poor or as unethical under all circumstances and highlights the importance of understanding the circumstances under which these clinicians might consider engaging in this practice.

Responses to the open-ended questions provided some insight into the circumstances under which clinicians might consider a friendship relationship with a former client.

The circumstance most frequently identified by respondents as influencing their decision to establish a friendship relationship was the amount of time elapsed between the termination of treatment and the initiation of the relationship. Most respondents specified that they would not establish a relationship unless more than two years had past since treatment had ended. Eight respondents indicated that between six months and two years should elapse and thirteen respondents did not specify any particular amount of time (e.g., "a long time had passed..."). Respondents' recognition of this circumstance as important is consistent with the findings in Section III of the survey. When more time had elapsed following treatment (i.e., two years versus two weeks), respondents indicated that they would be significantly more likely to establish extratherapeutic contact.

Once again, clinicians' recognition of the importance of a certain amount of time elapsing following treatment is consistent with the standard set for sexual relationships with former clients as addressed in the Ethical Principles (1992). It appears that clinicians have applied this same standard in their thinking about potential friendship relationships with former clients.

The second most frequently identified circumstance was external or situational factors. This category related to

the development of the friendship relationship as a result of contact/involvement with the former client outside of the therapy relationship. Specifically, respondents indicated the following situational circumstances; becoming neighbors with a former client, children meeting in school and becoming friends, belonging to the same church or community organization, participating on same sports or recreational team, serving on the same committee, overlapping social circles, and living in the same small town and paths frequently crossing. In other words, if circumstances created continued contact, they seemed to feel some ongoing relationship might be appropriate.

The third most frequently endorsed circumstance was treatment factors. Responses related to the nature of the treatment impacting clinicians' decisions to establish friendship relationships were included in this category. Most respondents indicated that they would consider establishing the friendship only when the treatment was brief, and successfully completed. Furthermore, many indicated that the type of treatment provided to the client was important. For example, respondents would consider establishing friendships only when the treatment was "problem-oriented." The treatment would have to focus only on "situational and external" factors rather than transference issues. Others suggested that the treatment could not have

been, "transferentially complicated," and that the transference had to be "minimal."

In summary, the three primary factors identified by these clinicians as influencing their decisions generally represented factors which were external to the personal and emotional characteristics of the client and the relationship between the client and therapist. The factors which they deemed most relevant were related to treatment and situational circumstances.

It is also noteworthy that in addition to the nine categories of circumstances identified by the respondents, many spontaneously indicated in some fashion, the need for caution in establishing friendship relationships with former clients. This caution was expressed in a few different ways. Some respondents indicated that although they might establish a friendship relationship, the friendship would not be close one and would not involve frequent contact. Several other respondents indicated that the circumstances that would have to exist in order for them to establish the friendship would be so exceptional that the likelihood of these circumstances actually occurring was extremely low. In a similar vein, some clinicians reported that they would not rule out the possibility of engaging in most behaviors and therefore to say that they would "never" consider a friendship with a former client was too extreme.

However, most of these respondents went on to say that it would be highly improbable that they would engage in this practice. The frequency of these "caution remarks" and the considerable hesitancy that these respondents expressed, suggests that although these respondents reported that they would consider establishing a friendship relationship, it is unlikely that they would ultimately engage in this practice.

Of particular importance in understanding the motivations for establishing the friendship relationships is the information provided by the respondents who reported having established a friendship relationship with a former client. These respondents were asked to select the "most significant friendship relationship" that they established with a client and to answer several questions about this relationship.

The majority of respondents indicated that the friendship relationship was initiated following the termination of treatment. Very few reported that the relationship began either before the onset of treatment or during the treatment. The amount of time that elapsed between the termination of treatment and the initiation of the relationship varied considerably, however the majority of relationships were established within one year following the termination of treatment.

This finding is not consistent with the results in Section III which suggests that the amount of time that elapses following treatment is important in influencing clinicians decisions to establish friendship relationships. Many of the clinicians who have established friendships have apparently engaged in these friendships within a short period of time following treatment, suggesting that the amount of time elapsed is not something that many of these clinicians seriously considered.

