Boundary Violations: Character & Contexts

Edward Dickeson

School of Psychology

University of Adelaide

This report is submitted in partial fulfillment of the degree of Master of Psychology (Clinical) and was supervised by Associate Professor Rachel Roberts, University of Adelaide and Dr Matthew Smout, University of South Australia

Submitted: October, 2019.

Contents

Statement of Authorship

This report contains no material which has been accepted for the award of any other degree or diploma in any University, and, to the best of my knowledge, this report contains no materials previously published except where due reference is made.

I give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the School to restrict access for a period of time.

Statement of Contribution

I was involved in the project as follows:

- conception of the research question;
- individual intensive empirical literature review;
- individual data analysis;
- individual reporting of results and discussion; and
- individual or shared data collection.

Word count not including tables, figures or references:

Literature review: 3,989

Research project: 6,508

Acknowledgements

To my supervisors, Associate Professor Rachel Roberts of the University of Adelaide and Dr Matthew Smout of the University of South Australia. I can now look back and see several important decision points of this project where the entire thing would have failed completely were it not for their guidance.

To the two-hundred-and-seventy-five mental-health professionals who took the time to complete the survey.

To my student cohort for being a friendly and humble group to learn alongside.

For my wife Emily and our children Hannah and Ambrose.

Literature Review:

Sexual Boundary Violations: Empirical Support of Gabbard's Taxonomy

Edward Dickeson

School of Psychology

University of Adelaide

Abstract

Likely the most well-known of its kind, Gabbard's (1994) taxonomy of sexual transgressing therapeutic practitioners includes; the impulsive and exploitative Predatory Practitioner; the older, disillusioned Lovesick Practitioner; and the vulnerable, self-sacrificing Masochistic-Surrendering Practitioner. These categories were formulated through clinical observation, and the extent to which they reflect the actual occurrence of sexual boundary violations is unclear. This narrative review sought empirical studies which have reported findings relevant to Gabbard's taxonomy. In addition, each category was considered from an original perspective, drawing from a broader range of philosophic and psychodynamic commentaries. Quantitative evidence was found to be generally consistent with Gabbard's descriptions, although despite its widespread reference, no instance was found where an empirical study had used the taxonomy as a framework for hypothesis testing. This review concludes on the observed gulf between the qualitative and quantitative contributions to the topic of boundary violations and argues for new research attempting to unify them.

Keywords: sexual boundary violations, professional ethics, countertransference, Glen Gabbard.

Introduction

"Those early analysts were absolutely predatory, almost every single one of them; Otto Rank was screwing Anais Nin, Jung was screwing Sabina Spielrein, and Toni Wolff and Ernest Jones screwed everybody." (Yalom, 1996, p. 104)

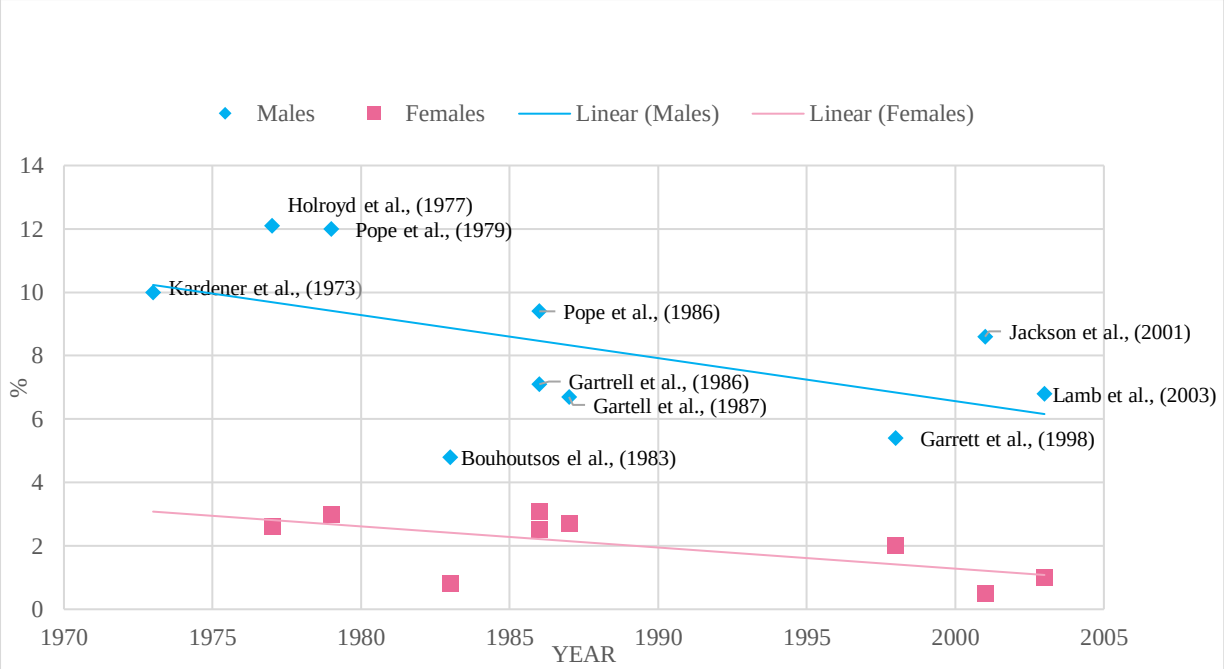
This description given by Paul, from Irvin D. Yalom's *Lying on the Couch*, speaks to the pervasive reputation for sexual misconduct that the field of psychotherapy has carried since its beginnings. The Medical Board of Australia (2018) calls sexual boundary violations (SBVs) unethical and harmful due to the inherent power imbalance that exists between practitioner and client, the likelihood of emotional and physical harm encountered by the client and the consequent loss of confidence the general public has for the health professions. These concerns, as well as the unique opportunity for sexual exploitation to occur within therapeutic practice, have been recognised as early as Hippocrates (Hulkower, 2016), but despite this, after two millenniums SBVs continue as a disturbing fixture within the health professions.

The likelihood of SBVs seems to be enhanced in the provision of mental-health related services, where the emotionally charged nature of the client-worker relationship typically involves a more intimate level of communication. Psychiatrists for example, compared with other physicians, are referred at disproportionately high rates to practitioner monitoring bodies as a result of sexual misconduct (Brooks, Gendel, Early, Gunderson & Shore, 2012). Additionally, mental-health clients face particular vulnerability given that their very accessing of these services, brings into question their credibility as a complainant, as demonstrated by the following statement given by the then chairman of the American Psychological Association Insurance Trust.

It seems fair to state that the greatest number of actions are brought by women who lead lives of very quiet desperation, who form close attachments to their therapists, who feel rejected or spurned when they discover that relations are maintained on a formal and professional level, and who then react with allegations of sexual improprieties (Brownfain, 1971, p. 651).

Incidentally, at the time of these remarks, over 10% of male psychiatrists and psychologists would admit to having had erotic contact with one of their clients (See *Figure 1*).

Figure 1: Historical trends of self-reported psychiatrist and psychologist sexual boundary violations



Note: Minimum female and male combined samples size is n = 321, in Jackson et al. 2001.

Anonymous, self-reporting indicates a historical decline in the instance of sexual misconduct by both male and female psychologists and psychiatrists over the past 50 years. Reasons for this decline are likely two-fold. Firstly, male psychotherapists report sexual misconduct at a rate 4-5 times higher than their female colleagues and during the same period as the observed decline, females became the predominant gender in the field; rising from 20% in 1970 to 72% in 2005, of American psychology doctorate recipients (Cynkar, 2007). It

seems likely that what Ostertag and McNamara (1991) refer to as the "feminisation of psychology", did something to quell a culture of wanton promiscuity that had existed since the period described in Yalom's novel. Secondly, over the past five decades, a growing portion of the psychological literature has become dedicated to the condemnation, documentation and explanation of mental health professionals who engage in sexual contact with their clients.

Gabbard's Taxonomy

Prominent among the authors is Glen O. Gabbard whom, based on clinical experience as a treater and evaluator of therapists reprimanded for SBVs, suggested that such professionals generally fall into four broad categories: (1) The Psychotic Practitioner - the smallest group, whose transgressions occur within the context of a psychotic disorders such as schizophrenia; (2) The Predatory Practitioner – characterised by features of antisocial personality disorder; (3) The Masochistic-Surrendering Practitioner, whose excessive devotion to their clients ultimately leads to a deterioration of boundaries and eventual, often relenting to client pressure, sexual contact; and, (4) The Lovesick Practitioner – who so enraptured by their client, views the romantic involvement as a reasonable exception to ethical norms, often enacting such a transgression later in their careers and during a period when significant upheaval is occurring in their own personal life (Gabbard, 1994).

When SBVs are discussed, Gabbbard's taxonomy is usually mentioned as an available framework for differentiating transgressor types. In spite of this, no effort appears to have been made at considering how well the taxonomy has aligned with empirical evidence. This narrative review is aimed at providing a summary of existing thought and findings relevant to therapeutic boundary violations, guided by the framework of Gabbard's taxonomy, with the exception of the Psychotic Practitioner, whose actions are explained entirely by its description. An initial systematic literature search was conducted (see APPENDIX A) with

further relevant areas explored by the author outside of these initial search parameters (e.g. *Therapist drift*, *The Wounded Healer*).

The Predatory Practitioner and the Myth of Pure Evil

Gabbard (1994, p. 126) describes the Predatory Practitioner as one with prevalent anti-social features. Their sexual deviancy typically involves bizarre and sadistic elements which originated before the individual joined the profession. Their worrisome nature is often noted early in their training, however their ability to manipulate supervisory systems and their willingness to threaten litigation, often enable them to avoid professional revocation.

The literature provides some support to the existence of a segment of helping professionals who are characterised by anti-social features and whom are responsible for a disproportionately high amount of client exploitation. When education, age and marital status are controlled for, male physicians known to have committed SBVs, have produced anti-social personality profiles indistinguishable from sex offenders in the wider forensic population (Langevin, Glancy, Curnoe and Bain, 1999). Additionally, SBV therapists have proven distinguishable, with significantly greater anti-social features, to therapists reprimanded for non-SBV related transgressions (Roback et al., 2007). And finally, in a longitudinal study, Garfinkel, Bagby, Waring & Dorian (1997) screened a sample of first-year psychiatry trainees using the Minnesota Multiphasic Personal Inventories and tracked these individuals for 17 years. Two of the participants later had their licenses revoked due to SBVs and this pair were retroactively identifiable, showing significantly higher levels of traits consistent with the predatory profile; psychopathic deviancy, hypomania and evasiveness.

When considering this evidence, it should be noted that Gabbard (1994) reports that psychopathic predators only constitute a minority of SBV transgressors. Moreover, he warns that the predatory motif has a tendency to be overemphasised when therapeutic institutions

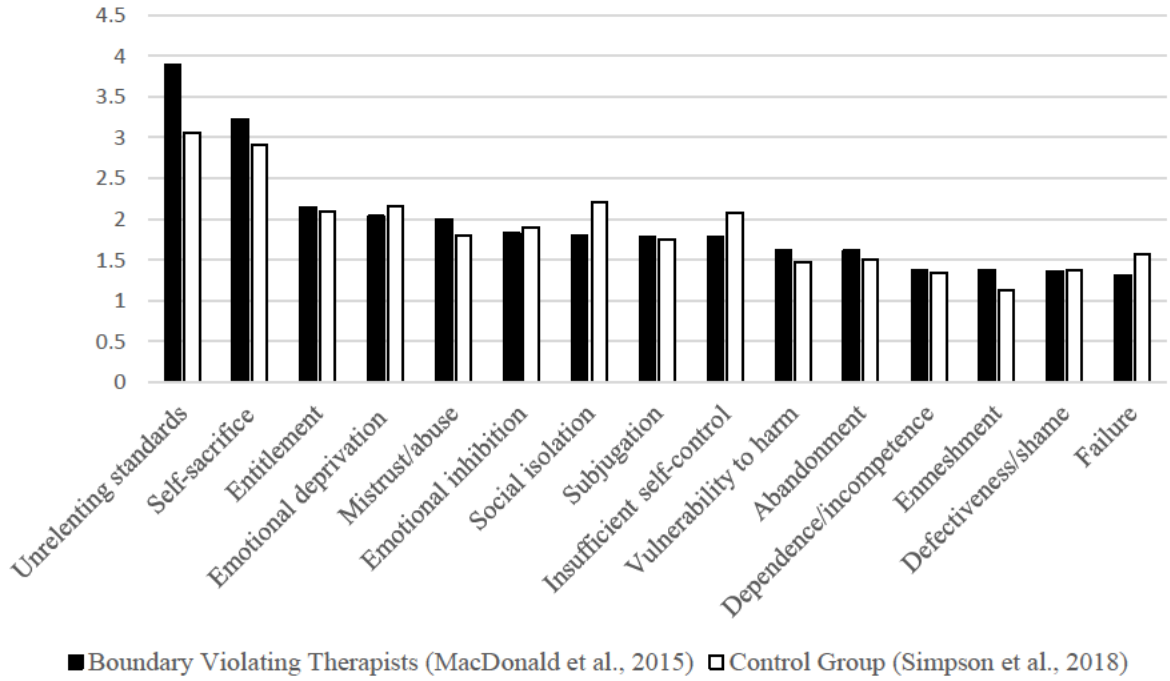
consider the issue of SBVs (Gabbard, 2017). In his essay *The Myth of Pure Evil*, Baumeister (2012) states that bias is inherent whenever we deem another's actions as 'evil'. Because the label of evil contains both the description of a wrongdoer and an explanation for their motives, it can be used to explain away any abhorrent action through a form of circular reasoning. Baumeister describes that by deliberately trying to understand another's wrongdoing, we are forced to elevate their moral standing whilst simultaneously lowering our own. Similarly, Celenza and Gabbard (2002) suggest that by emphasising and disowning boundary transgressing practitioners, the therapeutic profession maintains a cleansed perception of itself and individual therapists can in turn deny their own capacity for similar transgressive behaviour.

