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Close encounters of a therapeutic kind

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Close Encounters of a
Therapeutic Kind

ABSTRACT

This study was designed to determine how clinical outpatient social workers deal with accidental encounters with their clients outside of the therapeutic setting. The study also addressed whether or not clinicians felt that extratherapeutic encounters affect the therapeutic alliance.

Twelve clinical outpatient social workers were interviewed in a qualitative study. This research was an attempt to examine how clinical outpatient social workers handle extratherapeutic encounters and their experiences when dealing with such an encounter. The study is also focused on how clinical social workers prepare clients, if at all, for the fact that they very well may run into clients outside of the therapeutic setting.

The findings from the interview conducted concluded that it is inevitable that clinical social workers will face extratherapeutic encounters during their career. Other findings that are examined in this study include; preparing clients for encounters, the effects encounters can have on the therapeutic alliance, and training and supervision in the field regarding extratherapeutic encounters.

CLOSE ENCOUNTERS OF A THERAPEUTIC KIND

A project based upon an independent investigation,
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CHAPTER I

INTRODUCTION

It's happened to me…I was grocery shopping at a local supermarket browsing the local produce aisle and suddenly a client was standing two inches away updating me on her latest issue with her mother. I felt cornered, maybe even a little violated. Then I noticed the sweatpants and shirt I pulled on before I left the house had a huge dirt stain because my dog had an early morning excursion in a mud puddle. The thought floats through my mind, "OMG, did I even brush my hair?!" It all started as a lazy and relaxed Sunday morning with the dog and had rapidly warped into a therapeutic session by the asparagus and arugala. Just when you think you are wrapping up the conversation without being avoidant, disrupting the therapeutic alliance or completely violating confidentiality, the produce sprinklers come on and drench us both. Humor continues to be my favorite defense in these situations and worked well for this one. But, I just want to tell you if it can happen to me, it could happen to you. Are you prepared? I wasn't.

As a social worker in Western Massachusetts I have had experiences of running into clients outside of the working relationship regularly. One day I finally asked myself how do I handle this? Many thoughts cross my mind in how I can handle the extratherapeutic encounter including avoidance. But, I love my work, am committed to the field, and have come to the realization that I love the town in which I work. Being a therapist in this community is part of my life, even if it means I'm "on" even when the clinical hour has ended.

The purpose of this study is to determine how clinical outpatient social workers deal with accidental encounters with their clients outside of the therapeutic setting. Accidental encounters have also been referred to as chance encounters or chance extratherapeutic encounters and are defined as unplanned, random, or unexpected encounters between the therapist and a current client that take place outside the therapist's office (Zur, 2007, p.109). Literature suggests that parameters should be established between the client and therapist regarding such encounters to alleviate situations that could be harmful to the client's therapeutic progress. It is the hope of this researcher that this study will begin a process of defining those parameters.

Much of the research collected on extratherapeutic encounters is based on clinical social work in rural and non-metropolitan areas. In small community social work, it is assumed that the percentage of extratherapeutic encounters seems to be more frequent for clinicians than for those who work in more metropolitan areas. While looking at general research in the area of accidental encounters, ethical issues such as confidentiality, self-disclosure, and professional boundaries are all topics that arise. Very little of the research about extratherapeutic encounters examines how these encounters affect the therapeutic alliance, how it affects the therapist, and ultimately how it affects our clients. Also, very little of the research includes information for clinicians on how to best prepare our clients and ourselves for such encounters.

Clinical social workers inevitably will face a situation where they will run into a client outside of the therapeutic setting. These unplanned occurrences between clinicians and clients will be referred to in this study as extratherapeutic encounters. Social workers are often taught that the best way to handle extratherapeutic encounters is to make eye

contact with the client and allow the client to approach you or make the primary acknowledgement. In theory this sounds straightforward but is often not the scene that unravels in the reality of life experiences in the field. When a clinical social worker meets a client outside of the therapeutic context, the client may learn information about the worker that had been previously undisclosed. For example, if a client observes a therapist dropping his or her children off at school, it may be surprising to the client that her therapist is a parent. Another component of accidental disclosure is when the therapist learns or observes something about a client that the client had not decided to share in therapy. You could see a client outside of the therapeutic setting doing something you did not know they identified with, for example smoking or a client's sexual identity. There has been no true definition or terminology used in the literature to describe the types of disclosure that arise from accidental encounters, however in this study the term used to do so is accidental disclosures. 'Accidental disclosures' will encompass the types of disclosures that come about based on extratherapeutic encounters.   Some of these encounters may be harmless to the therapeutic alliance. Some encounters outside of the therapeutic setting could strengthen the alliance or some may be detrimental to the clinical relationship.

The mystery in extratherapeutic encounters is that we don't know how they will impact the relationship. As social workers, we hold biases and assumptions about clients even when we are ethically bound and personally determined not to do so. How an extratherapeutic encounter may affect those assumptions we hold as therapists and affect the services our clients receive is at question in this research.

In school and supervision, discussion of extratherapeutic encounters sometimes arises in casual conversation, but I was never aware of the most ethical way to handle them. I also found that others I worked with did not have a clear handle on how to deal with these situations. Everyone I had worked with had a different way of dealing with extratherapeutic encounters, most of which included some type of avoidance. Personally, I do not want to live an avoidant life because of my professional role in the community, which has led me to researching extratherapeutic encounters. How should we deal with accidental encounters? How can we manage our own feelings about these encounters and hold the feelings of our clients as they see us outside of the therapeutic setting and on top of that make sure our behavior and actions around the encounters are ethical and protect our clients' rights? Maidment states,

> Practitioners are faced with dilemmas on a daily basis that test the limits of prescribed boundary setting, particularly when working in rural and remote areas and with socially isolated clients. Even so, social work students are strongly socialized in their training and education to 'keep a distance.' Ordinarily gestures such as giving a hug, being presented with a small gift or receiving an invitation to a party can result in an immediate response of internalized prohibitions. Yet these small but powerful interactions are part of what makes up a meaningful relationship (2007, p.116).

It is my intention in this research to explore how often encounters are experienced by other social workers in the field and how they deal with them. It is also a hope that out of this research the researcher can offer guidance for clinicians that have had experiences with extratherapeutic encounters to help to find a general protocol for social workers who encounter clients outside of work regularly.

The following study has been conducted for clinical social workers. In this research twelve clinical outpatient social workers were interviewed to find out what their

experiences have been like when and if they have experienced an extratherapeutic encounter. How an extratherapeutic encounter can or cannot change the therapeutic alliance will be explored. Advice from clinicians on how they handled such circumstances was ascertained. The following research will attempt to examine how clinical outpatient social workers handle extratherapeutic encounters and their experiences when dealing with such an encounter. The study is also focused on how clinical social workers prepare clients, if at all, for the fact that they very well may run into each other outside of the therapeutic setting.

This research could be helpful in offering suggestions to clinicians in the field who may encounter clients outside of the therapeutic setting on a regular basis. Having a plan or knowing what to expect during these encounters is important to factor into the daily life of a social worker and important for a social worker to discuss with clients as well. When a client knows what to expect during a chance encounter, it allows for less harm to take place to the therapeutic alliance and allows an opportunity for growth and trust to build within the therapeutic relationship. This is often a topic that is overlooked in practice settings and policies within the field; this research should help to shed more light on the extratherapeutic encounters.

The following research thesis will describe the literature that is related to extratherapeutic encounters, the methods in which the study was designed, and the findings and discussion of the research in its totality. Chapter two will be a review of literature relevant to topics of extratherapeutic encounters. Chapter three will discuss the method in which this research was designed and implemented. Following the methods and design, chapter four will be a presentation of the findings that this researcher found

through a qualitative design. Lastly, chapter five will be a discussion of the study and

findings, and of the researcher's bias. In chapter five there will also be a discussion of

future research that could be helpful when studying this practice issue in the future.

LITERATURE REVIEW

CHAPTER II

The purpose of this study is to determine how clinical outpatient social workers deal with accidental encounters with their clients outside of the therapeutic setting. Thus, this literature review will explore current understandings of accidental encounters between a therapist and his or her client. This chapter will also identify how psychodynamic practice may be impacted by accidental encounters and the how these encounters can influence or affect the therapeutic alliance. Although accidental encounters can occur in any setting, much of the literature reviewed focuses on rural and non-metropolitan communities, as accidental encounters are a common dilemma social workers face in the field in these practice settings. Psychodynamic practice and the phenomenon of non-metropolitan practice will be explored in this chapter as well. Other issues that arise in the face of the accidental encounter include self-disclosure, confidentiality and professional boundaries, all of which will be discussed in this chapter.

Several issues are discussed when looking for recommendations about how clinical social workers should deal with accidental encounters. Related topics such as confidentiality, self-disclosure, professional boundaries and psychodynamic practice are all examined. Most of the literature that discusses extratherapeutic encounters focuses on small and rural communities, where it is more likely for a clinical social worker to run into his or her clients outside of the office. In small or rural communities the accidental encounter can become a major dilemma to a clinician. However, running into a client

outside of the office or clinical setting can happen to any social worker employed in any

area, and it is this researcher's assumption that the experiences are similar, whether the

contact occurs in a rural or urban setting. The literature reviewed in this chapter that

reports on practice in rural communities and the issues associated with external non-

therapeutic contact with clients will be applied, as it is relevant to all communities.

The Accidental Encounter(s)

Accidental encounters have also been referred to as chance encounters or chance

extratherapeutic encounters and are defined as unplanned, random, or unexpected

encounters between the therapist and a current client that take place outside the therapist's

office (Zur, 2007, p.109). Whether it happens in the grocery store or at the gym,

accidental encounters between a therapist and current or past clients are often inevitable.

However, such encounters are often overlooked and mistreated in the study of practice

and in the field. The problematic nature of accidental encounters with clients was first

considered by E. Glover (1940) in his early writings.

> The earliest investigation into incidental encounters, or "ex-tramural" contact, was
> by Glover (1940), who asked 24 practicing analysts several open-ended questions
> about meeting or attempting to avoid clients in public. He did not statistically
> analyze his data but noted that his subjects felt these encounters gave rise to
> transference and countertransference complications because neutrality was
> compromised, confidentiality jeopardized, and personal privacy threatened.
> Analysts in his study admitted to rarely being successful at completely avoiding
> extramural contacts and typically found encounters with clients to be disagreeable
> or as one aptly stated, "a nuisance." (Sharkin and Birky, 1992, p. 326)

Little empirical research has been completed on incidental encounters since Glover's

early work, but he concluded that encounters were viewed as having a negative impact on

the psychoanalytic work and impacting transference and neutrality (Sharkin &

Birky,1992). Glover's study provides insight to the analyst's experience, yet he does not

explore the client experience and the role the extratherapeutic encounter has on the therapeutic alliance.

Sharkin and Birky (1992) were also interested in investigating the therapist's reactions to seeing their clients outside of the therapeutic setting. In their research, they surveyed 573 psychologists of whom 547 reported incidental encounters with clients outside of therapy.