Respondents were asked to provide a variety of information pertaining to the client's treatment including, the modality, the duration of the treatment, the treatment approach/orientation, and the treatment setting. Results indicated that the majority of clients were treated in individual therapy, in a private practice setting. This suggests that friendship relationships may be most apt to occur in a more secluded setting where therapeutic practices are more difficult to observe and supervise. Furthermore, a private practice setting may be more conducive to the development of a friendship relationship. The client and therapist may be involved more directly in a private practice setting given that the presence and influence of an agency situation does not exist. In some instances this may lead to greater intimacy in the relationship and more ambiguous therapeutic boundaries.

Respondents indicated a variety of treatment approaches with these clients, though psychodynamic, cognitive, and existential/humanistic orientations were most frequently reported. Psychodynamic and cognitive therapists were disproportionately represented in the original subject pool; therefore, the relatively high number of psychodynamic and cognitive clinicians treating these clients should not be misinterpreted. The proportion of existential/humanistic clinicians who engaged in friendship relationships is higher than the proportion represented in the entire subject pool. This is consistent with findings in Section I which suggests that existential/humanistic clinicians are more likely to engage in extratherapeutic contact with current and former clients, particularly in comparison with psychodynamic clinicians.

There was a considerable range in the amount of time that these clients were in therapy though the majority of them were in treatment for 12 months or less. However, several client were in therapy for a more extended period of time (i.e., between 12 and 48 months). Thus, although many of the respondents who had not established a friendship relationship indicated that they would consider a friendship only when the treatment was brief, this did not seem to be a significant consideration for the clinicians who reported friendship relationships. It appears that

given the protracted duration of treatment for some of these clients, the friendship followed a relatively intense and involved therapeutic relationship.

Some personal information about the clients was obtained. Results found that male and female clients are equally likely to be involved in a friendship relationship with a former therapist. Most of the clients were the same age (within 5 years) as the therapist or were younger than the therapist. Only a few clients were older than the therapist.

Generally, respondents indicated good feelings about these relationships as the average rating was between Positive and Very Positive. Furthermore, 92% of the respondents rated the relationship as at least "Positive", only 8% indicated that it was either only "Slightly Positive" or "Not At All Positive." It is not surprising that these relationships were viewed positively given that these clinicians are likely to engage in a variety of types of dual roles. They may not perceive these practices as problematic or as creating negative repercussions. Furthermore, given these positive perceptions of these relationships, it is likely that the clinicians would consider establishing future friendship relationships with former clients. However, it should be noted that these positive feelings about the relationships represent the clinicians'

perceptions only. It is not known how the clients perceived the relationships or how someone outside of the relationship would view the quality of it.

Respondents were also asked the number of clients with whom that they had established a friendship relationships, and the percentage of their total clients that this number represents. Results indicated a considerable range in the number of clients that respondents had established a friendship relationship with (range 1-50), however, the majority of the respondents indicated that this number represented less than one percent of their total clients. Furthermore, most respondents reported only having established either one or two friendship relationships. This suggests that these clinicians appear to be discriminatory in this practice as they do not engage in this type of relationship with most of their clients. There appear to be certain circumstances under which these clinicians decide to engage in this practice.

Responses to the open-ended question provided some insight into these circumstances. The range of circumstances identified by these clinicians seemed to fall into ten general categories however the following four categories of circumstances were identified by the largest amount of respondents: Client characteristics, Mutuality of feelings, interests, and values, External/situational factors,

and Client is colleague or in same profession. In contrast to the circumstances identified by the clinicians' who have not established friendship relationships, these clinicians were much more attuned to the personal characteristic of the client and to the nature and compatibility of the relationship between them (i.e., the client and the therapist).

The respondents identified a variety of client characteristics which influenced their decision to establish the friendship. Generally, these characteristics fell into three categories including, 1) the psychological health of the client (e.g., "client was basically healthy, managed her life well"), 2) the therapist's perception that the client was isolated or needed friendship relationships (e.g., "he did not have strong personal relationships outside of his business responsibilities") and 3) other characteristics which therapists found attractive that did not fall into either of these other two categories (e.g., "sense of humor, client's eagerness for the relationship, pleasant, giving, intelligent, sophisticated").

Whereas 38.4% of the respondents who have established friendship relationships identified client characteristics as important in their decision to establish the friendship, only 17.8% of those who have not had relationships identified this factor as potentially important. Furthermore,

the type of client characteristics identified as important differed between the two groups. The clinicians who have not established friendships described the psychological health of the client as important; other personal characteristics were rarely mentioned.