Even with the evidence of elevated anti-social traits, it is unlikely that the future actions of even the most egregious SBV prone therapists could ever be confidently pre-empted. One issue being the considerable overlap that appears to exists between the profiles of therapists who do and do not sexually exploit their clients. Early Maladaptive Schemas (EMS), describe an individual's ingrained patterns of thinking toward themselves, others and the world (Young, Klosko & Weishaar, 2003). For the purpose of the current literature review, the means were compared of two independent studies (*Figure 2*) which both used the Young Schema Questionnaire Short Form (YSQ-SF; Young & Brown, 1998). One was a sample of healthcare providers facing reprimand for SBVs (MacDonald, 2015; n = 100, 93% male), the other was a convenience sample taken from Australian and United Kingdom psychologists (Simpson et al., 2018; n = 87, 100% male).

The YSQ-SF is a 75-item, self-report instrument designed to capture the 15 categories of maladaptive schemas as posited by (Young, Klosko & Weshaar, 2003). The higher the score, the more influential that category of schema is considered to be on the individual. The boundary-violating practitioners produced similar profiles to that of the comparison group

with both groups being most predominantly characterised by the same two schemas; 'self-sacrifice' – excessive priority of others needs at the expense of self, and, "unrelenting standards' – hyper-criticalness towards one's self with unrealistic expectations of performance and conduct (Refaeli, Bernstein & Young, 2010).

Figure 2: Early Maladaptive Schemas of Sexual Boundary Violating Practitioners Compared to a Control Group



These findings are antithetical to the description of the Predatory Practitioner for which one might have expected the prevalence of 'Entitlement' – a belief that one is superior to other people, entitled to special rights and privileges, or 'Insufficient Self-control' – refusal or inability to restrain the excessive expression of one's emotions and impulses (Refaeli, Berstein & Young, 2010). Not only were MacDonald and Colleagues' (2015) sample of boundary-violating therapists most characterised by an unhealthy level of dedication to their pursuits and an unhealthy level of consideration to the needs of others, independent sample t-tests indicated that that their scores were elevated even in comparison to their colleagues. For the 'unrelenting standards' schema, the SBV practitioners ($M = 3.89$, $SD = 1.13$) reported significantly higher scores than the control group ($M = 3.06$, $SD = 1.13$), $t(185) = 4.729$, $p >$

.001, two-tailed, d = .69. Likewise for 'self-sacrificing', the SBV practitioners (M = 3.22, SD = 1.07) again reported significantly higher scores than the control group (M = 2.91, SD = 1.07), $t(185) = 1.976$, $p > .05$, two-tailed, d = .29.

These results suggest that rather than being distinguishable from their colleagues, SBV-prone therapists possess the same, and perhaps even more of, the schematic content that is typical of the profession at large. Potential implications relate not just to explaining the behaviour of the small minority of practitioners who transgress ethical boundaries, but more broadly to considering a general vulnerability that exists within the profession itself. Such a vulnerability may even be inseparable from an individual's motivation to join the profession to begin with.

Masochistic Surrender and the Wounded Healer

Differing from other transgressors, Masochistic-Surrendering Practitioners are not satisfying their own sexual desire when they engage in SBVs (Gabbard, 1994). Instead, these individuals are characterised by their tireless devotion to their work and their ultimate willingness to give everything they have to their clients. Initially, the practitioner responds to the perceived special circumstances of the therapeutic encounter, for example they may allow sessions to run overtime, provide the client with their personal phone number or offer to meet outside of official appointments. These misguided attempts to save or rescue, escalate until the practitioner has provided a relationship that far exceeds professional norms and by doing so, have provided the client with considerable leverage over them. Sex occurs as the final resource that such a practitioner can offer, often in the context of a client threatening blackmail or suicide (Gabbard, 1994). While such a professional may initially appear to have benevolent motivations, theoretical explanations of the Masochistic-Surrendering Practitioner point towards the pursuit of a more subtle form of self-gratification. Gabbard (2017, p.53) suggests that many such therapists are, through their work, re-enacting childhood experiences

of mistreatment at the hands of their parents – a topic that has been written of extensively in the wider literature.

It is well documented that a disproportionately high rate of childhood adversity is reported from the ranks of the healing professions (Bamber & McMahon, 2008; Gavin & Smith, 2015; Wise, Hersh & Gibson, 2012). The relationship between childhood adversity and a person gravitating towards the healing professions, is commonly encapsulated by Carl Jung's archetypal figure "The Wounded Healer" (Newcomb, Burton, Edwards & Hazelwood, 2015), the core features of which involve an individual who after experiencing extreme hardship, dedicates their existence to the service of others, empowered by their own similar experiences.

Theoretically, a child growing up in adverse conditions may develop both the attributes and motivation to enter the healing professions. Childhood adversity often involves reversed caregiving roles which necessitates that a child behaves selflessly and develops exceptional attunement or empathy (Lackie, 1983). Additionally, because of the absence of healthy attachment figures, such an individual may have difficulty deriving self-worth absent from their willingness to sacrifice themselves for others; first as children and later as practitioners. The theme of self-sacrifice is inseparable from the wounded healer archetype, the quintessential Western example being the story of Jesus Christ who has to suffer brutal execution in order to become the saviour of humanity. While perhaps some practitioners attempt to embody this example, the archetype is often also mentioned as being prone to the same vulnerabilities within the therapeutic relationship as the Masochistic-Surrendering Practitioner (Halewood & Tribe, 2003; Ivey & Partington, 2014; Newcomb et al., 2015). Comparatively is Gabbard's (1994) use of the term 'masochism' to describe his profile, referring to these individuals apparent eagerness to sacrifice their own careers and personal lives for the service of their clients.

As mentioned, evidence of this phenomenon is seen in the prominence of self-sacrificing EMS among psychologists (Simpson et al., 2018) and the even greater prominence among those who have transgressed sexual boundaries (MacDonald, 2015). Additionally, 613 practitioners reprimanded for sexual misconduct, were more likely to report family-of-origin dysfunction compared to a control group (Samenow, Yabiku, Ghulyan, Williams & Swiggart, 2011) and from a randomly drawn sample of 323 practitioners, those who reported childhood abuse were more than four times as likely to admit engaging in erotic contact with a client (Jackson & Nuttell, 2001).

The Masochistic-Surrendering Practitioner and the Predatory Practitioner may signify a spectrum of helping professionals marked on one end by 'caring too much' and on the other by 'not caring enough'. Dickeson and Smout (2018) found significant relationships between boundary violation propensity and experiential avoidance – maladaptive efforts to avoid or suppress aversive internal experiences like unpleasant thoughts and feelings (Hayes, Wilson, Gifford, Follette & Strosahl, 1996), from which they hypothesised that certain boundary violations may occur in the context of excessive, rather than absent, sympathy. Practically speaking, it is such a practitioner's inability to defuse from their automatic physiological responses, cued by the presence of a suffering client, which makes them initially susceptible to error-prone judgment.

Gabbard (1994) suggests Masochistic-Surrendering Practitioners typically display shame and remorse in the wake of SBVs and, differing from other transgressors, are often amenable to rehabilitation. The potential relevance of experiential avoidance suggests a possible framework for such rehabilitative efforts to be conceptualised. At its core, Acceptance Commitment Therapy (ACT) aims to reduce experiential avoidance in individuals by helping them to embrace aversive internal stimuli through meditative practice and value-driven action (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Subsequently it is

implied that if practitioners can be trained to increase psychological flexibility, the impact of sympathetic tendencies toward poorer clinical judgement might be reduced (Dickeson & Smout, 2018). These and other practical factors are further relevant to the final category of Gabbard's taxonomy.

Lovesickness and The God Complex

The Lovesick Practitioner has a romantic attraction to their client, thus combining the sexual interest of the Predatory Practitioner with the over-involvement of the Masochistic-Surrendering Practitioner. Unlike the above-mentioned categories which reflect the extreme ends of domineering and submissive personalities, the Lovesick Practitioner is described predominantly by context. Gabbard (1994) describes an older male, who is professionally isolated and who falls in love with a younger female client whilst in the midst of a significant life-stressor such as a divorce or mid-life crisis.

The criteria of life-stressors, advanced age and working in professional isolation, is consistent with the quantitative literature. In their survey of mental-health practitioners (n = 323, 42% males), Jackson and Nuttall's (2001) reported a moderate (r = .33), positive correlation between previous sexual activity with a client and practitioner psychological distress. Furthermore, Samenow and colleagues (2011) reported that practitioners whom had committed an SBV (n = 613, 94% male) were almost seven times more likely to be divorced compared with a control group. At least two past studies have also indicated solo, private-practices to be a work setting that produces disproportionately high instances of SBVs (DuBois et al., 2017; Thoreson, Shaughnessy, Heppner & Cook, 1993). Finally, with regard to age, in both Stake and Oliver's (1991) sample of therapists (n = 320, 65% male), and Garrett and Davis' (1998) sample of British psychologists (n = 581, 38% male) those with more years of experience expressed more permissive attitudes towards sexual misconduct and produced higher scores on measurements of overt sexual behaviour. Additionally, Rodolfa

and colleagues' (1994) survey of psychologists (n = 386, 52% male) found that while younger, male therapists were significantly more often attracted to clients, older, male therapists were significantly more inclined to actually consider engaging in an erotic, boundary transgressing relationship.

In addition to these contextual factors, Gabbard (1994, p. 127) describes a narcissistic vulnerability typical of the Lovesick Practitioner; "*desperate need for validation by their patients, a hunger to be loved and idealised, and a tendency to use patients to regulate their own self-esteem*." Not only does this observation appear to also reflect aspects of the Predatory and Masochistic-Surrendering Practitioners, similar comments have also been made of the entire psychological profession. In his seminal essay *The God Complex; The Belief that One is God, and the Resulting Character Traits*, Ernest Jones (1913), a member of Freud's inner circle and whose career would later became marred by rumours of sexual impropriety (Gabbard, 1995), describes how an individual fantasising of and wishing to embody god-like features, would naturally be drawn to the profession of psychology. According to Jones, such an individual seeks a "short-cut" to knowledge of other people's minds and the therapist's role within the therapeutic relationship might offer a distilled opportunity to play god. If granting Jones' thesis, it is possible to argue how the prevailing contextual factors descriptive of the Lovesick Practitioner might come to eventuate.

Unique to almost any other human relationship, therapists are given unequalled access into their client's private lives, who will often in turn revere them and carry the thought of them outside of session (Kottler, 2017). Hence in some measure, the therapist has taken on the god-like qualities of omniscience, omnipotence and omnipresence. Jones (1913, p. 247) states that the most characteristic feature associated with a god complex is the individual's tendency for aloofness. Jones described how if one can remain inaccessible and surround their personality in a cloud of mystery, they can avoid displaying any vulnerability which

would immediately disrupt the illusion and trigger the jarring experience of being exposed as human. Again, the therapist's consultation room offers the perfect environment to enact this fantasy and provide a medium of existence that may become preferred over one's own actual life. Gabbard (2016, p. 40) writes how the Lovesick Practitioner may '… *be in a solo private practice situation in which virtually all of their contacts with other people, from early morning until late into the evening are with patients*." The life-stressor which often triggers the Lovesick Practitioner's transgression, may in part have been the consequence of the neglect with which such individuals treat their personal lives in favour of their work.

Another relevant consequence of the aloofness and grandiosity described by Jones is the distance that it placed between these individuals and the rest of their profession. Therapist Drift, the tendency of therapists to gradually deviate from evidence-based intervention (Waller, 2009), is explained in some part by the false confidence that comes with experience (Waller & Turner, 2015), or as Celenza (2017, p. 162) writes "*As we get older, seasoned, and well-trod, the lure of exceptionalism increases as well*." Gabbard (1994) notes that over time many therapists become disillusioned and resentful towards their institutions, and this may result in an impulsive preference for the autonomy of solo-private practice.