> The most intensely experienced feelings reported by therapists during incidental encounters were surprise (87%), uncertainty (87%), and discomfort (83%). Examples of therapists' comments were "she seemed comfortable and unaware of how awkward I experienced the encounter" and "we met in a waiting room and both sat stiffly on the couch." These results and comments suggest that the experience of an incidental encounter may be difficult for therapists and provide empirical validation of Glover's (1940) anecdotal evidence that therapists find such contact disagreeable. In addition, as hypothesized by Spiegel (1990), efforts to maintain personal and therapeutic boundaries and confidentiality may come at some emotional cost to therapists. (Sharkin & Birky, 1992, p.327)

In Sharkin and Birky's study, sixty percent of respondents were concerned about violations of confidentiality and seventy three percent reported that violations of therapeutic boundaries were of concern during their incidental encounter. Two other issues that the researchers investigated were whether or not the incidental encounter was addressed in therapy and whether or not the therapists were prepared for such an encounter. Forty-three percent of their respondents did not address the issue in therapy, twenty percent of the cases reported the client initiated a conversation about the encounter, and only thirty-two percent of therapists initiated a conversation about the incident (Sharkin & Birky, 1992).

Pulakos (1994) conducted research on the client's perspective of incidental encounters gathering 147 students from a college mental health clinic. Pulakos reports,

When asked how they responded in this situation, most clients (62%) indicated that they gave their therapists a brief acknowledgment, 26% stated that they engaged the therapists in conversation, and 9% stated that they ignored their therapists. A similar pattern was found in responses to the question of "How did your therapist respond?" 59% of the clients stated that their therapists acknowledged them briefly, 22% engaged them in conversation, and 8% ignored them. When asked how they would like their therapists to respond if the situation occurred again, 54% of the clients wanted a brief acknowledgment, 33% wanted a conversation, and 3% wanted to be ignored. For all three questions, an "other" response category accounted for a small percentage of the answers. (Pulakos, 1994, p. 301)

Both Pulakos and Sharkin and Birky found that most of the time the therapist did not bring up these incidental encounters in therapy, but neither of them explored whether or not the therapist had discussed or prepared for this possibility in any of his or her sessions prior to the accidental encounter.

Additionally, Pulakos's study found that clients experience a wide range of emotions after experiencing an incidental encounter with their therapist in the community. Some felt excited and confident, while others were left confused, anxious and embarrassed (1994). While it is not known precisely how a client will respond to an incidental encounter, it is important that social workers and therapists prepare clients. The more clients are prepared for the encounter then better the therapist can respond to their needs in that moment. The therapist and clients should be able to discuss what might happen if they were to see each other outside of therapy.   A discussion of how the client might feel and how he or she would be most comfortable handling it is necessary. This conversation between the clinician and the client could actually strengthen the relationship. As Zur states, given the complexity of clients' responses to such encounters, many researchers and therapists believe that clinicians must prepare their clients for accidental encounters (2007).

Zur (2007) is one of the few authors who have started to make recommendations on what therapists can do to appropriately handle extratherapeutic encounters. Zur (2007) points out that the conversation need not be a lengthy, time consuming analysis but a brief talk, about what it might be like and how the client would like to handle an encounter or how the therapist typically handles it. When managing accidental encounters it is important to consider discussion and acknowledgement of community context, respecting the client's perspective, protecting his or her client's confidentiality and maintaining firm professional boundaries (Zur, 2007).

Hyman (2002) reports that some therapists do initiate an agreement with their clients regarding extratherapeutic encounters. This agreement articulates the behaviors that each party will abide by if the chance encounter occurs (2002). Hyman believes that,

> Initiating the agreement is a mistake, because setting rules may communicate to the client that the relationship is not real and that the client is only important in the therapy room. However, if the client introduces the topic of developing guidelines about handling unexpected extra therapeutic encounters because of concerns about privacy, than the therapist should respect this and behave accordingly. Therapists may choose to discuss the possibility of chance contacts. If clients express concern, than an agreement, such as having the client wave if contact is welcomed, can be formulated. (p. 358)

Research studies suggest that psychologists and mental health professionals should be better prepared for handling extratherapeutic encounters in the field (Pulakos, 1994). If these accidental encounters are not handled appropriately it could affect the psychodynamic relationship. Another and crucial reason for therapists to prepare their clients for accidental encounters is the effect of the encounter itself on the psychodynamic relationship.

Accidental Encounters and Psychodynamic Theory

In a psychodynamic therapeutic relationship, the therapist is neutral (Langs, 1990). A therapist acts as a blank slate while the clients reenact their relationships and project their feelings onto the therapist to be interpreted and analyzed (Faulkner, 1997).

> The key to psychodynamic practice is the therapist's ability to remain neutral and keep anonymity. Neutrality is the absence of personal opinions, self-revelations, directives, manipulations and all other non-interpretive responses except for those that involved the establishment of management of ground rules at the behest of a patient's derivative material. (Langs, 1990, p. 463)

Berzoff, Flanigan and Hertz (2002) define the term psychodynamic as "having to do with inter-energy that motivate, dominate, and control people's behaviors; these energies are based on past experiences and present reality" (p.4). Berzoff states that transference refers to re-experiencing and reenacting current relationships, earlier wishes, feelings and experiences from past relationships (2002). Countertransference refers to the therapist's reactions to the client's transference. The term has come to be defined as all the emotional reactions of the clinician as related to the client (Berzoff, 2002).

Although transference and countertransference are key to psychodynamic work, other psychological treatment modalities refer to the same concepts. Sussman (1995) states,

> At some point in their development most psychotherapeutic traditions have come to see the therapist as the central tool of psychotherapy. They have also observed that a therapist's wishes, fears and conflicts and unresolved issues can easily interfere with treatment. This difficulty goes by different names and theoretical systems. Psychoanalysts, who have studied the phenomena extensively, speak of many varieties of 'countertransference' and 'blindspots' that interfere with analysis. (p. 126)

In Sussman's (1995) qualitative study, ten clinicians affiliated with Harvard Medical School were interviewed. The interviewer presented guided fantasies of

extratherapeutic encounters with patients, questions regarding actual chance meetings that therapists have had with patients, and therapists' descriptions of them inside and outside the clinical setting. Sussman concludes that therapists are far more accepting of their patient's humanity then they are of their own: "They can be quite harsh in their self-criticism and are often ashamed of the same human foibles that they try to help patients accept in themselves" (1995, p. 131). Sussman found that shame, vulnerability and inadequacy were the main components that therapists felt about extratherapeutic encounters (1995). Sussman finds that these are the issues that take precedence over the therapeutic alliances, affecting transference and counter-transference reactions. Sussman states,

> Therapist's emotional responses, when conscious, are important sources of data, as they can help to reveal subtle processes in the patient and the treatment relationship. Problems arise however, when our emotional responses are based on personal issues and unresolved conflicts of which we are unaware. To be effective tools we need to recognize and understand the sources of our emotional reactions. (1995, p.126)

Sussman (1995) also examines ego defenses during the extratherapeutic encounter. He writes about the therapists feeling more adequate inside the clinical hour rather than outside. They imagine that their patients see them as mature, balanced, sensitive, caring, talented and secure people. While most therapists reported seeing themselves embodying some of these characteristics while in session, when not working therapists reported feeling and acting in ways that are described as immature, unbalanced, anxious, and narcissistic (Sussman, 1995). The contrast between therapists imagining how their patients see them and how we they see themselves contributes to therapists fearing involuntary exposure to their patients.

One could conclude that a therapist's desire to have his/her patients see him or her as "all good" is in conflict with an extra-therapeutic encounter that could be detrimental to that notion of "all good." The therapist may feel the client will misenterpret or look down on the therapist's actions outside of the therapeutic setting. Yalom (1980) discusses this dilemma of therapists wanting their clients to see them as "all good." When writing about clinicians, Yalom notes,

> A belief and personal specialness is a defense of our own mortality. He believes that many therapists avoid their fears and sense of limitation by inflating their sense of self and their spheres of control in the therapy room. They expect their clients to look at them as omnipotent guides…in effect they are all that their clients aspire to be. …The result is a circle of unrealistic beliefs that only can be maintained in the therapy room. (As cited in Hyman, 2002, p. 353)

Yalom's statement about this all-knowing fantasy unconsciously manifests itself as avoidance in unexpected encounters. He agrees with Sussman that clients and therapists often use avoidance as a primary defense during extratherapeutic encounters.

While studying extratherapeutic encounters, Sussman (1995) suggests that therapeutic postures often facilitate treatment. They may also represent defensive stances designed to protect difficult feelings of exposure and shame, ultimately protecting their egos. Greenson and Wexler (1969) feel that neglecting the real relationship and focusing too much on transference interpretation reduces all life to explanation, which is not the objective of therapy. Contrary to Sussman's assessment, Gody (1996), who, with her children, had encountered a client at the grocery store, described that she was angry with her children and in view of her client, and felt that she appeared as if she was losing control. Gody felt embarrassed, yet, the client communicated that she was relieved that Gody was "regular person"(p. 431). Despite what the therapist may internalize as

embarrassment or shame, the client may internalize the encounter in a positive manner building the therapeutic alliance (Gody, 1996).

Hyman (2002) also agrees that unplanned contact adds a new dimension to the relationship as the client views the therapist outside the structured clinical hour, a situation that may implicitly reveal personal information about the therapist. This can be an awkward experience for both of them leading to avoidant behavior for both parties (Hyman, 2002). Thus, avoidance defends the therapist from experiencing anxiety. From the client's perspective, Hyman argues that avoidance negates all that therapy attempts to accomplish, and is not beneficial to therapy or the client's social functioning (2002). Discovering how to best handle extratherapeutic encounters can help alleviate avoidance for both the client and the therapist. When a therapist knows how they will handle extratherapeutic encounters it will ultimately strengthen the therapeutic alliance with their client. It seems that if extratherapeutic encounters are not addressed as they occur or prior to the encounter happening at all, it can be detrimental to the client, therapist and the working relationship.

Gody (1996) discusses the unintentional self-disclosure that occurs in extratherapeutic encounters and the anxiety that this produces in the clinician. She states that the therapist may wish to be known and act normally, which causes anxiety because it is in conflict with the wish to remain the object of therapy. As a result, the therapist may respond formally and a distance may be maintained or avoidance of the contact may be pursued all together impacting the therapeutic alliance (1996). Similarly, Strean (1981) as cited by Hyman (2002) reports that extratherapeutic contact may produce transference and countertransference fantasies and effects such as Oedipal and sadistic

urges. As a result therapists may take steps to avoid extratherapeutic contacts. Sussman

writes,

> By reflecting on our images of ourselves inside and outside the clinical hour and
> our feelings about chance encounters we gain insight into which parts of our
> professional persona are there to support our work and which parts stem from our
> fears, self criticism and difficulty accepting unexamined aspects of
> ourselves.(1995,pp.133-134)

Extratherapeutic encounters force clinicians to face their own urges and anxiety

about their personal and professional lives when in the face of the client outside of the

therapeutic setting. If these encounters affect the social worker personally, it can be

assumed that in some way the work of this individual will be impacted. Inherently this

will affect the services that are provided to the client, particularly if neither party is

prepared for such an encounter. As much of the literature has suggested, such encounters

are more prevalent in small community practice settings.