Several respondents indicated that external and situational factors influenced their decisions to establish the friendship. The factors described by these respondents included, becoming neighbors with the former client, attending the same church, client was spouse of husband's colleagues, similar activities in small town, overlapping group of friends, and therapist's and client's children met and became friends. These were the same type of external/situational factors described by the respondents who have not established relationships. Furthermore, the two groups of clinicians saw this factor as nearly equally important (i.e., 26% versus 29% of the respondents).

Compatibility of interests, values, and life experiences between therapists and their clients was another factor that many of the clinicians recognized as particularly important in their decision to establish the friendship relationship. Furthermore, many of these respondents indicated that the friendships were established with clients who were colleagues in the mental health profession. Though both of these factors were identified as central to

these respondents' decisions to establish the friendship, a smaller percentage of respondents who have not engaged in this practice identified compatible interests, values, and activities and client's profession as important.

The results of the open-ended question suggest that the clinicians were influenced primarily by particular client characteristics in their decisions to engage in friendship relationships. The characteristics include, the psychological health of the client, personal characteristic that were appealing to the therapist (e.g., sense of humor), the perception of the client as socially needy or isolated, and mutual interests, activities, values and life experiences (including profession) between the client and therapist.

These respondents were apparently less influenced by factors which were more directly related to the previous treatment and therapy relationship. For example, only one respondent indicated that the amount of time that elapsed following treatment was important. Furthermore, only two respondent mentioned the importance of discussing with the client that treatment would not resume with that therapist once the friendship was established. Both of these factors were identified as considerably more important to the group of respondents who had not established friendship relationships. These clinicians (i.e., those who have not had

friendship relationships) seemed more focused on factors related to their role and responsibility as a therapist, and they perceived factors related to client characteristics as less relevant in the decision to establish a friendship relationship with a former client. It seems that the clinicians who have established friendships developed these relationships and selected clients in a manner similar to the way in which people in general (i.e., nonprofessional situations) go about establishing friendships. The emphasis on personal characteristics and the compatibility of personalities and interests raises some concern that these clinicians may have minimized their professional role and obligation to their client.

In addition to identifying the ten categories of factors, several respondents spontaneously provided additional information regarding their thoughts and experiences about these friendship relationships. These data were summarized and grouped into two general categories; 1) caution in engaging in this practice, and 2) hesitancy in engaging in this practice in the future. A small number of respondents acknowledged that the relationship did not work well and therefore indicated some hesitancy in establishing these relationships in the future. For example, one respondent made the following comment,

> We became friends...later however due to a death in her family the client decompensated, made many

> unrealistic demands and became hard to limit to an acceptable level of intimacy. This experience had me rethink my attitude toward friendships.

Other respondents acknowledged the need for caution when establishing these relationships or mentioned the limitedness of the friendships they had established. For example, one respondent wrote,

> Life generally is too complicated to say one would never under any circumstances do (x). However, in general I believe in erroring on the side of caution and with the exception described below have always felt it would have been a breach of boundaries though I have certainly had clients with whom I would have enjoyed a friendship had we met under other conditions.

Others indicated that although they had established a friendship relationship, the relationship was limited in some manner. Respondents depicted the limitedness of their friendships in the following ways, "Was not a deep friendship," "We were separated by a distance of 2,500 miles, primarily phone and letter contact," "When she left for another city after seven years of treatment with me, we corresponded regularly on a "friendly" basis, i.e., my letters contain some limited personal disclosure and we x-change small gifts at Christmas time," "Friendship is limited to updating therapist with her life. We meet at a restaurant for lunch and each pays for lunch. As such, friendship is quite limited, could be considered "in vivo" treatment. However, no notes are kept, no charges made and the time is spent in simply she reporting."

Although these clinicians established friendships, the limitedness of these relationships suggests that the clinicians were concerned with boundaries and therefore they tried to restrict the friendship in some way. Thus, even though some of the clinicians established friendship relationships, a number of them were quite thoughtful about this decision and were seemingly aware of the potential negative repercussions of the practice.