Regarding advanced years, it is possible that if the entire careers of certain, mostly male, therapists had come to represent some grandiose fantasy, such an illusion would reliably be shaken by a mounting evidence of physical and mental decline. A therapist's judgment, compromised already by several decades of an ingrained god-complex, may become especially distorted in the face of their own mortality. Perhaps the therapist begins to welcome and even encourage erotic transference from their younger, female clients in order to serve as counterpoint to the possibility that they have become old. Alternatively, the actual acknowledgement of their advancing years motivates these men to escalate their flirtations,

either as the last-minute seizing of a long-abstained opportunity, or else an effort to secure adequate companionship for their approaching retirement.

Given that the Lovesick Practitioner is described primarily by contextual factors, it is possible that this category actually describes the circumstances in which those sitting anywhere across a continuum of dormant predatory or surrendering characteristics, begin making transgressions within the therapeutic relationship. Practitioners with anti-social features like impulsivity and domineering personalities, might initially excel among their colleagues and be successful in instilling their clients with a greater sense of optimism. Overtime however, their overbearing presence likely leads them to become estranged from their professional base, allowing their practice to become more unorthodox and self-indulgent. Likewise, the Masochistic-Surrendering Practitioners' tireless devotion to their work is likely to have initially brought admiration from their colleagues. However, their lack of self-care and poor work-life balance eventually creates the conditions of personal upheaval in which boundary violations are more likely to occur. And for both profiles, the narcissistic satisfaction which their professions have provided them, could overtime exacerbate a feeling of 'specialness' and the sense that for them, normal rules do not apply.

If this trajectory is true, then practitioners who identify as having excessively domineering or self-sacrificing characteristics early in their careers, might be able to mitigate their risk of compromising professional boundaries later in their careers. Based on the lovesick profile, this would include; the need for additional supervision when operating in private practice, potential restrictions placed on the number of clients a practitioner can see each day and an overall greater emphasis on work-life balance, particularly when approaching retirement.

Summary and Future Directions

Using the lens of Gabbard's (1994) taxonomy, this paper considered the current literature regarding the known characteristics of therapeutic practitioners who engage in SBVs with clients. Sexual contact between practitioner and client has long been recognised as unethical within the therapeutic disciplines however its occurrence has been historically pervasive, particularly within psychotherapy where the privacy and intimacy intrinsic to the discipline, provides a set of conditions that seem to increase their occurrence. The rate with which practitioners engage in SBVs has declined over the past 50 years, possibly due to the increase of women practitioners which may have disrupted misogynistic aspects of the profession's earlier culture. Despite this decline, the frequency of SBVs might still be considered alarming, with the most recent surveys reporting 6-8% of male, mental-health practitioners admitting to such past transgressions (Jackson & Nuttall, 2001; Lamb, Catanzaro & Moorman 2003). The most widely recognised taxonomy of perpetrator characteristics was developed by Gabbard (1994), whose categories include the Predatory, Masochistic-Surrendering, and Lovesick practitioners. With regards to the predatory profile, investigations have suggested that practitioners with confirmed instances of SBVs, do have profiles with elevated anti-social traits (Langevin, Glancy, Curnoe and Bain, 1999; Garfinkel, Bagby, Waring & Dorian, 1997; Roback et al., 2007) however there are logical grounds to be cautious in overemphasising such characteristics in explaining the phenomena. Additionally, a comparison of schematic content indicates that there is more in common than what separates, boundary-violating practitioners from their colleagues (MacDonald, 2015; Simpson et al., 2018). This paper drew comparisons between the Masochistic-Surrendering Practitioner with the wounded healer archetype, which is often used to explain why a disproportionately large number of therapeutic practitioners report high instances of childhood adversity (Newcomb et al., 2015). In contrast to entirely selfish or predatory

motives, evidence suggests that practitioners with such experiences will be more likely to violate boundaries (Samenow, Yabiku, Ghulyan, Williams & Swiggart, 2011; Jackson & Nuttell, 2001), possibly in a misjudged effort to play the role of saviour to their client (Halewood & Tribe, 2003; Ivey & Partington, 2014; Newcomb et al., 2015). In these circumstances, the associated role of experiential avoidance may offer an ACT based approach for transgression prevention (Dickeson & Smout, 2018). The description of the Lovesick Practitioner is consistent with quantitative findings linking boundary violations to advanced age, professional isolation and significant life stressors (DuBois et al., 2017; Garrett & Davis, 1998; Jackson and Nuttall, 2001; Rodolfa et al., 1994; Samenow et al., 2011; Stake and Oliver, 1991; Thoreson, Shaughnessy, Heppner and Cook, 1993). This review emphasised how certain aspects of the psychotherapeutic occupation may actually perpetuate narcissistic tendencies (e.g. Jones, 1913) and suggested that the lovesick profile may simply be the contextual circumstances in which troublesome therapist personality features finally become problematic.

A limitation of this literature review is that by seeking to align quantitative evidence with Gabbard's (1994) taxonomy, it may have failed to locate unrelated or even contradictory findings. In relevance to this, none of the papers located in this review directly cited Gabbard in the rational for their hypotheses. On the subject of therapeutic boundary violations, there appears to exist a large gulf between the qualitative, psychodynamic writings in which the largest amount of critical thinking has taken place, and the much smaller number of empirical investigations. No known previous study has ever attempted an exhaustive, quantitative investigation of the practitioner characteristics associated with boundary violations using empirically validated instruments to measure the relevant constructs. For such an undertaking, Gabbard's taxonomy does provide a logical framework for selecting testable contexts and practitioner characteristics that are potentially associated with boundary

violations. Always and still, a small amount of transgressions results in a large amount of harm for individual clients and embarrassment to the wider therapeutic disciplines. As such, research of this description is justified.

References

Bamber, M., & McMahon, R. (2008). Danger—early maladaptive schemas at work!: the role of early maladaptive schemas in career choice and the development of occupational stress in health workers. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *15*(2), 96-112. doi: 10.1002/cpp.564

Baumeister, R. F. (2012). Human evil: The myth of pure evil and the true causes of violence. In M. Mikulincer & P. R. Shaver (Eds.), *Herzliya Series on Personality and Social Psychology. The Social Psychology of Morality: Exploring the Causes of Good and Evil* (pp. 367-380). Washington, DC, US: American Psychological Association. doi: 10.1037/13091-020

Brooks, E., Gendel, M. H., Early, S. R., Gundersen, D. C., & Shore, J. H. (2012). Physician boundary violations in a physician's health program: a 19-year review. *Journal of the American Academy of Psychiatry and the Law Online*, *40*(1), 59-66. Accessed online: http://jaapl.org/content/40/1/59

Brownfain, J. J. (1971). The APA professional liability insurance program. *American Psychologist*, *26*(7), 648.

Celenza, A. (2017). Lessons on or about the couch: What sexual boundary transgressions can teach us about everyday practice. *Psychoanalytic Psychology*, *34*(2), 157. doi: 10.1037/pap0000095

Celenza, A. 8c Gabbard, G. O. (2002). Analysts who commit sexual boundary violations: A lost cause. *JaPa*, *51*, 52-617.

Cynkar, A. (2007). The changing gender composition of psychology. Retrieved from https://www.apa.org/monitor/jun07/changing.aspx

Dickeson, E., & Smout, M. F. (2018). Is the wounded healer or the psychologically inflexible healer in undergraduate psychology and social work programs more empathic or willing to violate professional boundaries? *Australian Journal of Clinical Education*, *3*(1), 1-13.

DuBois, J. M., Walsh, H. A., Chibnall, J. T., Anderson, E. E., Eggers, M. R., Fowose, M., & Ziobrowski, H. (2017). Sexual violation of patients by physicians: a mixed-methods, exploratory analysis of 101 cases. *Sexual Abuse: A Journal of Research and Treatment*,1, 1-21. doi: 1079063217712217.

Gabbard, G. O. (1994). Psychotherapists who transgress sexual boundaries with patients. *Bulletin of the Menninger Clinic*, *58*(1), 124.

Gabbard, G. O. (1995). The early history of boundary violations in psychoanalysis. *Journal of the American Psychoanalytic Association*, *43*(4), 1115-1136. doi: 10.1177/000306519504300408

Gabbard, G. O. (1996). Lessons to be learned from the study of sexual boundary violations. *American Journal of Psychotherapy*, *50*(3), 311-322. Accessed online: https://doi-org.proxy.library.adelaide.edu.au/10.1176/appi.psychotherapy.1996.50.3.311

Gabbard, G. O. (2016). *Boundaries and boundary violations in psychoanalysis (2nd ed.)*. US, Virginia. American Psychiatric Pub.

Gabbard, G. O. (2017). Sexual boundary violations in psychoanalysis: A 30-year retrospective. *Psychoanalytic Psychology*, *34*(2), 151. doi: 10.1037/pap0000079

Galvin, J., & Smith, A. P. (2015). Stress in UK mental health training: a multi-dimensional comparison study. *British Journal of Education, Society & Behavioural Science*, *9*(3), 161-175. doi: 10.9734/BJESBS/2015/18519

Garfinkel, P. E., Bagby, R. M., Waring, E. M., & Dorian, B. (1997). Boundary violations and personality traits among psychiatrists. *The Canadian Journal of Psychiatry*, *42*(7), 758-763. doi: 10.1177/070674379704200709

Garrett, T., & Davis, J. D. (1998). The prevalence of sexual contact between British clinical psychologists and their patients. *Clinical Psychology & Psychotherapy: An International Journal of Theory and Practice*, *5*(4), 253-263. doi: 10.1002/(SICI)1099/0879(199812_5:4<253::AID-CPP171<3.0CO;2-4

Halewood, A., & Tribe, R. (2003). What is the prevalence of narcissistic injury among trainee counselling psychologists? *Psychology and Psychotherapy: Theory, Research and Practice*, 76(1), 87-102. doi: 10.1348/14760830260569274

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy*, 44(1), 1-25. doi: 10.1016/j.brat.2005.06.006

Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of consulting and clinical psychology*, *64*(6), 1152.

Hulkower, R. (2016). The history of the Hippocratic Oath: outdated, inauthentic, and yet still relevant. *Einstein Journal of Biology and Medicine*, *25*(1), 41-44. doi: 10.23861/EJBM20102542

Ivey, G., & Partington, T. (2014). Psychological woundedness and its evaluation in applications for clinical psychology training. *Clinical Psychology & Psychotherapy*, *21*(2), 166-177. doi: 10.1002/cpp.1816

Jackson, H., & Nuttall, R. L. (2001). A relationship between childhood sexual abuse and professional sexual misconduct. *Professional Psychology: Research and Practice*, *32*(2), 200. doi: 10.1037/0735-7028.32.2.200

Kottler, J. (2017). *On being a therapist*. Oxford University Press. Oxford, United Kindgom.

Lackie, B. (1983). The families of origin of social workers. *Clinical Social Work Journal, 11*(4), 309-322. Accessed online: http://www.academia.edu/download/31660888/Families_of_Origin_of_Social_Workers.doc

Lamb, D. H., Catanzaro, S. J., & Moorman, A. S. (2003). Psychologists reflect on their sexual relationships with clients, supervisees, and students: Occurrence, impact, rationales and collegial intervention. *Professional Psychology: Research and Practice*, *34*(1), 102. doi: 10.1037/0735-7028.34.1.102

Langevin, R., Glancy, G. D., Curnoe, S., & Bain, J. (1999). Physicians who commit sexual offences: Are they different from other sex offenders? *The Canadian Journal of Psychiatry*, *44*(8), 775-780. doi: 10.1177/070674379904400803

MacDonald, K., Sciolla, A. F., Folsom, D., Bazzo, D., Searles, C., Moutier, C., ... & Norcross, B. (2015). Individual risk factors for physician boundary violations: the role of attachment style, childhood trauma and maladaptive beliefs. *General Hospital Psychiatry*, *37*(5), 489-496. doi: 10.1016/j.genhosppsych.2015.06.002

Medical Board of Australia. (2018). Sexual boundaies in the doctor patient relationship. Retrieved December 26th, 2018, from https://www.medicalboard.gov.au/codes-guidelines-policies/sexual-boundaries-guidelines.aspx

Newcomb, M., Burton, J., Edwards, N., & Hazelwood, Z. (2015). How Jung's concept of the wounded healer can guide learning and teaching in social work and human

services. *Advances in Social Work and Welfare Education*, *17*(2), 55. Accessed online: https://www.researchgate.net/publication/285591160_How_Jung%27s_concept_of_the_wounded_healer_can_guide_learning_and_teaching_in_social_work_and_human_services

Ostertag, P. A., & McNamara, J. R. (1991). "Feminization" of psychology: The changing sex ratio and its implications for the profession. *Psychology of Women Quarterly*, *15*(3), 349-369. doi: 10.1111/j.1471-6402.1991.tb00413.x

Rafaeli, E., Bernstein, D. P., & Young, J. (2010). *Schema therapy: Distinctive features*. Routledge. ProQuest Ebook.