Small Community Social Work and Accidental Encounters

A majority of the research completed on social work in rural communities

occurred in the 1980s. Much of this literature focuses on the ethical challenges social

workers face when living and working in these areas. The nature of small community

and non-metropolitan social work differs because in small communities therapists and

clients are more likely to run into each other outside of the therapeutic setting, face

multiple roles and issues of confidentiality. Helbok (2003) reports that therapists are not

prepared to deal with these unusual dilemmas. Clinicians who work in these areas also

have to be "experts" in various types of issues for which their clients may want treatment.

Clinicians in small communities also need to be aware of ethical issues in their social

work environment. Training and education is key to ethical treatment of clients (Helbok, 2003).

Other literature concurs with the beliefs that confidentiality, dual relationships and boundaries are primary concerns for therapists practicing in rural areas (Riebschleger, 2007; Ringstad, 2008; Sterling, 1992; Strom-Gottfried, 1999). The literature also stressed the importance of the psychotherapists' training and competency when looking at specific concerns of practice in small towns (Helbok, 2003). The authors are referring to the importance of training and competence to ensure clinicians practice ethically when dealing with issues of extratherapeutic encounters and dilemmas that small community social work present in the field.

When issues surrounding dual relationships arise in small communities, clinical quality diminishes if the therapist is not prepared to handle and confront the integrity of the relationship (Helbok, 2003). Ringstad (2008) conducted a survey on dual relationships and clinical practitioners' behaviors, beliefs and opinions regarding non-sexual dual relationships. Ringstad explained in her research that there was no consistency in the attitudes therapists expressed about dual roles with clients, although the participating therapists revealed that dual roles occur more frequently in small towns (2008).

When practicing social work in small communities dual roles and extratherapeutic encounters occur more frequently, causing a higher rate of ethical dilemmas that therapists encounter in their careers. There is an obvious danger if professional boundaries are violated in the therapeutic relationship (Gottfried, 1999). Strom-Gottfried (1999) discusses the findings of research that identified complaints reported to the

National Association of Social Workers (NASW). Over half of the complaints reported

to NASW were infractions of boundary violations (1999). Gottfried states,

> Further steps are needed to assist workers whose practice setting, location or
> specialization puts them at particular jeopardy for boundary violation. For
> example, workers in rural areas, who are part of tightly knit religious, ethnic, or
> cultural communities, and those in fields (such as substance abuse recovery)
> where roles between helpers and helpees may blur can benefit from increased
> attention to the types of dilemmas they encounter.(p.448)

Gottfried's point is yet another example stressing the importance of training therapists in

rural settings about ethical boundaries (1999).

When social workers practice in small communities they also face issues of

confidentiality. In non-metro communities specifically, Irey and Kirkland (1981) state,

"social workers cannot view individuals – including individuals in their relationship to

workers – apart from the social context" (p. 320). The authors pose a question: "Is

confidentiality possible in the helping profession in a rural community?" (p.320). They

suggest that the definition of confidentiality must deal with the social context of a

specific environment. Confidentiality becomes limited in a rural context, which is a

problem for the psychotherapists who promise confidentiality to the client. The

limitations on confidentiality in small communities can create discomfort and anxiety in

the therapeutic relationship. This can happen as a client and therapist may attend the

same community events, have mutual friends and become informed about each other

indirectly. Based on the nature of a small town, a client's car could be noticed in the

therapist's parking lot or driveway, creating further barriers to protecting the rights of

client confidentiality. Therapists who do not acknowledge the intimate environment of a

rural setting could potentially harm the therapeutic relationship. Irey and Kirkland (1981) assert,

> People in rural communities are intricately related through family ties, historical events, and high visibility of behavior, all of which affect the relationship between worker and client and call into question whether the helping relationship can truly be a confidential venture. This is also the case in many other social contexts, including closely-knit urban communities and residential settings such as correctional facilities and nursing homes. (p.320)

Sterling (1992) also reviews the potential threats to ethical boundaries that exist when working in small communities. Sterling's first point in her article is similar to those presented in other articles; she personalizes her experience as a therapist in a small community. Sterling states,

> It is a general assumption that self-disclosure is a controllable variable by the therapist; that personal data about the therapist is something to be carefully and cautiously doled out according to therapeutic need and only in the service of facilitating the therapeutic process. What is usually not considered is the relative lack of control that therapists who work in small communities possess over what is known about them. The proximity and community communication channels provide ample opportunity for gathering information about a therapist. (pp. 105-106)

While accidental encounters and multiple roles are more prevalent in non-metropolitan areas, these encounters happen to many social workers no matter where they live and work. For clinical social workers in non-metropolitan areas these ethical issues may arrive more frequently. It is clearly challenging for a therapist to offer privacy, confidentiality and appropriate boundaries when practicing within the small community they also live in.

Confidentiality and Accidental Encounters

Social work guidelines and ethical standards for patient/client confidentiality were originally established by a medical model and early psychoanalytic theory (Sharkin &

Birky, 1992). Confidentiality can broadly be described as the policy, law and ethics that protect a client's right to privacy (1992).

Confidentiality could be considered the foundation of the therapeutic relationship. It creates the basis of the therapeutic alliance because it allows the therapist and client to form boundaries within the alliance and boundaries around information shared outside of the relationship (Millstein, 2000). When a client enters the therapeutic alliance, he or she gives up personal and private information about him/herself in order to gain therapeutic assistance. Once private information is disclosed, it becomes an expectation that the disclosure remains confidential (Smith-Bell & Winslade, 1994). However, therapists often discuss clients in supervision or with other colleagues to gain understanding and other perspectives on client behavior. It is understood that the client's identity is protected and the information shared outside of the relationship is shared responsibly (Strom-Gottfried, 1998).

Unknowingly a client may greet his or her therapist in an extratherapeutic encounter, not thinking about how he or she will explain to his or her friend whom he or she greeted. The friend of the client may not be aware of the therapeutic relationship and the client may then feel uncomfortable about having to explain this. The encounter may affect the therapeutic alliance and the confidentiality of the client. Discussing the possibility of running into your client outside of the therapeutic setting may allow your clients to be more aware of it's possibility and know how to handle it.

Millstein's study using field supervisors at Simmons College in Massachusetts concluded that confidentiality was necessary for maintaining a therapeutic relationship (2000). Millstein states,

"Social workers today confront many ethical issues related to confidentiality. Our ability to protect confidentiality is diminished by increasing demands for accountability, mandated duty to protect or ward provisions, expanding court involvement in professional decision making, and widening access to client record information through the requirements of third-party payers and the expanded use of technology." (2000, p. 270)

While this agreement on the importance of confidentiality in the therapeutic relationship was apparent among respondents in Millstein's study, it was notable that less than half of her respondents always inform their clients with a written confidentiality policy and agreement (2000). While the NASW code of ethics has standards regarding issues of confidentiality, there is no unified process in how clinicians have to follow through with the standard (NASW, 2008). Millstein (2000) concurs that there is a significant gap between theory and practice. She states,

Although verbal discussion is valuable and the Code of Ethics does not prescribe beyond 'discussion,' most current wisdom suggests the importance of having clients receive written materials that they sign…Given this current practice wisdom, we need to better understand what makes it difficult for social workers to carry out this practice. (p. 278)

If clinical social workers are not discussing confidentiality with their clients then it is probably safe to assume that few conversations are occurring about how the therapists will respond outside of the therapeutic setting during a chance encounter. This may suggest the importance of therapists speaking with their clients about how they may want to handle an accidental encounter, should one occur and how the client's confidentiality can be protected. Similar to issues of confidentiality, professional boundaries must be established in order to practice, both of which can be effected by the accidental encounter.

Professional Boundaries and Accidental Encounters

Boundaries, as they are relevant to the social work profession, can be described as the level of separation between a client and the therapist (Strom-Gottfried, 1999). Boundaries are considered one of the foundations of psychoanalysis (Simons & Williams, 1999). Simons and Williams describe boundaries as a tool that mental health professionals use to gain trust, a working alliance and a foundation for therapeutic work. Simons and Williams indicate the development of boundaries varies based on the nature of the patient, therapist, and the sociocultural setting (1999).

Boundaries in the NASW Code of Ethics have been established since 1979. Violations of these boundaries have existed in the form of the sexual encounters, dual or overlapping relationships or blurring of roles with the client. Therapists' acts of sexual encounters with clients, dual relationships and blurred roles are all clearly identified as boundary violations that are considered unethical behavior (Strom-Gottfried, 1999). Training of clinical social workers often includes and emphasizes the importance of building firm boundaries in the therapeutic relationship: "Discussions focused on ethics are commonly embedded within principles that highlight the need for practitioners' respect of clients' rights, self determination, confidentiality, duty of care, fairness and justice" (Maidment, 2006, p. 115).

Simons and Williams (1999) agree that treatment boundaries and ethics along these lines are guidelines for good clinical practice, but they emphasize in their work that for every guideline there may be a circumstance for which it does not apply. Simons and Williams write,

> Boundary guidelines should be considered in relation to sociocultural contexts, particularly in small communities and rural settings. Nevertheless, a line can be drawn between boundary flexibility and boundary violations based on the rule of abstinence. Regardless of sociocultural settings, the defining question that the psychiatrist must ask is 'Am I making this intervention or taking this action for the benefit of the patient's treatment or for my own personal benefit? (p. 1441)

Although extratherapeutic encounters are not dual relationships, they could be considered a boundary extension (Hyman, 2002). Hyman (2002) states,

> Although an out of office encounter does not constitute a dual relationship per say, the fact that it is literally outside the confines of the ongoing therapeutic transaction places it in the realm of a boundary extension that calls for intelligent management. (p.350)

Hyman, Simons and Williams agree that there is a fine line between boundary violations that raise ethical concerns and situations that occur such as a boundary extension or extratherapeutic contact. If not handled appropriately by the therapist, such encounters could lead to disciplinary action. Incidental encounters can pose ethical dilemmas; the authors stress a need for therapists to understand how to handle extratherapeutic encounters.

Discussion must be raised about the connection between boundary violations and chance encounters with clients outside of the clinical hour. Where is the line? Maidment (2006) reminds social workers:

> These considerations can be examined further when we are reminded of the following AASW code, Social workers' private conduct will not compromise the fulfillment of professional boundaries (p.116)

Maidment (2006) suggests that clinical social workers walk a fine line during chance encounters especially practitioners who are faced with dilemmas on a daily basis that test the limits of prescribed boundary setting. As described in the literature, understanding social work ethics and practicing responsibly is essential for the efficacy of clinical social

work. Professional boundaries are described as the level of separation between the client and therapist. It is important for the clinician to determine the level of self-disclosure they will use in their practice as they relate to accidental encounters.

