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## Psychotherapists' decisions regarding boundary crossings in outpatient practice

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Victoria E. Brinckerhoff  
Psychotherapists' Decisions  
Regarding Boundary Crossings in  
Outpatient Practice

### **ABSTRACT**

This research study was a quantitative, exploratory investigation of the experiences and opinions of outpatient psychotherapists regarding decisions about crossing boundaries within clinical practice. The focus was on boundary-crossing behavior, as distinguished from boundary-violating behavior, in that boundary crossings are not necessarily harmful, and at times may be helpful to the client. An electronic questionnaire, developed specifically for this research, was administered anonymously to 46 practicing clinicians in the United States.

The major areas of inquiry were the following: boundary-crossing decisions with which clinicians experienced the most difficulty, factors influencing decisions regarding boundary dilemmas, and types of resources that clinicians have utilized in the past and would find helpful in the future for assisting them in making these decisions and maintaining awareness of their own professional boundaries. Additionally, demographic characteristics of the clinicians were correlated with their reported behaviors, decisions, and preferences.

Although participants perceived many of the boundary crossings addressed in the study to cause minimal difficulty to their own and other clinicians' decision-making, a major finding was in the detailed accounts of how complex and challenging specific boundary dilemmas were experienced in their practice. Participants noted a range of contextual factors that were influential in making boundary decisions. Additionally, participants perceived a need for training, supervision, and practice guidelines to be provided for assistance with boundary management.

Many felt that the most effective resources were supervision and collegial consultation, but noted several barriers to accessing and utilizing these resources.

**PSYCHOTHERAPISTS' DECISIONS REGARDING  
BOUNDARY CROSSINGS IN OUTPATIENT PRACTICE**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Masters of Social Work

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2012

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## **CHAPTER I**

### **Introduction**

The purpose of this research study was to investigate psychotherapists' opinions and experiences regarding difficulty boundary decisions they make in outpatient practice. The study focuses on behavior that has been identified as boundary-crossing behavior, as distinguished from boundary-violating behavior, in that boundary crossings are not necessarily harmful, and at times may be helpful to the client. The study was conducted through a quantitative questionnaire, administered to 46 practicing clinicians via the internet.

Throughout the course of developing and maintaining treatment relationships, psychotherapists are challenged with the task of defining and negotiating boundaries that will optimally facilitate their clients' progress in therapy. The mental health field has struggled to define appropriate boundaries due to the fact that complexities of each treatment relationship impact clinicians' boundary-management decisions. These decisions may be influenced by an array of contextual factors, including characteristics of the clinician, the client, the therapeutic relationship, and the environment.

The field has distinguished between two types of boundary transgressions based on their outcomes: boundary violations and boundary crossings. While it is generally agreed upon that certain behaviors by therapists present boundary violations that necessarily harm the client, boundary crossings remain a topic of debate among clinicians and scholars. Some view boundary crossings as benign deviations from the established limits of the treatment relationship (Gutheil

& Gabbard, 1998; Davidson, 2005; Brown and Trangsrud, 2008), while others acknowledge that crossing a boundary can directly lead to positive or negative outcomes in the therapeutic alliance (Miller & Maier, 2002; Reamer, 2003; Pope & Keith-Spiegel, 2008; Speight, 2011). According to this conceptualization, “boundary crossings can enrich therapy, serve the treatment plan, and strengthen the therapist-client working relationship. They can also undermine the therapy, sever the therapist-patient alliance, and cause immediate or long-term harm to the client” (Pope & Keith-Spiegel, 2008, p. 651). Practicing psychotherapists' perceptions regarding boundary crossings and their potential outcomes were explored in the study.

Psychotherapists are regularly presented with challenging boundary decisions, and therefore boundary management is a topic that is relevant for all mental health professionals (Peternelj-Taylor & Yonge, 2003; Brown & Trangsrud, 2008). Many resources are available to help clinicians with difficult boundary decisions, including education and training, codes and policies regarding boundaries, and supervision and consultation regarding specific boundary dilemmas. However, the literature examines the fact that psychotherapists across disciplines still struggle with self-awareness and decisions regarding when to cross particular boundaries, and regularly encounter barriers to obtaining necessary assistance (Gutheil & Gabbard, 1993; Walker & Clark, 1999; Peternelj-Taylor & Yonge, 2003; Pope & Keith-Spiegel, 2008; Fronck et al., 2009). Because most of the literature addressing boundary crossings has been anecdotal rather than empirical (Peternelj-Taylor & Yonge, 2003; Miller et al., 2006), further exploratory research is needed on this topic, especially from the perspective of practicing clinicians.

This research study explored psychotherapists' experiences with difficult boundary decisions with their outpatient clients, looking at contextual factors that may have influenced these decisions. The participants, 46 practicing clinicians, completed a questionnaire designed

exclusively for this research. Participants were also asked about the types of resources they have utilized for help with boundary decisions, the perceived helpfulness of these resources, and barriers to accessing them. The results of this study present a first-hand account of psychotherapists' experiences with and opinions regarding various boundary crossings, as well as insight into methods that might be useful for assisting with difficult boundary decisions.

Chapter II, which follows, reviews the pertinent literature regarding conceptualizations of boundary crossings, factors that have been found to influence clinicians' boundary decisions, resources that may be helpful in resolving boundary dilemmas, and barriers to accessing these resources. Chapter III provides details of the Methodology of the study; the Findings of the study will be presented in Chapter IV; and a Discussion of the major findings can be found in Chapter V.

## **CHAPTER II**

### **Literature Review**

This exploratory research study explored outpatient clinicians' experiences with decision-making regarding boundary crossings in clinical practice and their opinions about what is needed to help with these complex decisions. The research questions that were explored include 1) Which potentially boundary-crossing behaviors do clinicians experience as the most difficult in their outpatient practice? 2) Which factors influence their decisions about resolving boundary dilemmas that arise? 3) What types of resources have psychotherapists utilized in the past, and what would they find most helpful in the future, for assisting them in making decisions and maintaining awareness of their own professional boundaries? 4) Do any demographic characteristics of the clinicians in the sample correlate with their reported behaviors, decisions, and preferences?

The research questions are based on boundary-crossing behaviors that have been identified in the literature as challenging for psychotherapists. Multiple contextual factors, noted in previous writings to influence clinician's boundary decisions, were also addressed in this study. Lastly, inquiries about resources available to psychotherapists for assistance in making these decisions, and barriers to accessing them, were included in this research. This chapter will review the pertinent literature related to boundary crossings, factors that influence them, and resources that may be helpful in decision-making related to boundary decisions.

## **Boundaries and Boundary Crossings in Clinical Practice**

As part of creating and maintaining the therapeutic relationship, psychotherapists are continuously confronted with decisions about how to construct, negotiate, and maintain boundaries with clients. Epstein and Simon (1992) describe this ongoing decision-making process as one that

requires the therapist to find the right balance between empathy and limits with each patient. ...In requesting help, patients invite the therapist to enter their inner world. The therapist in turn exposes her or his psyche to serve as a sensitive instrument to discern, contain, and contend with the patient's conflicts. (p. 150)

Naturally, the role of psychotherapist often involves dilemmas regarding how to maintain professional boundaries while fostering the genuine human connection that is the change agent.

Boundaries are defined as “the limits that circumscribe the relationship between a healthcare professional and a patient” or client (Miller & Maier, 2002, p. 309). When the healthcare professional is a psychotherapist, this relationship involves creating a safe environment for the client, which is necessary in order to effect therapeutic change (Gutheil & Gabbard, 1998). “The establishment of clear boundaries is designed to create an atmosphere of safety and predictability within which the treatment can thrive” (p. 410). Gutheil and Gabbard explain that “...*external* boundaries are established so that *psychological* boundaries can be crossed through a variety of mechanisms common to psychotherapy, including empathy, introjection, identification, projective identification, and the interpretation of transference” (p. 410; italics in original text). While clinicians generally agree that boundary maintenance is an important part of the therapeutic relationship, there is disagreement in the field regarding how to determine what constitutes appropriate boundaries that will optimally facilitate therapy.

The relationship between clinician and client is unique in that it is characterized by the fiduciary responsibility of the therapist to act in the best interest of the client (Walker & Clark, 1999; Miller & Maier, 2002; Peternelj-Taylor & Yonge, 2003; Davidson, 2005). The asymmetrical power differential inherent in the relationship defines the client as vulnerable and the psychotherapist as the professional authority designated to the role of helper. Both the expectation of the client and the obligation to the profession prescribe that the clinician use this power only in ways that are beneficial to the client (Peternelj-Taylor & Yonge, 2003).

However, many professionals agree that the very nature of this role can make boundaries difficult to maintain. Often, “boundary issues involve circumstances in which social workers [and other clinicians] encounter actual or potential conflicts between their professional duties and their social, sexual, religious, or business relationships” (Reamer, 2003, p. 121). Due to the fiduciary nature of the relationship, psychotherapists often must behave differently within therapeutic relationships than they would in other professional or social relationships. Inherent in this is the responsibility for clinicians to act in a way that minimizes confusion or misinterpretation on the part of the client about the nature of the relationship (Peternelj-Taylor & Yonge, 2003). Speight refers to a “duty of neutrality, which means knowing one's place and allowing the client's agenda to take center stage. ...The clinician is expected to maintain an objective, professional distance while developing an effective working relationship with the client” (2011, p. 136). The literature on boundaries across professional disciplines generally normalizes clinicians' struggles to define and sustain the amount of distance that will present minimal risk to the client and allow the therapeutic process to flourish. Psychiatric nursing literature cautions that

the familiarity and trust that develop between a nurse [or other therapist] and a client, coupled with the seductive pull of helping, the complexity of the client's treatment needs, and a general lack of understanding of boundary theory, can threaten the integrity of the relationship and ultimately lead to boundary violations. (Peternelj-Taylor & Yonge, 2003, p. 55)

While Peternelj-Taylor and Yonge illustrate an important concept, this statement represents the field's tendency to view boundary excursions as mostly negative incidents that can potentially lead actions that are harmful to the client.

This particular conceptualization began in the late 1980s and early 1990s, when the topic of therapeutic boundaries achieved a substantial amount of scrutiny throughout multidisciplinary psychotherapy literature, largely in response to the rising phenomenon of therapists violating sexual boundaries with their clients and consequently facing repercussions from ethical committees and the legal system. As a result, the majority of the writing about boundary transgressions from this era frames boundary crossings of any kind as behavior that might put a clinician at risk for eventually violating a sexual boundary by compromising the relationship over time (Miller & Maier, 2002). Several authors refer to the analogy of the “slippery slope,” which first appeared in the sexual boundary violation literature to describe situations in which clinicians begin by crossing what appear to be minor boundaries, but eventually lead to serious ethical blunders, namely sexual exploitation of clients (Simon, 1989; Gabbard, 1989, cited in Gutheil & Gabbard, 1993).

In contrast to this perspective, more recent literature has framed boundary transgressions as normal parts of the therapeutic process that are not always harmful, but more often neutral or even helpful to the client. In a highly influential publication, Gutheil and Gabbard (1993)

developed a framework for distinguishing between what have come to be referred to as boundary violations and boundary crossings. A boundary violation is described as an act that necessarily compromises the therapeutic process and harms the client or places him or her in a greater position of vulnerability. There is general agreement within the field that boundary violations are unacceptable and often punishable. In contrast, the concept of a boundary crossing is presented as “a descriptive term, neither laudatory or pejorative” (p. 190), that may help or hinder the therapeutic process, depending on the context of the case and the therapeutic relationship. The present study focuses on the latter, boundary-crossing behavior, which is less clearly defined in the field and continues to be a topic of debate among clinical practitioners.

Since the publication of Gutheil and Gabbard's framework, much of the literature on boundaries has viewed boundary crossings as a type of transgression that can lead to positive or negative consequences, depending on the context (Gutheil & Gabbard, 1998; Miller & Maier, 2002; Reamer, 2003; Brown & Trangsrud, 2008; Pope & Keith-Spiegel, 2008; Speight, 2011). Some publications even go as far as to label boundary crossings as necessarily “benign” occurrences (Gutheil & Gabbard, 1998; Brown and Trangsrud, 2008). Davidson's description of what is labeled a “boundary breach” is in accordance with this conceptualization of a boundary crossing, that is, “an action that transgresses a commonly accepted standard of behavior for reasons that may be understandable given exceptional circumstances, and the implications of which are not harmful to the client” (2005, p. 519).

Still, some authors, such as Pope and Keith-Spiegel (2008), view boundary crossings as transgressions whose consequences may be positive or negative:

Nonsexual boundary crossings can enrich therapy, serve the treatment plan, and strengthen the therapist-client working relationship. They can also undermine the therapy,



sever the therapist-patient alliance, and cause immediate or long-term harm to the client. Choices about whether to cross a boundary confront us daily, are often subtle and complex, and can sometimes influence whether therapy progresses, stalls, or ends. (p. 651)

While one group of authors (Borys & Pope, 1989; Pope & Vetter, 1993; Davidson, 2005) have referred to boundary crossings as “incidental events,” “one-time choices,” or “brief excursions,” followed by “a return to established limits of the professional relationship” (Peternelj-Taylor & Yonge, 2003, p. 57), others have insisted that boundary crossings are never isolated incidents in that they are always part of a pattern of boundary-related behavior and can often lead to changes in the nature and professionalism of the the therapeutic relationship (Miller & Maier, 2002; Pope & Keith-Spiegel, 2008). The latter group tends to view the topic of boundary crossings in terms of longer-term consequences, either through an ethical or risk-management lens.

From an ethical point of view, boundary issues are among the most challenging ethical dilemmas that clinicians face on a day-to-day basis (Reamer, 2003). Pope & Vetter's 1992 survey of practicing psychologists found that when asked to identify and describe ethical dilemmas they have experienced, the second most frequently reported incidents, next to confidentiality issues, involved managing challenges to boundary maintenance. Much of the literature on boundaries asserts that clinical practice must be solidly grounded in an ethical framework, and that the ethical implications of clinicians' boundary decisions must be considered throughout the therapeutic process in order to protect the client (Borys & Pope, 1989; Gutheil & Gabbard, 1993; Walker & Clark, 1999; Miller & Maier, 2002; Davidson, 2005; Pope & Keith-Spiegel, 2008).

Risk management in terms of therapeutic boundaries has been described as “the use of professional judgement to anticipate how a course of action might cause difficulties for the therapist and to then select a better course” (Mintzer, 2011, p. 1). According to Mintzer's NASW publication, while ethical decision-making refers to choosing to engage in behavior that will protect the client and uphold the societal reputation of the profession, risk management decision-making focuses on protecting the therapist and his or her practice (2011).

Fronek and colleagues (2009) contend that viewing boundary behavior solely from a risk management perspective is not a sufficient way to frame the decisions clinicians make. These authors stress that typically, trainings on boundaries that practicing psychotherapists receive in the workplace “usually focus on the risk management aspect, that is, the legal implications of professional boundary management rather than the transfer of knowledge and skills relating to clinically reflective practice and ethical decision making” (p. 162). The conclusion is that in order to provide appropriate and responsive care, therapists must more widely consider the impact of boundary decisions on themselves, their clients, the therapeutic relationship, and the profession as a whole:

Training inclusive of critical reflection enables practitioners to examine their current practice, explore relational power imbalances and relate theoretical perspectives to their personal practice approaches. This raises it above the level of training based on risk management approaches alone and challenges practitioners to grow professionally. (p. 163)

Many other authors agree that while a risk management perspective can be helpful in preventing clinicians from sliding down the “slippery slope” to potential boundary violations, there is much more to boundary maintenance than simply managing risk (Reamer, 2003; Speight,

2011). In evaluating clinicians' experiences with boundary decisions, the present study goes beyond risk management by asking clinicians about the contextual factors they consider on a case-by-case basis when it comes to boundaries with outpatient clients.

Regardless of the frame through which the literature views boundary crossings, most publications agree that the implications of a boundary transgression are determined not by the behavior itself, but by the context in which it occurs (Gutheil & Gabbard, 1993, 1998; Walker & Clark, 1999; Miller & Maier, 2002; Davidson, 2005; Miller, Commons, & Gutheil, 2008; Pope & Keith-Spiegel, 2008). Therefore, boundary decisions should be made on a case-by-case basis. Pope and Keith-Spiegel (2008) eloquently elaborate on this in terms of psychotherapists' duty to their clients' treatment needs:

No shortcuts in logic can free us from the responsibility of thinking through the nature and implications of what we are doing with our clients. No one-size-fits-all abstractions, theories, or assurances can substitute for considering carefully the individual boundary crossing in context: What effects could this boundary crossing have on this particular client in this particular array of contexts? (p. 644)

Although it is widely recognized that crossing a boundary may put a clinician at risk for an ethical violation, many authors contend that *not* crossing a boundary can jeopardize treatment as well. Gutheil and Gabbard first brought attention to the potential for overly “sterile” treatment in their 1998 publication, which cautioned that “when pendulums begin to swing, they commonly swing too far” (p. 409). Davidson (2005) has illustrated this bidirectional conceptualization of potential boundary transgressions by creating a novel teaching model for the social work profession, which includes the “Professional Relationship Boundaries Continuum.” While one end of the continuum represents “entangled” boundaries, that is, the traditional notion

of exploitative boundary behavior; the other end represents “rigid” boundaries, which Davidson contends can be equally exploitative. The center of the continuum signifies a wide range of “balanced” boundaries, which includes potential “boundary breaches” in either direction that are likely to facilitate the therapeutic process.

Several other authors have since agreed that an overly rigid approach to professional boundaries can lead to clinical practice that is less than optimal and sometimes harmful. For example, Miller and Maier (2002) argue that “because of the wide publicity about sexual violations, many therapists have taken refuge in a clinical orthodoxy at the expense of attention to individual patients' needs. Boundary crossings must be examined in the context of the individual treatment relationship—how it affects the patient and the therapist” (p. 312). As a response to this, authors now caution clinicians against literally interpreting standards of practice or generic lists of “boundary do's and don'ts,” which can be helpful in averting exploitation, but can also lead to restrictive practice unless contextual factors are also considered (Walker & Clark, 1999; Miller & Maier, 2002; Peternelj-Taylor & Yonge, 2003).

The literature also points out that while professional codes of ethics and agency policies may provide a guide for ethical practice, they often do not take clinical context and individual treatment needs into consideration. Furthermore, codes of ethics, including but not limited to the National Association of Social Workers (NASW) and the American Psychological Association (APA), tend to present vague guidelines regarding culturally responsive practice in terms of appropriate boundaries (Pope & Vetter, 2002; Speight, 2011).

In her discussion of therapeutic boundaries as they relate to the concept of cultural solidarity, Speight (2011) brings attention to the fact that strict or rigid boundaries can compromise the sense of human authenticity that is often vital to achieve therapeutic gains. For

example, rigidity in terms of professional boundaries may indicate a lack of caring or concern in Latin cultures, and has been viewed as negatively unsympathetic and distancing by African American clients. Speight posits that the traditional notion of psychotherapist that represents anonymity and distance may represent a “Eurocentric” approach to practice, stating that “it is important to make clear that the dominant, hegemonic view of professional boundaries represents just one particular approach to boundaries that is culturally bound” (p. 15). It may be necessary for culturally competent practice that many clinicians broaden their concept of what constitutes appropriate and facilitative boundary-related behavior.

### **Types of Boundary Crossings Addressed in the Present Study**

As evidenced by the literature presented, some scholars studying boundary behaviors in clinical practice have attempted to organize discussions by creating categories and frameworks to distinguish different types of boundary transgressions. The present study concentrated only on certain domains of boundary-related behavior, as determined by previous literature. This study's focus was on boundary-crossing behaviors, as defined by Gutheil and Gabbard (1993) and many subsequent authors. While most practicing psychotherapists would probably agree that boundary violations are harmful to clients and would easily be able to identify boundary-violating behaviors, there is less agreement regarding the nature and outcome of boundary crossings in clinical practice. Due to the fact that boundary crossings remain an area in which there is a great deal of disagreement and room for clinical judgement and interpretation, I decided to focus this study on boundary crossings.

In reference to Davidson's (2005) Boundary Continuum, the focus of this study is generally on the middle section of the continuum, addressing boundary crossings on both the “rigid” and “entangled” side of the continuum, but not boundary violations at the far ends of the

continuum. Again, the intention of the study was to explore clinician's experiences with and opinions about behaviors and situations that are less than straightforward regarding whether they present a boundary concern.