Roback, H. B., Strassberg, D., Iannelli, R. J., Finlayson, A. R., Blanco, M., & Neufeld, R. (2007). Problematic physicians: a comparison of personality profiles by offence type. *The Canadian Journal of Psychiatry*, *52*(5), 315-322. doi: 10.1177/070674370705200506

Rodolfa, E., Hall, T., Holms, V., Davena, A., Komatz, D., Antunez, M., & Hall, A. (1994). The management of sexual feelings in therapy. *Professional Psychology: Research and Practice*, *25*(2), 168. doi: 10.1037/0735-7028.25.2.168

Samenow, C. P., Yabiku, S. T., Ghulyan, M., Williams, B., & Swiggart, W. (2012). The role of family of origin in physicians referred to a CME course. In *HEC forum*, 24(2), pp. 115-126). Springer Netherlands. doi: 10.1007/s10730-011-9171-8

Stake, J. E., & Oliver, J. (1991). Sexual contact and touching between therapist and client: A survey of psychologists' attitudes and behavior. *Professional Psychology: Research and Practice*, *22*(4), 297. doi: 10.1037/0735-7028.22.4.297

Strasburger, L. H., Jorgenson, L., & Sutherland, P. (1992). The prevention of psychotherapist sexual misconduct: Avoiding the slippery slope. *American Journal of Psychotherapy*, *46*(4), 544-555. doi: 10.1176/appi.psychotherapy.1992.46.4.544

Thoreson, R. W., Shaughnessy, P., Heppner, P. P., & Cook, S. W. (1993). Sexual contact during and after the professional relationship: Attitudes and practices of male counselors. *Journal of Counseling & Development*, *71*(4), 429-434. doi: 10.1002/j.1556-6676.1993.tb02660.x

Waller, G. (2009). Evidence-based treatment and therapist drift. *Behaviour Research and Therapy*, *47*(2), 119-127. doi: 10.1016/j.brat.2008.10.018

Waller, G., & Turner, H. (2016). Therapist drift redux: Why well-meaning clinicians fail to deliver evidence-based therapy, and how to get back on track. *Behaviour Research and Therapy*, *77*, 129-137. doi: 10.1016/j.brat.2015.12.005

Wise, E., Hersh, M., & Gibson, C. (2012). Ethics, self-care and well-being for psychologists: Reenvisioning the stress-distress continuum. *Professional Psychology Research and Practice*, 43(5), 487. https://doi.org/ 10.1037/a0029446

Yalom, I. D. (1996). *Lying on the couch: A novel*. Basic Books.

Young, J. E., & Brown, G. (1998). Young schema questionnaire short form. *New York: Cognitive Therapy Centre*.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. Guilford Press.

Zerubavel, N., & Wright, M. O. D. (2012). The dilemma of the wounded healer. *Psychotherapy*, *49*(4), 482.

Boundary Violations: Character & Contexts

Edward Dickeson

School of Psychology

University of Adelaide

Abstract

Therapeutic boundary violations occur when a practitioner transgresses their defined professional role to the detriment of a client. Much of the existing literature on this topic has been strictly theoretical. Past efforts to apply empirical rigor have been hampered by the difficulty in measuring a practitioner's propensity to violate therapeutic boundaries. This cross-sectional, non-experimental investigation tested the validity of three self-report instruments designed to measure boundary violation propensity and following this, used them to investigate practitioner characteristics and contextual factors relevant to their prediction. Hypothesised predictor variables were based on Gabbard's (1994) taxonomy of transgressor types – the impulsive and exploitative Predatory Practitioner; the older, disillusioned Lovesick Practitioner; and the vulnerable, self-sacrificing Masochistic-Surrendering Practitioner. Australian mental health workers (N = 275), completed an online survey. All three boundary violation instruments demonstrated similar correlations with related variables of expected magnitude and direction. Results suggest that both high levels of callous and caring practitioner personality traits, are predictive of boundary violations, while practitioner narcissism was responsible for the largest amount of variance. These findings have relevance to future efforts in reducing the occurrence of boundary violations.

Keywords: therapeutic boundaries, professional ethics, narcissism, interpersonal circumplex.

Therapeutic boundaries define the roles and limitations of the relationship between practitioner and client (Smith & Fitzpatrick, 1995). Clients typically come to therapy in a state of heightened vulnerability and so boundaries, imposed by professional and legal standards, are designed to protect them from encountering harm. Despite this, every year a certain portion of practitioners deviate from their professional code and jeopardise the wellbeing of their clients by violating therapeutic boundaries.

A boundary violation occurs when the practitioner exploits a client as a means of seeking their own gratification (Gutheil & Gabbard, 1993). Sexual Boundary Violations (SBVs) are typically deemed to be the most serious type of transgression, with the impact encountered by clients often compared to childhood sexual abuse (Epstein & Simon, 1990). The concern raised is not recent, as evident by the condemnation of client sexual exploitation appearing as early as Hippocrates (Hulkower, 2016). Additionally, the occurrence of SBVs remains worrisome, with estimates that 7% of male and 1.5% of female therapeutic practitioners have engaged in erotic contact with a client (Hook & Devereux, 2018). Given the seriousness and pervasiveness of this topic, over the past 30 years, authors have attempted to identify the characteristics and contexts associated with boundary violations.

One of the most widely cited typologies of the characteristics of practitioners who commit SBVs, was provided by Gabbard (1994) who, based on his clinical experience, identified; the Predatory Practitioner – characterised by features of antisocial personality disorder; the Lovesick Practitioner, who becomes enraptured by their client, usually later in their career and while in the midst of professional isolation and substantial life crisis such as a divorce; and the Masochistic-Surrendering Practitioner, whose over-identification with their clients, often in the context of similar experiences of childhood trauma, ultimately leads to a deterioration of boundaries. It is possible to view Gabbard's categories on a continuum, ranging from Predatory Practitioners with sexual designs and without sympathy for the

client's wellbeing, Lovesick Practitioners with both sexual designs and sympathy, to Masochistic-Surrendering Practitioners with no sexual designs and excessive sympathy. Additionally, in an updated addition of his title *Boundaries and Boundary Violations in Psychoanalysis*, Gabbard (2016, p. 17) states that narcissism of one kind or another is involved in almost all cases of boundary violations. A potentially relevant distinction is that of narcissistic grandiosity, characterised by self-assurance and dominance, and narcissistic vulnerability, characterized by negative emotions and a need for recognition (Miller, Price, Gentile, Lynam & Campbell, 2012), which may align respectively across the proposed spectrum from Predatory to Masochistic-Surrendering Practitioners.

No known previous effort has been made to empirically test Gabbard's (1994) taxonomy, although existing quantitative studies appear to have produced theoretically consistent evidence of characteristics prevalent among boundary violating practitioners. As with Gabbard's predatory description, practitioners reprimanded for SBVs have produced personality profiles with elevated anti-social traits compared to their colleagues (Langevin, Glancy, Curnoe and Bain, 1999; Garfinkel, Bagby, Waring & Dorian, 1997; Roback et al., 2007). Many of the contextual factors contained in Gabbard's lovesick description have also been supported, with practitioners who admit past instances of SBVs or who indicate more permissive attitudes towards erotic client contact, being more likely to be divorced, working in solo practice (DuBois et al., 2017; Samenow et al., 2011; Thoreson, Shaughnessy, Heppner & Cook, 1993), and to be older than their colleagues (Garrett & Davis, 1998; Rodolfa et al., 1994; Stake & Oliver, 1991).

Relevant to Gabbard's Masochistic-Surrendering profile, is the wounded healer motif and the observation that a large portion of therapeutic professional's report having endured high rates of childhood adversity (Newcomb, Burton, Edwards & Hazelwood, 2015). Some have suggested that such individuals struggle to maintain boundaries because of their overly

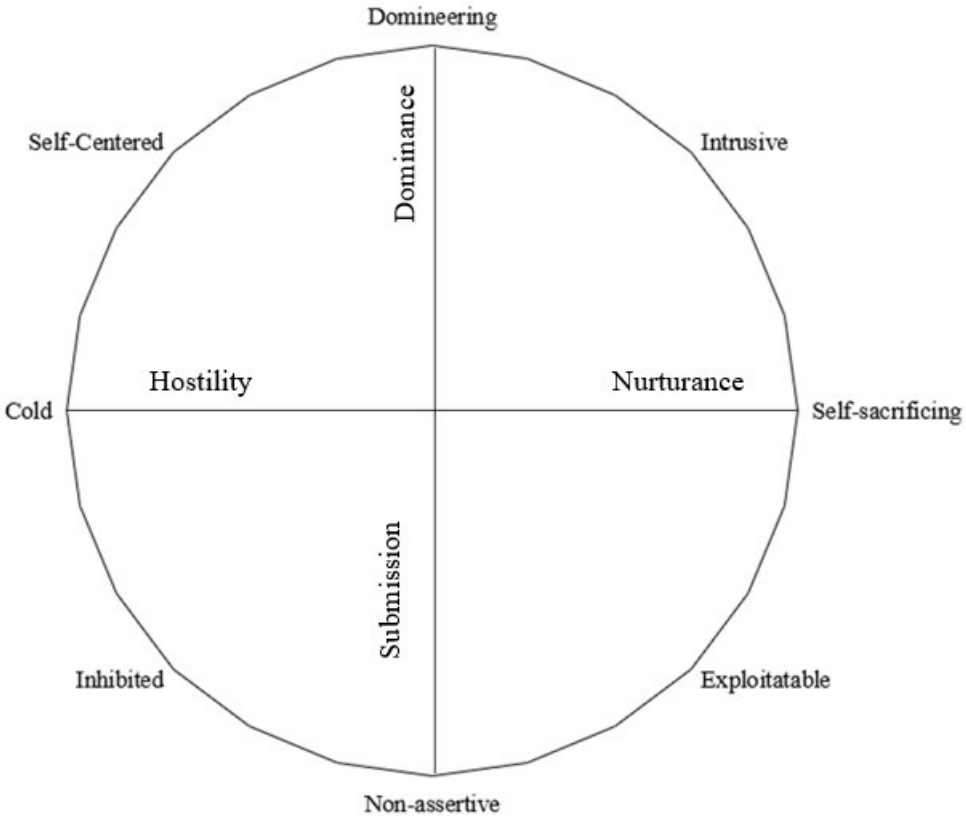
zealous efforts to care for their clients, repeating their own childhood experiences of parentification (Lackie, 1983). Two past studies have indicated that practitioners who have committed SBVs, report rates of childhood adversity even higher than the rest of their colleagues (Samenow, Yabiku, Ghulyan, Williams & Swiggart, 2011; Jackson & Nuttell, 2001). Furthermore, MacDonald and colleagues' (2015) sample of SBV infracting healthcare providers were predominantly characterised by self-sacrificing schemas – a tendency to prioritise the needs of others, even at one's own expense (Rafaeli, Bernstein & Young, 2010). Dickeson and Smout (2018) also produced evidence of compassion-driven boundary violations, reporting that boundary violation propensity was related to both interpersonal distress – vicarious distress triggered by witnessing another's suffering (Davis, 1980), and experiential avoidance - maladaptive efforts to avoid or suppress aversive internal experiences (Hayes, Wilson, Gifford, Follette & Strosahl, 1996). While gender, narcissism, age, practice setting, childhood trauma and excessive or absent sympathy, represent potential risk indicators of ethically impaired practitioners, the role of experiential avoidance offers a possible preventative approach. Following an Acceptance Commitment Therapy (ACT) model, if practitioners can be trained to decrease their levels of experiential avoidance, instances of client contact leading to strong internal reactions and impaired clinical judgment might be reduced (Dickeson & Smout, 2018).

Each of the above-mentioned studies are limited by the difficulty inherent in trying to measure a practitioner's propensity to violate therapeutic boundaries. Researchers have often simply asked participants to report past instances of erotic contact with clients, a method that likely increases underreporting and provides no information regarding less serious types of transgressions. Additionally, relying on past instances of SBVs limits the identification of practitioners who might be at risk of developing unethical tendencies in their practice. Attempts have been made to develop standardised instruments designed for measuring a

practitioner's propensity to violate therapeutic boundaries, including the Boundary Violations Propensity Questionnaire (BVP-Q; Dickeson & Smout, 2018), the Sexual Boundary Violation Index (SBV-I; Swiggart, Feurer, Samenow, Delmonico & Spickard, 2008), and the Boundaries in Practice Scale (BIP; Kendall, Fronek, Ungerer, Malt, Eugarde & Geraghty, 2011). However, these instruments have had limited use and no previous effort has been made to test their convergent validity nor test them for social-desirability bias. With better supported validity, such instruments could be more confidently applied to widening the empirical knowledge of the factors relevant to therapeutic boundary violations.