Self-Disclosure and Accidental Encounters

The issue of self-disclosure, when a clinician shares personal information about him/herself with a client, is a subject on which many clinicians and researchers disagree. Self-disclosure is best described as verbal communication of personal information about oneself to another (Chelune, 1979). This can happen in session, but of interest to this researcher is accidental encounters, which may involve or invite an unintentional disclosure. When a clinical social worker meets a client outside of the therapeutic context, the client may learn information about the worker that had been previously undisclosed. For example, if a client observes a therapist dropping his or her children off at school, it may be surprising to the client that her therapist is a parent. Another component of accidental disclosure is when the therapist learns or observes something about a client that the client had not decided to share in therapy. For example, perhaps a client has not disclosed that she smokes. While self-disclosure on the part of the client is necessary for successful therapy, self-disclosure on the part of the clinician is a much more debated topic (Jeffrey & Austin, 2006).

Jeffery and Austin (2007) discuss both sides of the self-disclosure debate. They examine the detrimental effects of the therapist's self-disclosure as well as information based on the positive affects the disclosure. Jeffery and Austin explain that arguments in favor of self-disclosure are based on more of a relational model of therapy, contrary to what psychodynamic work may imply. They state,

> The need to relate is not a unilateral process, but rather one in which both client and therapist engage fully within the therapeutic relationship. In addition to providing information about the therapist's personal experience, the process of self-disclosure creates an environment where clients can feel an overarching sense of trust in the honesty of the therapist. (p.97)

The authors suggest that when self-disclosure is used appropriately in the therapeutic setting it can strengthen the alliance between the client and therapist. Yet, psychodynamic literature suggests that self-disclosure can contaminate the therapeutic process by taking the focus away from the client and focusing more on the therapist (Barrett & Berman, 2001). Jeffery and Austin also argue that a clinician's self-disclosure can be detrimental to the therapeutic relationship because it impacts the ability to interpret transference and counter-transference.

In a literature review on the subject, Cozby (1973) identifies three major parameters of self-disclosure. He discusses the quantity of the disclosed information, the degree of the intimacy of the disclosed information and the time necessary for the disclosure of desired information. Cozby also cites several authors who discuss many dynamics of self-disclosure including the reciprocity of disclosure as it relates to mental health relationships (1973). As cited in Cozby, Jourard (1959) found that there was a correlation between self-disclosures received to those self disclosures that were given to by the therapist. Jourard calls this the reciprocity of self-disclosure. Crozby explains,

> The interviewer or therapist who discloses, in addition to eliciting greater disclosure from subjects "i.e., inducing reciprocity effect," is rated as a more trustworthy clinician and more positively in general than the clinician or experimenter that does not disclose. (p.86)

This might suggest that a clinician's self-disclosure may strengthen the therapeutic alliance and give the client a better understanding of the therapist as a human. In a

relational model of treatment, this allows clients to better relate to their therapists and potentially makes their own rate of self-disclosure higher in session. Self –disclosure, as it is relative to accidental encounters, could potentially strengthen the alliance, as a client may observe the therapist out in public and realize that he or she, too, is a person (Crozby, 1973).

Vondrasek and Vondrasek (1971) and Polanski (1967), as cited in Cozby (1973) state that the technique of self-disclosure is clinically very sloppy. Cozby concludes that disclosure to certain patients would have an adverse effect on the course of therapy (1973). In addition, certain therapists could feel uncomfortable disclosing, and the patient might perceive that discomfort. If clinicians offer their own disclosures, it puts their experiences into the therapeutic space, leaving less room for interpretation of the client's issues. If an accidental disclosure occurs through an extratherapeutic encounter, how might that affect the therapeutic relationship and how should it be addressed in session?

Extratherapeutic encounters can happen in a rural or urban setting. These encounters between a therapist and a client can be detrimental or helpful to the therapeutic relationship. Literature suggests that parameters should be established between the client and therapist regarding such encounters to alleviate situations that could be harmful to the client's or therapist's therapeutic progress. The next chapter will discuss the method in which the researcher will explore how extratherapeutic encounters are handled by practicing clinical outpatient social workers.

CHAPTER III

METHODOLOGY

The purpose of this study was to explore extratherapeutic encounters and how social workers in clinical outpatient practice commonly deal with them. The researcher asked participants questions to solicit qualitative data regarding gender, age, years in practice, city of residence, city of practice, experience with accidental encounters and if the encounters had affected therapeutic alliances.

Study Design and Sampling

A qualitative, exploratory study was chosen for this topic because much of the information sought was not clear in former research. Flexible interviews were conducted with twelve clinical outpatient social workers. Of the twelve participants, three had less than five years experience, three had more than fifteen years experience and the six remaining participants possess a range of experience in the field.

Each participant was required to hold a Masters Degree in Social Work and be currently employed as a clinical outpatient social worker. A recruitment process was developed for selecting a sample that fit the requirements of the study. An email (See Appendix C) was sent to clinical outpatient social workers that this researcher had worked with. Interested volunteers contacted me and participated if they fit the requirements. They also identified other clinical outpatient social workers, which provided a snowball method of sampling. To those candidates who were interested in participating, I sent an informed consent (See Appendix A) to review prior to our

interview. We then agreed upon a mutual meeting time to conduct the recorded interviews.

Twelve interviews were conducted, and each participant answered all of the questions asked.

Data Collection

The Smith College School for Social Work approved the design of this study through the Social Work Human Subjects Board (see Appendix B). Informed consent letters were sent or emailed to all potential candidates prior to interviews. The informed consent letter described the study and the defined criterion for the potential volunteers. It also outlined the risks and benefits of participating in the study. All informed consent forms were signed by participants and collected prior to any interviews taking place.

The interviews were conducted using a flexible open-ended method that concentrated on extratherapeutic encounters. The focus of the interviews were to attain opinions of clinical outpatient social workers, participants' thoughts on how encounters affected the therapeutic alliance and how social workers could best handle encounters. Participants were also asked about whether or not they prepare their clients for accidental encounters. Interviews were recorded in person or over the phone. They were conducted in a neutral location that the participant chose and felt comfortable in. The length of the interview ranged from seven to fifteen minutes depending on the information offered by the participant. A list of questions guided the interview (see Appendix D). Clarifying questions were asked to some participants when necessary. All personal information was disguised during transcription.

Sample Characteristics

The study consisted of twelve participants who had a Masters Degree in Social Work and were currently working as clinical outpatient social workers. Two of the participants were male, and ten participants were female. The mean age of participants is 45.6 with a range of 25 to 63 years of age. Three participants were required to have less than three years experience and three participants had to have more than 15 years of experience in the field in order to obtain a wide range of experiences. The average number of years in practice was 10.3 ranging from one year to thirty-three years in practice. Four participants lived and worked in the same community in which they practiced. Seven participants did not live in the same city or town in which they practiced but did live within the same county, and one participant lived in a different state from the one in which he/she practiced.

Data Analysis

Transcripts were reviewed in order to identify relevant content and themes. These included the experiences of participants with accidental encounters, how accidental encounters affect the therapeutic relationships, and issues that arose personally for clinicians because of the extratherapeutic contact. Topics discussed also included how the clinician prepared him/herself and his/her client, if at all, for extratherapeutic encounters.

This study did not have a large enough sample size to make universal generalizations from the findings. Although, the results from the interviews did highlight the experiences of clinical outpatient social workers and their knowledge of extratherapeutic encounters. It was my hope that the data presented stimulated further discussion and research about this clinical practice issue as it globally affects social

workers. This chapter outlined the method of which this study was designed. The

following chapter will discuss the findings of this qualitative.

CHAPTER IV

FINDINGS

This descriptive qualitative research examined the attitudes of clinical outpatient

social workers and their experiences with extratherapeutic encounters. Twelve

interviews were conducted over a four-week period with clinical outpatient social

workers. The participants' experiences in the field ranged from over twenty years to less

than one year of practice in a clinical outpatient setting. Interview questions were

designed to elicit the impact that extratherapeutic encounters had on the therapeutic

alliance. The research also focused on how clinicians prepared for and/or dealt with

extratherapeutic encounters. Much of the literature found in this area of research had

little documentation of best practice. This study was completed in order to better define

extratherapeutic encounters and their handling by clinicians in a way that is least

disruptive to the therapeutic alliance.

This researcher asked five demographic questions to elicit variables that may have

impacted the way participants answered the other study questions. The questions elicited

the participants' gender, age, educational and professional history, city or residence, city

of work and number of years in clinical practice. The study was comprised of twelve

participants with a mean age of 45.6 years and an average of 10.3 years in clinical

practice. Two male and ten female practicing clinical outpatient social workers

participated in the study. The study was designed to gather a wide range of experiences

from clinical outpatient social workers. Snowball sampling was used to find participants

for the study. In this chapter, all demographic information connects to the direct quotes and data collected in the research.

This is exploratory and descriptive research pursuing content and thematic information. The first section of this chapter focuses on the experiences of participants with accidental encounters and the effects that accidental encounters have had on the therapeutic relationship. The second section examines whether or not clinicians who participated in the study prepared their clients for extratherapeutic encounters and if/how they have found appropriate measures to do so. The third section of this chapter examines the experiences of clinicians with extratherapeutic encounters in relation to training and supervisory experiences. Finally, a description of what has been most useful to clinicians when dealing with extratherapeutic encounters is discussed.

Accidental Encounters: "Does it really happen?"

A main portion of this thesis explores how accidental encounters have affected the therapeutic relationship. Eleven out of twelve participants experienced more than one accidental encounter. The female social worker that had no experiences with extratherapeutic encounters had been in the field for less than two years and did not live in the same community that she worked in; she felt that this might have contributed to the lack of encounters with clients outside of the office. Another clinician who did encounter clients in the community stated,

> It was only in this community [small county where she ran into clients]. I think part of it is that I live in the city that I worked. When I worked in domestic violence agencies in Worcester and the Boston area, I did not live in the same town, so I never saw clients. It was really a non-issue (40 years of age, female, clinical social worker).

Although these are relevant points, the research conducted was not conclusive in finding

that extratherapeutic encounters only happened to clinicians who lived and worked in the

same community.