Methodological Limitations

This study represents an initial empirical attempt to gather information about the practice of establishing friendship relationships between therapists and their former clients. Friendship was specifically defined in the survey as, "ongoing, social, nonsexual contact." Though defining friendship helped to ensure that the respondents were interpreting "friendship" in a similar manner, the definition used may not represent the variety and diversity of relationships that actually exist between therapists and their former clients. Some of the results of the current study suggest that "friendship" relationships with former clients vary widely. For example, some clinicians indicated that they had established, "ongoing, social, nonsexual contact," however, they had restricted this contact primarily to phone conversations. The objective response format used in the current study limited the amount of description

and information that respondents were able to provide. Respondents were not asked to give detailed descriptions of their friendships. Defining what is meant by "friendship" is important because the prevalence, the circumstances under which they are established, as well as the impact of them on clients, may be dependent upon the type or nature of the friendship relationships. Therefore, the results of this study argue for more indepth descriptions and analyses of friendships as they occur in the real world in future research endeavors.

The representativeness of the present sample must be considered in interpreting the findings. The subject sample was determined through a random sampling of licensed, doctoral level, psychologists who are members of the American Psychological Association. Though the selection process was a random sampling of these APA members, it is likely that the respondents are not representative of all licensed psychologists. For instance, many psychologists are not members of APA and therefore these clinicians were obviously excluded from the sampling. Another sampling bias is that nearly all of the respondents in this study (97%) were caucasian. Given these biases, the results of this study may not be generalizable to some groups of psychologists.

Conclusions and Future Directions of Research

The results of this study indicate that the majority of clinicians have not established friendship relationships with their former clients. Furthermore, when presented with a hypothetical clinical vignette, most clinicians expressed considerable hesitancy in engaging in extratherapeutic contact. Nonetheless, despite the caution and conservativeness of most clinicians, some clinicians have established friendships of various types with former clients. In addition, a substantial percentage of clinicians would not rule out the possibility of engaging in this practice even though they had not yet established this kind of relationship. Given this, it is important to understand the motivations and factors associated with the development of these relationships.

Several sets of findings shed some insight on the factors that may influence clinicians' decisions to establish such contacts. First, there was evidence that the respondents who had established friendships differed from those who had not, on a few personal and demographic variables. Clinicians who endorsed an existential/humanistic theoretical orientation and lived and worked in the same small or rural community, were more likely to have had friendship relationships than the clinicians who endorsed a psychodynamic orientation and who lived or worked in other

settings. Second, results indicated that the clinicians who had established friendship relationships, had also engaged more frequently in a variety of other extratherapeutic contacts with current and former clients than clinicians who denied having established a friendship relationship. This finding suggests that as a whole, clinicians who have established friendships may have more liberal ideas about appropriate therapeutic boundaries with current and former clients. The third set of findings suggest that the amount of time that elapses following treatment and the concordance or discordance of the sex of the client and therapist influence clinicians' decisions to establish extratherapeutic contact and their perceptions of the ethicality of these behaviors. Clinicians who had established friendships were also more likely to engage in these extratherapeutic behaviors and to perceive them as less ethically problematic.

Another set of findings suggested that certain client characteristics and treatment factors were influential in clinicians' decisions to establish the friendship relationships. The majority of the relationships were established within a relatively short period of time following treatment. Most of the clients were treated in individual therapy in a private practice setting. The duration of treatment varied widely suggesting that the amount of time

spent in treatment was not a significant factor influencing clinicians' decisions to establish the friendship relationships. There was nearly an equal number of male and female clients that became friends with their former therapists and most of them were the same age or younger than their therapists. Most clinicians indicated that the number of clients with whom they have established friendships represents less than 1% of the total number of clients they have treated.

In the open-ended format, these clinicians identified a variety of circumstances that influenced their decisions to establish the friendships, however they were apparently most influenced by client characteristics and some situational circumstances (e.g., living in the same small community). In contrast to the clinicians who had not established friendship relationships, these clinicians identified less frequently factors related specifically to clients' treatment.

Results also indicated that the majority of clinicians who denied having established friendship relationships avoided this practice because they felt it was "poor practice." However, many of these respondents indicated that they would consider engaging in this practice under certain circumstances. The circumstances identified by these clinicians were primarily related to treatment issues

(i.e., the type and duration of treatment and the amount of time elapsed following treatment) and situational circumstances. They perceived client characteristics as less relevant in their decisions to establish friendships with former client. These clinicians as a whole seemed more focused on their role and responsibilities as therapists in considering potential friendships than the clinicians who had established friendship relationships.