A proposed direction for such research is to consolidate and attempt to reproduce past quantitative findings so that a hierarchy of importance could be sought of practitioner characteristics that are predictive of boundary violations. Additionally, this topic of enquiry could be advanced by undertaking further explorations of psychological facets that may relate to impaired ethical judgement. Ultimately, the therapeutic relationship and any problems that occur within it, are interpersonal by nature. A consensus approach for considering interpersonal dynamics is to place relevant features in a circular order, guided by two dimensional factors; dominance versus submission and nurturance versus hostility (Alden, Wiggins & Pincus, 1990). This configuration known as the interpersonal circumplex, is typically divided into octants which evenly represent points across the proposed range of possible interpersonal dynamics, domineering, intrusive, self-sacrificing, exploitable, non-assertive, inhibited, cold and self-centred (see Figure 1). An individual's interpersonal style measured as radiating further from the centre reflects more problematic tendencies in that direction.

Figure 1: The Interpersonal Problems Circumplex (Alden, Wiggins & Pincus, 1990).



The interpersonal circumplex offers a promising model for exploring the relevant characteristics of practitioners who are prone to violating therapeutic boundaries. Not only does the circumplex have strong empirical support for its claim to be an exhaustive and all-inclusive representation of interpersonal behaviour (Gurtman, 2009), at face value, its octants appear to align with the features described in Gabbard's (1994) taxonomy. As with the Predatory Practitioner, the 'self-centred' octant describes overly controlling, manipulative and uncaring interpersonal tendencies, while similar to the Masochistic-Surrendering profile, 'self-sacrificing' describes an interpersonal style of trying excessively to please others, being overly generous, trusting and permissive (Alden, Wiggins & Pincus, 1990). A quantitative study using the circumplex could potentially test and advance the existing clinical observations that have been made about the type of practitioners prone to violating therapeutic boundaries.

The Current Study

Boundary violations are detrimental to individual clients and cause hindrance to the wider profession, establishing a greater understanding of the factors which predict their occurrence is of interest to the field. Certain features have been suggested as common among boundary violating practitioners, however quantitative enquiries on this topic face the inherent difficulty in accurately measuring a practitioner's tendency to violate boundaries.

The aims of the current study are two-fold; firstly, attempts will be made to test the validity of three existing self-report instruments that are designed to estimate a practitioner's propensity to violate therapeutic boundaries, namely the BVP-Q, SBV-I and BIP. These instruments will be tested for convergent validity by having them completed by the same sample with the expectation that they will share strong correlations. Additionally, it is expected that participants who disclose having previously committed boundary violations will score higher on each of these instruments. These instruments will also be tested for their incurrence of social desirability bias.

Contingent of evidence supporting the validity of the boundary instruments, the second aim of this study is to test for statistical relationships between those, and theoretically proposed predictors of practitioner boundary violation propensity, based roughly on Gabbard's (1994) taxonomy. Although Gabbard made his formulations specifically to SBVs, their use as a framework for the present study is expanded to test hypothesized predictors for any tendency towards unethical conduct within the therapeutic relationship.

The following hypothesise were proposed:

Hypothesise 1: Reflecting Gabbard's (1994) Predatory Practitioner, boundary violation propensity measured by all three instruments will be predicted by low levels of empathic concern and high rates of impulsivity, narcissistic grandiosity and self-centred interpersonal tendencies.

Hypothesise 2: Reflecting Gabbard's (1994) Lovesick Practitioner, high scores on all three boundary instruments will be predicted by advanced age, being divorced, being a solo practitioner, spending more weekly hours of client contact and feeling unsatisfied with one's own life.

Hypothesise 3: Reflecting Gabbard's (1994) Masochistic-Surrendering Practitioner, high scores on all three boundary instruments will be predicted by high levels of interpersonal distress, narcissistic vulnerability, experiential avoidance, childhood adversity and self-sacrificing interpersonal tendencies.

Method

Design

The study employed a cross-sectional, within group, non-experimental design. The outcome variable was impaired professional judgment as measured by three separate instruments. Predictor variables were instruments measuring narcissism, social desirability, impulsivity, childhood adversity, satisfaction with life, emotive empathy, experiential avoidance and interpersonal problems derived by the interpersonal circumplex. Whether participants worked primarily in a managerial role was sought to be potentially used as a control variable. Four variations of the survey were distributed, with instrument order randomised to negate chances that certain instruments would cause a priming effect on later ones.

Procedure

Ethics approval was obtained from the Human Research Ethics Subcommittee of the University of Adelaide, after which data was collected from March until May, 2019, using an anonymous online survey tool (https://www.surveymonkey.net). Participants were eligible if they were over the age of 18 and actively involved in the delivery of mental health care to clients. Contact details of Australian therapeutic practitioners, including psychologists,

psychiatrists, psychotherapists and social workers, were sought from public listings. Additionally, invitations to participate in the survey were placed on appropriate online forums and websites. The first page of the survey provided information regarding participation and instructed that beginning the survey was an indication of informed consent (see APPENDIX B). Contacts for mental health emergency and support as well as links to various professional codes of ethics were provided at the beginning and end of the survey. Participants spent a mean time of 34 minutes completing the questionnaire.

Measures

Demographic Questionnaire Participants were asked their age, gender, relationship status, place of origin, highest level of education, occupation, primary work setting and their number of weekly client contact hours. Because it was anticipated that being in a supervisory role would likely be associated with lower levels of boundary violation propensity, participants were asked whether their work role primarily involved managerial duties so that this could be controlled for if necessary.

Past Boundary Violations Questions were designed to enquire about participants actual past boundary transgressions. Firstly, they were asked (*Yes* or *No*) if they had ever initiated a hug with a client, formed a social relationship with a client, drunk alcohol, flirted or engaged in erotic contact with a client. Secondly, participants were asked on scales of 1 to 4 (1 = *Never*, 4 = *Often*) the frequency with which they had spoken to clients in a way which they would not be happy to repeat in front of their colleagues and the frequency with which they had received feedback from colleagues or supervisors that they had become too involved with their clients. To minimise the chances that these disclosures would prime later ones, this section was placed at the very end of all four variations of the survey. Additionally, this section was preceded by an additional reassurance of participant anonymity.

Boundary Violations Propensity Questionnaire (BVP-Q; Dickeson & Smout, 2018; see APPENDIX C) is an 11 item, self-report questionnaire designed to measure a therapeutic practitioner's propensity to violate client boundaries. Participants indicate how likely they would be on a scale of 1 to 6 (1 = *not likely*, 6 = *highly likely*) to make the same ethically problematic decision as described in each vignette. Higher scores indicate a greater propensity to violate therapeutic boundaries. BVP-Q scores correlate negatively with exposure to ethics related course work among undergraduates studying psychology and social work. Alpha reliability from the current study was acceptable (Cronbach *a* = .74; Females *a* = .71, Males *a* = .79).

Sexual Boundary Violation Index (SBV-I; Swiggart, Feurer, Samenow, Delmonico & Spickard, 2008; see APPENDIX D) is a 25-item, self-report questionnaire designed to assess the attitudes, thoughts, and behaviours of mental health clinicians at risk of sexual misconduct with patients and staff. Participants indicate how frequently they have engaged in certain behaviours on a scale of 0 to 3 (0 = *never*, 3 = *often*), with higher scores indicating a higher risk of sexual boundary violating behaviours. The SBV-I showed strong convergence with an existing measure of sexual addiction (Swiggart et al., 2008). Alpha reliability from the current study was acceptable for females and excellent for males (Cronbach *a* = .89; Females *a* = .77, Males *a* = .94).

Boundaries in Practice Scale (BIP; Kendall, Fronek, Ungerer, Malt, Eugarde & Geraghty, 2011; see APPENDIX E) is an 11 item, self-report questionnaire designed to measure a therapeutic practitioner's knowledge, comfort and ethical decision-making in response to ethical dilemmas that commonly arise in the context of professional boundaries. Only the ethical decision-making scale was used in the current study. Participants indicate how ethical on a scale of 1 to 4 (1 = *never ethical*, 4 = *always ethical*) the action taken is in each vignette. Higher scores indicate more worrisome ethical decision making in the context

of therapeutic boundaries. During its development, the BIP showed sound face, content and construct validity. Alpha reliability from the current study was acceptable for females and very good for males (Cronbach *a* = .79; Females *a* = .69, Males *a* = .87).

Marlow-Crowne Desirability Scale (MC; Strahan & Gerbasi, 1972; see APPENDIX F) consists of a 10-item dichotomous (*yes* or *no*) scale. Higher scores indicate that the participant may respond to test items in such a way as to avoid the disapproval of people who may read their responses.

Circumplex Scale of Interpersonal Problems (CSIP; Boudreaux, Ozer, Oltmanns & Wright, 2017; see APPENDIX G) is a 64 item, self-report questionnaire designed to measure interpersonal problems in alignment with the interpersonal circumplex model of social behaviour. Participants indicate how much they experience each problem on a scale from 0 to 3 (0 = *not a problem*, 3 = *serious problem*). High scores indicate greater interpersonal problems across the 8 circumplex scales; domineering, self-centred, distant/cold, socially inhibited, non-assertive, exploitative, self-sacrificing and intrusive. In its development, the CSIP fitted well to a theoretically consistent quasi-circumplex model and converged with existing self-report measures of interpersonal problems, personality and pathology. Alpha reliabilities from the current study ranged from Cronbach *a* = .85 (Intrusiveness; Females *a* = .85, Males *a* = .89) to *a* = .9; (Exploitable; Females *a* = .9, Males *a* = .91).

Brief Inventory of Pathological Narcissism (B-PNI; Schoenleber, Roche, Wetzel, Pincus & Roberts, 2015; see APPENDIX H) is a 28-item, self-report questionnaire designed to measure facets of maladaptive narcissism. Participants indicate how typical a statement is of themselves on a scale from 0 to 5 (0 = *not at all like me*, 5 = *very much like me*). High scores indicate greater levels of narcissism across 7 subscales compromising narcissistic grandiosity – exploitativeness, grandiose fantasy, self-sacrificing self-enhancement, and narcissistic vulnerability – contingent self-esteem, entitlement rage, devaluing, hiding-the-

self. The B-PNI showed convergent and discriminant validity with existing self-report instruments for measuring narcissism. Alpha reliabilities from the current study ranged from Cronbach *a* = .72 (Devaluing) to *a* = .87; (Grandiose fantasy).

Barratt Impulsiveness Scale Brief Version (BIS-BF; Steinberg, Sharp, Stanford & Tharp, 2013; see APPENDIX I) is an 8-item version of the widely used self-report questionnaire designed to measure impulsivity (Patton, Stanford & Barratt, 1995). Participants indicate how often they have certain experiences on a scale of 1 to 4 (1 = *rarely/never*, 4 = *almost always/always*). Higher scores indicate greater impulsivity, as seen by correlations with objective neuropsychological measures (Spinella, 2007). Alpha reliability from the current study was acceptable (Cronbach *a* = .78).

Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen & Griffin, 1985; see APPENDIX J) is a 5 item, self-report questionnaire designed to measure global cognitive judgments of one's life satisfaction. Participants indicate how much they agree with each statement on a scale of 1 to 7 (1= *strongly disagree*, 7 = *strongly agree*). Higher scores indicate greater satisfaction. The SWLS has been shown to have high (.84) test-retest reliability after 1 month and shows good convergent validity with other assessments of subjective well-being (Pavot & Diener, 1993). Alpha reliability from the current study was very good (Cronbach *a* = .88).

Brief Experiential Avoidance Questionnaire (BEAQ; Gámez, Chmielewski, Kotov, Ruggero, Suzuki & Watson, 2014; see APPENDIX K) is a 15-item, self-report version of the Multidimensional Experiential Avoidance Questionnaire (MEAQ; Gámez, Chmielewski, Kotov, Ruggero & Watson, 2011). Participants indicate how much they agree with each statement on a scale of 1 to 6 (1= *strongly disagree*, 6 = *strongly agree*). Higher scores indicate greater experiential avoidance. The BEAQ exhibits strong convergence with respect to each of the MEAQ's 6 dimensions and correlated in expected ways with measures of

avoidance, pathology and quality of life while being distinguishable from negative affect and neuroticism. Alpha reliability from the current study was good (Cronbach *a* = .82).

Interpersonal Reactivity Index (IRI; Davis, 1983; see APPENDIX L) is a 28-item, self-report questionnaire designed to measure different aspects of empathy. Participants indicate how well each item describes themselves on a 5-point scale (A = *does not describe me well*, to E = *describes me very well*). Higher scores indicate greater degrees of each aspect of empathy. Only two of its subscales, indicating adaptive (Empathic Concern; EC) and maladaptive (Personal Distress; PD) emotional (as oppose to cognitive) empathy were used in the current study. The IRI has shown convergent validity with a number of theoretically expected constructs and has shown modest test-retest reliability ranging from .62 to .71 (Davis, 1983). Alpha reliability in the current study was acceptable for both EC (*a* = .75) and PD (*a* = .79).