When examining these findings it was important to define what living and

working in the same community meant. Some participants lived and worked in entirely

different cities or metropolitan areas. Other participants lived in non-metropolitan areas

that share similar community resources. The probability of chance encounters occurs

more frequently because of shared community resources. Of the eleven participants in

this study who had extratherapeutic encounters, six participants lived and worked in the

same community, three lived in one community and worked in the neighboring

community that may have shared similar resources and three lived in different cities from

which they worked. All eleven participants in the study who have had extratherapeutic

encounters described these encounters as happening on more than one occasion. The six

clinicians who lived and worked in the same community all commented on the high

frequency with which accidental encounters occurred, even if those incidents might have

been as simple as a passing in the grocery store. Not all clinicians reported on whether

the accidental encounters occurred with current clients, although two clinicians

commented upon running into clients who had terminated therapy. One clinician who

was 40 years old and had been practicing for more than twenty years discussed her

experience with an accidental encounter. She recalled,

> I was studying for final exams and I was driving back and was craving this
> hot fudge sundae, so I thought I'll stop at this Friendly's – so I stopped at
> Friendly's and the woman who was behind the booth who was waiting on
> me in the to-go line said, "Oh my god, you're my counselor from the ____
> _____center." And I just wanted to die. And ya know, what does that

mean that she goes to the _____ ____center and what do you do and you know I nodded my head and she proceeded to say she was gonna tell me everything, she said I need to call and I said well you know you have my office number and it was nice to see you and I really tried to keep it short, cause I was in a long line, and everybody heard her.

Another clinician, who was 55 years old, disclosed a recent interaction with a client that happened to her in the community, outside of the therapeutic setting:

Just this past week a close friend of mine, who I will call 'John' lost his father and I have been friends with John for years, so of course I wanted to go to the wake and coincidentally I just started seeing his sister who I will call 'Sarah' in my private practice. So going to the funeral home and going and greeting the family, I didn't know how I was going to handle it. When I went into the receiving line, their Mother was the first person I met and she asked me who I was and why I was there…and Sarah was standing right next to her, and I said I'm a long time friend of your son John and I kind of ignored her, and it was awkward only for a moment because she piped up and said, "Ooh! mom, that's my therapist." So there we were.

While this section of the chapter focuses on the accidental encounter itself, it is important to consider the clinical effects that these encounters may have had on the therapeutic connections with clients. Another clinician added her experience that she viewed as having a negative impact on the therapeutic alliance. She stated,

I think the most memorable, it is kind of embarrassing, was a Saturday morning the weekend of Easter, and I was in a grocery store and I was purchasing alcohol and I ran into a family who I was doing family stabilization with – intensive outpatient work with the family. They were very Christian – religion really hadn't come up in terms of our work together but they had made minor mention of it. I ran into them and I was with my boyfriend and he had alcohol and he could tell by my body language that they must be clients, cause the kids started yelling my name. They had approached me and I had beer in my hand and they handed me a flyer for their church and for the service that was going to be coming up the next day. And it was the most awkward thing I had ever encountered. I wanted to be enthusiastic for the kids but the mom was inviting me to their service. And they were eyeing my boyfriend who was trying not to

eye them as he was checking out with this alcohol – It's not like we were going to begin drinking at noon – we were buying it for later in the night. It was such a convergence of my "sins" and they were trying to religiously stimulate this conversation and I was totally – it was just awkward. It pushed the professional and personal boundaries. (26 year-old female, clinician).

All clinicians who had extratherapeutic experiences with clients mentioned the violation of boundaries that occurred. A 59 year-old female clinician who had been in the field for five years mentioned,

> My husband and I were out at a restaurant having dinner and one of my former clients was a waitress there. I had no idea she was waiting tables there, I thought she had been painting, which I think she still does occasionally. I had no idea she was a waitress there. So we sat down and she came bouncing down the stairs and she said, "Hi ____, how are you?" And I said "Oh, hi how are you?" and she starting going on and on about how much I had helped her and she asked me if this was my husband and I said yes and she went on telling him what a great help I was for her and all of her abuse problems, boyfriends and that I stood by her for years and years as she had gone from leaving him to going back to him and I just wanted to say, "This isn't appropriate, this is kind of a boundary issue here." But she had already started running along with it and going on and on and when she turned away my husband looked at me and I said, well I guess you know she's a client and it wasn't any real way to stop that, so… That was interesting and uncomfortable simply because it was not appropriate. I always tell my clients that when we are out in public I will not pay any attention to them, not because I'm uncomfortable but because I want them to feel comfortable. If I have someone with me in my family or friends or something, it is really not ethical for me to be going up and talking to them – so don't think that I am being rude or that I don't like you, it's just that it is a boundary issue.

One clinician, who had been in the field for fifteen years, told two memorable stories of extratherapeutic encounters. She stated,

> The first is that a number of years after I worked with a mom at the parent center who had a fair amount of difficulty who had I think 7 or 8 children and so I knew her as a client who had a lot of struggles and issues and now six years later my son was taking her daughter to the prom and it turned out to not be a difficult thing; it was a friend of a friend and there wasn't any going to each other's houses for photos or anything like that. I was a

little concerned about how it was going to be for her and for me. How would it be if the two families would be involved in this, I think it was removed enough in years that I didn't totally panic but it was ironic (50 years of age, clinician, female).

This particular clinician lived in the same community where she worked. She also worked in a private practice and had multiple roles in other mental health agencies in the city in which she lived. Of another accidental encounter, she recalled,

The other one is that my husband is pretty involved in the community and there was an event at a church and my husband pulled me over to this young woman, and it was one of my clients, and so I um, just let her take the lead and said hello – and she said, "Oh we know each other" and I have reminded him several times not to ask questions if we run into someone he doesn't know. And she seemed a little surprised about it and um, I did let her know that I wouldn't typically be at this (this is a weekly church thing) that she was involved in and I let her know that I wasn't planning to be there regularly and she was only 17 and I think my expectation was that because she was young it wouldn't bother her at all and I think she felt – it did feel really awkward to her and which would lead into therapy, and someplace where I might have gone wrong if it weren't for that encounter.

While the previous encounters described were very specific, the most commonly described encounters by participants in the study were run-ins at the grocery store or local mall. A 36 year-old clinician stated that she frequently ran into clients in the community:

I was in the grocery store one time and I saw a little boy that I had been working with for quite a number of months and when I saw him I looked at him briefly and looked away – not to look too long or be obvious…and then I realized that he was looking at me rather discretely and so I looked back and smiled and he waved at me. So I smiled and waved back with no exchange of words.

This is precisely what a simple extratherapeutic encounter may be, which is much less complex than the other examples cited earlier in this section.

These findings show that it did not matter where one lived and/or practiced, extratherapeutic encounters occurred more frequently than one expected and the

encounters happened when he/she least expected it. They may have involved a clinician's family and friends or a run-in at the grocery store or local shopping center. Based on this research, extratherapeutic encounters undoubtedly occur. It is necessary to discuss how the clinicians in this particular study prepared their clients for these occurrences.

To Prepare or Not to Prepare

When clinical outpatient social workers in this study were asked if they prepared their clients, five participants said yes, six said they prepared clients sometimes and one clinician did not prepare clients at all. It becomes clear in this portion of the chapter that the question of whether or not preparing clients is a good idea is grey area. Clinicians have ethics to follow and boundaries to maintain. Clinicians use their judgment as to how encounters should best be handled with their clients. The following section examines how clinicians did or did not prepare their clients and how they decided to prepare clients on a case-by-case basis.

The one clinician who did not have any experience with extratherapeutic encounters is the same clinician in this case who did not prepare her clients for extratherapeutic encounters. The twenty-five year-old clinician who had been in the field for just under two years stated,

> I actually do not (prepare clients) which is probably unfortunate. It hasn't really come up and I think a lot of people do talk about it, like they (clinicians) have this spiel about what they say – whether its in the intake or when they are talking about their work style, what they are going to do if they see you out, what their no show policy is…I really don't feel like I have a set of things I say, I have left that out because it never really comes up but I probably should.

It should be noted that this clinician did not live and work within the same city. The following examines those clinicians who prepared their clients for extratherapeutic encounters either always or sometimes.

Clinicians Who Prepare: Sometimes

Six clinicians in this study, when asked whether or not they prepare clients for extratherapeutic encounters, had various answers including sometimes, on occasion, and with certain clients; all which alluded to the fact that they prepared clients on a case-by-case basis. A clinician who lived and worked in the same community and had been in the field for eight years said,

> I don't routinely bring it up with people unless they have expressed a real, or some strong desire or concern over the aspects of confidentiality and then we do get into a little more detail and then I do discuss the public piece, especially because I live and work in the same community, and it happens. So if I know somebody is really very concerned I usually make it part of my explanation in the scope of confidentiality. In a typical intake, I do not go into it. (55 year-old, female, clinician)

Another clinician who had been practicing for over twenty years explained that he did not typically prepare clients unless he suspected their paths would cross because they lived near each other or may have worked in the same building. He stated,

> So if I know I'm going to see someone or if there is a high chance of seeing someone, I might warn them…Warn means there is danger so I guess I might give them the heads up. (63 year-old, male, clinician)

A clinician who has been practicing for less than a year agreed. She felt that given the nature of her clinical outpatient work environment, she did not typically need to prepare clients. However, she had a personal experience at work that made it necessary. She stated,

I did, I have a client who I saw a few times, where I actually work in the same environment as her and so, I do see her from time to time and I said "Look we are going to see each other, how do you want to play it off." It's actually one of those clinical moments where I judge myself because I wish I had left it up to her more – and I said, "You know if I see you if you don't acknowledge me I won't acknowledge you but otherwise if anybody asks, we are friends from work." That was actually off putting for her, and she didn't want to think of me as a friend. And we were the same age, I always wonder if that was off-putting to her to have to think that people would have to think we were friends, like somehow it made it feel less professional to her and her boundary with me. I kick myself with that one and I still see her and she stopped coming after that – it was kind of short-term work anyhow, but I just feel like I crossed a boundary with that. I don't discuss it with them because for many of them I don't really see them again. When I do, it is usually at the end of a session. (26 year-old clinician, female)

These two particular clinicians who did not always prepare their clients for extratherapeutic encounters had something in particular they looked for in the relationship. They thought about the likelihood of whether they would run into a client frequently, and if they thought that likely, they decided to discuss the possibility with their clients.

"I do it more after the fact." (50 year-old clinician, female) This particular clinician felt that she should probably prepare her clients more often but what most often happened, because she lived and worked in the same community, was that she followed up with her client about the encounter the next session, making sure the client felt okay about it and that it did not disrupt the clinical relationship. This particular clinician also referred to thinking about the likelihood that she would see this client in the community but stated that she did not routinely prepare clients. When asked why she did not prepare clients routinely, she stated,

Because the work requires so much to do that it's not the first priority and some clients don't see it as an issue. I think that it is more individual.