Due to the fact that clinician's decisions about self-disclosure, an area of boundary crossings that has been explored extensively in the literature, the present study excluded any questions about self-disclosure. Also, as a great deal of the literature focuses on sexual boundary issues, this area was not included in this study. It was also excluded because any sexual boundary transgressions would fall under the category of boundary violations, rather than the focus here on boundary crossings.

Also, due to the controversial nature of the issue of physical touch and its relationship with potential boundary violating behavior, the questionnaire did not inquire about any situations that involved physical touch with clients. It was made clear in the recruitment process that these potentially controversial topics would not be addressed in this research. It was expected that psychotherapists would be more likely to participate knowing that they would not be asked to disclose personal experiences with boundary dilemmas that were highly controversial or emotionally-charged.

Drawing on boundary crossings identified as challenging by previous authors, I chose twenty-one boundary crossing behaviors to include in this study, and they were organized into three categories. The categories included potential boundary-crossing behaviors that could occur “During Sessions,” those that involve “Communication Outside of Sessions,” and those that may be described as “Social Interactions” outside of the clinical relationship.

Although many of the behaviors included in the questionnaire have been explored by past literature, the majority of the writings have been anecdotal rather than empirical (Peternelj-

Taylor & Yonge, 2003; Miller et al., 2006). One empirical study found a significant amount of disagreement among social workers regarding their opinions about the appropriateness of particular boundary crossings and whether they would engage in various boundary-related behaviors, suggesting that continued exploration about boundary crossings is warranted (Jayaratne, Croxton, & Mattison, 1997). The present study sought to empirically explore practicing clinician's experiences with and opinions about boundary-related behaviors and situations that have been identified as challenging to psychotherapists.

**“During sessions” items:** The first category of boundary crossings about which participants were inquired included circumstances that may arise during therapy sessions that may put psychotherapists in the position of deciding whether or not to cross a boundary. One frequently discussed topic is decision-making about accepting small gifts from clients (Borys & Pope, 1989; Pope & Vetter, 1992; Walker & Clark, 1999; Miller & Maier, 2002; Reamer, 2003; Brown & Trangsrud, 2008; Pope & Keith-Spiegel, 2008; Speight, 2011), as well as giving gifts to clients (Gutheil & Gabbard, 1993; Walker & Clark, 1999; Miller & Maier, 2002; Reamer, 2003; Miller et al., 2006; Brown & Trangsrud, 2008; Speight, 2011). The present study asked participants about their experiences with both giving gifts to and receiving gifts from clients.

One national study of APA members found that a sizable proportion of the psychotherapists surveyed reported experiencing ethical dilemmas related to payment sources, plans, settings, and methods (Pope & Vetter, 1992). This type of dilemma was reported third most frequently, and was only surpassed by ethical issues related to confidentiality, and dual relationship conflicts. As monetary issues are a topic that have appeared quite often in the literature regarding boundary dilemmas, the present study included questions about difficulties with late payments and missed appointment fees (Pope & Vetter, 1992; Gutheil & Gabbard,

1993; Miller & Maier, 2002; Reamer, 2003; Pope & Keith-Spiegel, 2008) and about lending small amounts of money to clients (Jayaratne et al., 1997; Miller et al., 2006).

As spirituality has been acknowledged as a source of strength for many psychotherapy clients and has been increasingly integrated into treatment over recent years, one question asks about praying in session with clients. More than a decade ago, Jayaratne and colleagues (1997) found that about 44% of social workers surveyed considered this behavior appropriate, but less than 20% had incorporated prayer into their own therapy sessions with clients.

Other items involved with “during sessions” behavior included clinician's decisions about whether to extend session time (Gutheil & Gabbard, 1993; Walker & Clark, 1999; Reamer, 2003; Miller et al., 2006; Pope & Keith-Spiegel, 2008), and whether to lend materials such as books or audio recordings to clients, which is likely to be a common and less controversial practice among psychotherapists than lending money to them.

The final two items in this category related to use of language in sessions as a boundary crossing tool used by psychotherapists (Gutheil & Gabbard, 1993; Jayaratne et al., 1997; Miller & Maier, 2002; Speight, 2011). Several authors referenced the type of language used and word choice as a potential boundary-crossing behavior that could have a negative impact on therapy, or could or strengthen the therapeutic alliance. For example, Speight (2011) provided an account of a psychotherapist trainee incorporating “Black vernacular” into her dialogue with a Black client as a way to facilitate solidarity and a more authentic therapeutic alliance between them (p. 17). The present study included questions about using expletives and slang as well as addressing clients by familiar terms other than their names.

**“Communication outside of sessions” items:** The second category of boundary-crossing behaviors involved asking how clinicians make decisions about communicating with



clients outside of in-session contact. Several authors have identified off-hours telephone calls with clients as boundary crossings that may either facilitate therapy or be a warning sign for future boundary-violating behaviors (Gutheil & Gabbard, 1993; Walker & Clark, 1999; Miller et al., 2006). While recognizing that it is sometimes necessary to certain types of clinical treatment for therapists to be available to clients outside of structured sessions, Walker and Clark (1999) have identified four practices related to off-hours telephone communication that may indicate boundary problems:

clinicians giving clients their personal telephone numbers (rather than the number to an answering services or crisis line), a pattern of initiating calls to clients rather than receiving them (except in serious emergencies or to monitor client safety), frequent or lengthy calls, and a pattern of late-night or weekend calls. These practices involve the clinician's personal space and privacy. Unchecked, such access invites the possibility of increasing levels of intimacy. (p. 1437)

Participants were asked about their decisions regarding whether to provide their home or cellular telephone number to clients (Jayaratne et al., 1997; Walker & Clark, 1999), which is becoming more of a common practice in psychotherapy, especially in certain modalities such as Dialectical Behavioral Therapy. In 1992, a national study found that more than half of participating psychologists had provided a personal telephone number to clients and an even larger number considered this practice to be appropriate. The present study explored whether providing a personal telephone number is a decision that clinicians currently view as a challenging one. This study also asked about telephone calls to clients to “check in,” to remind clients of appointment times, and communication with clients while on vacation.

One issue that was not specifically addressed in the literature reviewed, but is becoming more of a concern as the internet becomes more prominent in professional and social interactions, is the incorporation of email communication with clients. In acknowledgement of this technological shift, the questionnaire addressed possible ethical and/or confidentiality issues that could come up if clinicians communicate with clients through the internet. Lastly, based on the literature, participating psychotherapists were asked about their experiences regarding continuing communication with clients after termination of the treatment relationship (Borys & Pope, 1989; Pope & Vetter, 1993).

**“Social interactions” items:** The final category included behaviors that may come up in non-clinical (e.g. social or professional) relationships, but when presented as a component of a therapist-client relationship, may challenge the boundaries of the clinician's role. Several authors have discussed potential challenges of running into clients in the community (Miller et al., 2006; Speight, 2011), which was addressed in this study. When this occurs, participants were asked if they have decided to initiate greetings with their clients at the time.

Other potential conflicts of interest that have been identified as challenging in literature have been addressed in the present study, including whether to recommend services for a client that are outside of the human service field, asking a client for advice in his or her area of interest or expertise, and transporting a client in one's personal vehicle (Gutheil & Gabbard, 1993, 1998; Miller et al, 2006; Speight, 2011).

As mentioned earlier, technological advances and the shift in the social climate toward connection via the internet have introduced additional challenges to maintaining balanced professional boundaries. As part of this societal trend, many clients and therapists today use social and professional networking websites to communicate with friends, family, and

colleagues. To address potential boundary dilemmas that could arise as a result of this, this study included a question about participants' potential dilemmas that could arise involving communication with clients via networking websites.

A final potential boundary dilemma that is discussed in the literature arises when clients invite their psychotherapists to meaningful life events, such as weddings or graduations. When a client or client's family member dies, potentially difficult decisions are considered about whether to attend a funeral or other type of memorial service. The present study asked participants about their decisions when presented with the opportunity to attend a meaningful event in a client's life.

### **Factors That May Influence Boundary Crossing Behaviors in the Clinical Relationship**

Clinicians may be presented with any number of the decisions discussed above throughout the course of their careers in clinical practice, however, boundary decisions are not made in a vacuum. They are influenced by a number of factors, including characteristics of the environment, the clinician, the client, and the therapeutic alliance. In this regard, the literature discusses many important contextual factors when considering possible outcomes of boundary decisions. The present study took these factors into account by asking participants to consider challenging boundary decisions and identify the factors that influenced each decision.

**Environmental factors:** Several environmental factors of the therapeutic interaction have been noted to have influence over the way therapists construct and maintain boundaries with outpatient clients. Because different levels of care present different types of boundary issues (Miller & Maier, 2002), the present study focuses only on outpatient clinical practice. However, many other factors besides level of care are explored to learn how they impact decision-making related to boundaries.

Clinicians who practice in urban, suburban, and rural locations are faced with many different types of challenges (Borys & Pope, 1989; Pope & Vetter, 1992; Gutheil & Gabbard, 1993, 1998; Jayaratne et al., 1997; Davidson, 2005; Pope & Keith-Spiegel, 2008; Fronck et al., 2009; Speight, 2011). Several publications have suggested that clinicians practicing in rural settings may be faced with more boundary challenges due to issues such as professional isolation and a greater likelihood for dual relationships to arise with clients.

Additionally, some authors have observed that other types of “small communities” may present difficulties with boundary decisions as well (Pope & Vetter, 1992; Pope & Keith-Spiegel, 2008; Speight, 2011). For example, psychotherapists who identify themselves as part of a particular religious community may be faced with unique boundary decisions (Pope & Vetter, 1992), as well as clinicians who are African American and living in a small community or identify as members of a lesbian, gay, or bisexual community (Speight, 2011). Demographic questions in the present study have asked participants to identify their primary practice locale (i.e. rural, suburban, or urban) and whether they are involved in clinical or advocacy work with any of several types of special interest and/or sociocultural groups.

Much of the literature also identifies practice setting as a factor that can influence boundary behavior among clinicians (Borys & Pope, 1989; Walker & Clark, 1999; Pope & Keith-Spiegel, 2008; Speight, 2011). Psychotherapists in private practice are often more isolated in terms of making boundary decisions compared to their colleagues working for agencies or in larger group practices (Borys & Pope, 1989; Jayaratne et al., 1997; Pope & Keith-Spiegel, 2008). This relative isolation and potential reduction in opportunities for collegial consultation may result in differences in the decision-making process and resulting outcomes in terms of professional boundaries. In an empirical survey of social workers' adherence to professional

standards, Jayaratne and colleagues (1997) found that private practitioners were more accepting of dual relationships with clients and less strict about financial arrangements. Fronek et al. (2009) suggest that clinicians who are part of a team practice or organization that is committed to boundary management are less likely to make difficult boundary decisions alone, and that professional isolation can be a risk factor for engaging in irresponsible or harmful boundary decisions.

In their paper advocating for the use of clinical supervision for risk management of boundary issues, Walker and Clark (1999) state, “It can be argued that a higher fiduciary duty exists for mental health professionals who serve clients in less structured settings and that the relaxation of professional roles carries with it an increased responsibility to define practice-specific ethical guidelines to protect the vulnerable client (p. 1436). According to these authors, psychotherapists practicing in “less structured settings” may be more at risk for making poor boundary decisions and therefore may benefit more from specific strategies to manage this potential risk.

While private practitioners, particularly those with offices in their own homes, are certainly serving clients in settings with less structure as compared to a hospital or community agency, so are those clinicians who are involved in an in-home treatment model. Several publications have noted that the “shift in the professional climate” (Gutheil & Gabbard, 1993, p. 192) that occurs with providing therapy to clients in their own homes presents a greater chance for boundary crossings—both harmful and beneficial—to become part of the treatment (Pope & Vetter, 1992; Gutheil & Gabbard, 1993; Walker & Clark, 1999; Peternelj-Taylor & Yonge, 2003; Reamer, 2003; Speight, 2011). To address influential environmental factors, participants in the present study were asked to indicate their primary practice location (e.g. office space inside

home, office space outside home, community agency, etc.) and were asked to estimate the percentage of their caseload that they see in private practice, if applicable.

**Characteristics of the therapist:** Previous research has identified several characteristics of psychotherapists themselves that may affect their opinions and behaviors when it comes to constructing and maintaining clinical boundaries. Several authors have stated that the gender of the therapist is likely to influence opinions and experiences with boundary decisions, (Davidson, 2005; Miller et al., 2006; Pope & Keith-Spiegel, 2008), and some writers have found empirical differences in actual boundary crossing behavior depending on the gender identification of the therapist (Borys & Pope, 1989; Jayaratne et al., 1997). Both of these studies found that male therapists were significantly more likely to engage in several boundary crossing behaviors with clients, and to believe that doing so was more ethical than did female therapists. Participants in the present study were asked to identify their gender in order to explore any differences across gender identifications.

Much of the literature also notes that the cultural background of the clinician may have a significant affect on their construction of boundaries with clients (Gutheil & Gabbard, 1993; Davidson, 2005; Miller et al., 2006; Pope & Keith-Spiegel, 2008; Speight, 2011). Despite the seemingly widespread acknowledgement that the clinician's race and ethnicity impact clinical boundaries, Miller and colleagues (2006) point out that unfortunately, these aspects of psychotherapists' cultural background are typically not considered in “traditional” notions of boundaries. Speight (2011) suggests that clinicians of color may be less inclined than white clinicians to adhere to strict clinical boundaries, as communities of color are more likely to perceive traditional therapeutic boundaries as lacking genuineness or depriving the therapeutic alliance of a sense of solidarity, especially in clinical work with clients of color. The present

study attempted to explore relationships between clinician's racial and ethnic backgrounds and their experiences with boundaries in clinical practice by asking participants to identify their racial/ethnic background as part of the survey.

Another factor that is thought to influence perceptions and behaviors related to boundaries has to do with clinicians' level of experience, in life and in clinical practice. Several authors refer to generational differences and years of experience as factors that might affect how clinicians view boundaries (Borys & Pope, 1989; Walker & Clark, 1999; Miller & Maier, 2002; Davidson, 2005; Miller et al., 2006; Fronek et al., 2009; Speight, 2011), but there is disagreement about what this relationship is. While some authors believe that inexperience makes psychotherapists more vulnerable to close boundaries and therefore puts them at risk for making irresponsible boundary decisions, others feel that experience has led to greater comfort with closer clinical boundaries, and view this as a positive characteristic of the therapeutic alliance.

In her discussion of boundaries and cultural solidarity, Speight (2011) stated that her boundaries became closer than what she was taught they “should” be in graduate school as she gained more experience with the ways her own culture informed her construction of boundaries with clients, stating, “The boundaries I established with my clients were qualitatively different from the boundaries I was taught to maintain in graduate school” (p. 141). Speight described her closer and more flexible boundaries as an improvement in her clinical work over time, which she concluded has helped foster a more genuine relational component within her treatment relationships.

Empirically, Borys and Pope's (1989) national survey found that more experienced psychotherapists perceived dual professional roles as significantly more ethical than respondents

with less experience, suggesting that more inexperienced clinicians may maintain a stricter view of ethics regarding this particular type of boundary transgression. These researchers did not discuss the specific implications of this finding, but did make recommendations that more resources be available to clinicians throughout their careers as “help to increase sensitivity to those dual relationships that are unethical and potentially harmful” (p. 291). They stressed that although not all dual relationships lead to harmful repercussions, clinicians who are less mindful of the ethics of crossing this boundary may be at a greater risk for negatively impacting the treatment relationship. The present study aimed to continue to investigate whether there were any differences in opinions and experiences related to boundary dilemmas as a function of years of clinical experience.

In addition to identifying gender, race, and experience as factors, some of the literature suggests that there may be differences in conceptualization of appropriate boundaries among different disciplines (Borys & Pope, 1989; Pope & Keith-Spiegel, 2008). One national survey of boundary dilemmas involving dual relationships found significant differences in how psychologists, psychiatrists, and social workers rated the ethics of certain boundary behaviors as well as their ratings of how frequently they engaged in those behaviors (Borys & Pope, 1989). To reduce social desirability bias, these researchers distributed two versions of the survey, one that inquired about participants' ethical viewpoints and one that asked inquired about their actual behaviors. No participant answered both versions of the survey to ensure that their responses to one would influence their responses to the other. This research was relatively unique in that it compared responses across disciplines, whereas most previous research has concentrated on participants from only one profession. Consequently, not much data exists regarding whether different clinical professionals perceive boundaries differently or respond differently when



boundary dilemmas arise. By including six different professional disciplines in the present study, there was a potential opportunity to analyze responses for differences across some of these professions.

**Characteristics of the client:** As part of ethical and practical decision-making, clinicians exercise their clinical judgement by considering how clients with different characteristics will respond to particular interventions. This consideration is the same for boundaries. Some psychotherapists may utilize certain boundary crossing behaviors as direct and intentional interventions, while in other situations, boundaries may simply serve to provide structure and predictability to the therapeutic relationship. While some clients may require or tolerate closer boundaries, others may challenge established limits or benefit more from stricter boundaries. Characteristics of clients that may be taken into consideration when making boundary decisions include demographic, diagnostic, interpersonal, and circumstantial factors.

Among demographic characteristics of clients that have been found to influence boundary decisions are the client's socioeconomic status (Pope & Vetter, 1992; Walker & Clark, 1999; Pope & Keith-Spiegel, 2008), gender (Borys & Pope, 1989; Pope & Keith-Spiegel, 2008), race and ethnicity (Jayaratne et al., 1997; Gutheil & Gabbard, 1998; Walker & Clark, 1999; Reamer, 2003; Davidson, 2005; Brown & Trangsrud, 2008; Pope & Keith-Spiegel, 2008; Speight, 2011) and age (Gutheil & Gabbard, 1998; Brown & Trangsrud, 2008; Pope & Keith-Spiegel, 2008). For example, Brown and Trangsrud (2008) pointed out that giving and receiving gifts tends to be more common and accepted in work with children and with clients from certain cultural backgrounds. In this study, participants were asked to identify which of these characteristics of their clients may have influenced their decision-making in terms of boundary crossings. Also explored in this regard were the client's religion and sexual orientation.

Decisions about boundary crossings are also likely to be influenced by a therapist's clinical judgment of the client's functioning. Several authors have referred to clients' baseline acuity as a factor that may influence decision-making (Walker & Clark, 1999; Miller & Maier, 2002; Reamer, 2003; Brown & Trangsrud, 2008; Speight, 2011). Additionally, Pope & Keith-Spiegel (2008) note that boundaries may be more difficult to maintain with a client who is in the midst of a crisis situation. This can be differentiated from clients who chronically experience difficulty accessing coping skills in stressful times.

Peternelj-Taylor and Yonge (2003) note that boundary maintenance can be challenging in work with “severely traumatized and needy [sic] clients, who consistently whittle away at the therapeutic boundaries set by the therapist” (p. 58). These authors caution that psychotherapists may be more vulnerable to boundary violations when working with this challenging population. Several authors have noted that the difficulty of boundary maintenance can be magnified when working with clients with character pathology (Gutheil & Gabbard, 1993; Walker & Clark, 1999; Miller & Maier, 2002; Pope & Keith-Spiegel, 2008).

**Characteristics of the treatment relationship:** The last group of factors that have been identified as influential to the construction and maintenance of boundaries in clinical practice include characteristics of the treatment relationship, therapist-client dyad, or therapeutic alliance. This may include combinations of client and therapist characteristics that may interact to render a particular boundary crossing more helpful or more harmful to treatment. For example, Speight (2011) posits that certain African American clinicians, such as herself, may feel that certain boundary crossings are more necessary or helpful to treatment when they occur in treatment with a African American clients and are decisions that are made through the lens of cultural solidarity. Some clinicians, such as Speight, believe that clinical boundaries may be constructed differently

based on the demographic characteristics of those involved in the treatment relationships, particularly traits that therapists and clients have in common with one another.

While some boundary crossings, especially those related to cultural solidarity, can enrich therapy, Walker and Clark (1999) caution that other types of boundary crossings related to identification with the client can place clinicians at risk if not fully considered. These authors warn psychotherapists that “over-identifying” with clients or perceiving that there is a “unique relationship” that warrants a particular boundary crossing may signify countertransference issues that could allow harmful boundary crossings to occur if not examined.