Adverse Childhood Experiences Questionnaire (ACE-Q; Felitti et al., 1998; see APPENDIX M) is a 10-item, self-report questionnaire designed to measure the occurrence of adverse events in an individual's family-of-origin prior to the age of 18. Respondents indicate whether certain experiences occurred (*yes* or *no*). Higher numbers of affirmed items indicate greater childhood adversity. The ACE-Q is a refined amalgamation of several other widely used childhood adversity measures, each with good evidence of construct and criterion-related validity (Dong et al., 2004). Test-retest reliability for the items over a period of more than twelve months resulted in adequate reliability (Dube, Williamson, Thompson, Felitti, & Anda, 2004). Alpha reliability in the current sample was acceptable (Cronbach α = .72).

Data Analysis

Power analysis Following the recommendations of Cohen (1992), an estimate of required sample size was calculated. To perform a multiple regression analysis with a medium effect size (.15), desired level of power (.80), statistically significant probability

level (.05) and 9 predictor variables, it was calculated that a minimum of 122 participants would be required.

Data screening Single invitations were sent to 6,163 email addresses obtained from publicly available professional listings. It was clear that on some occasions, these initial emails were then forwarded on to the staff of that relevant organisation. This, along with the likelihood that many of these email accounts were no longer in use, make it impossible to calculate a precise response rate. Based on the 358 participants who began the survey, it is estimated that this amounted to approximately a 5% return rate. The data was deleted for 83 (23%) participants who did not complete the survey, all data from the remaining 275 participants was used in the main analysis. Little's Missing Completely at Random test was conducted and showed as non-significant. Missing cases were replaced using Expectation Maximisation procedure. Box plots were screened and all univariate outliers were changed to a value equivalent to 3.2 standard deviations from their mean.

Statistical analysis All statistical analyses were conducted on SPSS v25 software. All hypothesise were initially examined using bivariate Pearson's product-moment correlation coefficients (*r*) while hierarchical multiple regression analysis was then used to estimate the most salient predictor variables.

Results

Sample Description

Table 1 provides a summary of the participants' demographic characteristics. The participants were mostly female (73.5%), either married or in a relationship (75.5%), described their place of origin as being Australia or New Zealand (77.1%), holding Master's degrees (52%), psychologists (47.2%), working in solo private practice (42.2%), and not in managerial roles (81%). Their ages varied (M = 50, SD = 12.37, range 21 – 74), as did their number of weekly client contact hours (M = 18.4, SD = 9.4, range 0.1 – 45).

Table 1

Demographic Characteristics of the Study Population

	Variable	*n*	%
Gender	Female	202	73.5
	Male	70	25.5
	Prefer not to say	3	1
Relationship status	Single	27	9.8
	Divorced or separated	27	9.8
	Widowed	6	2.2
	Married or in a relationship	208	75.5
	Prefer not to say	7	2.5
Place of origin	Africa	5	1.8
	Americas	3	1.1
	Australia / New Zealand	212	77.1
	East Asia	2	.7
	Europe	34	12.4
	Middle East	3	1.1
	Pacific Islands	7	.7
	South Asia	3	1.1
	Other	8	2.9
	Prefer not to say	2	.7
Highest education	Master's degree	143	52
	Doctorate degree	46	16.7
	Bachelor's degree	42	14.6
	Postgraduate diploma	35	12.7
	Vocational or high school	9	3
	Prefer not to say	2	.8
Occupation	Psychologist	123	47.2
	Counsellor/Psychotherapist	67	24.4
	Social Worker	40	14.5
	Hypnotherapist	12	4.4
	Psychiatrist	9	3.2
	Other	15	5.5
	Prefer not to say	2	.8
Primary work setting	Private (solo)	116	42.2
	Non-Government Org	64	23.2
	Private (not solo)	54	19.6
	Government Org	30	10.9
	University / training centre	7	2.5
	Other	3	1.2

	Prefer not to say	1	.4
Managerial role	No	222	81
	Yes	48	17.5
	Prefer not to say	4	1.5

Note, *N* = 275

Descriptive statistics including mean, standard deviation, median and range were calculated for each of the main dependent and independent variables used in the study and these are reported in Table 2.

Table 2

Descriptive statistics for each of the main study variables

Variable	Mean	SD	Median	Range
Boundary Violation Propensity Questionnaire	19.34	5.58	19	27
Sexual Boundary Violation Index	29.2	4.23	28	23
Boundaries in Practice Scale	14.42	2.2	14	13
Pathological Narcissism Inventory	31.27	20.41	27	96
Impulsiveness	13.52	3.03	14	14
Brief Experiential Avoidance Questionnaire	33.74	10.09	33	54
Satisfaction with Life	25.96	5.9	28	30
Adverse Childhood Experiences	2.32	2.15	2	9
IRI: Personal Distress	14.13	4.55	13	22
IRI: Empathic Concern	28.46	4.16	29	23
CSIP: Domineering	9.99	3.04	9	24
CSIP: Self-Centred	9.59	2.4	9	12
CSIP: Cold	11.53	4	10	19
CSIP: Inhibited	12.03	4.14	11	21
CSIP: Non-Assertive	12.6	4.34	11	21
CSIP: Exploitable	12.83	4.53	12	24
CSIP: Self-Sacrificing	13.54	4.38	13	23
CSIP: Intrusive	10.13	2.7	9	13
Spoken inappropriately to clients	1.6	.68	2	3
Received feedback about becoming too involved	1.2	.45	1	2

Note. IRI = Interpersonal Reactivity Index, CSIP = Circumplex Scales of Interpersonal Problems

Participant Disclosure of Past Boundary Transgression

Fifty-one (18.5%) of the participants disclosed having initiated a hug with a client, 12 (4.4.%) had formed a social relationship, 15 (5.5%) had flirted or consumed alcohol, 2 of

which (.7% of the total sample) also admitted to having had sexual intercourse with a client, both of these participants being male.

Validation of Boundary Violation Measures

As shown in Table 3, to test the validity of the three instruments measuring boundary violation propensity, Pearson's product-moment correlation coefficients were used to assess whether relationships were consistent with theoretical expectations.

Bivariate Pearson's product-moment correlation coefficients (*r*), showed significant relationships between the three boundary measures. The moderate correlations were low enough to suggest that the instruments were measuring distinct aspects of boundary violation propensity, subsequently we continued to analyse each of the instruments as separate dependent variables. All three instruments showed significant relationships with small to moderate effect sizes with the additional validation measures; a tendency to speak to clients inappropriately, receiving collegial concern of impaired boundaries, having ever initiated a hug, formed a social relationship, drunk alcohol, flirted or had sex with a client. The only exception being the BVP-Q which showed no relationship with having ever initiated a hug with a client. The BVP-Q was also the only instrument that showed no relationship with social desirability bias which had medium and small, significant relationships with the SBV-I and the BIP respectively. Participants working predominantly in managerial roles did not score differently on any of the boundary instrument and so this variable was not controlled for in the subsequent analyses.

Table 3

Bivariate Correlations between three measures of boundary violation propensity and a series of questions designed test convergent validity.

	BVP-Q	SBV-I	BIP
BVP-Q	1	-	-
SBV-I	$r = .451$ $p < .001$	1	-
BIP	$r = .526$ $p < .001$	$r = .489$ $p < .001$	1
Marlow-Crowne (Social Desirability)	$r = -.083$ $p = .169$	$r = -.351$ $p < .001$	$r = -.136$ $p = .026$
Spoken to clients in a way that you wouldn't in the presence of competent co-workers?	$r = .152$ $p = .013$	$r = .362$ $p < .001$	$r = .266$ $p < .001$
Received feedback (e.g. from a colleague or supervisor) that you become too involved with your clients?	$r = .301$ $p < .001$	$r = .478$ $p < .001$	$r = .248$ $p < .001$
Initiated a hug from a client; No (1), Yes (2)	$r = .040$ $p = .506$	$r = .220$ $p < .001$	$r = .135$ $p = .025$
Formed a social relationship with a client; No (1), Yes (2)	$r = .240$ $p < .001$	$r = .295$ $p < .001$	$r = .279$ $p < .001$
Drunk alcohol, flirted or had sex with a client; No (1), Yes (2)	$r = .341$ $p < .001$	$r = .459$ $p < .001$	$r = .291$ $p < .001$
Managerial roles (1), Non-Managerial roles (2)	$r = -.051$ $p = .408$	$r = -.006$ $p = .918$	$r = -.036$ $p = .559$

Note. BVP-Q = Boundary Violation Propensity Questionnaire, SBV-I = Sexual Boundary Violation Index, BIP = Boundaries in Practice Scale. Statistically significant correlations are highlighted in blue (two tailed).

Predicting Boundary Violation Propensity

Correlations reported in Table 4, are variables that previous research has reported to be associated with boundary violation propensity. As expected, male gender ($r = .147$ - $.255$), experiential avoidance ($r = .144$ - $.230$), narcissism ($r = .318$ - $.394$), and impulsivity ($r = .196$ - $.262$), correlated positively with all three boundary measures, showing small to moderate effect sizes. Other hypothesised predictors; empathic concern, number of weekly client contact hours, childhood adversity and satisfaction with life show small, significant relationships with only one or two of the boundary instruments. Contrary to our hypothesis,

boundary violation propensity was not related to age, being divorced, operating in solo private practice or with interpersonal distress.

Table 4
Bivariate correlations between three measures of boundary violation propensity and a series of theoretically associated variables

	BVP-Q	SBV-I	BIP
Age	$r = .082$ $p = .190$	$r = .012$ $p = .85$	$r = -.02$ $p = .754$
Female (1), Male (2)	$r = .147$ $p = .015$	$r = .255$ $p < .001$	$r = .183$ $p = .002$
Solo Private Practice (1), Other (2)	$r = -.08$ $p = .188$	$r = .035$ $p = .566$	$r = .021$ $p = .73$
Not divorced (1), divorced (2)	$r = .031$ $p = .617$	$r = -.013$ $p = .829$	$r = -.006$ $p = .924$
Brief Experiential Avoidance Questionnaire	$r = .230$ $p < .001$	$r = .184$ $p = .002$	$r = .144$ $p = .017$
IRI – Personal Distress	$r = .01$ $p = .864$	$r = .110$ $p = .069$	$r = -.014$ $p = .814$
IRI – Empathic Concern	$r = -.035$ $p = .568$	$r = -.121$ $p = .046$	$r = -.066$ $p = .272$
Narcissistic Grandiosity	$r = .342$ $p < .001$	$r = .402$ $p < .001$	$r = .334$ $p < .001$
Narcissistic Vulnerability	$r = .291$ $p < .001$	$r = .331$ $p < .001$	$r = .258$ $p < .001$
Impulsivity	$r = .262$ $p < .001$	$r = .255$ $p < .001$	$r = .196$ $p = .001$
Weekly client hours	$r = .095$ $p = .118$	$r = .142$ $p = .01$	$r = .131$ $p = .030$
Childhood Adversity Questionnaire	$r = .114$ $p = .058$	$r = .155$ $p = .01$	$r = .034$ $p = .579$
Satisfaction with Life	$r = -.215$ $p < .001$	$r = -.129$ $p = .032$	$r = -.097$ $p = .107$

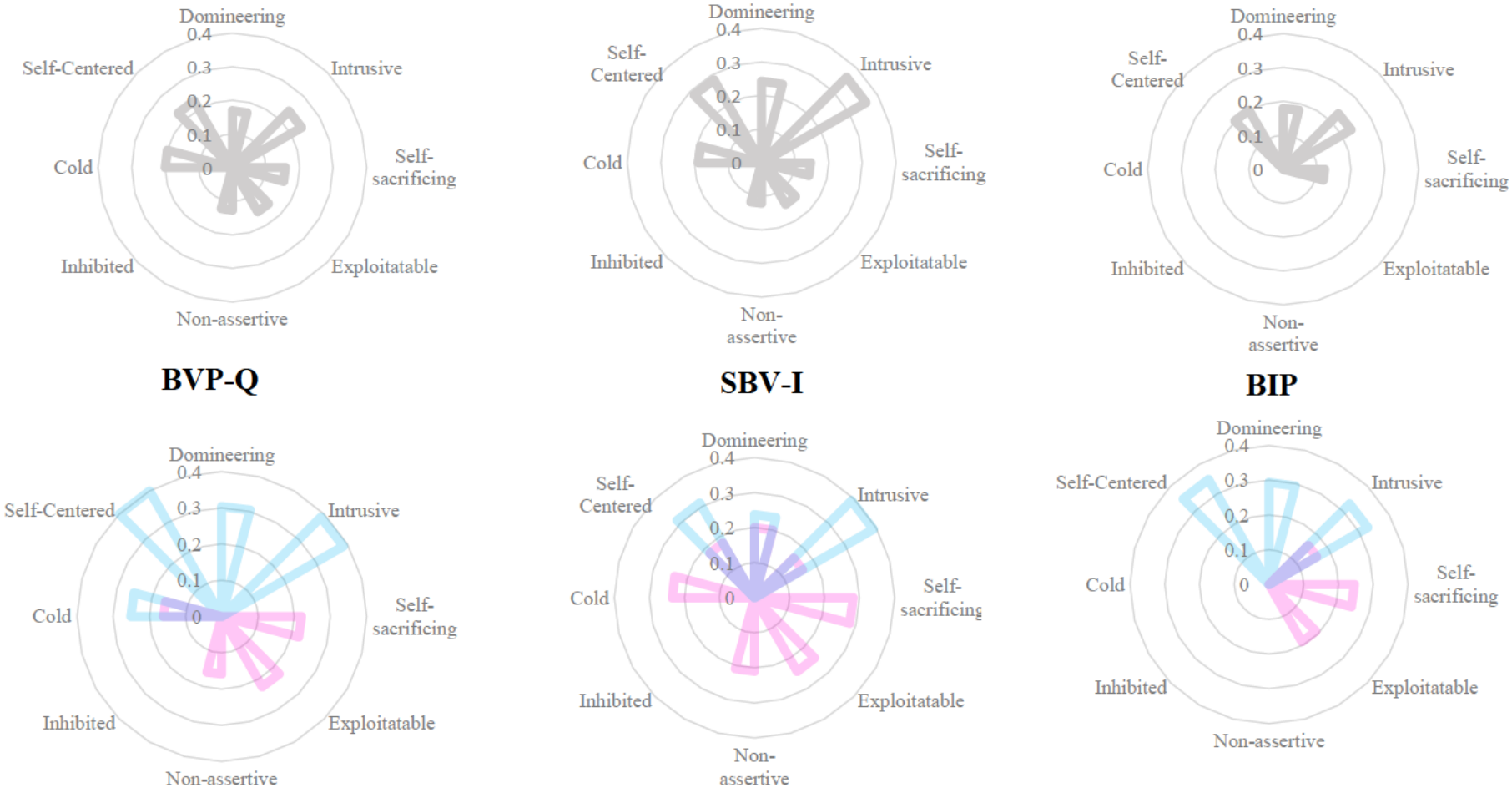
Note. BVP-Q = Boundary Violation Propensity Questionnaire, SBV-I = Sexual Boundary Violation Index, BIP = Boundaries in Practice Scale, IRI = Interpersonal Reactivity Index. Statistically significant correlations are highlighted in blue (two tailed).