Obviously if there were a close connection I would probably not take a referral or if there was that than I would need to. I guess there was a family that I did talk about that even when I knew there was a distant family member that was in treatment that I wouldn't be sharing anything. So I guess it is a little more individualized? (50 years of age, clinician, female)

Another clinician who used to work and live in the same community said she prepared her clients much more so before she had moved out of the community where she worked. Now she sees the problem as a non-issue. She explained that she prepared for extratherapeutic encounters more so before because she and her clients used many of the same supermarkets and shopping centers and it posed a much bigger issue in regards to treatment when those encounters occurred. (54-years of age, clinician, female)

As several of the clinicians have cited in the section, they used their own judgment as to how to best prepare their clients, if at all. One clinician who had been in the field for five years explained that she prepared her clients for these encounters most of the time. She stated,

I have had clients that I do that [prepare] with; I incorporate it into my confidentiality procedure at the beginning of our work together. When I first meet the client we review informed consent, confidentiality and often times I will touch on what to expect if I am out in the community, if they are out in the community, as to site an example of confidentiality, but so they also do not feel as though I am rejecting them if I don't start a conversation with them or engage them, so that they understand that is to protect their own confidentiality. They can engage with me at any level they like but I would not be initiating it. (36 years of age, clinician, female)

This clinician did not make it clear as to why she chose to prepare certain clients and not others. It should be noted that all clinicians who responded in this section lived in the same town or a neighboring community of the town/city in which they worked. While all made judgment calls on how useful it would be to discuss this with clients, their decision

was made on a case-by-case basis and it seems to have been successful for these clinical outpatient social workers. Few of them had mentioned negative effects of extratherapeutic encounters on the therapeutic alliance.

Clinicians Who Prepare Clients for Extratherapeutic Encounters

Five clients in this particular study stated that they did prepare their clients for extratherapeutic encounters. Two clinicians who participated had requirements from the agencies they worked for that mandated them to talk about accidental encounters with their clients as the work they did took place in smaller communities. While two clinicians worked for agencies that required them to talk to their clients about accidental encounters and confidentiality, it is worth noting that these clinicians did not live in the same town/city that they worked in, but rather worked in neighboring community mental health facilities.

The three other clinicians who discussed the possibility of chance encounters with their clients had various reasons and factors for doing so, ranging from creating appropriate boundaries with clients, living in the same community and sharing community resources with clients and the type of mental health agency at which they worked.

One clinician who prepared her clients, and had been working in the field for six years, found that she talks about confidentiality, self-disclosure and seeing her clients in the community in the first session. She stated that she has always done this but has found it more useful since she had been living and working in the same community. She stated,

That is the disclaimer I give to people, adults get it, and kids don't really get it…especially the younger ones have a much harder time. So what I will do is say if we are seeing each other out in the community I can't say hi to you unless you say hi to me. And the kids are like, "That's stupid, why?" And I explain it. To protect your privacy, to protect my privacy and so I have seen people out in the community and they have made eye contact with me and not said hello and so I've taken that cue. And I have had other people walk up to me and have that conversation. – So that is the preparation piece. But again there are clients I've seen in the community that will come into the next session and say "Who was that you with at the mall?" So then my boundary has to be a case-by-case basis. So what do I want to talk about, why is that person asking me that question? Is answering this to join in some way or is answering this just going to feed their nosiness. (36 year-old, clinician, female)

Other clinicians who prepared their clients made a distinct statement that they do so because they live in the community in which they work and the chances of running into their clients frequently occurs.

One clinician did not start preparing her clients until fairly recently when she found that two of her new clients participated on the same sports teams as her own child. At this time she realized that this could interfere with her private and professional therapeutic alliance(s). This clinician stated,

I had to say it up front because the one child goes to the same school my son attends. I basically had to express to them that I live in the same town that they do and the possibility that we may cross paths exists and I'm not going to acknowledge them unless they acknowledge me…. And you know – its not compromising at all to the therapy or what so ever, because I've run into them numerous times, my son is on a football team and their son is on the same team and you know they just say, "Hi like I'm another mother." Nothing beyond that – it's not a problem at all. I think it helps that they [parents] are an educated couple. But boundaries are boundaries and they don't cross over those. (55 years of age, clinician, female)

Similarly, a 48 year-old male clinical outpatient social worker who lived and worked in the same community as his clients prepares his clients regularly. While his agency did not have a protocol for it, it was expected. He stated,

>We do prepare clients– it does happen all the time here. If I see someone on the street and I haven't spoken about it in our previous encounter in the next session I say, "You know we saw each other, what should we do?" And they often say, well you know you can say hi and I say I'm going to let you say hi first and make that choice, and if you say hi I will be very happy to say hi back, but I won't say hello first. Its not that I don't want to but that day you may not want to say hi to me. Because they very often, our clients they want to believe me. So I want to give them the option of to not face me. I try to prepare them in the first session, so it gets it out of the way but I also speak to the larger therapeutic dynamic, that this takes place not just in here in the therapy room but it's an ongoing relationship and we're going to have to negotiate. Many of our clients are borderline and so developing the boundaries of therapy is really the therapy. You know it's not so much content - as much as work – and that is true of much of work even when they are not borderline people. (48 years of age, clinician, male)

While none of the clinicians who regularly prepared their clients within the first few sessions of treatment referred to ethics specifically, they all mentioned the importance of boundaries and issues of self-disclosure that they felt attributed to the therapeutic alliance and the reasons why they did prepare their clients for such encounters.

Eleven participants in this study felt it necessary at times, if not always to prepare clients for run-ins outside of the therapeutic setting. The following section of this research will discuss how the clinicians viewed extratherapeutic encounters and their effect on the therapeutic alliance.

Extratherapeutic Encounters and Effects on the Therapeutic Alliance

Clinicians were asked whether or not they thought extratherapeutic encounters affected the working relationship. Of the participants asked, six clinicians did not think that the alliance was affected, one was not sure as she had never experienced an accidental encounter and five clinicians reported that they felt like the alliance was affected by this encounter. Several themes emerged from the interviewed clinicians who

expressed attitudes about why or why not the relationship was affected, including specific variables such as the type of agency and population, preparing clients, and the use of these encounters in the therapeutic setting.

The most obvious and repetitive theme when clinicians were asked about how the extratherapeutic encounter affected treatment were those clinicians who prepared their clients for encounters outside of the clinical hour. Four of the six clinicians asked this question did not think extratherapeutic encounters affected the relationship because they prepared their clients for these occurrences. The remaining two clinicians who felt encounters did not affect the relationship did not offer insight as to why. A female clinician who had been in the field for twenty years working primarily with a domestic violence population stated, "In most cases I'd have to say no because the standard of what I would do is sit down and say to people, 'Look, this is a small community' and we would proceed to talk about how we are going to handle running into each other." Another female clinician who had been in the field for five years and also prepared her clients for running into each other in the community, responded to the question, "I don't think so because most of them will just look at me because they have remembered what we have said or they just very quietly say hello and look away, smile or something."

In several of the interviews the clinicians commented on how different types of agency settings and the population they were working with affected how they handled and dealt with accidental encounters. The settings and/or populations that may have affected the way the encounters were handled were wrapped around services and child and adolescent clinical work. A male clinician, age 48, who had been practicing less than

a year and saw his clients outside of the setting sometimes more than once a day

explained,

> Because we are a wrap around program we provide case management as
> well as therapy, so we see people outside frequently. I see people all the
> time at the grocery store – some people I see a few times a day. Basically,
> it makes it a little more casual and one of the things we are mostly about is
> getting clients integrated in the community, so I don't think it [encounters]
> does except for that I have to be very careful and make sure I talk about it
> therapy. When I first do an intake with people my first session, I make
> sure to say – we're going to see each other all the time, what should we
> do?

Other clinicians who commented on how their agency setting and population made a

difference in whether or not encounters affected therapy because of their impressions or

work in children's treatment. One clinician stated, "I think with children it [encounters]

is a little different. With children I would talk about confidentiality but I have to say I

didn't prepare kids because the boundaries are different."

What is interesting about the effects of extratherapeutic encounters on the alliance

is that two clinicians commented on how the encounter could be used to talk about the

therapeutic relationships and the various elements of that relationship. Both clinicians

who commented on this aspect of extratherapeutic encounters had more than fifteen years

experience in the field. A male clinician who had been in private practice since the 1970s

stated,

> Generally accidental encounters have somewhat, on occasion, affected the
> clinical experience in that it opens up the discussion of the relationship
> between therapist and client. Sometimes there are discussions about the
> therapeutic relationship and its boundaries because of the accidental
> encounter.

The ways in which clinicians handle extratherapeutic encounters and how these

encounters potentially strengthen the therapeutic alliance or weaken the process, causes

this researcher to wonder why the subject is rarely discussed in the education and training of social workers. The following section of this chapter examines the experiences of those clinical outpatient social workers who participated in this study and their recollection of training and supervision around such issues.

Training and Supervision Concerning Extratherapeutic Encounters

Eight of twelve of the participants in this study had no training or experiences talking about extratherapeutic encounters in their studies or with supervisors in the field. While some clinicians stated that it was possible it came up in case vignettes in their studies or in a conversation including issues of boundaries and self-disclosure, it was clear that these participants had no formal training or specific knowledge about how to manage extratherapeutic encounters.

Four clinicians recalled talking about extratherapeutic encounters in supervision. None of the clinicians recalled talking about extratherapeutic encounters as a part of their Master's Degree in Social Work education surrounding practice issues. A 55-year-old clinician said that her supervisor had informed her that it would happen. In fact it was discussed with her in supervision right after her supervisor had an uncomfortable encounter. She stated,

> My supervisor did say to me, "You are going to run into people in the community." He did not advise me to discuss it before it happened, you know he didn't suggest that I do that but he did tell me it would happen and I remember one day he said I just had a really uncomfortable encounter where my personal life and my professional life just collided and he didn't say any more than that, it had just happened and he was feeling kind of raw. I remember him coming in saying that to me.

It seemed to be a theme with other clinicians who had discussed it in supervision as well. This was the only time it was brought up and unless it was a mandatory agency policy

that extratherapeutic encounters are discussed with clients, it was more of a random

discussion. Another clinician stated that she had discussed encounters with her

supervisor in a previous agency she had worked for in a city. Based on the city's location

the occurrence was to be more likely. In response to being asked if she had discussed

chance encounters in a supervisory setting she responded,

> Yes they did. It was back in PA and I sort of sensed that I would discuss it
> because you know it's a bigger city and the likelihood of my running into
> people was really likely because of where I was located in the agency and
> city wise. And I knew that those kinds of things were probably going to
> happen and you know I didn't have any difficulty with it and you know
> surprisingly I really didn't run into that many people… I've run into more
> people since moving to MA.

It is interesting that an inner-city agency expected therapists to run into clients more

frequently than those who shared many resources in small area or town. This was the first

time any of the participants had mentioned such a phenomenon. A 48-year-old male

clinician, in his experience post MSW, stated,

> Yes, at this one [current employer]. I actually started a job on a college
> campus and nobody there warned me but I knew it based on my primary
> position. In this position it is considered very carefully.

While some agencies and clinicians valued preparing their clients for an

inevitable experience of seeing their therapist outside of the therapeutic setting it is

apparent that there was no protocol within the social work profession or educational

preparation that examines how these encounters best be handled. Due to a lack of

information on such encounters and how they affect the relationship, the participants in

this study were asked to consider their best practice advice that they would offer to the

field when thinking about extratherapeutic encounters.