In addition to cultural and countertransference issues, many authors indicate that the length of time a therapist and client are in treatment together and the stage of therapy may influence boundary decisions (Pope & Vetter, 1992; Gutheil & Gabbard, 1993, 1998; Peternelj-Taylor & Yonge, 2003; Reamer, 2003; Pope & Keith-Spiegel, 2008; Speight, 2011). In their discussion of changes in self-disclosure toward the end of the treatment relationship, Gutheil and Gabbard (1993) state the following:

While it may be technically correct for a therapist to become more spontaneous at the end of the therapeutic process, therapists who become more self-disclosing as the therapy ends must be sure that their reasons for doing so are not related to their own unfulfilled needs in their private lives but, rather, are based on an objective assessment that increased focus on the real relationship is useful for the patient in the termination process. (p. 194)

Although the present study intentionally excluded self-disclosure as a boundary crossing, participants were asked to indicate whether they believe the length of time a client has been in treatment with them has any influence over particular boundary crossing decisions. To address possible countertransference or identification issues, participants we also asked whether their

decisions have been influenced by something they had in common with the client or a perceived strong bond, connection, or investment with the client.

Lastly, in terms of the “real relationship,” Gutheil and Gabbard (1993) also mentioned social convention and manners as a factor that might influence certain behaviors that may be considered boundary crossings. Participants in the present study were given the option to indicate whether any of their boundary decisions were influenced by thinking that it would have been counterproductive or impolite to not engage in a particular boundary-related behavior.

### **Resources to Help Clinicians With Boundary Dilemmas, and Barriers to Resource Utilization**

Although there is disagreement among clinicians and authors regarding the definitions of boundaries and boundary crossings, particularly whether certain types of crossings are enriching or harmful to therapy, there is general agreement that boundaries are an issue with which clinicians struggle. The fact that there is so much disagreement on this topic may signify that psychotherapists need additional assistance with these complex and difficult decisions. Based on the mixed results of their survey of social workers, Jayaratne and colleagues (1997) expressed concern that “practitioners are losing sight of important principles and thus need more specific guidelines to direct behavior. Without further clarification to resolve ambiguity and confusion, professionals clients, and the professional itself are in jeopardy” (p. 196). To help address this problem, these authors specifically called for additional assistance from NASW in defining professional standards of practice related to boundaries in clinical practice. While a clearer Code of Ethics could surely be helpful to clinicians struggling with boundary dilemmas, having guidelines to follow is not the only way for clinicians to obtain help with these difficult decisions. The literature has identified several ways for psychotherapists to access help with

boundary decisions, from face-to-face consultation to codes and policies outlining best practice. The following assessment of resources also addresses areas that need improvement and barriers that clinicians may experience in accessing these resources.

**Education and training:** The first type of resource that may be available to practitioners could be considered proactive or preventative. This includes any education provided to psychotherapy trainees in their graduate, doctoral, or medical programs that addresses the issue of boundaries in clinical practice. While some practitioners may receive adequate preparation for approaching boundary issues during their educational training, most of the literature seems to agree that there is a troublesome lack of focus on boundaries available to clinicians before they enter the field (Borys & Pope, 1989; Vamos, 2001; Peternelj-Taylor & Yonge, 2003; Davidson, 2005; Brown & Trangsrud, 2008; Speight, 2011). Several authors express concern that there is very little education about boundaries presented during graduate programs (Vamos, 2001; Brown & Trangsrud, 2008; Fronek et al., 2009). In fact, some programs that train psychotherapists in practice do not include any curriculum directly addressing this topic (Vamos, 2001; Fronek et al., 2009). Regarding boundaries in social work education, Davidson (2005) states:

If social work educators have not effectively prepared students to think and act judiciously, they have done a great disservice to clients, practitioners, and the social work profession. This places educators in a considerable position, responsible to guiding students to consider deeply the intricacies of their professional relationship boundaries.

(p. 513)

This dearth of adequate training is seen across fields of practice. Vamos (2001) points out that with increased focus on the medical model and research, the field of psychiatry is seeing a “reduction in emphasis on training and experience in psychotherapy” (p. 616). According to

Vamos, this could detrimentally result in the importance of self-awareness being overlooked, leading to an overall decrease in the ability to self-monitor and manage countertransference for its potential impacts on practice. Likewise, Davidson (2005) deduces that critical thinking skills, self-awareness, and prevention strategies are “challenging competencies to teach effectively, and the occurrences of boundary violations in social work practice may indicate that social work ethics education is not yet adequately meeting the challenge” (p. 525).

Several authors suggest that ethics education need not stop at the classroom and advocate for continuing educational courses and trainings for students and practicing clinicians alike that focus specifically on boundary issues that arise in clinical practice (Borys & Pope, 1989; Peternelj-Taylor & Yonge, 2003; Fronek et al., 2009; Speight, 2011). Vamos (2001), Davidson (2005), and Fronek et al. (2009) have all developed training courses that focus on boundaries and have been carried out successfully with psychotherapists and psychotherapy trainees from multiple disciplines.

It has also been suggested that clinicians educate themselves by consulting the existing research and literature on boundary crossings and violations (Borys & Pope, 1989; Reamer, 2003; Pope & Keith-Spiegel, 2008), but that they not passively accept opinions and findings of others without seeking out additional resources and considering contextual factors on a case-by-case basis. The present study asked participants about their experiences with receiving education regarding boundaries, including in their graduate or post-graduate curriculum and/or as part of optional or mandatory continuing education trainings.

**Codes and policies:** In addition to direct training, practitioners must have codes and guidelines informing their day-to-day practice. These can come in two forms: Codes of Ethics promulgated by professional associations such as NASW, and policies outlined by agencies or

institutions that employ psychotherapists. Several authors refer to professional Codes of Ethics as ways for clinicians to guide their practice (Borys & Pope, 1989; Pope & Vetter, 1992; Jayaratne et al., 1997; Reamer, 2003; Davidson, 2005; Brown & Trangsrud, 2008; Pope & Keith-Spiegel, 2008), but most of these authors caution that adherence to these Codes is not enough to ensure ethical practice regarding boundary decisions:

Awareness of ethical codes and legal standards is an essential aspect of critical thinking about ethics and of making ethical decisions. Codes and standards, however, inform rather than determine our ethical decisions. They...cannot protect us from ethical struggles and uncertainty. (Pope & Keith-Spiegel, 2008, p. 640)

There seems to be agreement that due to all the contextual factors influencing each potential boundary dilemma, professional Codes of Ethics cannot possibly be specific or complex enough to guide each decision that arises. Therefore, many authors advocate for the use of Codes and standards to guide practice, while additionally addressing each decision or dilemma on a case-by-case basis that takes all factors into consideration. Davidson (2005) notes:

Because the parameters of these [treatment] relationships are greatly influenced by their context, we would balk at the notion of attempting to create a rule bound document that could effectively capture all the many contextual nuances and specifically define the behavioral expectations of every professional relationship. In addition to the impossibility of this task, such a document would essentially be the antithesis of the use of professional judgment. (p. 512)

With this considered, several authors have argued that Codes offered by the APA, NASW, and American Counseling Association are too vague regarding professional boundaries and need

improvement, especially related to cultural considerations impacting these decisions (Pope & Vetter, 1992; Jayaratne et al., 1997; Brown & Trangsrud, 2008).

While not all-encompassing, agency-specific tools and policies may provide slightly more specific guides for ethical practice than professional Codes (Borys & Pope, 1989; Walker & Clark, 1999; Peternelj-Taylor & Yonge, 2003; Fronek et al., 2009). Walker and Clark (1999) propose that “the complexities of the practice environment suggest that program directors might need to develop ethical guidelines adjusted to local culture, program aims, and the capabilities of providers (p. 1436). Despite the potential usefulness of such a practice,

the development of professional boundary policies is not a commonplace practice and organizations tend to rely on Codes of Ethics developed by organizations and professional groups. Codes of Ethics are important and integral to boundary management, however, they do not necessarily provide clear directions for practitioners in many situations. ...Therefore additional guidelines may be needed for organizations in addition to skills that help practitioners negotiate complex and multilayered relationships. (Fronek et al., 2009, p. 165-6)

The present study sought to explore how many of the participants have been employed at agencies that have policies regarding boundary management with outpatient clients, and how helpful they perceive such policies to be. Participants were also asked if they had ever consulted their professional Code of Ethics for help with a boundary dilemma and how helpful they believe Codes of Ethics to be in resolving potential boundary issues.

**Supervision and consultation:** While education and guidelines may provide background, preventative strategies, or general guides for how to approach boundary dilemmas, face-to-face consultation on the specifics of a case with another professional in the field is often



recommended. However, many barriers, particularly fear of judgement, have been noted to serve as barriers to psychotherapists discussing their cases with supervisors and colleagues. These barriers and some methods for seeking consultation despite them are discussed below.

Supervision can be considered the best tool for managing risk while including all of the complexities of a case in the decision-making process, and it is recommended throughout the boundary literature as one of the primary resources for clinicians with boundary dilemmas (Borys & Pope, 1989; Walker & Clark, 1999; Vamos, 2001; Miller & Maier, 2002; Peternelj-Taylor & Yonge, 2003; Reamer, 2003; Brown & Trangsrud, 2008; Fronck et al., 2009; Speight, 2011). In their discussion of supervision as a resource for risk management and ethical practice, Walker and Clark (1999) assert that supervision can provide clinicians with a great deal of support and guidance by following four principles: it must be 1) proactive rather than reactive, 2) sensitive to the supervisee's personal situation, 3) attentive to the details and complexities of the supervisee's cases, and 4) exploratory and “Socratic” rather than directive and investigative.

Many authors have acknowledged that clinicians can have difficulty feeling comfortable enough to approach supervisors with boundary issues, due to fear being judged and the power dynamics that typically exist in the supervisory relationship (Borys & Pope, 1989; Miller & Maier, 2002; Pope & Keith-Spiegel, 2008; Fronck et al., 2009). Concern about being reprimanded for boundary behavior that may be judged as inappropriate or harmful can and does inhibit clinicians from obtaining potentially helpful supervision.

The fact that the topics that clinicians are most reluctant to speak about in supervision are often the very topics that need to be discussed in order to prevent boundary crossings from adversely impacting the therapy or developing into violations (Walker & Clark, 1999; Pope & Keith-Spiegel, 2008). Pope and Keith-Spiegel (2008) caution that:

Reluctance to let others know about a potential or actual crossing or to mention it in supervision, peer consultation, or our records may be a red flag that the crossing could benefit from open exploration with a colleague who does not have a direct interest in the outcome. (p. 647)

In addition to psychotherapists' and trainees' reluctance to seek assistance addressing boundary concerns, Fronek and colleagues (2009) note that supervisors and administrators often play a large role in maintaining the status quo of failing to welcome supervision around these issues. These authors refer to a common “lack of managerial acknowledgement of the extent of boundary blurring and violations that does occur in the practice setting” (p. 165). Resistance to recognizing and addressing boundary issues from those with power and authority within an agency or organization can be a large barrier that inhibits supervisees from accessing the help they need. Trainees and less experienced psychotherapists are often those who have the greatest access to supervision to discuss these issues, but supervisors and managers too are in need of support from program directors and leaders within agencies around acknowledging and resolving boundary issues (Miller & Maier, 2002).

In recognizing the usefulness of consultation along with widespread reluctance to seek such consultation within the confines of traditional supervision, several suggestions are offered. For example, Peternelj-Taylor & Yonge (2003) suggest that “for supervision to be truly effective, it should be undertaken by someone other than one's direct supervisor, for the power differential that exists automatically places the nurse [or other psychotherapist] in a position of vulnerability” (p. 63). Consultation with colleagues other than one's supervisor can be less intimidating and just as useful (Miller & Maier, 2002; Peternelj-Taylor & Yonge, 2003; Reamer, 2003; Pope & Keith-Spiegel, 2008; Fronek et al., 2009; Speight, 2011). Fronek and colleagues

(2009) observed that social workers are more likely to seek consultation from a member of an interdisciplinary team than from a direct supervisor when faced with an ethical dilemma.

Whether it occurs through direct supervision or consultation with peers in the field, “there must be a space for therapists to discuss their boundary locations and boundary crossing without fear of being judged as sliding down that dreadful 'slippery slope’” (Speight, 2011, p. 153). The present study explored participants' experiences, or lack thereof, of consulting with colleagues and supervisors regarding boundary dilemmas. It also inquired about the perceived helpfulness of each method and clinician's opinions of barriers that may inhibit them from utilizing these and other resources for help with boundary management.

**Barriers to awareness:** Before clinicians can seek out resources to help them work through difficult boundary decisions, there needs to be an awareness that additional help is needed. A problem often occurs at the stage of self-awareness, that is, clinicians do not realize that they could benefit from help with their decision-making (Gutheil & Gabbard, 1993; Peternelj-Taylor & Yonge, 2003; Pope & Keith-Spiegel, 2008; Fronek et al., 2009). While the literature makes it is clear that ongoing awareness about boundaries in clinical practice is warranted, it also states that clinicians are often incognizant of (Peternelj-Taylor & Yonge, 2003) or reluctant to examine (Pope & Keith-Spiegel, 1989; Walker & Clark, 1999) their own behavior in relation to professional boundaries. “Many practitioners are unaware of what constitutes many boundary dilemmas, how to address them and how their own interactions resolve or compound dilemmas” (Fronek et al., 2009, p. 163) Unfortunately, at present there exists “limited availability of training and support to help practitioners deal with these issues” (p. 163). Clinicians need to have ways of increasing awareness and receiving reinforcement and clinical consultation to clarify boundary expectations and help them to work through dilemmas that arise.

One possible barrier to help seeking and utilization is that clinicians may believe that they should not require help with these decisions. In their influential publication on boundaries in clinical practice Gutheil and Gabbard (1993) explain that “Clinicians tend to feel that they understand the concept of boundaries instinctively, but using it in practice or explaining it to others is often challenging” (p. 188). It is quite possible that psychotherapists are indirectly taught—by the very nonexistence of educational resources and other tools to help with such dilemmas—that they intuitively have the skills to manage boundary dilemmas. In advocating for post-graduate training and continuing education on professional boundary maintenance, Fronek and colleagues (2009) point out:

there is little ongoing training that assists them [practitioners] in the management of complex, ambiguous, and potentially harmful situations. This absence of training and education initiatives in practice settings may lead to assumptions that practitioners and managers have the skills to deal with boundary issues in practice. (p. 162)

In addition to receiving messages and perhaps believing that boundary management is an intuitive process, many clinicians also build the cognitive defense of separating themselves from colleagues who may make poor boundary decisions. This tendency for therapists to create imaginary distance between themselves and “those colleagues who violate boundaries” puts them at greater risk for making harmful boundary decisions because it leads to the conclusion that awareness is not necessary (Peternelj-Taylor & Yonge, 2003). A common theme throughout the literature on boundaries illustrates that no psychotherapist is infallible or immune from misstepping a boundary (Vamos, 2001; Peternelj-Taylor & Yonge, 2003; Davidson, 2005; Pope & Keith-Spiegel, 2008). These authors agree that no matter what the circumstance, every

psychotherapist must maintain self-awareness of his or her boundaries within clinical relationships.

In addition to these cognitive mechanisms, the manner in which the concept of boundaries is presented to many psychotherapists may contribute to a reluctance maintain self-awareness and seek assistance with decisions when necessary. Although many boundary crossings can be helpful and enriching to the therapeutic process and do not lead to harmful violations or sexual transgressions, many clinicians are trained to beware of all boundary crossing behaviors in order to avoid the “slippery slope.”

Thus, we are left with a picture where clear boundaries are critical to effective therapy and the altering of boundaries is to be avoided because of the real danger of client exploitation. ...Rarely are boundary crossings discussed as beneficial, therapeutic, or positive events within therapeutic relationships. (Speight, 2011, p. 137)

This can result in fearful and overly-reserved practice that ultimately is harmful to the client or inhibits therapeutic progress from occurring. Without resources to explore boundary crossings in their own practice, psychotherapists are limited in ways to explore when boundary crossings *are* appropriate and can be enriching to therapy.

Most authors agreed that locating and maintaining balanced boundaries are challenging work. Clinicians' could benefit from additional assistance in making these decisions, but first must identify when assistance is necessary.

In conducting a needs assessment for healthcare practitioners regarding boundary issues, Fronck and colleagues (2009) identified several barriers to self-awareness and utilization of resources that tend to lead to boundary breaches:

These included the lack of local policy; poor communication and clarity regarding organizational expectations; relative practitioner inexperience; heterogeneity of educational backgrounds and previous training in professional boundaries; a historical culture that enabled boundary crossings; and the limited availability of training and support to help practitioners with these issues. (p. 162)

Although the main goal of Fronek et al.'s (2009) research was to create and evaluate a one-day interdisciplinary workshop that focused on boundary dilemmas and how to resolve them, the authors advocate for a “multi-level framework” to address boundary issues in the workplace. This includes professional Codes of Ethics and agency policies to guide practice, education about boundaries that is proactive and continues throughout clinicians' careers, and availability of supervision or collegial consultation related to boundary dilemmas that arise in practice. Fronek et al. (2009) state that in combination with one another, multiple resources can cultivate the necessary culture of openness around critical reflective practice and ethical decision-making when it comes to boundary issues.

The present study sought perspectives of clinicians themselves related to the types of resources in which they have participated, the resources they perceive to be the most helpful in resolving boundary dilemmas, and their opinions of the barriers that make access to these resources challenging for clinicians.

### **The Present Study**

Opportunities to cross boundaries are a part of psychotherapy that regularly present challenges for clinicians across disciplines. This purpose of this research study was to explore the decisions that psychotherapists are making regarding boundaries with their outpatient clients, with particular attention to gray areas in which the most beneficial decisions are not clear. Given

the significance of context, a description of the factors that influence these clinician's boundary decisions was also explored.

The results of the study will provide a description of clinicians' boundary-crossing experiences in the field and the factors that they view as influential to their decision-making. The data will also provide first-hand insight into the types of resources that therapists believe should be provided in order to increase and maintain awareness of boundaries in everyday psychotherapy practice.

The following chapter will discuss the specifics of the study's methodology.

## **CHAPTER III**

### **Methodology**

#### **Study Purpose and Research Questions**

This study investigated psychotherapists' opinions and experiences regarding difficult boundary decisions they have made in outpatient practice. The research focused on behavior that has been classified as boundary-crossing behavior, which is distinguished from boundary-violating behavior (such as sexual transgressions), in that boundary crossings are not necessarily harmful to the client. The study was conducted through a quantitative questionnaire administered to practicing clinicians via the internet.

The following four research questions were explored: 1) What kinds of potentially boundary-crossing decisions cause clinicians the most difficulty in their outpatient practice? 2) Which contextual factors influence clinicians' decisions about how to resolve boundary dilemmas that arise? 3) What types of resources have clinicians' utilized in the past, and what would they find helpful in the future, for assisting them with difficult boundary decisions? 4) Do any demographic characteristics of the clinicians in the sample correlate with their reported behaviors, decisions, and opinions? Please see Appendix E for the full questionnaire.

#### **Sampling**

The sample recruited for the study consisted of clinicians with a Master's degree, Doctorate degree, or MD who have received graduate or postgraduate training to practice psychotherapy. Participants were required to treat at least part of their clinical caseload on an



outpatient basis. Clinicians were eligible to participate if they identified as practicing Clinical Social Workers, Psychologists, Marriage and Family Therapists, Psychiatrists, Mental Health Counselors, or Psychiatric Specialists. Due to the location and professional network of the researcher, it is likely that clinicians who participated in this study reside in the Northeastern region of the United States, particularly Rhode Island, Connecticut, and Massachusetts; but the electronic nature of the survey allowed for it to be accessed by psychotherapists residing in any geographical region of the country.

A nonprobability sampling technique was used to recruit participants for the study, resulting in a convenience sample consisting of 46 outpatient psychotherapists. Due to the method of sample selection and relatively small sample size, the sample was not expected to be representative of the greater population of psychotherapists in the United States, nor was it intended to equally represent all disciplines that practice psychotherapy. It is unlikely that psychotherapists from regions other than the Northeastern United States, and those from rural communities were as likely to be represented.

Another factor that may have influenced the sample self-selection is the fact that the study was administered via the internet. Although electronic surveys are more likely to be accessed by individuals with regular internet access, implying that participants may be of a higher socioeconomic bracket than the general population, because participants were professional therapists with at least a Master's degree, they likely had attained a relatively high socioeconomic status. Therefore, the electronic nature of this particular study was not considered to be a limiting factor in terms of socioeconomic status of participants.