This study used a variety of research approaches in gathering information about friendship relationships between therapists and their former clients. These different approaches made it possible to assess various aspects of this practice and the result of this was that some findings seemed to be more thoroughly and clearly elucidated. For example, Section II of the survey suggested that the clinicians who have established friendships generally have more liberal ideas about therapeutic boundaries than the clinicians who have not established friendship relationships. However, the results of the vignettes seem to provide more information regarding the degree to which clinicians are willing to engage in extratherapeutic contacts. Most clinicians, including those who had established friendships, were fairly hesitant to engage in these behaviors. Furthermore, the sex of the client was identified in the vignettes as an important factor in clinicians' decisions

to establish friendship relationships however, neither of the group of clinicians (i.e., the ones who had established a friendship relationship and the ones who had not) readily identified this as a relevant factor in their open-ended responses. This suggests that the sex of the client may be a factor which is important although, clinicians may be less consciously aware of its relevance in their decision-making process. Future research may also benefit from employing a variety of approaches in assessing this practice.

The results of this study also indicate that future directions of research should include a more thorough investigation of the variety and types of friendship relationships that actually occur between therapists and clients. Respondents described a variety of types of friendship relationships that they had established or could imagine establishing. Identifying more precisely the various ways in which these friendships have been established is important in the process of assessing the circumstances under which these relationships occur and the impact of them. It is likely that the motivations for engaging in friendship relationships and the impact of them are somewhat dependent upon the nature of the friendships that are established. Therefore, it may be most productive for future researchers to compare groups of clinicians

according to the type of friendships that they have established.

Future research should also consider how various factors and circumstances interact and finally lead a clinician to establish a friendship relationship. Many factors were identified in the present study that likely influence clinicians' decisions to establish friendships; however, this study did not address the relationship among these factors. It is not apparent how all of these factors actually come together and contribute to clinicians' decisions. For example, the relative importance of these factors is not clear. Furthermore, the extent to which the influence of these factors is static rather than changing and dependent upon a variety of other circumstances is not addressed in this study. Generally, it is likely that the decisions to engage in this practice are complex, multi-determined, and somewhat idiosyncratic.

As Borys (1988) suggested, future research needs to explore the development or evolution of sexual and nonsexual dual role practices. The research to this point has not attempted to understand the context in which these practices arise. Most dual roles have been studied in isolation and independent of a larger therapeutic context. The present study has offer some insight into the circumstances that may be relevant to understanding the larger context.

Until research of this type is conducted, an accurate and realistic understanding of the evolution and impact of these relationships is difficult to assess.

In conclusion, the practice of nonsexual dual roles, particularly friendship relationships with former clients, may take a variety of forms. Furthermore, clinicians' motivations for establishing these relationships may be equally varied. Therefore it may not be reasonable to expect that the ethical guidelines can provide specific and explicit standards for the myriad of types of friendships and continued kinds of contact with former clients that actually exist. Future research should strive to determine factors influencing different types of contacts and the impact of these contacts with former clients. This information could then be used to educate clinicians and to help provide increasing specificity to the ethical guidelines.

APPENDIX A

SURVEY

SECTION I

Please answer the following questions about yourself.

1. Gender: _____ 2. Age: _____ years

3. Race/ethnicity:
   _____ Caucasian
   _____ African American
   _____ Latino/Latina
   _____ Asian American
   _____ Native American
   _____ Other(specify)_____

4. What is your marital status:
   _____ Married
   _____ Separated/divorced
   _____ Single
   _____ Cohabiting with partner
   _____ Widowed
   _____ Other(specify)_____

5. Highest degree earned (e.g., Ph.D., Psy.D.) and area of specialty (e.g., Clinical):
   Degree: _____ Specialty _____

6. Are you licensed or certified as a psychologist? _____ Yes _____ No

7. Years of experience providing psychotherapy services (post-licensure): _____ Years

8. Are you currently providing psychotherapy services to any adult clients (i.e., clients 18 years and older)? _____ Yes _____ No

   If you answered "**Yes**" to the above question, what is the approximate number of adult clients you have treated in therapy in the past 2 years? _____ Clients

   If you answered "**No**" to question #8, have you provided therapy services to any adult clients in the last five years?
   _____ Yes _____ No