Best Practices when dealing with Extratherapeutic Encounters

Clinicians who participated in the study were not at a loss for words when offering advice to other clinicians in the field. The topic seems to be unexplored in the field, although all participants wanted to offer their insights about it. Advice offered by these clinicians including gaining knowledge about what to expect from extratherapeutic encounters, letting clients know what to expect from the encounters, regarding and developing a sense of simple regard. While the field does not have a term for it, one clinician spoke of simple regard: as acting like oneself, making eye contact and being approachable; if the client says hi, say hi back, and if not just continue on. Many clinicians referred to this, but offered no term, for the purposes of these findings it will be referred to as "simple regard."

Simple Regard

A 55 year-old female clinician suggested that the stance of simple regard was what worked best for her. She lived and worked in the same community for eight years and saw clients outside of the therapeutic setting quite frequently. She stated,

> Just the stance of simple regard, you know I'm not going to completely ignore them [the client] and not look at them. Just act like you would with anybody, such as a stranger or acquaintance. I'm in a detached stance if I'm in a store just doing what I'm doing, I wait for them to make that acknowledgement and I do meet their eyes quickly and give them that chance if they don't I just move on. (55 year-old clinician, female)

Five other clinicians in the study referred to the same stance when giving advice to others in the field. They agreed that simple regard was best. Although she did not use the term simple regard, another clinician stated,

> It depends on the situation, but I know I was prepared to not acknowledge them until they acknowledge you who prevent a big scene and it protects

their confidentiality by not going up to them if they do not want that. That's tricky though, especially with kids because you don't want to break confidentiality or have them feel like you don't want to say hi or anything. You should probably try to be relaxed about it and maybe say hi and not engage in much conversation (25 year old clinician, female).

A 63 year-old male clinical outpatient social worker advised others to do what he does:

What I do is generally I do not say hello unless the client says hello first. If we catch each other's eyes, I may nod and smile at a distance. If they say hello I'll say hello if they come over I will talk to them and I try to leave it up to the client and give the client space and not walk over the client or panic. Or I might glance at the client and if we catch each other's eyes I might give a nod.

The clinicians in this study tended to agree that acting respectfully and minding oneself was a completely appropriate way to deal with extratherapeutic encounters. Another female clinician who had been in the field for five years explained, "I would just say that you should give brief eye contact and allow the client to engage at any level of interaction he/she would like." One other clinician offered similar advice,

I think if you can remain calm - it is the best thing if you can act kind of nonchalant, especially if you have someone with you, I try to tell them something that sounds realistic, I try to be as truthful as I can without coming out and saying I know them through therapeutic relationships. I try to fudge some sort of plausible excuse. I found that it really works, whether it was a husband, or sister or my daughter, no one has ever questioned it. Sometimes they don't ever even ask, my husband is sometimes very careful about not asking because he knows it could be a client. (59 year-old clinician, female)

This particular clinician also offered advice about simple regard with clients, but also to the people who accompany clinicians. Friends or family that clinicians are out with should also have some prior knowledge of how to handle the encounters.

Expect it

Social workers enter the field for various reasons. Given how many participants experienced extratherapeutic contacts within their own practices it is inevitable that social workers will face this dilemma. While preparing clients is not mandatory in the field, preparing ourselves and our friends and family is an important point brought up the previous quote. One clinician in particular had a specific theory of her own that she offered as advice to others in the field. She thought social workers should expect it and prepare their families and friends:

> I used to have an arrangement that if I'm with somebody – my friend, my partner whatever, and I ran into somebody [a friend or acquaintance] in the community I would say "hey how's it going" but I didn't introduce them, then the cue then for that person was to introduce themselves b/c I've totally forgotten this person's name. Once I started working here and running into clients in the community that didn't work anymore because it would be awkward if my partner introduced himself or herself to a client. So I came up with a cue word, "melbatoast." So the rationale is this, most often it happened in the grocery store, so if I'm walking down an isle and I see a client I will say something like…oh honey why don't you go get the melbatoast. And that's the cue that there is a client in the room, so she will leave or pretend she is busy or whatever. (36 year-old clinician, female)

Another clinician who had been in practice for fifteen years concurred when asked about advising others,

> I think, prepare yourself, number one. I think that if you are working and living in the same community it will limit you in some ways. I mean …well, if I thought oh I'd like to go to a seedy bar tonight I would make the decision not to go because I think it [chance encounter] would happen. Not that all my clients are in seedy bars but, there is one particular place where one of my friends said, oh lets go there and I said oh no, I can't go there. It does limit you in some ways and I think particularly if my children were younger I would probably do more preparing of clients that I might be at some events with them.

There were few clinicians who referred to how the extratherapeutic encounter affected them personally or affected how the client may judge them, especially when answering a question about giving advice. It is important to note that extratherapeutic encounters lead to a certain level of self disclosure, and that accidental self disclosure can lead to effects on the therapeutic relationship even if it is at the basic level of transference and counter-transference. Expecting the accidental encounter as a clinician will lead to handling the situation professionally and enable the client to better handle it. Preparing oneself is just as important as preparing the client, as other clinicians suggested in this study.

Prepare Your Client

Five clinicians in this research study offered advice to clinicians in that they all suggested that preparing clients was a wise decision when thinking about practice habits. A female clinician, forty years of age, stated, "I think telling people up front is the best way to handle issues. That way, everyone – the client knows what to expect and it's out there." Another 54 year-old, female clinician stated, "I think that if you make it a practice to discuss it prior to an incident happening then both you and the client should be somewhat clear on what to expect. That avoids any conflict of any nature." This clinician in particular definitely expected these occurrences to happen and also advised that clinicians have to plan:

> The clinician has to have a plan the clinician has to have a plan with the people they are with because you'll run into clients all the time and how you want to manage that for yourself. I've shown pictures of my wedding to some of my clients and there are other clients who I won't even tell how old I am. There are people I work with whom would not give anything up at all. So it is a matter of knowing what you are comfortable with and also why you are comfortable with that.

A fifty year-old clinician added, "I think it's probably a really good idea to let clients know that you know how you would expect an encounter to go in public." A forty-eight year old clinician who lived and worked in the same town stated,

> Be honest about it and deal with it in a straightforward and casual manor. It's most helpful. It's bound to happen and it might be awkward you know you try to speak to all possibilities with your client, state to them you might be excited to see me, or feel awkward, you might want to not see me that day. People may wonder who I am and if they don't know who I am they may wonder so if you don't want to tell people than that's something to consider. Give them all the possibilities so they can see me in a more complicated light as well.

While none of the clinicians in this research reported any serious concerns about interactions they encountered outside of the clinical setting, they all had very useful advice for clinicians in the field to consider while thinking about their practice and habits in and outside of their office.

The next chapter will discuss the bias of the researcher, observations from the interviews, and offer suggestions for future research in this area of social work practice.

CHAPTER FIVE

DISCUSSION

It was this researcher's attempt to conduct research exploring and depicting the experiences of twelve clinical outpatient social workers with extratherapeutic encounters. In this study it was confirmed that extratherapeutic encounters happen no matter where a social worker may live or work, contrary to much of the literature presented. While encounters may happen more regularly in rural social work, it was inferred from the interviews conducted in this research that accidental encounters are unavoidable.

Based on the research in this study, the social workers that participated all had an individual way of experiencing accidental encounters, and it was also confirmed that there is not a universal strategy for social workers to handle extratherapeutic encounters. This chapter will be a discussion of the observations of social workers' reactions and responses to the research questions that were asked of them. In addition, the chapter will also contend with the biases that this researcher had before and while conducting the study. Future studies of extratherapeutic encounters and its effects on the therapeutic relationships will also be recommended. The first section of this chapter will discuss observations this researcher had of the participants and commonalities in the interviews that were not documented within the recordings of each interview.

Observations of the Interviews

This researcher observed that study participants were often more comfortable reporting on their experiences once the recording device was turned off and the interview

formally concluded. This researcher cannot explain the phenomenon of subjects freely adding content that they declined to include in their actual interview once they felt they were of the record, so to speak. The limited scope of this study cannot address this but it may be interested topic for future research; what informs the differences in the content between on the record and off the record?

This researcher observed that, the minute that the participant was notified that the interview had concluded, the participant would appear to speak more candidly about their experiences as clinical social workers engaged in an extratherapeutic encounter. During the actual interviews many of the participants reported that they did not find that extratherapeutic encounters interfered with the psychodynamic treatment. However, in speaking with the researcher after the interview, it seemed they were more forthcoming and less formal; many of their statements indicated something very different than what they reported earlier in the interview including the notion that their encounters often did have an effect on the therapy in some way, even if it was minor. While I do not believe any of the participants intended to be misleading or confusing with the information that they reported in any way, I found the inconsistency noteworthy. I wonder if these contradicting statements could have happened based on the fact that clinicians were being recorded. Perhaps, they spoke more freely about the topic and felt more comfortable with the interviewer at the end of the research questions. Perhaps they perceived that this researcher was pulling for only certain kids of responses. Perhaps they were trying to be "good" subjects and presented their answers as more deliberate than they were.

The "informal" conclusions that I drew from the discussions that occurred after the interviews were over, were that clinicians initially did not give a lot of thought about

whether or not these encounters had affected the psychodynamic and/or the therapeutic relationship. The initial reaction during the interview was typically blunt, "No, the encounter does not affect the relationship." Any therapist would hope and expect it did not, and they would assume it as handled appropriately. Afterwards there were several indications that the clinicians were unsure about this, or second-guessed whether it did or did no affect the relationship. Participants would then recall other stories of extratherapeutic encounters that gave examples of the alliance being affected by an encounter they had experienced outside of the therapeutic setting. Some effects that were mentioned in these informal, unrecorded, discussions were that the encounter actually strengthened the relationships, while others thought if was not helpful in building the alliances and had a negative impact on treatment.

After the interview was over and the recording device was off a few participants talked about not just their own feelings about encounters, and their own lack of knowledge in how to best handle such situations. It appeared to the research that once the discussion was more informal, participants became much more relaxed about describing their experiences and shared much more detail about their encounters and how either the client or the clinician felt a variety of feelings about the encounters. The feelings that were described made this researcher concerned that these could definitely affect counter-transference and transference within the therapeutic alliance. Potentially these unexamined, inhibited feels on the part of the social worker could have significantly changed the therapeutic relationships between the client and clinician.

The other prominent observation that is worth noting in regards to the findings in this research has to do with the participant's way of speaking about extratherapeutic

encounters. All clinicians in the research, with the exception of one who had not had an experience with an encounter, referred to extratherapeutic encounters and the effects on the client, or extratherapeutic encounter in regards to their own feelings about how it affected them as a clinician. None of the participants in the study was able to hold the ambiguity of both the experiences of the client and their own simultaneously.