Additionally, it is possible that younger psychotherapists may have been more likely to respond to a survey that is administered electronically and anonymously, while older generations

of clinicians might prefer to answer a survey sent through the mail or administered in person. Therefore, it was anticipated that due to the method of administration, respondents may have comprised a younger and perhaps less experienced strata of therapists overall. As it turned out, although participants were not asked their age, they reported an average of 11 years of psychotherapy experience.

Recruitment of participants occurred via the internet primarily through an email that described the study, invited readers to participate if eligible or forward to potential participants if ineligible, and provided a hyperlink to the website that contained the questionnaire (surveymonkey.com). This recruitment letter was drafted in three versions, as recruitment involved reaching out to three different groups of individuals.

First, social services staff at the researcher's clinical internship placement, a private psychiatric hospital, were asked to participate and/or pass on the letter to colleagues after a brief presentation by the researcher at an agency meeting. Written permission was obtained from the hospital for recruitment of staff. Following the presentation, all staff members in the department received a recruitment letter via email (See Appendix H). The same email was sent to all social services staff, and none of the staff was asked to indicate interest in participating in the study. It was made clear during the initial presentation and recruitment letter that participation in the study was completely anonymous, that is, that the researcher would have no way of knowing whether hospital staff participated in the study or passed on the recruitment letter to colleagues.

The second group that was recruited consisted of clinicians in the community, who were reached via a snowball method of emails. The original recruitment letter was sent to a number of the researcher's classmates and colleagues to ask for their participation if eligible, and to also forward the letter to colleagues who may fit inclusion criteria (See Appendix F).

The final group of clinicians recruited for the study were local outpatient clinicians who had previously provided their professional email address to a public-access electronic database of psychotherapists. The online directories that were consulted for this stage of recruitment included [www.theravive.com](http://www.theravive.com) and [www.networktherapy.com](http://www.networktherapy.com). This stage of recruitment began two weeks after the first stage of recruitment began, as the desired sample size was not obtained through the first two groups of emails. At this time, a third modified version of the recruitment letter was sent to therapists in the community (See Appendix G).

Due to the anonymous nature of the survey and the snowball sampling method, it was difficult to control for diversity of the sample. However, in the final round of sampling that consisted of reaching out to community therapists, many of whom had publicly specified certain demographic characteristics about themselves on the internet, deliberate efforts were made to recruit potential participants from diverse sociocultural and practice backgrounds. Outreach at this later phase of recruitment focused more deliberately on contacting clinicians of color and clinicians with diverse gender identifications, degree levels, and professional backgrounds. However, as this was an exploratory study and emphasis was placed on obtaining a sufficient sample size, there was less of an opportunity to focus on obtaining a diverse participant pool than was desired.

### **Ethical Considerations**

Participating in this study posed a low risk to participants. However, because participants were asked in part to reflect on their own boundary behaviors with clients, it is possible that participation in the study may have caused them some uncomfortable feelings. Participants were made aware of this risk during the Informed Consent process. Potential participants were also informed prior to beginning the questionnaire that although all responses would be anonymous

and kept confidential, they had the right to refuse to answer any question on the survey without repercussions, and could exit the survey at any time (see Appendix C for Informed Consent Form).

Additionally, the researcher anticipated that if participants used their clients' names or other identifying information about clients, this information would be treated confidentially and immediately deleted. Participants were informed of this during the Consent process. As it turned out, no participants provided any identifying information about their clients, so there was nothing to delete in this regard.

Participation in the study provided participants a unique experience to reflect upon the concept of boundaries in psychotherapeutic practice, including some of their own clinical decisions. Clinicians may have benefited from participating in the survey by using it to examine and evaluate their own practice in terms of the boundaries they construct with their outpatient clients. Participants may have also benefited from the opportunity to think about the types of resources that they might personally find helpful in terms of making difficult boundary decisions. Lastly, participants' responses contribute to the development of knowledge about boundaries in clinical work. Unfortunately, no tangible benefit was able to be offered to participants in this study.

### **Data Collection Methods**

Each study participant anonymously responded to a quantitative, self-administered, internet-based questionnaire developed exclusively for the purpose of the present study. The questionnaire was dispersed electronically through Survey Monkey ([surveymonkey.com](https://www.surveymonkey.com)), an online resource that facilitates questionnaire distribution and provides anonymity to users.

When potential participants clicked the hyperlink on the recruitment email they received, they were directed to the Boundaries in Outpatient Clinical Practice survey on surveymonkey.com (see Appendix E for full Questionnaire). Upon arriving at the webpage, individuals were prompted to answer three screening questions assuring that they met inclusion criteria, that is, that they were currently practicing outpatient psychotherapy in the United States, had received graduate or postgraduate training to do so, and belonged to one of six identified professional disciplines (see Appendix B for Screening Questions). Clinicians who answered “Yes” to each of these questions were then directed to the Informed Consent form and were required to agree to its terms and conditions by selecting “I agree.” If potential participants answered “No” to any of the screening questions or declined to provide informed consent, they were thanked for their interest, and directed away from the survey (see Appendix D for Disqualification Page). Participants who completed this initial process affirmatively were granted access to the questionnaire.

The first series of questions on the survey gathered demographic information from participants. These multiple-choice and open-ended questions asked participants to identify their professional discipline; degrees, certifications, and licenses; years of psychotherapy practice; racial/ethnic identification; gender identification; percentage of caseload seen in private practice; primary geographic practice locale; primary type of outpatient practice setting; and whether they are involved with clinical or advocacy work with any particular special interest or sociocultural group (e.g. community of color, school community).

After providing demographic information, participants were briefly reintroduced to the nature and purpose of the study. They then completed the main part of the survey in which they responded a series of questions regarding their experience with and opinions about boundary

decisions in outpatient clinical practice and resources that may help with potential boundary dilemmas.

In the first set of questions following collection of demographic data, participants were asked to review three categorized lists of boundary-related decisions and rate each decision on a 4-point Likert-type scale based on the amount of difficulty they believe each potential situation can cause for outpatient clinicians. The behaviors were listed in three categories: During Sessions, Communication Between Sessions, and Social Interactions; and each category included between six and nine items. Participants were asked to rate each item, but were permitted to skip any item throughout the course of the entire survey if they preferred not to answer.

In the next section of the survey, participants were asked to review each of the three categorized lists again. From each category, participants were asked to choose the one boundary decision from each list with which they have personally experienced the most difficulty. Then they answered additional questions about the decisions that they selected from each category. First, they were asked to choose all applicable contextual factors from a list of possible contextual factors (such as the client's age, lack of social supports, or duration of the treatment relationship) that have influenced their decision-making. This procedure was followed for all three categories.

Following these answers under each category, participants were also asked to respond to an open-ended question asking them to think of a time they were faced with the decision indicated and elaborate on their decision-making process and/or the outcome.

Lastly, for each selected item in each of the three categories, clinicians were asked to approximate about how frequently they have decided to engage in the indicated behavior.

The final portion of the questionnaire focused on participants thoughts about resources that have been or could be helpful to clinicians faced with potential boundary dilemmas. In this section, participants were first asked to review a list of resources that they may find helpful in assisting with boundary decisions. They were asked to indicate which resources they have consulted in the past, discuss barriers they have experienced to accessing and utilizing such resources, and rate each item on a 4-point Likert-type scale for how helpful they believe each resource could be if all were made available to clinicians.

The entire survey was expected to take between ten and twenty minutes to complete, depending on the time participants spent thinking about and responding to open-ended questions.

### **Data Analysis**

All survey data gathered through the multiple-choice and open-ended questions in the Boundaries in Outpatient Clinical Practice Survey were securely stored on and first tabulated by Survey Monkey software. Data analysis was completed using SPSS software, with the assistance of the Smith College School for Social Work Statistical Analyst. Descriptive statistics were used to analyze the demographic data. To ensure anonymity of participants, demographic data was coded to describe the aggregate participant pool rather than being utilized to describe each individual psychotherapist who completed the survey.

Further, several bivariate analyses; including a Cronbachs alpha, oneway ANOVAs, a LSD post hoc test, Spearman rho correlations, and crosstabulations; were utilized to analyze multiple choice questions and to determine whether there were significant differences in responses by demographic groups. Survey questions were also analyzed using descriptive statistics to indicate overall frequencies of responses for each item and each categorized set of

items. Data coding and content analysis were used to analyze responses to open-ended questions, and these responses were examined for emergent themes.

If this study is used for publication or presentation, any possible identifying information about participants will be disguised. All data collected has been stored on the website surveymonkey.com, which is fire-walled, password-protected, and encrypted. All data will be stored on the website's server for three years, as required by Federal regulations, after which they will be destroyed or kept secure as long as they are needed.

The following chapter discusses the study's findings.



## **CHAPTER IV**

### **Findings**

This research study explored psychotherapists' opinions and experiences regarding difficult boundary decisions made in outpatient practice. The focus was on behavior that has been identified as boundary-crossing behavior, as distinguished from boundary-violating behavior, in that boundary crossings are not necessarily harmful to the client, and at times may be helpful. A quantitative questionnaire, posted on the website [surveymonkey.com](http://surveymonkey.com), was administered to 46 practicing clinicians.

The following research questions were addressed: 1) Which potentially boundary-crossing behaviors do clinicians experience as the most difficult in their outpatient practice? 2) Which factors influence their decisions about resolving boundary dilemmas that arise? 3) What types of resources have psychotherapists utilized in the past, and what would they find most helpful in the future, for assisting them in making decisions and maintaining awareness of their own professional boundaries? 4) Do any demographic characteristics of the clinicians in the sample correlate with their reported behaviors, decisions, and preferences?

This chapter discusses the findings of the research.

#### **Description of Participants**

The 46 participants in this study were psychotherapists with Master's or Doctorate degrees in the following clinical fields of practice: Clinical Social Work, Mental Health Counseling, Psychology, and Marriage and Family Therapy. Although therapists from Psychiatry

and Psychiatry Nursing were invited to participate, there were no volunteers from this group who completed the study. All participants were currently practicing outpatient psychotherapy in the United States.

Although 74 individuals initially responded to the questionnaire, 28 were excluded from the study for the following reasons: 7 did not meet the inclusion criteria, 5 did not provide informed consent to participate, 7 only answered demographic questions, and an additional 9 exited the survey without completing it. These 28 individuals were removed from the data set so that the validity of the findings would not be compromised. However, participants who skipped questions throughout the survey were not excluded, as long as they completed the survey.

The following sections report on participants' responses to the demographic questions.

**Professional discipline and licensure:** Clinical Social Workers represented the largest professional group (47.8%,  $n = 22$ ) in the sample. Next were Mental Health Counselors, who represented 23.9% ( $n = 11$ ), followed by Psychologists (15.2%,  $n = 7$ ) and Marriage and Family Therapists (13.0%,  $n = 6$ ),

Participants were also asked to indicate their specific degrees and certifications, and indicate whether they were licensed. Various degrees and certifications were reported, which varied by discipline and state requirements, but all participants had acquired the appropriate degrees and certifications for their professions. Only 3 participants indicated that they were not licensed.

**Clinical experience:** Years of clinical experience reported by participants ranged from 1 to 46 years—the mean number of years was 14.28, and the median number of years in practice was 11. Almost half of all participants (45.7%,  $n = 20$ ) indicated that they had 10 years of experience or less.

Participants were split into five groups based on years of clinical experience in order to make comparisons across groups. Table 1 below illustrates the distribution of participants according to years of psychotherapy experience.

Table 1

*Clinical Experience Distribution*

| Years of Experience | Frequency | Percent |
|---------------------|-----------|---------|
| 1-5 years           | 9         | 19.6%   |
| 6-10 years          | 12        | 26.1%   |
| 11-15 years         | 8         | 17.4%   |
| 16-25 years         | 8         | 17.4%   |
| 26+ years           | 9         | 19.6%   |

**Race and ethnicity:** The largest racial/ethnic group represented was White or Caucasian (86.7%, n = 39); followed by Hispanic, Latino, or Spanish origin (6.7%, n = 3). Of the remaining participants, 1 identified as Black or African-American, 1 as Haitian-American, and 1 as Pakistan-American; and 1 did not respond to this question.

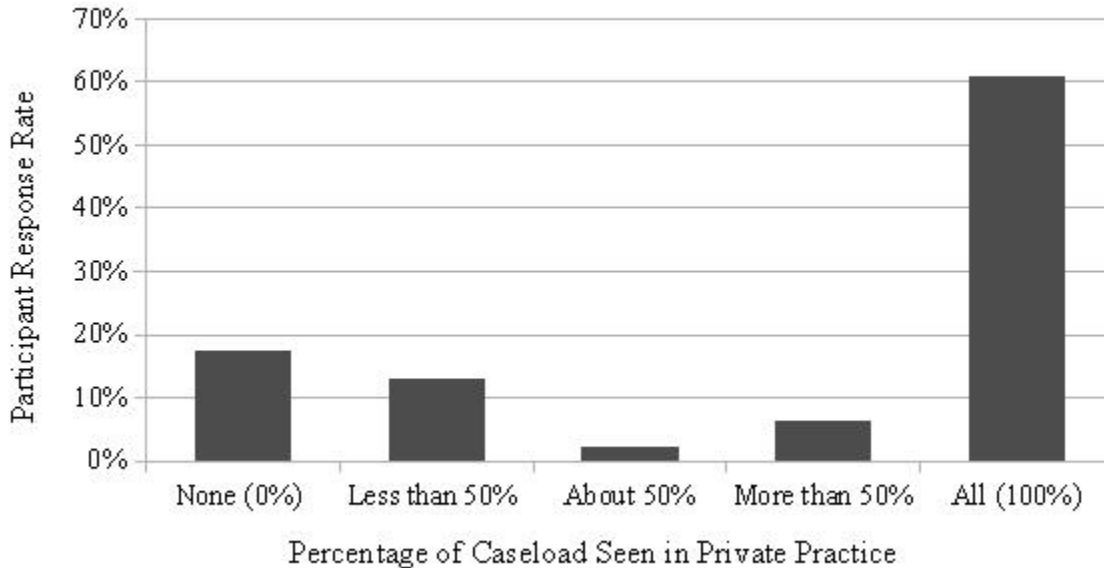
**Gender:** The majority of participants in this study identified as women (82.6%, n = 38), while 17.4% (n = 8) identified as men. No participants identified as transgender or other gender.

**Private practice:** Most participants (82.6%, n = 38) saw at least a portion of their caseload in private practice. The largest group of respondents (60.9%, n = 28) reported that 100% of their caseload was seen in private practice, which may be related to one major source of recruitment being databases containing mostly private practitioners. Only 17.4% (n = 8) of participants, reported that they were not involved in private practice at all.

The remaining 21.7% (n = 10) of the sample treated a portion of their caseload privately, but the percentage seen privately varied. Table 2 below illustrates the distribution of participants based on percentage of caseload seen in private practice.

Figure 1

*Percentage of Caseload Seen in Private Practice*



**Geographic practice locale:** Most participants had their primary practice located in either urban (43.5%, n = 20) or suburban (50%, n = 23) areas. Only 6.5% (n = 3) of participants had their primary practice in a rural environment.

**Primary practice setting:** The largest number of participants practiced primarily in rented office space outside of their homes (63.0%, n = 29). The next group, which was considerably smaller (19.6%, n = 9), practiced primarily at agencies or community mental health centers.

The remaining 17.4% of participants (n = 8) practiced in the following primary locations: 6.5% (n = 3) in an office space inside their homes; 6.5% (n = 3) in a hospital outpatient clinic; and 4.3% (n = 2) split their time evenly between two practice settings: 1 between home-based and community mental health center practice, and 1 between a home office and a rented outside

office. Only 1 clinician indicated in-home treatment as 1 of 2 primary practice settings. No respondents practiced within a school or court setting.

**Involvement with special populations:** All participants were asked to indicate whether they were involved in clinical or advocacy work with any particular special interest groups or sociocultural groups. Most participants (67.4%, n = 31) indicated that they only worked with a general population. The remaining 32.6% (n = 15) were involved with one or more special interest or sociocultural communities. Table 3 below describes the distribution of participants involved in clinical or advocacy work with special populations.

Table 2

*Involvement with Special Interest or Sociocultural Groups*

| Special Interest or Sociocultural Group   | Frequency | Percent* |
|---|-----------|----------|
| Community of Color                        | 8         | 17.4%    |
| College or School Community               | 6         | 13.0%    |
| Multilingual Community                    | 4         | 8.7%     |
| Religious Community                       | 4         | 8.7%     |
| Physically or Mentally Disabled Community | 4         | 8.7%     |
| LGBT Community                            | 3         | 6.5%     |
| Other Community**                         | 5         | 10.9%    |

\*Percent (including participants who responded “No”) totals more than 100% because participants were able to indicate more than one group or community with which they work.

\*\*Other communities included athletes, deaf and hard of hearing community, families of divorce and children's advocacy, HIV/AIDS community, and victims of crime.

### Survey Questions

This section presents the quantitative findings and descriptive statistics for participants' responses to the survey questions. The boundary crossings included on the survey were divided

into three categories: 1) During Sessions, 2) Communication Outside of Sessions, and 3) Social Interactions. The findings for each category are presented separately.

For each boundary crossing, participants were asked to indicate the amount of difficulty they believe it can cause in their *peers' decision-making*, and then to choose the one item in each category that has been the most difficult in *their own decision-making*. Then, based on the item they chose as most difficult, they estimated how frequently they have chosen to cross that boundary in their practice.

Participants were also asked to indicate contextual factors that have influenced their decisions. Finally, participants were asked about various resources that may help with boundary management.

**Decisions made during sessions:** Participants were asked to respond to questions about each of the following 9 “during sessions” boundary crossings:

- ♣ extending session time in a non-crisis situation;
- ♣ lending a small amount of money to a client;
- ♣ allowing late payments or missed appointment fees to lapse;
- ♣ giving a client a small gift;
- ♣ incorporating slang and/or expletives into therapeutic dialogue;
- ♣ lending a book, audio recording, or other literature/media to a client;
- ♣ praying in session with a client;
- ♣ addressing a client by a familiar term such as “dear” or “man;”
- ♣ accepting a small gift from a client.

The majority of participants reported that they perceived these boundary crossings to cause either no difficulty or little difficulty *in their peers' decision-making*; their mean scores

ranged from 1 (no difficulty deciding) to 2 (little difficulty deciding), on a Likert-type scale from 1-4. Of the three categories of boundary crossings, the “during sessions” section included both the item that participants rated to be most difficult and the item that they rated to be the least difficult.

The decision that participants perceived to present the least difficulty *to their peers* was lending money to a client, which received an mean rating of 1.15 on the 1-4 scale. The decision that was perceived to present the most difficulty was allowing fees to lapse, with a mean rating of 2.00. Every other boundary crossing included on the survey was perceived to present less than “little difficulty deciding,” or a mean score of 2.

The “during sessions” item that was also rated to present the most difficulty *to the participants themselves* was allowing fees to lapse, with 31.1% (n = 14) participants choosing this item. The second most frequent response was that none of the boundary crossings listed had caused participants any difficulty in their decision-making, selected by 17.8% (n = 8) of participants. The third most frequently-chosen response was extending session time, which was selected by 13.3% (n = 6) of participants.

The boundary crossings noted as causing the least difficulty in *participants' decision-making* included lending money to a client, incorporating slang or expletives into dialogue, praying in session with a client, and addressing a client by a familiar term other than their name; each of these items was only selected by 2.2% (n = 1) of participants. One participant did not respond to this question.

Based on the in-session boundary crossing that participants indicated as most challenging in their own practice, they were asked to estimate the frequency with which they have decided to cross that boundary. Most participants (74.0%, n = 34) indicated that they crossed these

boundaries during sessions either sometimes (42.2%, n = 19) or very infrequently (37.8%, n = 17). Very few participants chose always (2.2%, n = 1) and never (2.2%, n = 1). No participants (0.0%, n = 0) responded that they crossed in-session boundaries very frequently. One participant left this question blank. Table 3, depicted below on page 59, presents the frequency distributions for all three boundary crossings categories.

**Decisions regarding communication outside of sessions:** Participants responded to questions about each of the following 6 boundary crossings that involve communication outside of sessions:

- ♣ communicating with a client through email;
- ♣ providing your personal phone number (home or cell) to a client;
- ♣ calling a client between sessions to check in;
- ♣ calling a client to remind him or her of an appointment;
- ♣ communicating with a client while you are on vacation;
- ♣ continuing communication with a client after termination, without restarting treatment.