As seen in Figure 2, all three boundary measures showed small, positive correlations to several areas of the circumplex. As hypothesised, self-centredness and self-sacrificing problematic interpersonal tendencies were both significantly associated with all three

boundary measures. Of the circumplex octants, ‘intrusive’ showed the strongest correlations with all three boundary measures. ‘Inhibited’ was the only octant to never be associated with boundary violation propensity. The pattern of relationships on all three measures were noted to change considerably when the sample was separated by gender; female boundary violation propensity correlated predominantly with problematic submissive and nurturant interpersonal styles, ‘non-assertiveness’, ‘self-sacrificing’ and ‘exploitable’. Conversely, male boundary violation propensity correlated predominantly with problematic domineering interpersonal styles; ‘intrusive’, ‘domineering’ and ‘self-centred’.

Figure 2

Statistically significant (< .05) correlations of BVP-Q, SBV-I and BIP (from left to right) applied to the CSIP. Total sample (above) and separated by gender (females = pink, males = blue).



In order to identify the most salient predictors of boundary violation propensity, a regression analysis was performed on each boundary measure. To ensure that these analyses maintained sufficient power, only the predictor variables showing significant relationships with that boundary measure were included. For all three measures, narcissism and specifically, narcissistic grandiosity, emerged as the main contributing variable, a statistical pattern demonstrated by the following hierarchical regression model (see Table 5); Block 1. Gender; Block 2. All previously correlated predictor variables with the exception of narcissism; Block 3. Narcissistic grandiosity and narcissistic vulnerability. Keeping with our hypothesis, only the 'self-sacrificing' and 'self-centred' octants of the circumplex were used, representing each end of the hypothesised spectrum of interpersonal factors contributing to boundary violation propensity. Both of these variables were ipsatised prior to being entered into the model to prevent their common factor of interpersonal problems causing a suppression effect (Boudreaux, Ozer, Oltmanns & Wright, 2017). Collinearity statistics were examined on each model with no variance inflation factors found to be above 10, indicating sufficient divergence between all predictor variables.

Table 5

Linear regression models with predictors of boundary violation propensity entered simultaneously with gender controlled for

Block	**DV: BVP-Q**	*B* [95% CI]	β	R^2	*p*
1	Gender	1.881 [.365, 3.397]	.147	.022	.015
2	Experiential Avoidance	.082 [.01, .153]	.148	.012	.025
	Impulsivity	.377 [.163, .592]	.203	.043	.001
	Satisfaction with Life	-.131 [-.254, -.008]	-.138	.016	.037
	IPS CSIP: Self-Centeredness	.202 [-.19, .593]	.074	.004	.312
	IPS CSIP: Self-Sacrificing	.111 [-.153, -.008]	.056	.003	.408
3	Narcissistic Grandiosity	.134 [.044, .225]	.237	.056	.004
	Narcissistic Vulnerability	.03 [-.052, .113]	.067	.004	.469
	DV: SBV-I				
1	Gender	2.466 [1.344, 3.588]	.255	.065	< .001
2	Experiential Avoidance	.051 [-.003, .064]	.122	.042	.063
	IRI: Empathic Concern	-.065 [-.193, .065]	-.063	.004	.322
	Impulsivity	.284 [.122, .447]	.203	.043	.001
	Weekly client hours	.035 [-.018, .088]	.078	.007	.191
	Childhood Aversity	.211 [-.054, .373]	.108	.013	.067
	Satisfaction with Life	-.023 [-.015, .437]	-.032	.001	.625
	IPS CSIP: Self-Centeredness	.061 [-.236, .358]	.03	.001	.685
	IPS CSIP: Self-Sacrificing	.06 [-.147, .268]	.04	.001	.568
3	Narcissistic Grandiosity	.112 [.045, .179]	.261	.068	.001
	Narcissistic Vulnerability	.045 [-.017, .106]	.13	.017	.152
	DV: BIP				
1	Gender	.924 [.329, 1.52]	.183	.033	.002
2	Experiential Avoidance	.029 [.002, .057]	.134	.016	.036
	Impulsivity	.123 [.037, .21]	.169	.029	.005
	Weekly client hours	.018 [-.01, .047]	.079	.006	.199
	IPS CSIP: Self-Centeredness	.132 [-.022, .285]	.123	.012	.092
	IPS CSIP: Self-Sacrificing	.099 [-.008, .207]	.126	.012	.07
3	Narcissistic Grandiosity	.046 [.01, .082]	.203	.041	.013
	Narcissistic Vulnerability	.025 [-.007, .058]	.142	.02	.127

Note. BVP-Q = Boundary Violation Propensity Questionnaire, SBV-I = Sexual Boundary Violation Index, BIP = Boundaries in Practice Scale, IRI = Interpersonal Reactivity Index, CSIP = Circumplex Scales of Interpersonal Problems (ipsatised). Statistically significant correlations are highlighted in blue (two tailed).

On the BVP-Q, in block 1, gender added a significant 2.2% of the variance to the model, $R^2 = .022$, $p = .015$. In block 2 further significant variance was contributed to the model by experiential avoidance, accounting for 1.2%, $R^2 = .012$, $p = .025$, impulsivity, accounting for 4.3%, $R^2 = .043$, $p = .001$. and satisfaction with life, accounting for 1.6%, $R^2 = .016$, $p = .037$. In block 3, only narcissistic grandiosity added to the model, accounting for an additional 5.6% of variance, $R^2 = .056$, $p = .004$.

On the SBV-I, in block 1, gender added a significant 6.6% of the variance to the model, $R^2 = .065$, $p < .001$. In block 2, the only further significant variance contributed to the model was impulsivity, accounting for 4.3%, $R^2 = .043$, $p = .001$. In block 3, only narcissistic grandiosity added to the model, accounting for an additional 6.8% of variance, $R^2 = .068$, $p = .001$.

On the BIP, in block 1, gender added a significant 3.3% of the variance to the model, $R^2 = .033$, $p = .002$. In block 2 further significant variance was contributed to the model by experiential avoidance, accounting for a 1.6%, $R^2 = .016$, $p = .036$ and impulsivity, accounting for 2.9%, $R^2 = .029$, $p = .005$. In block 3, only narcissistic grandiosity added to the model, accounting for an additional 4.1% of variance, $R^2 = .041$, $p = .013$.

Discussion

Validation of Boundary Violation Measures

We initially tested the convergent validity of three instruments designed to measure a practitioner's propensity to violate therapeutic boundaries. The BVP-Q, SBV-I and the BIP showed evidence of this, with medium to large correlations with one another and small to medium correlations with participants' self-reported frequency of speaking to clients inappropriately and frequency of receiving feedback from colleagues that they become overly involved with their clients. Additionally, all three instruments were scored significantly higher, by participants who disclosed having previously formed a social relationship with a

client, or flirted, drunk alcohol or had sex with a client. These results add support to the use of all three instruments in differentiating practitioners who have a greater propensity to violate therapeutic boundaries.

Of the three instruments, the SBV-I showed the highest level of internal reliability and strongest effect sizes with the convergent measures. However, it also showed the highest susceptibility for social desirability bias, meaning that respondents may be less honest when completing it. The BVP-Q was the only instrument to show no significant relationship with social desirability, and this strength is particularly relevant given the taboo nature of the instruments purpose. The BIP showed the smallest convergence with our other validity measures whilst also correlating with social desirability, however its additional 'knowledge' and 'comfort' subscales, may make it the preferred instrument for certain purposes.

Given that all three instruments are purported to measure the exact same construct, one might have expected even higher correlations between them. Their variance is possibly due to the different way each instrument anchors its response options; the BVP-Q asks participants to estimate their future likelihood of ethical transgressions, the SBV-I asks participants to report their past frequency of ethical transgressions, and the BIP asks participants to provide their ethical judgment of different types of transgressions. Thus, even if all three instruments contained identical items, the same person could still respond to each one differently. A strength of this study's findings is that despite the unique range of risk indicators that each instrument appears to cover, they all responded in similar ways to our hypothesised predictors of boundary violation propensity.

Predicting Boundary Violation Propensity

Results from our study aligned closely with the existing literature of practitioner characteristics associated with boundary violations. As hypothesized, all three of Gabbard's

(1994) boundary violating practitioner types; the Predatory, Lovesick and Masochistic-Surrendering Practitioner, were supported to at least some extent by the data.

All three boundary instruments showed significant, positive relationships with impulsiveness, narcissistic grandiosity and the self-centred octant of the CISP, while the SBV-I showed an additional negative relationship with the empathic concern subscale of the IRI. These findings align with Gabbard's (1994) predatory profile which describes a therapeutic practitioner who seeks out opportunities to exploit their clients, solely as a means of fulfilling their own gratification. Our findings also echo past research which has implicated anti-social features among practitioners with confirmed SBVs (e.g. Garfinkel, Bagby, Waring & Dorian, 1997; Langevin, Glancy, Curnoe and Bain, 1999; Roback et al., 2007), supporting the notion that such characteristics could prove to be reliable indicators of individuals unsuited to the profession, or short of this, individuals requiring the greatest amount of supervision and accountability.

Our hypotheses made regarding the lovesick profile were partially supported. The more weekly hours that our practitioners spent with their clients, and the degree to which they felt dissatisfied with their lives, correlated with boundary violation propensity on two of the three instruments. These variables were measured due to Gabbard's (1994) assertion that Lovesick Practitioners often transgress during a period of significant life stress for which they have attempted to cope by becoming deeply immersed in their work. While these relationships were small and reached significance on only two out of three boundary measures, their contextual quality makes their implications quite obvious. It seems plausible that therapeutic practitioners can reduce their future capacity for unethical client interaction, by maintaining self-care and a healthy work-life balance. Additionally, effective monitoring of practitioners who have been brought to the attention of review boards, might best include

attention to the state of the individual's personal life and restrictions on their number of weekly client hours.

Evidence of the masochistic-surrendering profile was supported by positive correlations between all three boundary instruments with experiential avoidance, narcissistic vulnerability and self-sacrificing interpersonal tendencies, while childhood adversity correlated only with the SBV-I. Contrary to our hypothesis, the interpersonal distress subscale of the IRI showed no significant relationships with any of the boundary instruments. It is possible that interpersonal distress represents a more neurotic form of compassion-driven boundary violations and the higher attrition rate of such individuals might explain why the relationship was found by Dickeson and Smout's (2018) sample of aspiring practitioners, but not the current sample of established professionals. Otherwise, our results support the notion that under certain circumstances, therapeutic boundary violations occur when practitioners have become overly invested in their client's well-being. Differing from the predatory profile, whose features are perhaps seen as obviously deplorable, the selfless and caring aspects of the Masochistic-Surrendering Practitioner may be admired and even encouraged within the therapeutic disciplines. The reported association between these traits and therapeutic boundary violations, might encourage practitioners to implement protective measures to guard against compassion-driven ethical transgressions. Of possible relevance to this, we repeated the previously found relationship between experiential avoidance and boundary violation propensity (Dickeson & Smout, 2018), lending confidence to future research seeking to explore ways in which ACT principles might be used to guide ethical decision making within the therapeutic relationship. And the last finding relevant to masochistic-surrender, is the positive relationship found between childhood adversity and the SBVI. Gabbard (1994) observed that Masochistic-Surrendering Practitioners transgress boundaries in the context of intense counter-transference related to their own unresolved childhood

traumas. Although past studies have found significant childhood trauma histories among transgressing practitioners (Samenow, Yabiku, Ghulyan, Williams & Swiggart, 2011; Jackson & Nuttell, 2001), our small effect size, occurring with only one of the three boundary instruments, suggests that childhood adversity is, at most, of minor relevance to the prediction of boundary violations. Consistent with the wounded-healer motif, a large portion of therapeutic practitioners appear to have gravitated towards their professions due to their own adverse childhood (Newcomb, Burton, Edwards & Hazelwood, 2015). The present findings might quell some of the previously raised concerns of how these experiences relate to impaired ethical judgement.