9. Indicate your primary therapeutic orientation:

   ____Behavioral ____Gestalt ____Psychodynamic/Analytic
   ____Cognitive ____Feminist ____Other_____
   ____Family Systems ____Existential/Humanistic

10. Which one of the following best describes the primary clinical setting in which you most recently provided psychotherapy services:
    _____ Solo private practice
    _____ Outpatient Clinic
    _____ Group private practice
    _____ Inpatient facility
    _____ University counseling center
    _____ Specify _____

11. In which geographic area is(was) this employment setting (question #10):
    _____ urban _____ suburban _____ rural community or small town

    If you marked "rural/small town" please indicate whether you also live(d) in this same rural/small town area while you provided therapy:
    _____ Yes, live(d) in same rural or small town _____ No, live(d) elsewhere

SECTION II

Below are listed a number of behaviors which therapists may engage in as part of their clinical practice. Please indicate, by circling the appropriate number, the proportion or number of your clients with whom you have engaged in the behavior. In responding to each item, please consider only psychotherapy with adult clients (including family therapy). Unless otherwise indicated, items refer to behavior engaged in with clients who were in ongoing treatment at the time.

Behavior:	Frequency with which behavior has occurred:				
	Most Clts 5	Some Clts 4	Few Clts 3	1 or 2 Clts 2	No Clts 1
1. Accepted a client's invitation to a special occasion (e.g., wedding, graduation, funeral).	5	4	3	2	1
2. Accepted a service or product from a client in lieu of a fee.	5	4	3	2	1
3. Kissed a client.	5	4	3	2	1
4. Disclosed details of personal distress to a client.	5	4	3	2	1
5. Borrowed money from a client.	5	4	3	2	1
6. Accepted a gift from a client worth over $50.	5	4	3	2	1
7. Sold a service/product to a client.	5	4	3	2	1
8. Hugged a client.	5	4	3	2	1
9. Established a social (nonsexual) relationship with a client.	5	4	3	2	1
10. Asked for a favor from a client (e.g., ask for a ride home).	5	4	3	2	1
11. Provided therapy to a then-current student or supervisee.	5	4	3	2	1
12. Became sexually involved with a client.	5	4	3	2	1
13. Lent money to a client.	5	4	3	2	1
14. Invited a client to a personal party or social event.	5	4	3	2	1
15. Went into business with a client.	5	4	3	2	1

SECTION II (con't)

Behavior:	Frequency with which behavior has occurred:				
	Most Clts 5	Some Clts 4	Few Clts 3	1 or 2 Clts 2	No Clts 1
16. Engaged in sexual activity with a client after termination.	5	4	3	2	1
17. Accepted a client's invitation to a party.	5	4	3	2	1
18. Went into business with a former client.	5	4	3	2	1
19. Went out to eat with a client.	5	4	3	2	1
20. Gave a client a ride home.	5	4	3	2	1
21. Provided individual therapy to relative or friend of ongoing client.	5	4	3	2	1

SECTION III

Below is a hypothetical vignette depicting a situation where the possibility for engaging in social contact with a former client arises. Imagine that you encounter this particular situation and indicate by circling the number which best reflects how you would deal with or think about this situation.

You treated a same-sex client in individual therapy. Treatment was terminated because the goals of therapy were successfully reached. The client was a fairly high functioning person who was bright and engaging. You enjoyed working with this client and you felt that you had several things in common. One week following the termination of treatment you accidentally encounter the former client at the movie theater. The two of you talk and the client asks you to have lunch the following week.

1. How likely are you to accept the invitation to lunch?

Extremely Unlikely	Very Unlikely	Unlikely	Likely	Very Likely	Extremely Likely
1	2	3	4	5	6

2. How likely are you to develop a friendship relationship with this person?

Extremely Unlikely	Very Unlikely	Unlikely	Likely	Very Likely	Extremely Likely
1	2	3	4	5	6

3. How ethical would it be to establish a friendship relationship with this former client?

1	2	3	4	5	6
Definitely Not Ethical					Definitely Ethical

SECTION IV

Have you ever established a **friendship relationship** with a former client? Friendship is defined here as ongoing, nonaccidental, social, nonsexual contact. _____ Yes _____ No

If you indicated that you have established a friendship relationship (as defined above) with a former client please skip Part A (below) and go to Part B. If you have not established a friendship relationship with a client please complete Part A and then return the survey in the envelope provided.