First, participants were asked to rate the amount of difficulty they believe these boundary crossings can cause *in their peers' decision-making*. Similar to the “during sessions” boundary crossings discussed above, all items in this category received mean ratings between 1 (no difficulty deciding) and 2 (little difficulty deciding), on a Likert-type scale from 1-4. In terms of ratings of perceived difficulty, this category of boundary crossings received the smallest range of responses of all three categories.

The item perceived to cause the least amount of difficulty *for other clinicians* was providing a personal phone number, which received a mean rating of 1.28. The mean ratings on



the remaining boundary crossings ranged very narrowly from 1.43 to 1.51, with the highest-rated item being calling a client between sessions to check in ( $M = 1.51$ ).

When asked to indicate which of these boundary crossings has caused the most difficulty *in their own decision-making*, the majority of participants (37.0%,  $n = 17$ ) indicated that none of the items listed had presented them with any challenges. The next most frequently-selected were the following responses, which each received 13% ( $n = 6$ ) of the votes: these included calling a client to remind him or her of an appointment and continuing communication with a client after termination.

The responses that were selected least frequently were giving a personal phone number to clients and calling a client to check in; each were selected by only 6.5% ( $n = 3$ ) of participants. Notably, although calling a client to check in was perceived to be the most difficult decision in this category for participants' peers, it was rated as one of the least difficult decisions for the participants themselves.

When asked how often they decide to cross boundaries involving outside communication, the largest number of participants indicated that they do so very infrequently (34.9%,  $n = 15$ ), followed by never (25.6%,  $n = 11$ ) and infrequently (18.6%,  $n = 8$ ). Few participants (9.3%,  $n = 4$ ) indicated that they crossed these boundaries more often than sometimes, including frequently (4.7%,  $n = 2$ ), very frequently (0.0%,  $n = 0$ ), and always (2.3%,  $n = 1$ ). Three participants did not respond to this question. Table 3, depicted below on page 59, illustrates the frequency distribution for this question across all 3 categories of boundary crossings.

**Decisions regarding social interactions:** Participants were asked to respond to questions about each of the following 6 boundary crossings involving social interactions:

- ♣ initiating a greeting with a client in a public place;

- ⤴ recommending services for a client that are outside of the mental health field;
- ⤴ asking a client for advice in his her her field of expertise;
- ⤴ accepting an invitation to a meaningful event in a client's life;
- ⤴ transporting a client in your personal vehicle;
- ⤴ communicating with a client via a networking website, such as LinkedIn or facebook.

As in the first two categories of boundary crossings, the “social interactions” items were, on average, all perceived to cause between no difficulty and little difficulty *to peers*. On a Likert-type scale from 1-4, all items in this category received mean ratings between 1 (no difficulty deciding) and 2 (little difficulty deciding). The social interaction perceived to cause *peers* the most difficulty in decision-making was accepting an invitation to a meaningful event in a client's life, receiving a mean rating of 1.87. This decision was rated as the second most difficult in the survey, next only to allowing fees to lapse ( $M = 2.00$ ). The social boundary crossing that was perceived to cause the least difficulty in peers' decision-making was asking a client for advice in his or her field of expertise, which received a mean rating of 1.30 on the 1-4 scale.

When participants were asked to indicate the item in this category that has been the most challenging *in their own practice*, most responded that none of the decisions listed had caused them any difficulty (42.2%,  $n = 19$ ). However, the next most common response, accepting an invitation to a meaningful event in a client's life, was chosen by 22.2% ( $n = 10$ ) of participants. This was followed by the 15.6% ( $n = 7$ ) of participants who indicated that they struggle the most with initiating a greeting with a client in a public place.

The fewest participants indicated that recommending services outside of the mental health field had caused them the most difficulty (2.2%,  $n = 1$ ). The next least frequently-chosen items (4.4%,  $n = 2$ ) were asking a client for advice in his or her field of expertise, transporting a

client in your personal vehicle, and communicating via networking websites. One participant did not respond to this question.

When asked about the frequency with which they cross boundaries related to social interactions with clients, the majority of participants (83.3%, n = 35) indicated that they crossed these types of boundaries either very infrequently (35.7%, n = 15) or never (47.6%, n = 20). Very few participants indicated that they crossed them sometimes (7.1%, n = 3) or more often than sometimes (9.5%, n = 4). Four participants did not provide an answer for this question. Table 3 below depicts the frequency distribution for each category of boundary crossings.

Table 3

*Frequently With Which Participants Decide to Cross Boundaries*

|                   | During Sessions (n) | Communication Outside of Sessions (n) | Social Interactions (n) |
|-------------------|---------------------|---------------------------------------|-------------------------|
| Never             | 1                   | 11                                    | 20                      |
| Very Infrequently | 17                  | 15                                    | 15                      |
| Infrequently      | 5                   | 8                                     | 0                       |
| Sometimes         | 19                  | 5                                     | 3                       |
| Frequency         | 2                   | 3                                     | 2                       |
| Very Frequently   | 0                   | 0                                     | 1                       |
| Always            | 1                   | 1                                     | 1                       |

**Contextual factors that influence boundary decisions:** After participants selected the boundary crossing in each category that had caused them the most difficulty, they were asked to indicate which contextual factors have influenced their decision-making regarding that boundary crossing. Participants chose all factors that applied from the following list:

- ♣ the length of time the client has been in treatment with me;
- ♣ a crisis situation;
- ♣ the client's level of acuity (baseline);

- ⤴ the presence of character pathology or Axis II traits;
- ⤴ the client's lack of social supports;
- ⤴ deciding that it would be impolite or counterproductive to not engage in this behavior;
- ⤴ something I have in common with a client;
- ⤴ a particular strong bond, connection, or investment the client;
- ⤴ the client's age;
- ⤴ the client's race or ethnicity;
- ⤴ the client's sexual orientation;
- ⤴ the client's religion;
- ⤴ the client's gender;
- ⤴ the client's socioeconomic status.

In addition to these choices, participants also had the option to specify a different factor that was not listed, or to state that “None of these factors have influenced my decision-making.”

For most of the contextual factors listed, responses varied greatly according to the category of boundary crossing (e.g. during sessions, communication outside of sessions, or social interactions), so each category is presented separately. However, there were two factors that clinicians reported were not influential to their decision-making, regardless of the type of boundary crossing; the client's sexual orientation and the client's religion (0.0%, n = 0).

***Factors influencing “during session” decisions:*** Of the three categories of boundary crossings, participants' decisions “during sessions” were influenced the most by contextual factors. Eighty-seven percent of participants (n = 40) indicated that at least 1 contextual factor that has influenced their in-session boundary decisions. Only 13% (n = 6) of participants stated that no contextual factors have influenced their in-session decisions. The most influential contextual factor for “during sessions” boundary crossings was the length of time the clinician and client have been in treatment together; 58.7% (n = 27) of the sample indicate this factor as influential. The next most influential factor was a crisis situation (43.5%, n = 20). The following

factors were also deemed influential by more than 25% of clinicians: the client's lack of social supports (34.8%, n = 16) and the client's baseline acuity (28.3%, n = 13). Additionally, 23.9% (n = 11) of participants endorsed having been influenced by Axis II traits or character pathology, the client's race/ethnicity or socioeconomic status, or deciding that not crossing the boundary would be impolite or counterproductive to treatment.

The least influential factor for in-session boundary decisions was the client's gender (4.4%, n = 2). In fact, “during sessions” was the only category of boundary crossings that was influenced by gender; the other two categories (outside communications and social interactions) were not (0.0%, n = 0). The second fewest number of participants indicated “something I have in common with a client” as an influential factor (15.3%, n = 7).

Of the 4 participants who chose “other,” 3 specified that their “own issues,” including “forgetfulness” and “unresolved issues regarding money,” had affected their decision-making. The fourth participant indicated “wanting to join effectively and show the client that I like him/her.”

***Factors influencing “communication outside of sessions”:*** The most influential factor affecting participants' communication outside of sessions was a crisis situation (41.3%, n = 19). A smaller number (32.6%, n = 15) indicated that none of these contextual factors influenced their decision-making in this category. The only other factor deemed influential by more than one quarter of participants was the client's baseline acuity, endorsed by 28.3% (n = 13) of the sample.

The least influential factors in this category were the clients' socioeconomic status (2.2%, n = 1), something the clinician has in common with the client (4.4%, n = 2), and the client's age (8.7%, n = 4).

Four participants added a factor not listed, which has influenced their decision-making. These included issues related to confidentiality, email communication with deaf and hard-of-hearing clients, and concern that a client would forget an appointment. One participant cited agency norms as an influential factor, indicating that it was within the boundaries of the treatment program for a client to stop by or call after discharge to inform the clinicians of their progress in treatment.

***Factors influencing “social interactions”:*** Participants were least likely to view boundary crossings involving social interactions as being influenced by contextual factors; 50% (n = 23) of the sample indicated that no contextual factors had influenced these decisions. However, for those noting contextual factors, the most frequently selected were the client's age and the clinician's judgment that it would be impolite or counterproductive to not cross the boundary (19.6%, n = 9).

Aside from age, the only sociocultural characteristic of a client that was considered to be influential to decisions involving social interactions was the client's race or ethnicity (13.0%, n = 6); the client's socioeconomic status and gender were not considered influential.

The contextual factors considered to be the least influential to “social interactions” boundary crossings were a crisis situation, something the clinician has in common with the client, and Axis II traits (6.5%, n = 3).

Three participants indicated other factors that had influenced their decision-making for these types of boundary crossings. Two participants wrote, “the client's health,” “liv[ing] in a rather small community and work[ing] with young people.” The third participant noted, “What influences me the most is knowing who I am and holding the truth...always, as best I can” (ellipses in original text).

**Resources to help with boundary management:** Participants were asked to indicate which of the resources listed they had utilized in the past for assistance with boundary management. The most commonly utilized resource was consultation with colleagues, either informally or during peer supervision 89.1% (n = 41). The fewest participants (15.2%, n = 7) had attended a mandatory training at their place of employment. One participants contacted the NASW Ethics hotline and another utilized his or her special treatment unit as a resource. Table 4 below illustrates the distribution of resources that have been utilized by participants.

Table 4

*Resources Participants Have Utilized in the Past for Help With Boundary Decisions*

| Resource   | Frequency | Percent* |
|--|-----------|----------|
| Communicated/consulted with colleague(s)           | 41        | 89.1%    |
| Consulted with supervisor                          | 37        | 80.4%    |
| Received education in advanced degree program      | 37        | 80.4%    |
| Employed at agency with boundary policy            | 25        | 54.3%    |
| Consulted professional Code of Ethics              | 19        | 41.3%    |
| Attended optional training                         | 14        | 30.4%    |
| Attended mandatory training at place of employment | 7         | 15.2%    |
| Other**  | 2         | 4.3%     |

\*Percent totals more than 100% because participants were able to indicate more than one resource.

\*\*Responses listed in “Other” category included consulting NASW Ethics hotline and working for a particular type of treatment unit.

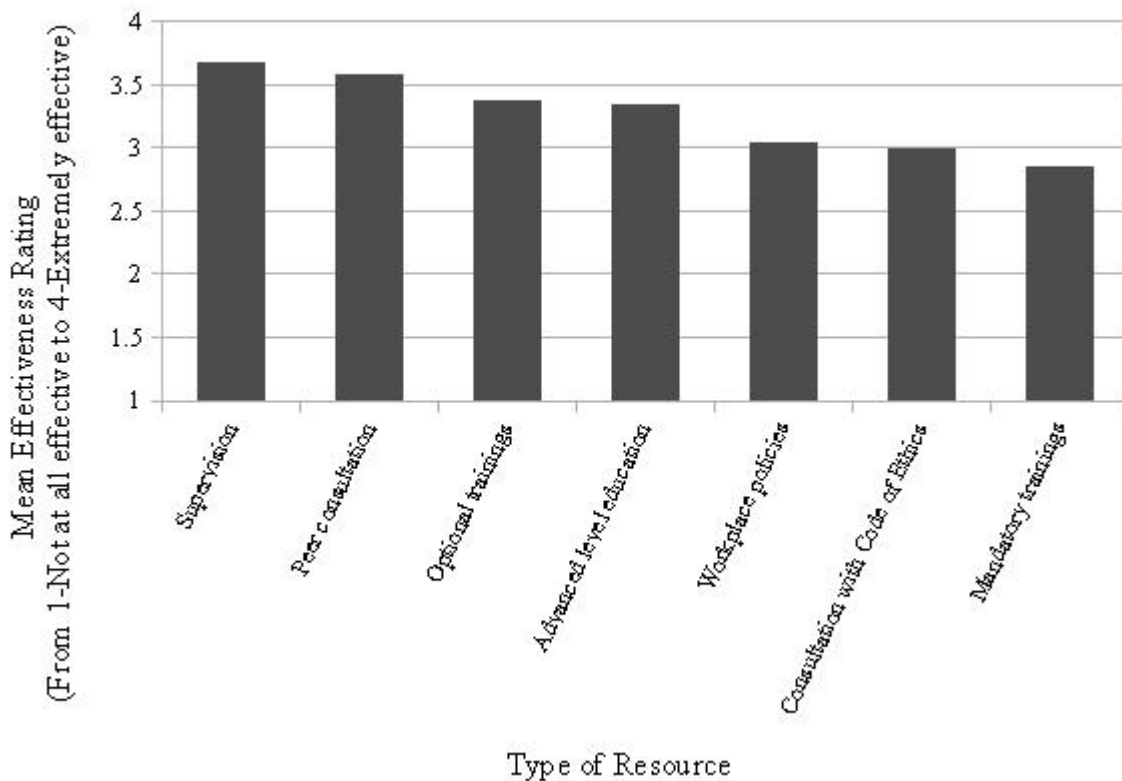
Participants were asked to rate each resource according to how effective they believe it could be in helping with current difficult boundary decisions. Each item was rated on a Likert-type scale from 1-4. The most effective resource was perceived to be discussing boundary issues in supervision, with an mean rating of 3.67, more than halfway between 3 (moderately effective),

and 4 (extremely effective). Following closely was formal or informal consultation with peers or colleagues, which received a mean rating of 3.59.

The resource perceived as the least effective, and the only resource that received a mean rating of less than 3 (moderately effective), was mandatory trainings on boundaries held at the workplace (M = 2.85). Figure 2 below illustrates the mean ratings for perceived effectiveness of each boundary management resource.

Figure 2

*Perceived Effectiveness of Boundary Management Resources*



**Correlations:** Several bivariate analyses were run using SPSS software to determine whether any correlations existed between the demographic characteristics of participants and



their opinions and experiences regarding boundary crossings and boundary management resources.

*Perceived difficulty for peers:* Several statistical tests were run to determine if participants differed in their perceptions of the level of difficulty that boundary crossings cause for their peers. Difficulty ratings were compared across professional discipline, years of experience, private practice percentage, and geographic practice locale (i.e. urban, suburban, or rural). The 21 different boundary-crossing behaviors that were rated by participants were collapsed for this analysis. A Cronbachs alpha was run to test the internal reliability of the 21 questions, and they were found to have very strong internal reliability ( $\alpha = .90$ ,  $N = 46$ ,  $n$  of items = 21). The questions were combined into a scale by taking a mean, and additional analyses were run on this scale.

A oneway ANOVA was run to determine if there was a difference in the mean score on the difficulty rating scale by discipline, and a significant difference was found ( $f(3,42) = 3.330$ ,  $p = .028$ ). An LSD host hoc test revealed that the differences were between Mental Health Counselors ( $m = 1.76$ ) and Clinical Social Workers ( $m = 1.36$ ), and between Mental Health Counselors ( $m = 1.76$ ) and Marriage and Family Therapists ( $m = 1.31$ ). The higher mean scores for the Mental Health Counselors indicates that as a group, they assigned higher difficulty ratings to the boundary crossing decisions than the other two groups. No associations were found between the Psychologists ( $m = 1.66$ ) and the other professions.

A Spearman rho correlation was run to determine if there was an association between years of experience and mean difficulty ratings. The experience groups presented in Table 1 were used for this correlation. A significant, weak, negative correlation was found ( $\rho = .303$ ,  $p$

= .041), indicating that more experienced clinicians perceived boundary-crossing decisions to cause less difficulty for their peers than did the clinicians with less experience.

A Spearman correlation was run to determine if there was an association between percentage of caseload seen in private practice and mean difficulty ratings. No significant correlation was found. There were also no significant differences found between geographic practice locale and difficulty ratings, as determined by a oneway ANOVA.

***Participants' own difficulty:*** In terms of the items indicated to cause the most difficulty for participants themselves, the significance of these findings could not be determined due to the small sample size. Crosstabulations were run, but the number of participants who chose each decision as most difficult was too small to determine any significance using Chi-square analyses.

One notable finding was the small number of participants (2.9%, n = 4) who indicated that none of the 21 boundary crossings had caused them any difficulty in their practice. The number of participants who answered “none” for all 3 boundary crossing categories combined was very small compared to the number who answered “none” for each separate category (17.4%, n = 8 for during sessions items; 37.0%, n = 17 for outside communications items, and 42.2%, n = 19 for social interactions items). This shows that almost all of the participants (91.3%, n = 42) chose at least one boundary crossing that had caused them some difficulty in their practice.

***Influence of race and ethnicity:*** Crosstabulations were run to determine whether the race or ethnicity of the participant was associated with whether their decision-making is influenced by the race or ethnicity of the client. Because of the small sample size and the small percentage of non-White respondents, participants were divided into 2 groups for this analysis: White Clinicians and Clinicians of Color. The number of respondents who identified as People of Color

was too small to use a Chi-square analysis to determine significance, but notable differences were revealed in the crosstabulations. Although the majority of respondents identified as White or Caucasian (86.7%, n = 39), the remaining 13.3% (n = 6) who identified as Clinicians of Color were much more likely to identify a client's race as an influential factor. Of the 3 times this question was asked—1 for each boundary crossing category— there was only 1 instance (0.9%) in which a White Clinician stated that the client's race was an influential factor. In contrast, race was indicated as an influential factor in 1/3 (33.3%) of the responses from Clinicians of Color.

***Past resource utilization:*** Statistical tests were run to determine if various demographic characteristics of the participants were correlated with the number of resources they had utilized in the past for assistance with boundary decisions.

A oneway ANOVA was utilized to determine if there was a correlation between number of resources used and years of clinical experience, using the 5 experience groups presented in Table 1. No significant association was found. A second oneway ANOVA was run to determine if there was an association between geographic practice locale and the number of resources utilized, and no significant correlation was found. Lastly, a Spearman rho correlation was run, and no significant relationship was found between percentage of caseload seen in private practice and number of resources utilized. Professional discipline was not correlated with past resource utilization.

***Resource effectiveness:*** Spearman rho correlations were run to determine whether participants perceived the effectiveness of particular resources differently as a function of years of experience. Clinical experience was the only demographic characteristic that was correlated with perceived effectiveness. There was a significant, moderate, positive correlation between years of experience and the perceived effectiveness of consulting a professional Code of Ethics

(rho = .503, p = .000). This suggests that more experienced therapists were more likely to consult their Code of Ethics for assistance with boundary decisions. None of the other resources correlated significantly with years of experience in terms of perceived effectiveness.

**Analysis of qualitative data:** Participants also responded to several open-ended questions on the survey, which were coded for themes. This section will present themes that emerged in the qualitative data.

**Elaboration on boundary crossing circumstances:** For each category of boundary crossings, participants chose the item that had caused them the most difficulty in their decision-making, and were asked to think of a time when they were presented with this decision and elaborate on their decision-making process. They were encouraged to include a description of how various contextual factors influenced their decision and to comment on any perceived impacts of the decision on the treatment. Not all participants responded to these open-ended questions; about 19.6% (n = 9) of participants elected not to respond to them.

Response rates varied for the 3 separate categories of boundary crossings: 80.4% of participants (n = 37) elaborated on “during session” boundary crossings, 65.2% (n = 30) responded regarding “communication outside of sessions,” and only 43.5% (n = 20) responded regarding a “social interaction.” No unique themes were discovered within each of these 3 categories of boundary crossings, so the categories were collapsed for qualitative analysis.

Six of the 87 total responses (6.9%) indicated that they could not respond to this question, as they did not struggle with any of the boundary decisions listed on the survey. One participant indicated that she did not understand what was being asked in the open-ended questions, and therefore could not provide a response. These 7 responses were excluded. The remaining 80 responses were coded, and the following themes emerged: impact on overall treatment, setting

clear boundaries, use of clinical judgment, responding to client requests or actions, countertransference, highly emotional content, and use of supervision and consultation.