Part of the discrepancy that was discussed was the personal stories that the clinicians discussed after the interview was over and the professional opinion they gave while being recorded. This too pertains to the way that clinicians were unable to talk about the way that these encounters affect them as people, not clinicians, but as a member of their community. As clinicians we constantly use ourselves as a way to connect to others and assist them with their presenting issues or histories that are impacting their current functioning. As vicarious trauma affects anyone in the mental health field, extratherapeutic encounters are very much related to it as well. It was not until the recorder was off that clinicians were able to admit that encounters aren't the favorite part of the job. Many clinicians reported that they feel, "We are always on." Even when they to the grocery store it is in the back of their minds they might run into a client and a client may even approach them about very serious topics outside of the therapeutic environment. To say that this does not affect how we as clinicians act in our communities, and how extratherapeutic encounters could potentially affect our own feelings and lives, not just the emotions and lives of clients, is something that needs to be discussed in the area of practice. It should be seriously considered when practicing therapy.

As mentioned earlier in this research there are major gaps between theory and practice. It is this researcher's opinion that extratherapeutic encounters are an area in social work that needs to be more clearly defined in practice. However in the life of a social worker or a client, there needs to be a bridge between that practice and the notion of theory and ethics that define the profession. Professionally, who would not love to be a social worker that never felt like he or she is on the job when the clinical hour has ticked away, but based on this research, that is not a practical expectation of the social work field. While as a social worker I would love to never worry about how I look when I leave my house or whom I am with or worry about what I want to be doing. However, it is not an appropriate expectation to think I will not encounter clients who will not make judgments about my appearance or behavior when they see me outside of the therapeutic setting. All of which if not handled appropriately by the social worker could scare a client away or affect the dynamics of the relationship within the clinical hour. Some of this could be my own insecurity about myself or of my working relationships with clients. But I do feel that my own "stuff" is only a small portion of this topic, what is larger and what I had hoped to begin in this research was bridging the gap between the theoretical knowledge we have and the reality of our lives as clients and clinical social workers. As a few of the participants in this research concluded, preparing yourself and your clients is recommended when dealing with extratherapeutic encounters.

Bias of the Researcher

No matter how hard we try as clinical social workers, we are human; we hold biases that may affect the dynamics of the therapeutic relationships. As a social worker and researcher, I became interested in this area of practice because these encounters have

happened to colleagues and myself on numerous occasions. I have witnessed first hand the negative effects an encounter can have and the strengthening that can occur in the relationship after extratherapeutic encounters have occurred. There may appear to be little that social workers can control when running into a client outside of the therapeutic milieu. As described in the research and based on my own experiences extratherapeutic encounters are inevitable and can happen when you least expect it. What a clinician can control is whether they have discussed with clients what would happen if they were to see one another outside of the therapeutic setting.

It has been my experience that preparing clients is the best way to ensure healthy boundaries and expectations of each other when roles cross paths in the external community. As I have struggled with encounters and watched fellow colleagues do the same, it was this idea and bias that made me explore this topic. While I tried to be neutral when exploring such issues with research participants, my bias may have been conveyed in follow up questions in the interview through tone and use of language with participants.

While studying extratherapeutic encounters I became very critical of myself in how I handle and cover confidentiality, self-disclosure and boundaries as they relate to extratherapeutic encounters. I took it upon myself to create my own standard to discuss extratherapeutic encounters with all clients who I work with, whether it is in a psychodynamic, therapeutic relationship or in other social service positions. Since I began preparing my clients, I have not had an incident that made me or the client feel uncomfortable, as I discussed the encounter with clients the following appointment. This is contrary to the experiences that happened prior to preparing clients. I establish with all

clients that it is possible that we may see each other outside of the therapeutic setting, and I articulate this example to client(s) while discussing issues of confidentiality. I have found based on these discussions that the boundaries and expectations are clear for both myself and for the client. Acting on extratherapeutic encounters when they occur according to the arranged agreement in the therapeutic setting allows for both client and therapist to follow through with that agreement and in turn builds trust within the relationship. While therapists do not have control whether or not the client will follow through with the agreement in a public setting, how they do respond and act can be used within the therapy as a tool to help understand the client's behavior. Using the encounter as a way to explore the client's actions allows the clinician to review the goals and work of the treatment through another lens. How that client responded to the extratherapeutic encounter helps the therapist to better understand that client's behavior as well as allow the therapist to use that as a point to build upon the therapeutic alliance.

My experience with preparing clients and dealing with extratherapeutic encounters has also posed issues of accidental disclosure on the part of myself as the therapist and in some experiences on the part of the client. These encounters that cause accidental disclosure also present moments that can make relationships stronger with clients, or if not handled appropriately can be detrimental to the relationships. Although it depends on each individual in treatment, I have found that talking about it is helpful in defining boundaries, discussing the therapeutic alliance, and strengthening the relationship and work with the client.

While researching this topic I became familiar with several aspects of extratherapeutic encounters. Ethically we should handle the situations by using the

encounters to model appropriate boundaries and protection of confidentiality. It was clear that while I became more familiarized with the research and topics that are connected to extratherapeutic encounters, I began to formulate my own opinions and ideas on how to best handle encounters outside of the work setting. While I tried diligently not to let my own ideas shape my research, it is clear that this is my own bias and it may have affected the research. Based on this, the next section will discuss future research in this area, part of the research that should be more finely tuned, and other areas that came up in the research that due to time constraints could not be studied for this particular project.

Future Research

While this research was conclusive in finding that extratherapeutic encounters are not unique to social work in small communities, it is important to look at the overall issue of how these encounters affect the social worker, the client, the therapeutic alliance and the psychodynamic aspects of the therapy in closer detail. Research looking specifically at social workers that experienced accidental encounters and did or did not prepare clients and exploring the effects those encounters had on a psychodynamic treatment relationship could be beneficial. Looking at therapists that practice psychodynamically that have or have not prepared clients for accidental encounters and examining the effects it has had on the relationship after the encounter would be beneficial. It could also be valuable to follow both the therapist and client in an extensive quantitative study to see the effects of an accidental encounter; exploring whether the therapists felt they had prepared their client, whether or not the clients felt they could handle the situation, and the way both clients and therapists felt during and after the encounter occurred. Further

examining the shift in dynamics (if any) of the relationship afterwards might also offer insights.

This research has only scratched the surface regarding extratherapeutic encounters. It is my opinion that this could be the beginning of a long series of studies and conversations about extratherapeutic encounters in the field of social work. Whether or not an encounter outside of the therapeutic setting happens once or more a day to a clinician or once a month or even once a year, clinicians and clients alike need to be prepared so that the therapeutic relationship continues to be of use despite these encounters. It may be beneficial to create an ethical guideline for professionals in the field when dealing with accidental encounters. The issues of neutrality, self-disclosure (accidental or otherwise) and boundaries and psychodynamic theory are relevant to these types of encounters. Accidental encounters can be disruptive in each one of these areas. I believe it is important to evaluate these unexpected outcomes and how these encounters affect the therapy.

Conclusion

To conclude this research, extratherapeutic encounters have been overlooked for many years. They can potentially have a great impact on a therapeutic relationship. This research is just the beginning of examining the effect of extratherapeutic encounters. Therapy is a complex and personal experience for clients and any disruption of the alliance needs to be attended to. While this research was limited in scope, it was confirmed that preparation of both the social worker professionally and personally, and of the client, are essential in maintaining a working relationship after an extratherapeutic encounter occurs.

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Appendix A

     My name is Ashley Benson; I am a graduate student at Smith College School For Social Work. I am conducting research for my MSW thesis. This research will be used for presentation and publication. The intention of this research is to explore if and how clinical social workers prepare their clients for the possibility of running into each other outside of the therapeutic setting.

     I will be interviewing twelve clinical outpatient social workers for a qualitative study. Participants in the study will be interviewed for approximately forty minutes. Participants who take part in the study will be interviewed face-to face in a quiet, neutral location where the conversation can be recorded. If a participant cannot meet face to face due to time constraints or physical location, a phone interview will take place. All interviews will be recorded with an audio recorder. Any information obtained through the interview will be recorded and transcribed for documentation and research purposes only. All transcription will be done myself, however if someone else were to assist in the transcribing process, a confidentiality form would be used. During the course of the interview any identifying information about yourself will be removed for the purposes of confidentiality.

     Participation in this research in completely voluntary, and you may decide at any time to withdraw from the study. At any time you can exit the interview or refuse to answer questions. If you do plan on exiting the process please contact me in writing by April 1, 2009, and any information you contributed to the research will be retracted. There are minimal risks to participants who decided to take part in the research.

     Participating in this research may better our profession's understanding of practicing social work in small communities. Although you will not be financially compensated for participating in the study, I am hopeful that the information provided will be of great value to the social work profession and community. By participating you will be making a contribution to the way we understand social work practice and future initiative to improve the way we practice.

     Any information collected could be used in publications or presentation. The data will be presented as a whole and if and when brief illustrative quotes or vignettes are used, they will be carefully disguised. All transcripts will be kept in a secure location for a period of three years as required by federal guidelines. Should the information collected need to be used for a longer period of time they will continue to be kept in a secure location and will be destroyed when no longer needed.

     If you have any concern about your rights or about any aspect of the study I would encourage you to call me at (413) 464-5408 or email abenson@email.smith.edu. You could also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. Please keep a copy of the consent form for your records.

     YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD

THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Thank you for your time and contribution to the field of social work.

Participants Signature _____ *Date* _____

*Researchers Signature*_____ *Date* _____

Ashley P. Benson

Appendix B

February 11, 2009

Ashley Benson

Dear Ashley,

Your final amendment has been reviewed and all is now in order. We are happy to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project. It will be interesting to hear what people have to say. I practiced in a small community for years and I got to thinking back on some encounters. It could be pretty uncomfortable.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Quincy McLaughlin, Research Advisor

Appendix C

Subject: Attention Clinical Outpatient Social Workers

Friends and Colleagues,

Interested in participating in a discussion of the unique challenges of encountering clients in the community? I need your help!!

I am a Smith School for Social Work Student conducting research about clinical social work for my Master's thesis. I am researching how clinical social workers deal with running into their clients outside of the therapeutic setting. I am requesting a brief interview in person or over the phone to help me conduct this research. Please contact me if you are interested at a.p.benson@hotmail.com or call me at (413) 464-5408. Your contribution is greatly appreciated!

Ashley P. Benson
Smith College MSW Student

Appendix D

INTERVIEW GUIDE

Gender:

Educational Background and Professional History:

Age:

 City – Residence: City – Work:

Number of Years in Practice?

Do you ever run into your clients outside of the therapeutic setting?

Is there a particular accidental encounter you would like to describe that stands out to you? If so, why?

Do you think accidental encounters have affected your therapeutic relationships? If so, how?
Please give an example…

 Do you ever discuss the possibility of encountering each other with your client? In other words, do you prepare your client or give your client the option to prepare for the possibility that you may run into each other outside of the setting?

If yes, at what point did you discuss this with your client? For example, during the first session, later sessions, etc.
      Why?
      How?
      If no, why not?

In your first position post MSW, did anyone in your agency or setting advise you to expect that you may run into clients in the community? Did anyone on staff advise you to discuss this possibility with your client before it happened?

What have you found most useful when dealing with these experiences?