Part A

Please complete this part if you have not established a friendship relationship with a former client.

1. Mark the statement which best describes why you have not established a friendship relationship with a former client.
   - _____ I believe that this practice is unethical.
   - _____ I believe it is poor practice.
   - _____ I believe this practice is okay in certain circumstances but these circumstances have not arisen with any of my clients.
   - _____ Other (specify)_____

2. Would you consider establishing a friendship relationship with a former client under any circumstances? _____ Yes _____ No

If you answered "**Yes**" to the above question (you would consider establishing a friendship relationship), briefly describe the circumstances under which you would consider establishing the relationship.

_____

_____

Part B

Please complete this part if you have established a friendship relationship with a former client. If you have established more than one friendship relationship with a former client, select the most significant friendship relationship that you have established and answer the following questions based on your experiences with this particular client. If you have only established one friendship relationship with a former client, then respond to the questions based upon your experiences with this person.

1. At what point in your relationship with this person was the friendship initiated?
   _____ Prior to treatment _____ During treatment _____ After treatment

   If you marked "After treatment" above, indicate how much time elapsed between the termination of treatment and the beginning of the friendship relationship.
   _____ Year(s) _____ Month(s) _____ Week(s)

2. Indicate the predominate treatment approach used with this client:
   _____ Behavioral _____ Gestalt
   _____ Cognitive _____ Psychodynamic/Analytic
   _____ Existential/Humanistic _____ Family Systems
   _____ Feminist _____ Other_____

3. Indicate the primary treatment modality: ____Individual ____Group ____ Other_____

4. What was the approximate duration of time in which you saw this person in therapy?
   _____ Years ____ Months

5. In what type of treatment setting did you treat this client (e.g., private practice, outpatient clinic)? _____

6. Please indicate the gender of this former client: _____ Female _____ Male

7. Was this former client: _____ About the same age as you (i.e., within 5 years)
   _____ Younger than you
   _____ Older than you

8. Indicate your global impression of the quality of this relationship:

Extremely Positive	Very Positive	Positive	Slightly Positive	Not At All Positive
5	4	3	2	1

9. With how many clients have you developed a friendship relationship? Approximately what percentage of your total clients does this represent? ____ Number of clts ____ Percent

10. Please briefly describe the factors that were most influential in your decision to establish a friendship relationship with this particular client?

_____

_____

APPENDIX B

COVER LETTER

June 24, 1993

Dear Psychologist,

I am a fifth year clinical doctoral student at Loyola University of Chicago and I am writing to seek your help in collecting some data for my dissertation. The enclosed brief survey, which we hope you will be willing to fill out, takes approximately 10 minutes to complete. The survey is being sent to a randomly selected, national sample of licensed psychologists.

We are interested in gathering information about clinicians' attitudes and practices regarding the structuring of relationships with current and former clients. The existing research indicates that there is considerable variability in how clinicians think about and deal with therapeutic relationship issues.

This is an anonymous survey. We recognize the sensitive nature of some of the survey questions and we are taking the following steps to assure your anonymity. First, you will not be identified by name or by any other sort of coding process. Second, we ask that you do not provide any identifying information on the survey. Third, when the surveys are returned, the envelopes will be destroyed.

We would greatly appreciate your completing the survey and returning it at your earliest convenience in the pre-paid, addressed return envelope provided. If you have any questions about the survey or would like a summary of the results, I (Kerry Aikman) can be reached at the following number, (708) 864-8368. Thank you very much for your valuable time.

Sincerely,

Kerry Aikman, M.A.
Doctoral Candidate

Patricia Rupert, Ph.D.
Dissertation Director

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VITA

The author, Kerry Aikman, is the daughter of Judy and Patrick Aikman. She was born on September 27, 1961, in Greencastle, Indiana. Ms. Aikman completed her undergraduate education at Butler University in Indianapolis, Indiana where she earned a Bachelor of Arts in psychology in May of 1984. She then attended Xavier University in Cincinnati, Ohio and graduated with a Master of Arts in clinical psychology. The year following her graduation from Xavier she worked in the Department of Psychiatry at the Medical University of South Carolina as a research assistant and psychometrician.

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APPROVAL SHEET

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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

March 28, 1994
Date

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