*Impact on overall treatment:* Participants were encouraged to include their opinion regarding whether their decision benefitted therapy or whether it hindered it in some way. Twenty-seven (33.8%) of the responses included a descriptions of how the participants felt treatment was affected by their boundary decisions. More than half of these responses (55.6%, n = 15) indicated that the decision to cross a particular boundary impacted treatment or had the potential to impact treatment in a positive way, with some of these respondents describing positive changes in their clients' in-session behavior as a result. For example, one clinician described a situation in which “a client was making his First Communion and I sent him a card. He didn't comment on it, but was much more open and engaged afterward.” Some participants discussed boundary crossings as tools to help build rapport, such as one who described “using language within the cultural context of an adolescent [...] used minimally” in this way.

Other participants described positive reactions from their clients directly in response to boundary crossings. One participant elaborated on initiating a greeting with a current client in a public place, writing:

This is a tough one that I engage in only very infrequently with clients for whom I judge it would be beneficial. I take into account the setting in which I see the client and the effect it may have on them. The few times that I have done this is it is mostly with kids, teens or adults who struggle with self-esteem issues. So far, I think my acknowledgement of them has been therapeutic. One client even said (in a very pleased tone) “Wow, you notice me even when I'm not in your office!”

Regarding the same type of boundary crossing, another participant described a brief public interaction with a previous client: “When seeing a previous client in person I felt that it may have been therapeutic to engage in a check-in conversation in the public space; the client was thrilled to tell me how she was doing.” A third respondent described a client thanking her for the way the public acknowledgement was handled.

While many participants described positive impacts of crossing boundaries, a few described situations in which boundary crossings negatively impacted treatment (18.5%, n = 5). Four of these 5 respondents described situations that had to do with monetary negotiations, observing that allowing late fees or missed appointment fees to lapse hindered therapy in some way. One participant felt that monetary issues are “left unresolved too often” and that not collecting payment is “not helpful to the therapy in terms of not insisting on responsibility regarding money with the individuals.” Another participant stated that being more lenient with payments can have positive or negative impacts on treatment, depending on the clinical context, and provided 2 examples:

Trusting that someone who is out of work, but looking for work, has been helpful, as a support in the belief that good things are on the way. On the other hand it was not helpful to another's therapy to trust that she would turn over checks to me, made out to her by Medicaid. It contributed to her devaluing the work, continually putting the question before her as to who deserved/needed the payment more.

There were 2 participants (7.4%) who stated that they did not believe crossing the boundary had any impact on overall treatment. Four (14.8%) were unsure whether the decision had an impact on the client or therapeutic alliance. Regarding email communication with clients,

one participant noted, “Scheduling issues have now become something I handle through email. I don't think the dialogue exists to discuss how this effects the treatment.”

*Setting clear boundaries:* Several of the open-ended responses (10.0%, n = 8) referred to the value of setting clear or firm boundaries with clients to frame the therapeutic relationship or avoid role confusion. Half of these responses (n = 4, 50.0%) carried the sentiment that “good limit setting with clients is always good for therapy,” while the others seemed to believe that flexible boundaries can be helpful to treatment in selected circumstances. One participant described a situation in which she felt that extending session time was clinically appropriate, but added, “At other times, I believe that setting concrete time boundaries may be a crucial part of the work with that client and I am careful with regards to this.” Another participant, elaborating on the process of defining and discussing boundaries outside of sessions, wrote, “my boundaries are clear and I struggle little/not at all with my boundaries with clients...in session. I spend time considering the issues outside of sessions (as in supervision)” (ellipses in original text).

Some respondents advocated that clinicians being clear about their boundaries early on, both in treatment and outside of sessions, can prevent boundary confusion in the future. One participant shared the belief that, “knowing how a therapist wants to handle any of the above circumstances, by and large, should be clear to a therapist BEFORE the the boundary issue is presented. In other words, know yourself well and know your boundaries!” Another respondent stated that he typically addresses the issue of seeing clients in the community proactively by discussing it during intake. This clinician elaborated, “since I'm African-American, and living in a largely white community, the chances of me not being seen or noticed is small. Also given the community I work with, it would appear rude not to engage with [clients] when seen.”

*Use of clinical judgment:* In elaborating on their boundary-crossing decisions, many participants (43.8% n = 35) described using clinical judgment and taking treatment needs into consideration on a case-by-case basis. Many of these responses referenced the contextual factors that the participants indicated were influential to their decision-making. One described a circumstance in which she allowed missed appointment fees to lapse for a period of time: “A client lost her job and was struggling financially. She was invested in therapy and clearly in need of services given the severity of her symptoms. It would be clinically inappropriate to terminate.”

Several respondents described how their boundaries might change throughout the course of treatment with clients. For example, some participants wrote that they were more likely to cross particular boundaries with clients with whom they have been in treatment for a longer period of time, while others described crossing certain boundaries at the beginning of treatment to build rapport. The following response illustrates how one participant used reminder phone calls as a supportive boundary crossing in the beginning of treatment:

The client had forgotten a previous session, and had asked for a reminder call for our next session. I struggled with whether to do this because I did not want to set a precedent, and wanted the client to take responsibility for attending his/her own appointment. I decided to make the reminder phone call during the early stages of therapy, and work toward helping him/her remember on his/her own later in therapy.

While this therapist described how her approach with this particular client changed as the treatment relationship progressed, another clinician discussed how her approach to boundaries while on vacation has evolved as she gained more therapeutic experience:



When a client has few social supports and has significant anxiety due to a crisis, I have made it clear that I am available even though I am on vacation. I do this much less now than in the past with the assumption that clients will survive until I return.

*Responding to client requests or actions:* Several participants (20.0%, n = 16) noted challenging situations in which their clients' requests or actions required them to make a boundary decision, sometimes immediately. One participant stated that her most difficult boundary dilemma occurred during a session when a client motioned to hug her, elaborating that “when the client opened her arms to hug me, although I felt uncomfortable I did not want her to feel that I was being impolite or rejecting her.” Other situations described included being asked to pray with a client, being invited to milestone events in clients' lives, calling while the clinician is on vacation or after termination of treatment, accepting small gifts from clients, and receiving emails or text messages from clients. Participants varied on ways they came to their decision and whether they decided to respond in the way the client had requested.

In one response, the clinician described a client asking him to pray with him or her, and deciding that “it would have been impolite/counterproductive to have refused to pray with the client.” Another participant described some of the factors that help him make decisions about responding to emails from clients:

If I decide to reply to a client's email with an email (as opposed to a call, or addressing it in session), I will always remind the client during our next session that I prefer not to communicate via email. Whether or not I email back usually depends on the content of the email and whether a response is required.

Most respondents who discussed their boundary decisions disclosed that at at least some of the time, depending on treatment needs, they have responded to clients by crossing the boundary. In one of the cases in which the clinician declined, she described:

A patient invited me to their graduation and I responded by asking what it would mean to them if I were there, what they would want me to know about their life, and then gave them validation and support verbally without attending the event.

Some of the participants conveyed confidence in their decisions to cross boundaries or not cross them, and many provided greater detail of the contextual factors that influenced these decisions. Only one clinician described mixed feelings about her decision to attend the funeral of her client's immediate family member after being invited by the client, stating "I am ambivalent if this was a good choice."

*Countertransference:* Nine participants (11.3%) indicated that countertransference played a role in their decision-making. Two of these clinicians directly referred to this as "countertransference," whereas the remaining 7 described the influence of their internal feelings and reactions on their decision-making. One participant indicated that she recommended a service for her client that was outside of the mental health field; she reflected that "this behavior was probably due to becoming inappropriately protective with a client and assuming more of a parental role than therapeutic." Another clinician noted that she responds differently when working with children than with adults, which affects her assertiveness in maintaining boundaries regarding payment for clinical services:

Clients that I have seen for longer periods of time I am more lenient on allowing them to be late with payments. When the parents are "smooth" talkers or good at swaying my decision, that makes it harder. When it is just the child I feel confident making decisions,

but when an older adult questions me I lose my ground and feel less sure of my decisions. Afterward I am always sure what my gut is telling me and I take note of it for the next time something arises.

Another participant wrote that “countertransference about not having gotten anything done in the session itself, when I have been responsible for starting late,” is something that can make him more likely to cross temporal boundaries by extending session time.

*Use of supervision and consultation:* Four participants (5.0%) indicated that consulting with supervisors or colleagues has been a notable part of their decision-making process. Three of these clinicians noted that they consulted with another clinician about a decision that arose during a therapy session; these included accepting gifts (n = 2) and using self-disclosure (n = 1). One participant described her process of seeking supervision to help her decide whether not to disclose personal information to a client:

I took my quandary/consideration to a trusted colleague and explored it in supervision (yes, still engage in supervision; it's so important). I thought about what initially made me think about self-disclosing the piece of information, why/how/what way this came up, and how this information might influence the therapeutic alliance. Ultimately, I engaged in further inquiry with the client (as it pertained to the information I was considering disclosing), and decided not to disclose the information.

*Highly emotional content:* Three participants (3.8%) noted that the decision to extend session time can be more difficult when the session consists of highly emotional content. One of these clinicians wrote:

I take a rather person-centered approach. If the client is discussing something particularly emotionally laden or difficult, I will allow my client to finish their thoughts. By choosing

to not hear what my client says at that time, it may be more emotionally devastating than [extending] the session.

One other participant noted that emotional content occurring at the end of the session can make ending sessions on time difficult, and the other participant wrote, “When an patient is upset, I am tempted to lengthen the session.”

***Barriers to resource utilization:*** Participants were asked to comment on any barriers that they felt may keep clinicians from utilizing resources for help with boundary issues. Only 37.0% (n = 17) of participants provided a response to this open-ended question. The following themes emerged: embarrassment and fear of judgment or repercussions, lack of awareness that help is needed, limited access to resources, problems with supervision, and lack of openness. One respondent could not think of any barriers to utilizing resources for this issue.

***Fear and embarrassment:*** Of the 17 participants who responded to this question, 41.2% (n = 7) indicated that fear and/or embarrassment has been a barrier to obtaining help with boundary issues. Three referred to “fear” of seeking supervision or consultation related to a boundary dilemma. One participant referenced fear of professional repercussions, writing, “I think that some clinicians may fail to discuss boundary issues with their supervisor out of fear that he/she may be 'written up' or receive some formal disciplinary action for approaching their supervisor.” The other 2 participants stated that they fear “professional criticism” and “that others will think that they are inadequate...which of course they are not!” (ellipses in original text). Another participant also referenced “peer judgment” and “vulnerability” as barriers to resource utilization, without specifically referencing “fear” or consultation.

Two respondents indicated “embarrassment” as a barrier, and 2 referred to “the shame attached to boundary violations.” One participant referenced the “slippery slope,” adding that “there is a struggle with knowing what is appropriate to ask your supervisor.”

*Lack of awareness that help is needed:* Six participants (35.3%) noted that utilization of boundary management resources may be prevented by a failure on the part of the clinician to recognize that help is needed. Three of these respondents stated that clinicians may not seek help with boundary decisions because they feel that they do not need it; 1 added that this can be due to “feeling that they already know what is right and should not have to ask anyone else.”

Three participants referred to certain characteristics of a clinician that may decrease awareness that help may be needed and therefore present barriers to ethical decision-making. One participant wrote, “therapists with Narcissistic feature tend to not consult peers/supervisors or seek info from outside sources,” clarifying that “therapist personality issues/pathology would create barriers.” Another respondent expressed the following sentiments:

some therapists are inclined to do whatever they want, and are not concerned about boundaries violations or ethical considerations when it comes to the client-therapist relationship. It is my opinion that these clinicians are not usually acting in the client's best interest, but are acting in their own best interest.

Lastly, one participant noted that problems with utilizing help can arise “when a clinician believes they are above needing to look at and review the ethics of their practice. Rationalization can be a wonderful defense.”

*Limited access to resources:* Five participants (29.4%) stated that they have encountered barriers to accessing resources that could be helpful with boundary issues. Three elaborated on the struggle clinicians sometimes face with accessing appropriate supervision or consultation.

Two stated that supervision often is not readily available in certain positions; one referred to the struggle to obtain assistance when dilemmas “require decisions with a speed that does not allow for as much consultation as would be optimal.” Referencing a more global problem with obtaining supervision, another respondent wrote that “supervision of LICSW’s in agencies is not mandatory per se – often the clinician has to seek out supervision which is more difficult when an anxiety-provoking situation is at hand.” Another participant, who supervises others, reported that she does not have her own supervisor with whom to discuss these issues.

One respondent stated that “isolation” of a clinician could be a barrier to accessing resources for help with boundary decisions. Another referred specifically to the lack of training opportunities available to psychotherapists on this topic, noting, “I would like to see more conferences devoted to this issue.”

*Problems with supervision:* Four participants (23.5%) referred specifically to problems with supervision as barriers to utilizing this particular resource; two who discussed having limited or no access to a supervisor, and two referred to discomfort or confusion regarding approaching supervisors to discuss boundary issues.

*Lack of openness:* Two participants stated that openness is an important factor in obtaining help with boundary decisions, and therefore a lack of openness can prevent progress in this area. One noted a “lack of openness regarding problems with countertransference” as a barrier. The other respondent wrote, “I think that supervisors who promote openness and questioning with regards to these issues would make it easier for supervisees to use this time as a resource.”

## **Summary of Major Findings**

In general, the boundary crossings addressed in this study were perceived by participants to cause very little difficulty to other outpatient clinician's decision-making. Furthermore, a large number of participants indicated that these boundary crossings had created few challenges for them in their own practice. The boundary crossings that were perceived to be most difficult in terms of decision-making tended to involve monetary arrangements, telephone communication, and responding to invitations from clients. The frequency of crossing boundaries varied, but overall most participants indicated that they decide to cross the most difficult boundaries relatively infrequently. The contextual factors that were most influential to participants' decisions included the duration of the treatment relationship, crisis situations, and clients' acuity at baseline.

Although participants assigned low difficulty ratings to most of the boundary decisions, many of them utilized the open-ended responses to elaborate on specific decisions that had been challenging for them personally. Common themes included the impact of the decision on overall treatment, setting clear boundaries with clients, using clinical judgment, responding to client requests or actions, managing countertransference, the influence of highly emotional content, and the use of supervision and consultation.

The data gathered regarding boundary management resources indicated that participants had utilized many of the resources on the list; especially consultation, supervision, and graduate education. All resources, except for mandatory agency trainings on the topic, were perceived to be at least moderately effective for helping with difficult boundary decisions. Participants also commented on a range of barriers to resource utilization; which included fear and

embarrassment, reduced awareness that help is needed, limited access to resources, problems with supervision, and lack of openness.

The following chapter will discuss these findings as they relate to the research questions; limitations of the study; suggestions for future research; and implications for practice, training, and policy.



## **CHAPTER V**

### **Discussion**

The present research study addressed the following research questions: 1) Which potentially boundary-crossing behaviors do clinicians experience as the most difficult in their outpatient practice? 2) Which contextual factors influence their decisions about resolving boundary dilemmas? 3) What types of resources have psychotherapists utilized, and what would they find most helpful for assisting them in making future decisions and maintaining awareness of their own professional boundaries? 4) Do any demographic characteristics of the clinicians in the sample correlate with their reported behaviors, decisions, and preferences? This chapter will discuss the findings presented in the previous chapter, in relation to each of these research questions. In addition, limitations of the study; suggestions for future research; and implications for clinical social work, training, and policy will be discussed.

#### **Boundary Decisions Clinicians Find Difficult**

The first research question explored which boundary decisions practicing psychotherapists identify as challenging, for their peers and for themselves. Regarding peers' decision-making, most boundary crossings were given low ratings by the majority of participants, indicating that they believe these decisions cause their peers little to no difficulty in outpatient practice. When asked to choose the boundary decision in each category that had been the most difficult in their own practice, a high number of participants responded that none of the boundary crossings listed had caused them any difficulty. However, there were very few

participants who reported no difficulty across all 3 categories, indicating that most clinicians had struggled with a decisions about boundary crossings to some extent.

Overall, participants responses regarding the difficulty of boundary-crossing decisions demonstrated a sentiment that boundary decisions are not perceived as major challenges to clinical practice. There could be several reasons that participants responded in this way. The first could be that clinicians feel confident in their ability and the abilities of their colleagues to handle boundary dilemmas without significant distress. Perhaps these clinicians agree with the participant who shared her opinion that the way a clinician would respond in a boundary dilemma should be determined before a challenging situation arises in practice. It is possible that the psychotherapists who participated in this survey feel that they have received adequate training to inform their decisions regarding boundary crossings. All participants indicated that they felt they had some help or support related to managing boundaries. This will be discussed further below in the section on resources for boundary management.

Another possible explanation for the low difficulty ratings could be a lack of awareness of the challenging nature of boundary decisions themselves. The boundary literature has frequently addressed the fact that clinicians may be unaware that they could benefit from assistance related to boundary decisions (Gutheil & Gabbard, 1993; Walker & Clark, 1999; Vamos, 2001; Davidson, 2005; Pope & Keith-Spiegel, 2008; Peternelj-Taylor & Yonge, 2003; Fronek et al., 2009). Similarly, clinicians' beliefs that they should already know the correct course of action can lead to a reduced awareness of the importance of boundary management decisions. This was noted by several participants in their discussion of barriers to help-seeking regarding these decisions. This sentiment among clinicians is also likely to lead to social desirability bias in their responses. Rubin and Babbie explain:

In a quantitative inquiry, we should be especially wary of the social desirability bias.

Whenever you ask people for information, they answer through a filter of a concern about what will make them look good. This is especially true if they are being interviewed in a face-to-face situation (Rubin & Babbie, 2011, p. 100).

Although this bias was a factor that was considered in the design of this study, particularly eliminating face-to-face interactions with participants by making the survey available online and making all responses anonymous, it still is possible that social desirability influenced how participants responded. If clinicians feel that viewing boundary decisions as challenging is an indication of inadequacy, as several participants mentioned in their open-ended responses, they will be less likely to admit that these decisions are difficult.

The number of participants who indicated they had not faced challenges with any boundary decisions were especially high for the categories regarding social interactions with clients and communication outside of sessions, but less so for decision-making during sessions. This indicates that this sample of clinicians have experienced a greater level of difficulty with boundary dilemmas during therapy sessions than outside of them.

Another possible explanation for these particular responses could be respondent bias. The Encyclopedia of Survey Research Methods describes respondent fatigue as “a well-documented phenomenon that occurs when survey participants become tired of the survey task and the quality of the data they provide begins to deteriorate. It occurs when survey participants' attention and motivation drop toward later sections of a questionnaire. (Lavrakas, 2008, p. 672). The first time participants were asked to choose a challenging boundary crossing, in the “during sessions” category, a large majority of participants chose one on which to elaborate in subsequent questions. The second and third time this question was asked, for the second two categories of

boundary crossings, the response rate decreased significantly. The remaining respondents indicated that none of the boundary decisions had caused them any difficulty. Respondent fatigue may pose a challenge to the validity of concluding that clinicians struggle more with in-session boundary decisions more than other kinds. This phenomenon, in relation to possible limitations in the design and length of the survey, is discussed further below.

**Monetary negotiations:** There were notable findings regarding 2 survey items related to monetary negotiations: lending a small amount of money to a client and allowing late fees or missed appointment fees to lapse. While negotiating fees was perceived to be the most difficult boundary crossing, lending money to clients was perceived as the least difficult. Lending money to clients was chosen as the in-session boundary decision perceived to cause peers the least difficulty in their practice, and was also chosen least frequently as a challenging boundary crossings for the participants themselves. However, participants reported that lending material items, such as books or audio recordings, to clients, was a slightly more challenging decision.

On the contrary, participants reported that they believe allowing late fees or missed appointment fees to lapse is the most difficult decision for psychotherapists, including themselves. Kreuger discusses society's difficulty in discussing monetary matters, which is mirrored and often amplified within the psychotherapeutic relationship (1991). Freud discussed the paradox of money's centrality in society with the taboo of discussing it, and Kreuger notes that decades later, many individuals “remain seclusive, embarrassed, and conflicted about discussing money” (p. 209). Many other authors continue to discuss the difficulty clinicians face with boundaries related to payment and fees (Pope & Vetter, 1992; Gutheil & Gabbard, 1993; Miller & Maier, 2002; Reamer, 2003; Pope & Keith-Spiegel, 2008). This literature and the data from the present study suggest that psychotherapists could benefit from additional resources to

help them mediate their role as professional social workers and the discomfort that many clinicians and clients alike experience related to monetary negotiations.

**Telephone communication:** The items that stood out in this category included participants' decisions to provide their personal phone number to clients and to call clients between sessions to check in. Regarding their own decision-making, participants indicated that both of these decisions were among the least challenging. Participants also perceived providing a home or cellular telephone number to clients as a decision that would cause little difficulty for their peers. It is possible that therapists refer to their treatment orientation to guide their decision-making regarding this decision, and therefore experience it as less of a challenge. For example, in Dialectical Behavior Therapy, which is a growing treatment modality it is customary for clinicians to provide their personal telephone number to clients for coaching between therapy sessions.

**Responding to invitations from clients:** According to the findings, the boundary crossing that participants perceived to pose the greatest challenge to clinicians in terms of social contact with clients was accepting an invitation to a meaningful event in a client's life. Although several authors have discussed this as a challenging boundary decision for many therapists, the number of participants who indicated this decision as challenging indicates that increasing discourse in the field regarding this dilemma may be helpful to psychotherapists. Little literature exists that explores clinicians' experiences with receiving invitations to meaningful social events from clients. The frequency and richness of participants' responses in the present study regarding this dilemma suggests that this is a common struggle for therapists, and that the field may benefit from additional exploration of this topic. Psychotherapists themselves might benefit from increased support in negotiating these decisions.

## **Influence of Contextual Factors on Boundary Decisions**

Contextual factors indicated by participants as the most influential to boundary decisions included length of the treatment relationship, a crisis situation, and the clients' acuity at baseline. While many authors have noted the influence of the length of the treatment relationship (Pope & Vetter, 1992; Gutheil & Gabbard, 1993, 1998; Peternelj-Taylor & Yonge, 2003; Reamer, 2003; Pope & Keith-Spiegel, 2008; Speight, 2011) and the client's acuity (Walker & Clark, 1999; Miller & Maier, 2002; Reamer, 2003; Brown & Trangsrud, 2008; Speight, 2011), the literature has focused less on boundary crossings that may occur when clients are in crisis. Future research should further explore the association between crisis situations and boundary crossing behavior among clinicians.

The data gathered regarding factors influencing boundary decisions suggests that participants may be more influenced by contextual factors when faced with in-session decisions than when making decisions involving communication outside of sessions, and the least influenced by context when the decisions involve social interactions. However, similar to the findings discussed above, this data may have been influenced by respondent fatigue; as participants were first asked to indicate factors relate to decisions made during sessions, then later about decisions out of sessions, and last about social interactions.

## **Research Utilization, Helpfulness, and Barriers**

Overall, the findings on resource effectiveness suggest that clinicians perceive boundary management resources to be helpful in their decision-making. Although the resources varied in their effectiveness ratings, the generally high ratings for most resources are evidence that psychotherapists benefit from these resources, and therefore they should continue to be made available.

Participants preferred resources for boundary management that included person-to-person interaction, including supervision and consultation. These two resources received the highest ratings for both past use and effectiveness. Unfortunately, the most common barrier that participants discussed was fear and embarrassment regarding discussing boundary dilemmas with colleagues, especially supervisors; and several respondents also elaborated further on problems with discussing these issues in supervision. This suggests that there is a need for increased dialogue and problem-solving related to collegial consultation for boundary dilemmas. This may include, as some participants suggested, attempts by clinicians and supervisors alike to increase their openness surrounding these issues, and perhaps normalizing methods for reducing embarrassment and fear of repercussions. One suggestion, originally offered by Peternelj-Taylor & Yonge (2003), is for psychotherapists to engage in supervision with a colleague other than their direct supervisor, in order to eliminate power dynamics and reduce feelings of vulnerability that may inhibit open discussions.

In terms of advanced level education that includes a discourse on boundary management, many authors have noted that Master's and Doctorate programs have not addressed this topic adequately (Vamos, 2001; Brown & Trangsrud, 2008; Fronek et al., 2009). Many graduate programs that train psychotherapists require a course in ethical practice as a degree requirement, and boundary issues are often discussed as part of these courses. However, it is troubling that almost 20% of participants in this study reported that they had not received any training in their graduate education directly related to boundary management. This data supports the literature's call for an increase in graduate curriculum that focuses on managing boundary dilemmas. Although quantitative responses indicated that participants are not experiencing a great level of difficulty with boundary decisions, the elaborations many participants provided on specific

boundary struggles suggests that they are experiencing complex and challenging decisions, which they may not be prepared to handle.

The only resource that was perceived to be less than moderately effective was mandatory trainings held at the workplace, however, the percentage of participants who had ever participated in this type of training was significantly lower compared to the other resources. This small number of clinicians who reported access to this type of training is consistent with the literature (Vamos, 2001; Davidson, 2005; Fronek et al., 2009). Clinicians who have not had the opportunities to participate in such trainings may not have the full knowledge to make a judgment on its potential helpfulness. It is also possible that the word “mandatory” used to describe these trainings caused hesitation for participants, who may feel more likely to engage and benefit from trainings that they voluntarily attend. Supporting this notion, optional trainings were perceived by participants to be the third most effective of the 7 resources included in this survey, following supervision and consultation. Participants were also twice as likely to have attended these optional trainings than to have been required to attend workplace trainings.

The findings also support the literature that demonstrates that not many agencies have policies that include issues with boundary management (Fronek et al., 2009). Similar to mandatory trainings, clinicians who have not been employed at agencies with policies on boundaries may not know the benefit of such policies. Still, although only about half of participants indicated that their agency had policies or procedures related to boundary management, they felt that a document like this would have been more than a moderately effective resource.

Regarding consulting professional Codes of Ethics, although participants perceived this resource to be moderately effective, less than half had referred to it for assistance when they



have experienced boundary dilemmas. This data may be supportive of the common grievance that Codes of Ethics are not specific enough and do not provide adequate guidance for boundary management. Possible solutions to this problem might include professional organizations revising their Codes of Ethics to be more specific in this area; and for clinicians to use other resources, such as trainings and supervision, in combination with consulting their Code of Ethics.

### **Correlations with Participant Characteristics**

The only difference that appeared among the professional disciplines was that Mental Health Counselors perceived boundary decisions as more difficult for their peers than Clinical Social Workers and Marriage and Family Therapists. As discussed above, this could be related to several factors, such as reduced awareness of the challenges of boundary decisions, lack of preparation in graduate curriculum, or a sentiment that colleagues are adequately prepared to handle dilemmas that might arise. Although there is insufficient data to determine what accounts for the Mental Health Counselors' higher difficulty ratings, the results suggest that there may be something qualitatively different about Counselors' training or outlook on this topic.

The other subgroup perceiving boundary crossings to be more difficult for their peers were the less experienced psychotherapists. Similarly, there are various speculations for this finding. Perhaps they were likely to have been more recently trained on this subject, and may be more aware of boundary dilemmas can pose to professionals. More experienced clinicians may have become more desensitized to these challenges or perhaps more confident in their colleagues' abilities to negotiate difficult boundary situations.

More experienced clinicians also differed from less experienced clinicians in terms of the types of boundary management resources they reported utilizing in the past. More experienced psychotherapists were more likely to have consulted their Code of Ethics for guidance around

boundary issues. It is possible that these clinicians began practicing in a time when there were fewer resources available for this type of dilemma, and thus relied more heavily their Code of Ethics. Hence, psychotherapists who have been practicing for less time may have been less likely to refer to their Code of Ethics because other types of resources are available. All other resources were utilized equally by participants regardless of experience levels.

The last notable correlation related to the impact of race and ethnicity within the psychotherapist-client dyad. Although the number of Clinicians of Color who participated in the survey was very small, the findings indicate that Clinicians of Color were much more influenced by their clients' race or ethnicity when making decisions about boundary crossings. However, there was insufficient data to explain in what ways race or ethnicity impacted these decisions. There was a lack of racial and ethnic diversity in the sample, and it is important that future research on this topic includes more Clinicians of Color. The racial homogeneity of the sample in this study is discussed further below as a limitation of the research.

### **Limitations of Methodology and Suggestions for Future Research**

**Sample:** In addition to the sample size being small, the present study focused on a relatively narrow population, which limits the generalizability of its findings. First, the research intentionally focused only on outpatient psychotherapists. Although this population was chosen deliberately due to the differences in boundary expectations, challenges, and behaviors across levels of care, similar explorations into boundaries at higher levels of care would also provide important insight. Clinicians who provide in-home treatment may be a particularly of interest due to the unique and often challenging boundary demands facing therapists practicing within this treatment model (Pope & Vetter, 1992; Gutheil & Gabbard, 1993; Walker & Clark, 1999; Reamer, 2003; Peternelj-Taylor & Yonge, 2003; Speight, 2011). Although therapists providing

in-home treatment were not excluded, the methods of recruitment may not have reached this subset of the population. The recruitment of therapists from online databases is likely to have led to a large number of respondents being private practitioners.

It is also notable that the sample was self-selected. Clinicians' motivation for participating in the study might be considered, as well as some of the reasons potential participants decided not to take part in the survey. Psychotherapists who lack confidence with boundaries or feel uncomfortable discussing the topics, due to factors such as fear and embarrassment that the participants described, may have been less likely to participate. If this is true, the subset of clinicians who participated might include therapists who are comfortable with their boundaries and therefore feel less challenged by boundary dilemmas. This may have led to low difficulty ratings for many of the boundary crossings and a large number of participants denying that they had experienced difficulty with any of the boundary crossings included in the survey.

In terms of demographic characteristics, the study sample was somewhat lacking in diversity. Although more women than men responded, the gender distribution was relatively representative of the large population of psychotherapists in the United States. Despite deliberate efforts to recruit Clinicians of Color via databases, a very small number of Clinicians of Color responded to the survey. According to Speight (2011), Clinicians of Color are likely to offer highly valuable insight into boundary decisions and offer unique perspectives on the topic, especially in terms of racial and ethnic solidarity. The finding that the Clinicians of Colors' boundary decisions were influenced by their clients' race more than White clinicians is an indication that speaking with this population may provide a unique frame of reference. Future research should continue to reach out to this group in order to obtain valuable information regarding boundary decisions.

The professional discipline of participants was relatively diverse, including 4 different professions, but no psychiatrists or psychiatric nurse specialists responded to the survey. These 2 professions might offer a different perspective related to boundary negotiations, which may be influenced by the dual role of providing psychotherapy and medication management. Future research should reach out to these professions.

**Study design:** As discussed earlier, social desirability bias may have influenced the low difficulty ratings seen across all categories of boundary crossings. However, participants' responses to the open-ended questions provided insight into many of the complex challenges facing clinicians, in addition to the fact that help managing these challenges is not easily accessed. The richness of the qualitative data, in addition to the fact that it was somewhat conflictual with the quantitative data, suggests that the field could benefit from further qualitative inquiry into this topic.

A limitation of the study design was that participants were not as able to discuss the details of boundary issues as they would have been with a design that utilized qualitative methods. In the future, interviews or focus groups may obtain more detailed information on topics such as how clinicians form their notion of boundaries, which situations are most challenging for clinicians and why, ways of resolving dilemmas, and perceived positive and negative impacts of boundary decisions on overall treatment. Although participants in this study discussed feeling embarrassed and vulnerable speaking to supervisors and colleagues regarding these issues, speaking to an uninvolved researcher might be experienced as less threatening. However, taking into account the greater risk of social desirability bias with in-person data collection methods, perhaps an anonymous survey with more open-ended questions would be a more valid method of obtaining this type of data.

Another issue with study design, previously mentioned, was the length of the survey and repetition of certain questions, which may have led to respondent fatigue. This phenomenon was noted for the questions noted above as well as with the open-ended questions; each time an open-ended question was asked, considerably less participants responded. Future research should consider these issues with study design.

### **Implications for Clinical Social Work Practice, Training, and Policy**

Although participants did not view most boundary decisions presented in this study as substantially difficult, many could call to mind and elaborate on specific situations in which they struggled with making a decision about crossing a boundary. This implies that most therapists, including clinical social workers, are experiencing some level of difficulty regarding boundary decisions with their outpatient clients. Additionally, the fact that all respondents had utilized at least one resource for assistance with this type of decision-making shows that challenges have been significant enough for clinicians to seek out help with decisions. As previously noted, the high effectiveness ratings given to most resources by participants indicates that they are benefitting from this help, and implies that these resources should continue to be available.

The data shows that not all participants had been formally trained in boundary management, including graduate education and post-graduate trainings. The fact that participants rated these types of training as highly effective is an indication that graduate curriculum should include education on this topic, and more ongoing trainings need to be offered to clinical social workers and psychotherapists in other disciplines.

Implications for social work policy might include institutions that provide education to psychotherapist trainees as well as those that provide employment to social workers. At the level of graduate education, Master's and Doctorate programs that train psychotherapists should be

required to include curriculum that addresses boundary decisions in clinical practice. This education may include a discussion of the other types of resources available to clinicians in the field, and serve to begin a discourse about the difficulty of some boundary decisions and how to reduce barriers to obtaining help with them.

Additionally, this research shows that once they enter the field, clinicians continue to benefit from policies that afford them assistance with boundary decisions. Although participants found agency policies addressing this topic to be effective, a relatively small number had been employed at agencies with policies like this. Because professional Codes of Ethics cannot be specific to provide guidance to clinicians facing boundary dilemmas, clinicians would benefit from policies at their agencies that specifically address ways to navigate challenging situations that are likely to arise for their employees.

## **Conclusion**

This research explored the opinions and experiences of outpatient clinicians regarding boundary crossings in clinical practice, and resources that may be utilized to assist with boundary decisions. The findings of this study demonstrated that although participants perceived most boundary decisions to present minimal difficulty to psychotherapists, many discussed specific challenging situations that they had encountered in their own practice. Participants indicated that their decisions regarding boundary crossings had been influenced by a range of contextual factors, including some that have been less documented in the literature on psychotherapist-client boundaries.

Finally, although participants perceived many resources to be effective for boundary management, particularly supervision and consultation, they noted low utilization for some of these resources and discussed several barriers to accessing them. This research indicates a need

for an increase in accessible boundary management resources for clinicians struggling with challenging boundary decisions, and for further research exploring how clinicians understand these challenges.

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## Appendix A: Human Subjects Review Approval

School for Social Work  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

March 14, 2012

Victoria Brinckerhoff

Dear Tori,

What a thoughtful and thorough revision! It is very nice and educational for me as well. Your project is now approved by the Human Subjects Review Committee and is fascinating.

*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.

I wish you the best of luck.

Sincerely,

A handwritten signature in black ink, appearing to read "David L. Burton". The signature is written in a cursive style with a long horizontal flourish extending to the right.

David L. Burton, M.S.W., Ph.D.  
Chair, Human Subjects Review Committee

CC:

## Appendix B: Screening Questions

### Boundaries in Outpatient Clinical Practice Questionnaire

Exit this survey

**\* 1. Have you received a Master's degree, Doctorate degree, or MD in one of the following disciplines: Clinical Social Work, Psychiatry, Psychology, Psychiatric Nursing, Marriage and Family Therapy, or Mental Health Counseling?**

- Yes
- No

Next

### Boundaries in Outpatient Clinical Practice Questionnaire

Exit this survey

**\* 2. Have you completed graduate or postgraduate training to practice psychotherapy?**

- Yes
- No

Prev

Next

### Boundaries in Outpatient Clinical Practice Questionnaire

Exit this survey

**\* 3. Are you currently practicing outpatient psychotherapy in the United States?**

- Yes
- No

Prev

Next

## Appendix C: Informed Consent Form

### Boundaries in Outpatient Clinical Practice Questionnaire

[Exit this survey](#)

#### INFORMED CONSENT

Dear Participant,

My name is Tori Brinckerhoff, and I am a graduate student at Smith College School for Social Work. I am conducting research for my Masters thesis, which explores outpatient psychotherapists' experiences and opinions regarding complex boundary decisions that arise in the field. The study focuses only on boundary-crossing behaviors (such as accepting an invitation to a meaningful event in a client's life), which remains a "gray area," a subject of ongoing debate. This is distinguished from boundary violations, classified as "wrongful acts" (such as sexual transgressions), which the survey does not ask about. There are no questions about physical touch, dual relationships, or self-disclosure.

To participate you must be currently practicing as an outpatient therapist in the United States in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, Psychiatric Nursing, Psychology, or Psychiatry. You must have received graduate or postgraduate training to practice psychotherapy.

This study will be conducted through a quantitative questionnaire that will be administered via this website (SurveyMonkey.com). You will be asked 9 demographic questions (such as gender and professional discipline). You will then be asked to look at a list of boundary-crossing behaviors and to note the degree of difficulty in decision-making you believe they present to other clinicians, and then to yourself. You will be asked to look at a list of contextual variables (including a client's crisis situation or the client's religion), which might affect your decision-making about boundary crossings. Finally, you will be asked your opinions about the sources of help which you have used in making difficult decisions, any barriers that may interfere with clinicians using resources to help with these issues, and your recommendations for effective

Because the questionnaire will include reflections on your own experiences with boundary dilemmas, there is a small risk that participation in the study could cause negative emotions to arise. Possible benefits from participating in the study include experiencing participation as informative, having the opportunity to reflect upon your practice, and knowing that your responses may be contributing to the development of knowledge regarding boundaries in clinical work. Unfortunately, no monetary or material compensation for your participation is able to be provided.

This survey is totally anonymous. Also, in the interest of confidentiality, you are asked not to provide any names or identifying information about clients in any of your responses. Any identifying date you include about yourself or your client will be treated confidentially and then deleted. All data from the questionnaire will be kept in a secure location for a period of three years, as required by Federal guidelines, and data stored electronically will be fully protected. If the material is needed beyond a three year period, it will continue to be kept in a secure location and will be destroyed when it is no longer needed.

Initial data will only be viewed by myself, my research advisor, and a statistician employed by Smith College. When material from this study is used for future presentation and possible publication, any possible identifying information will be removed.

Your participation in this questionnaire is voluntary. You have the right to refuse to answer any question on the survey. You may also withdraw from the study at any time by navigating away from the webpage on your browser. If you do this, any answers you provided to any previous questions will be deleted. However, once you complete and submit your answers to the full questionnaire, it will not be possible to withdraw, because you will not be able to be identified.

If you have any additional questions, please feel free to contact me directly at [REDACTED]. Should you have any concerns about your rights or any aspect of the study, you are encouraged to contact me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413)585-7974.

**\* 4. BY CHECKING THE BOX BELOW THAT SAYS “I agree,” YOU ARE INDICATING THAT YOU HAVE READ AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS; AND THAT YOU AGREE TO PARTICPATE IN THE STUDY. Please print a copy of this page for your records.**

I disagree

I agree

Prev

Next

## Appendix D: Disqualification Page

### Boundaries in Outpatient Clinical Practice Questionnaire

Unfortunately, you do not meet eligibility criteria for participating in this study.  
Thank you for your interest in my research!

Submit

## Appendix E: Questionnaire

### Boundaries in Outpatient Clinical Practice Questionnaire

Exit this survey

Please respond to the following demographic questions.

#### 5. What is your discipline?

- Clinical Social Worker
- Mental Health Counselor
- Psychologist
- Marriage and Family Therapist
- Psychiatrist
- Psychiatric Nurse Specialist

#### 6. Please list your degrees, certifications, and license(s). If you are not licensed, please write "Not licensed."

#### 7. How many years have you been practicing psychotherapy? Please round to the nearest year.

#### 8. How do you

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&promiseType=spc

- Black or African American
- Hispanic, Latino, or Spanish origin
- Asian
- Middle Eastern
- Native American or Alaskan Native
- Pacific Islander
- Mixed Race or Biracial
- White or Caucasian
- Other (please specify)

#### 9. Please select the gender you most identify with.

- Woman
- Man
- Transgender
- Other (please specify)



**10. Approximately what percentage of your outpatient caseload, if any, do you see in private practice?**

- None (0%)
- Less than 50%
- About 50%
- More than 50%
- All (100%)

**11. In which type of geographical area do you primarily practice outpatient psychotherapy?**

- Urban
- Suburban
- Rural

**12. In which of the following outpatient settings do you primarily practice?**

- Agency or community mental health center
- Hospital outpatient clinic
- Court setting
- School setting
- Rented office space outside my home
- Office space inside my home
- Clients' homes
- Other (please specify)

**13. Are you involved in clinical or advocacy work with any particular special interest or sociocultural group(s)? Please choose all that apply.**

- No; I work only with a general population
- College or school community
- LGBT community
- Community of color
- Multilingual community
- Religious community
- Physically or mentally disabled community
- Other (please specify)

## Boundaries in Outpatient Clinical Practice Questionnaire

[Exit this survey](#)

In clinical practice, psychotherapists are always making decisions about how to negotiate and maintain boundaries with their clients. This study explores boundary-related clinical decisions and actions in order to illuminate the gray areas around boundary negotiations and explore the contextual factors that influence therapists' decisions.



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## Boundaries in Outpatient Clinical Practice Questionnaire

[Exit this survey](#)

Clinicians often face difficult decisions about how to construct and maintain boundaries with their clients. Below are 3 categorized lists of boundary decisions that clinicians encounter.

Please rate all items in each category from 1 (No Difficulty Deciding) to 4 (Great Difficulty Deciding) according to the amount of difficulty you think each decision can cause for outpatient psychotherapists.

### 14. During Sessions:

|   | 1 (No Difficulty Deciding) | 2 (Little Difficulty Deciding) | 3 (Moderate Difficulty Deciding) | 4 (Great Difficulty Deciding) |
|---|----------------------------|--------------------------------|----------------------------------|-------------------------------|
| Extending session time in a non-crisis situation                              | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Lending a small amount of money to a client                                   | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Allowing late payments or missed appointment fees to lapse                    | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Giving a client a small gift  | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Incorporating slang and/or expletives into therapeutic dialogue with a client | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Lending a book, audio recording, DVD, or other literature/media to a client   | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Praying in session with a client  | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Addressing a client by a familiar term, e.g. "dear" or "man"                  | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Accepting a small gift from a client  | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |

**15. Communication Outside of Sessions:**

|   | 1 (No Difficulty Deciding) | 2 (Little Difficulty Deciding) | 3 (Moderate Difficulty Deciding) | 4 (Great Difficulty Deciding) |
|---|----------------------------|--------------------------------|----------------------------------|-------------------------------|
| Communicating with a client through email   | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Providing your personal phone number (home or cell) to a client                           | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Calling a client between sessions to check in   | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Calling a client to remind him or her of an appointment                                   | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Communicating with a client while you are on vacation                                     | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Continuing communication with a client after termination and without restarting treatment | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |

**16. Social Interactions:**

|  | 1 (No Difficulty Deciding) | 2 (Little Difficulty Deciding) | 3 (Moderate Difficulty Deciding) | 4 (Great Difficulty Deciding) |
|--|----------------------------|--------------------------------|----------------------------------|-------------------------------|
| Initiating a greeting with a client in a public place  | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Recommending services for a client that are outside of your field, e.g. a plumber or florist | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Asking a client for advice in his or her field or area of expertise                          | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Accepting an invitation to a meaningful event in a client's life                             | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Transporting a client in your personal vehicle   | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |
| Communicating with a client via a networking website, e.g. LinkedIn or facebook              | <input type="radio"/>      | <input type="radio"/>          | <input type="radio"/>            | <input type="radio"/>         |



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**17. Please now reflect on your own practice. Of the items in the category "During Sessions," which of the following has caused you the most difficulty in your own decision-making? Please choose one.**

- Extending session time in a non-crisis situation
- Lending a small amount of money to a client
- Allowing late payments or missed appointment fees to lapse
- Giving a client a small gift
- Incorporating slang and/or expletives into therapeutic dialogue with a client
- Lending a book, audio recording, DVD, or other literature/media to a client
- Praying in session with a client
- Addressing a client by a familiar term, e.g. "dear" or "man"
- Accepting a small gift from a client
- None of these has caused me any difficulty
- Other (please specify)

**18. Below, you are provided with a list of several characteristics of the client, circumstance, and therapeutic relationship that can be influential to the decisions therapists make about boundaries. Please indicate which of these factors are or have been influential to your own decisions about whether to engage in the behavior you indicated in the previous question (your answer to Question 17). Please choose all that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> The length of time the client has been in treatment with me                            | <input type="checkbox"/> The client's age  |
| <input type="checkbox"/> A crisis situation   | <input type="checkbox"/> The client's race or ethnicity                                  |
| <input type="checkbox"/> Something I have in common with a client   | <input type="checkbox"/> The client's sexual orientation                                 |
| <input type="checkbox"/> The client's level of acuity (baseline)  | <input type="checkbox"/> The client's religion   |
| <input type="checkbox"/> The presence of character pathology or Axis II traits                                  | <input type="checkbox"/> The client's gender   |
| <input type="checkbox"/> The client's lack of social supports   | <input type="checkbox"/> The client's socioeconomic status                               |
| <input type="checkbox"/> Deciding that it would be impolite or counterproductive to not engage in this behavior | <input type="checkbox"/> None of the above factors have influenced my boundary decisions |
| <input type="checkbox"/> A particular strong bond, connection, or investment the client                         |  |
| <input type="checkbox"/> Other (please specify)   |  |

19. Please think of a time that you engaged in the boundary-related behavior that you indicated in Question 17. Use the space below to elaborate on how you came to your decision. You may include a description of how any of the factors listed above influenced the decision, and any other comments you would like to add. Do you feel that your decision was beneficial to the therapy, or that it hindered it in some way? Your response may be as brief or as extensive as you would like.

20. Please estimate approximately how often you have chosen to engage in the boundary-related behavior you selected above (as your answer to Question 17).

- Never     Very Infrequently     Infrequently     Sometimes     Frequently     Very Frequently     Always

21. Of the items in the category "Communication Outside of Sessions," which of the following has caused you the most difficulty in your own decision-making? Please choose one.

- Communicating with a client through email
- Giving your personal phone number (home or cell) to a client
- Calling a client between sessions to check in
- Calling a client to remind him or her of an appointment
- Communicating with a client while you are on vacation
- Continuing communication with a client after termination and without restarting treatment
- None of these has caused me any difficulty
- Other (please specify)

**22. Please indicate which of these factors are or have been influential to your own decisions about whether to engage in the behavior you indicated in the previous question (your answer to Question 21). Please choose all that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> The length of time the client has been in treatment with me                            | <input type="checkbox"/> The client's age  |
| <input type="checkbox"/> A crisis situation   | <input type="checkbox"/> The client's race or ethnicity                                  |
| <input type="checkbox"/> Something I have in common with a client   | <input type="checkbox"/> The client's sexual orientation                                 |
| <input type="checkbox"/> The client's level of acuity (baseline)  | <input type="checkbox"/> The client's religion   |
| <input type="checkbox"/> The presence of character pathology or Axis II traits                                  | <input type="checkbox"/> The client's gender   |
| <input type="checkbox"/> The client's lack of social supports   | <input type="checkbox"/> The client's socioeconomic status                               |
| <input type="checkbox"/> Deciding that it would be impolite or counterproductive to not engage in this behavior | <input type="checkbox"/> None of the above factors have influenced my boundary decisions |
| <input type="checkbox"/> A particular strong bond, connection, or investment the client                         |  |
| <input type="checkbox"/> Other (please specify)   |  |

**23. Please think of a time that you engaged in the boundary-related behavior that you indicated in Question 21. Use the space below to elaborate on how you came to your decision. You may include a description of how any of the factors listed above influenced the decision, and any other comments you would like to add. Do you feel that your decision was beneficial to the therapy, or that it hindered it in some way? Your response may be as brief or as extensive as you would like.**

**24. Please estimate approximately how often you have chosen to engage in the boundary-related behavior you selected above (as your answer to Question 21).**

- Never     Very Infrequently     Infrequently     Sometimes     Frequently     Very Frequently     Always



**25. Of the items in the category "Social Interactions," which of the following has caused you the most difficulty in your own decision-making? Please choose one.**

- Initiating a greeting with a client in a public place
- Recommending services for a client that are outside of your field, e.g. a plumber or florist
- Asking a client for advice in his or her field or area of expertise
- Accepting an invitation to a meaningful event in a client's life
- Transporting a client in your personal vehicle
- Communicating with a client via a networking website, e.g. LinkedIn or facebook
- None of these has caused me any difficulty
- Other (please specify)

**26. Please indicate which of these factors are or have been influential to your own decisions about whether to engage in the behavior you indicated in the previous question (your answer to Question 25). Please choose all that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> The length of time the client has been in treatment with me                            | <input type="checkbox"/> The client's age  |
| <input type="checkbox"/> A crisis situation   | <input type="checkbox"/> The client's race or ethnicity                                  |
| <input type="checkbox"/> Something I have in common with a client   | <input type="checkbox"/> The client's sexual orientation                                 |
| <input type="checkbox"/> The client's level of acuity (baseline)  | <input type="checkbox"/> The client's religion   |
| <input type="checkbox"/> The presence of character pathology or Axis II traits                                  | <input type="checkbox"/> The client's gender   |
| <input type="checkbox"/> The client's lack of social supports   | <input type="checkbox"/> The client's socioeconomic status                               |
| <input type="checkbox"/> Deciding that it would be impolite or counterproductive to not engage in this behavior | <input type="checkbox"/> None of the above factors have influenced my boundary decisions |
| <input type="checkbox"/> A particular strong bond, connection, or investment the client                         |  |
| <input type="checkbox"/> Other (please specify)   |  |

**27. Please think of a time that you engaged in the boundary-related behavior that you indicated in Question 25. Use the space below to elaborate on how you came to your decision. You may include a description of how any of the factors listed above influenced the decision, and any other comments you would like to add. Do you feel that your decision was beneficial to the therapy, or that it hindered it in some way? Your response may be as brief or as extensive as you would like.**

**28. Please estimate approximately how often you have chosen to engage in the boundary-related behavior you selected above (as your answer to Question 25).**

- Never     Very Infrequently     Infrequently     Sometimes     Frequently     Very Frequently     Always



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**29. In which of the following have you participated or consulted for help with difficult boundary decisions? Check all that apply:**

- Received education regarding boundaries in school (i.e. in my Master's, Doctoral, or MD program)
- Consulted with my supervisor(s) regarding possible boundary issues
- Attended an optional training that was related to boundary issues (e.g. a seminar for CEUs)
- Attended a mandatory training or discussion regarding boundaries at my place of employment
- Been employed at an agency that has a policy regarding negotiation of professional boundaries, boundary crossings and/or boundary violations
- Communicated or consulted with colleagues (either informally or during peer supervision) regarding possible boundary issues
- Consulted my professional Code of Ethics
- Other (please specify)

**30. Please use the space provided to comment on any barriers you feel may keep clinicians from utilizing any of the resources listed above:**



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**31. Please rate each of the following on how effective you believe it would be in helping clinicians with difficult boundary decisions. (Assume that all are available).**

1 (Not at all effective)    2 (Slightly effective)    3 (Moderately effective)    4 (Extremely effective)

|  |                       |                       |                       |                       |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| Education regarding boundaries in school (i.e. Master's, Doctoral, and MD programs)    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Consultation with your supervisor regarding possible boundary issues                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Ongoing optional trainings offered related to boundary issues (e.g. seminars for CEUs) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Mandatory trainings regarding boundaries at your place of employment                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Agency policies around boundary negotiations, crossings, and/or violations             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Informal consultation or peer supervision colleagues regarding boundary issues         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Consultation with your profession's Code of Ethics                                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



Prev

Submit

Thank you for your participation!

Submit

## Appendix F: Recruitment Letter to Colleagues and Classmates

Dear Friends, Colleagues, and Classmates,

Many of you (especially my Smith classmates) are aware that I am working on my Master's thesis, which involves conducting an exploratory research study into how psychotherapists make decisions about boundaries in outpatient clinical practice.

I am sending you this email to ask for your help with recruiting participants for my research study, which is a brief online survey. If you meet eligibility criteria, I also invite you to participate in the study.

My study focuses on boundary-*crossing* decisions made by therapists, including the contextual factors that are considered in arriving at these decisions. This study will not ask about any boundary-*violating* behaviors, such as sexual transgressions, and does not include any questions about physical touch, dual relationships, or self-disclosure. Potential participants will be presented with an informed consent form as part of the online survey. Participants will not be asked for their signatures, but only to check a box if they agree to participate.

Clinicians are eligible to participate in my study if they are currently practicing outpatient therapy in the United States with a Master's degree, Doctorate degree, or MD in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, Psychiatric Nursing, Psychology, or Psychiatry. Participants must have received graduate or postgraduate training to practice psychotherapy.

Participating in the study is very easy. Filling out a user-friendly online questionnaire is the only requirement, which should take between ten and twenty minutes to complete. Below is a link to the website containing my thesis questionnaire.

If you meet criteria for participating, I encourage you to take part in my study. Participation is anonymous, so I will have no way of knowing whether or not you participated. If you do not meet criteria, I encourage you to please **forward this email** to any acquaintances or colleagues you know of who may be eligible to participate. The forwarding of this email to other potential participants would be very helpful!

By participating in this research, participants will help to illuminate the gray areas of boundary decisions and the complex factors that influence them. Responses will provide insight to clinical practitioners, supervisors, and educators into the difficulties therapists experience in the field in terms of boundary decisions, how they resolve dilemmas, and what therapists believe is needed to assist them with such decisions, if anything.

\*Please follow this link to the survey: <https://www.surveymonkey.com/s/5VCNSQM>

If you have any questions about my research or the nature of participation, please feel free to reply to this email or contact me at a later date. If you reply to this email, please be cautioned not to hit "Reply all."

Thank you for your time, assistance, and interest in my research topic!

Sincerely,  
Tori Brinckerhoff  
MSW Candidate, Smith College School for Social Work

## **Appendix G: Recruitment Letter for Community Therapists Listed in Online Databases**

Dear Colleague,

My name is Tori Brinckerhoff, and I am a graduate student at the Smith College School for Social Work, currently doing my final clinical internship in Providence, Rhode Island. I am writing to ask for your help in completing my Master's thesis by participating in a brief (10-20 minute) user-friendly electronic survey on the topic of boundary maintenance within the therapist-client relationship. You are receiving this email because you have identified yourself as an outpatient psychotherapist on a public online directory of therapists.

My research study is an exploratory investigation into the boundary decisions made by therapists, including the contextual factors that are considered in arriving at these decisions. My study focuses only on boundary-*crossing* decisions made by therapists, including the contextual factors that are considered in arriving at these decisions. By participating in this research and sharing your clinical insights about it, you will help to illuminate the gray areas of boundary decisions and the complex factors that influence them. Your responses could benefit clinical practitioners, supervisors, and educators.

Participating in the study is very easy; filling out an online questionnaire is the only requirement. This study will not ask about any boundary-violating behaviors, such as sexual transgressions, and does not include any questions about self-disclosure, dual relationships, or physical touch. If you become a participant, an informed consent form will be presented to you as part of the online survey. You will not be asked for your signature, but only to check a box if you agree to participate.

You are eligible to participate in my study if you are currently practicing outpatient therapy in the United States with a Master's degree, Doctorate degree, or MD in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, Psychiatric Nursing, Psychology, or Psychiatry. Participants must have received graduate or postgraduate training to practice psychotherapy.

If you meet criteria for participating, I encourage you to take part in my study. Participation is anonymous, so I will have no way of knowing whether or not you participated. If you do not meet criteria, I encourage you to please **forward this email** to any acquaintances or colleagues you know of who may be eligible to participate. The forwarding of this email to other potential participants would be very helpful! Below is a link to the website containing my thesis questionnaire.

Please follow this link to the survey: <https://www.surveymonkey.com/s/5VCNSQM>

If you have any questions about my research or the nature of participation, please feel free to reply to this email or contact me at a later date. If you reply to this email, please be cautioned not to hit "Reply all."

Thank you for your time and interest in my research topic!

Sincerely,  
Tori Brinckerhoff  
MSW Candidate, Smith College School for Social Work

## Appendix H: Recruitment Letter for Field Agency Staff

Dear Butler Hospital Staff Member,

My name is Tori Brinckerhoff, and I am a Graduate Social Work Intern in the Partial Hospital Program here at Butler. I am in my final year at the Smith College School for Social Work, and I am doing an exploratory research study, for my Master's thesis, into how psychotherapists make decisions about boundaries in outpatient clinical practice.

I would like to invite you to participate in my study questionnaire, which is a brief online survey. I am sending you this email because you are a clinician who may be involved in outpatient clinical practice, either full time, or in addition to your other work at Butler.

This exploratory investigation into boundary issues is similar in theme to the topic of boundary issues raised at the staff education fair that was recently held at Butler, but has a different emphasis. My study focuses only on boundary-*crossing* decisions made by therapists, including the contextual factors that are considered in arriving at these decisions. By participating in this research and sharing your clinical insights about it, you will help to illuminate the gray areas of boundary decisions and the complex factors that influence them. Your responses could benefit clinical practitioners, supervisors, and educators.

You are eligible to participate in my study if you are currently practicing outpatient therapy with a Master's degree, Doctorate degree, or MD in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, Psychiatric Nursing, Psychology, or Psychiatry. Participants must have received graduate or postgraduate training to practice psychotherapy. If you are not eligible, please consider passing this email on to colleagues who are.

Participating in the study is very easy. Filling out a user-friendly online questionnaire is the only requirement, and it should take between ten and twenty minutes to complete. This study will not ask about any boundary-violating behaviors, such as sexual transgressions, and does not include any questions about self-disclosure, dual relationships, or physical touch. If you become a participant, an informed consent form will be presented to you as part of the online survey. You will not be asked for your signature, but only to check a box if you agree to participate.

If you meet criteria for participating, I encourage you to take part in my study. Participation is anonymous, so I will have no way of knowing whether or not you participated. If you do not meet criteria, I encourage you to please **forward this email** to any acquaintances or colleagues you know of who may be eligible to participate. The forwarding of this email to other potential participants would be very helpful! Below is a link to the website containing my thesis questionnaire.

\*Please follow this link to the survey: <https://www.surveymonkey.com/s/5VCNSQM>

If you have any questions about my research or the nature of participation, please feel free to reply to this email or contact me at a later date. If you reply to this email, please be cautioned not to hit "Reply all."

Thank you for your time and interest in my research topic.

Sincerely,  
Tori Brinckerhoff  
MSW Intern, Butler Hospital  
MSW Candidate, Smith College School for Social Work

## Appendix I: Permission for Recruitment of Staff from Field Agency



BUTLER  
HOSPITAL

January 25, 2012

Smith College School for Social Work  
Human Subjects Review Board  
Northampton, MA 01063

To Whom It May Concern:

This letter is to grant permission for Victoria Brinckerhoff, a second year MSW Intern at Butler Hospital, to recruit Butler staff for her MSW thesis research study.

Victoria will be studying psychotherapists' opinions and experiences regarding the boundary decisions they make in outpatient practice. The study will focus on behavior that has been identified as boundary-crossing behavior (such as accepting an invitation to a meaningful event in a client's life), which remain in a "gray area" and a subject of ongoing debate. This is distinguished from boundary violations, classified as "wrongful acts," such as sexual transgressions. The study will be conducted through a quantitative questionnaire that will be administered to practicing clinicians via the internet. The survey is completely anonymous and all data will be kept confidential.

To help reach her target population, Victoria has been provided with a partial list of Butler Hospital staff members who are known to practice outpatient psychotherapy in addition to their inpatient work at the Hospital, and has been encouraged to contact any other staff who may also be eligible to participate. Victoria has permission to send a recruitment email to these identified staff members as well as all Social Services staff members. I understand that the recruitment email will include information about the purpose of the research, inclusion and exclusion criteria, nature of participation, and any possible risks associated with participation; and will provide a hyperlink to the website that contains her thesis questionnaire. The email will also invite recipients to forward the email and hyperlink to the research study on to colleagues who may be eligible to participate in the study.

Victoria also has permission to give a brief, 2-3 minute presentation about her research study to Social Services staff members at one of our weekly Social Services staff meetings. Victoria's presentation will include information regarding the purpose of the research, inclusion and exclusion criteria, nature of participation, and any possible risks associated with participation. At this meeting, staff will not be asked to indicate if they are interested in participating, but afterwards, Victoria will send a recruitment email to all Social Services staff members, requesting their participation in her research and/or requesting that they forward the email about the study to potentially eligible colleagues.

I am aware that although risks of participation are minimal, for any Butler Hospital staff member who participates in the study, there is a chance for unpleasant emotions to arise while they are thinking about and responding to survey questions that ask them to reflect on their practice.

Sincerely,

Laura Drury, MSW, LICSW  
Clinical Director of Social Services, Butler Hospital  
Smith College School for Social Work Alumna



345 Blackstone Boulevard, Providence, RI 02906  
Affiliated with the Brown University School of Medicine  
TDD/TTY