Of all findings, narcissistic grandiosity emerged as the single largest predictor of boundary violation propensity, showing the highest correlations to all three instruments and explaining the largest amount of variance in hierarchical regression models. This outcome is remarkably consistent with Gabbard's (2016, p. 57) amendment, in which he concludes the description of his taxonomy with an additional section, *The Common Ground of Narcissism:*

"A key manifestation of the analysts' struggles is the grandiosity inherent in virtually all cases. A recurring theme is a conviction that "I alone can save this patient". Altruistic wishes to rescue are transformed into omnipotent strivings to heal."

Identifying narcissism as an entirely maladaptive trait is however, problematic. Kottler (2017), suggests that narcissism, specifically a sensitivity to criticism and subsequent social attunement, are part of what makes certain individuals ideally suited to the therapeutic professions. Furthermore, given the complexity of mental illness and the often-ambiguous nature of treatment, it is likely that highly self-assured practitioners instil greater hope within their clients and subsequently facilitate better treatment outcomes. In any case, the present findings indicate the importance, in training and supervision, of helping therapeutic

practitioners learn to identify and manage their own narcissistic conflicts in the therapeutic relationship.

We did not anticipate the extent of gender differences found in the relationships between the three boundary violation instruments and the interpersonal circumplex. Confidence of these differences is increased however, given that all three instruments resulted in an almost identical pattern. For males, boundary violation propensity was most associated with high dominance; intrusiveness, domineering and self-centeredness. Conversely, female scores correlated most strongly with high nurturance and low dominance; self-sacrificing and exploitableness. These results may seem intuitive given that overly dominant and overly nurturant and submissive features are found to be more prominent interpersonal problems for men and women respectively (Boudreaux, Ozer, Oltmanns & Wright, 2017). It is unclear the extent to which differing relationships between boundary violation propensity and interpersonal problems are the result of differences in gender or more nuanced differences in gender expression. For example, it seems improbable that male practitioners could not be prone to boundary violations due to their having excessively nurturant and submissive tendencies, equally, it is assumed that certain boundary prone females would be characterised by high dominant traits. The interpersonal circumplex was selected as a predictor variable in this study, because it was gauged that its self-centred and self-sacrificing scales were theoretically consistent with Gabbard's (1994) description of Predatory and Masochistic-Surrendering Practitioners respectively. Although the measure appears to have fit well for this purpose, one contrary finding is that Gabbard posited that Masochistic-Surrendering Practitioners were predominantly male (Gabbard, 1994, p. 132). There are at least two possible explanations for this: firstly, Gabbard's taxonomy is specifically a description of sexual boundary-violating practitioners while the instruments used in the present study contain items which allude to non-sexual boundary violations. It is

possible that while female practitioners are, on average, more vulnerable to committing boundary violations due to self-sacrificing tendencies, the small portion of occasions which eventuate in erotic contact are predominantly committed by males. This would be consistent with male practitioners self-reporting SBVs at a rate 4-5 times higher than females (Hook & Devereux, 2018), just as the males in this study scored significantly higher on all three of the boundary measures. Secondly, it is possible that the increase of female psychologists since Gabbard's formulated his taxonomy (see Cynkar, 2007), has caused change to occur in the most salient practitioner characteristics relevant to boundary violations. Relevantly, only .7% of the present sample reported previously having engaged in erotic contact with a client. To our knowledge this is the smallest number ever reported in such a survey and may indicate a historical trend in the decline of SBVs (see Hook & Devereux, 2018). This result, along with the non-finding of previously supported contextual predictors of SBVs, particularly advanced age (Garrett & Davis, 1998; Rodolfa et al., 1994; Stake & Oliver, 1991), may reflect the passing of a more problematic culture which the profession has since rid itself of.

Limitations

Asking participants to disclose their past unethical conduct, likely exacerbates the common difficulties encountered when acquiring self-reported data. It is possible that boundary prone practitioners were disproportionately represented in the sample due to their different level of willingness to participate in such a survey. In addition, desirability factors may have led participants to understate their willingness to violate therapeutic boundaries or truthfully report past instances of their own transgressions. We anticipated these possibilities with carefully worded and placed assurances of participant anonymity. Additionally, the use of the Marlow-Crowne Desirability Scale allowed us to gauge the degree to which desirability biased our findings.

Also raising the potential for distorted sample demographics, practitioners without publicly listed contact details were less likely to have received invitations to complete the survey. This is particularly problematic given that professional isolation is thought to be a predictor for boundary violation propensity. Our recruitment strategy also yielded a low response rate, limiting the extent to which are findings can be generalised to the wider population of therapeutic practitioners.

This study may warrant criticism in that its large number of predictor variables, raises the possibility of false-positive findings. This issue is less concerning given that nearly all of the predicted variables showed significant correlations and that our interpretations were driven primarily by their differing effect sizes.

Finally, although our total recruited sample comfortably met the calculated requirements of our a-priori power analysis, when separated by gender, power was not reached by the males. Given that our results suggest distinct gender differences in the contributing factors to boundary violation propensity, it is possible that further gender specific results would have been found with a higher number of male participants. Despite this limitation, several correlations did emerge as significant among the males in our sample, and these were generally of even larger effect size than the relationships exclusive to the females. Thus, despite an underpowered male sample, outcomes reported in the current study are likely to be the largest and most important.

Conclusions and Implications

This study found evidence to support several factors as being relevant to the likelihood of therapeutic boundary violations. Consistent with Gabbard's (1994) taxonomy, both callous and overly caring interpersonal tendencies showed significant relationships with boundary violation propensity. Contextual factors were also implicated; including the number of weekly client contact hours, the more dissatisfied they felt with their own lives, and the

greater proclivity they had for experiential avoidance. Above all else, narcissism emerged as the most pertinent contributor to worrisome practitioner judgement.

These findings have the potential to guide future attempts at reducing the occurrence of therapeutic boundary violations. For example, the personality traits reported here through quantitative means, might increase the confidence that selection panels and training directors have in identifying inappropriate applicants for trainee programs. For example, Vacha-Haase, Davenport and Kerewsky (2004) reported that fear of litigation often deterred training directors from terminating psychology trainees on subjective grounds, such as deficient interpersonal skills. Training programs might also take from these findings, reason to emphasise self-reflection among trainees, specifically with regards to examining their own interpersonal tendencies and narcissistic vulnerabilities, thus increasing their ability to anticipate their own propensity for unethical conduct. The narcissistic belief that 'Only I can help the client', is particularly important to address explicitly because it may be born of good intentions and inadvertently reinforced by the context by which some therapists – e.g., clinical psychologists – are selected and trained: an exclusive group of high achievers taught that their skill determines clinical outcomes.

Finally, the current study supports the use and further refinement of self-report instruments like the BVP-Q, SBV-I and BIP. Future research might examine the communality between the measures and the extent to which each measure on its own relates to this communality. Ideally, they could eventually be used to assist in screening for practitioners in need of further training around professional boundaries. Such individuals could subsequently be supported in identifying their own characteristics relevant to ethical decision-making and to seek corrective strategies to manage these. Their usage in future empirical studies would likely uncover and refine additional practitioner characteristics and contextual factors associated with boundary violations and in doing so, could lead to a

reliable network of warning indicators. Perhaps the single worst outcome for a client approaching a mental healthcare service, is that they enter a therapeutic relationship with a practitioner who does not maintain appropriate boundaries. Subsequently, any further efforts to address this uncommon but consequential area of therapeutic practice would be worthwhile.

References

Alden, L. E., Wiggins, J. S., & Pincus, A. L. (1990). Construction of circumplex scales for the Inventory of Interpersonal Problems. *Journal of Personality Assessment*, *55*(3-4), 521-536. doi: 10.1080/00223891.1990.9674088

Boudreaux, M. J., Ozer, D. J., Oltmanns, T. F., & Wright, A. G. (2017). Development and validation of the circumplex scales of interpersonal problems. Doi: 10.1037/pas0000505

Cohen, J. (1992). Statistical power analysis. *Current Directions in Psychological Science*, *1*(3), 98-101. doi: 10.1111/1467-8721.ep10768783

Cynkar, A. (2007). The changing gender composition of psychology. Retrieved from https://www.apa.org/monitor/jun07/changing.aspx

Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of Personality and Social Psychology*, *44*(1), 113.

Dickeson, E., & Smout, M. F. (2018). Is the wounded healer or the psychologically inflexible healer in undergraduate psychology and social work programs more empathic or willing to violate professional boundaries?. *Australian Journal of Clinical Education*, *3*(1), 1-13.

Diener, E. D., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, *49*(1), 71-75. doi: 10.1207/s15327752jpa4901_13

Dong, M., Anda, R. F., Felitti, V. J., Dube, S. R., Williamson, D. F., Thompson, T. J., ... & Giles, W. H. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect*, *28*(7), 771-784. doi: 10.1016/j.chiabu.2004.01.008

Dube, S. R., Williamson, D. F., Thompson, T., Felitti, V. J., & Anda, R. F. (2004). Assessing the reliability of retrospective reports of adverse childhood experiences among adult HMO members attending a primary care clinic. *Child Abuse & Neglect*. doi: 10.1016/j.chiabu.2003.08.009

Epstein, R. S., & Simon, R. I. (1990). The exploitation index: An early warning indicator of boundary violations in psychotherapy. *Bulletin of the Menninger Clinic*, *54*(4), 450.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245-258. doi: 10.1016/j.amepre.2019.04.001

Gabbard, G. O. (1994). Psychotherapists who transgress sexual boundaries with patients. *Bulletin of the Menninger Clinic*, *58*(1), 124.

Gabbard, G. O. (2016). *Boundaries and boundary violations in psychoanalysis*. American Psychiatric Pub.

Gámez, W., Chmielewski, M., Kotov, R., Ruggero, C., & Watson, D. (2011). Development of a measure of experiential avoidance: The Multidimensional Experiential Avoidance Questionnaire. *Psychological Assessment*, *23*(3), 692. doi: 10.1037/a0023242

Gámez, W., Chmielewski, M., Kotov, R., Ruggero, C., Suzuki, N., & Watson, D. (2014). The brief experiential avoidance questionnaire: development and initial validation. *Psychological Assessment*, *26*(1), 35. doi: 10.1037/a0034473

Garfinkel, P. E., Bagby, R. M., Waring, E. M., & Dorian, B. (1997). Boundary violations and personality traits among psychiatrists. *The Canadian Journal of Psychiatry*, *42*(7), 758-763. doi: 10.1177/070674379704200709

Garrett, T., & Davis, J. D. (1998). The prevalence of sexual contact between British clinical psychologists and their patients. *Clinical Psychology & Psychotherapy: An International Journal of Theory and Practice*, *5*(4), 253-263. doi: 10.1002/(SICI)1099/0879(199812_5:4<253::AID-CPP171<3.0CO;2-4

Gurtman, M. B. (2009). Exploring personality with the interpersonal circumplex. *Social and Personality Psychology Compass*, *3*(4), 601-619. doi: 10.1111/j.1751-9004.2009.00172.x

Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *The American Journal of Psychiatry*. doi: https://psycnet.apa.org/doi/10.1176/ajp.150.2.188

Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology*, *64*(6), 1152. doi: 10.1037/0022-006X.64.6.1152

Hook, J., & Devereux, D. (2018). Sexual boundary violations: victims, perpetrators and risk reduction. *BJPsych Advances*, *24*(6), 374-383. doi: 10.1192/bja.2018.27

Hulkower, R. (2016). The history of the Hippocratic Oath: outdated, inauthentic, and yet still relevant. *Einstein Journal of Biology and Medicine*, *25*(1), 41-44. doi: 10.23861/EJBM20102542

Kendall, M., Fronek, P., Ungerer, G., Malt, J., Eugarde, E., & Geraghty, T. (2011). Assessing professional boundaries in clinical settings: The development of the boundaries in practice scale. *Ethics & Behavior*, *21*(6), 509-524. doi: 10.1080/10508422.2011.622186

Kottler, J. (2017). *On being a therapist*. Oxford University Press. Oxford, United Kingdom.

Lackie, B. (1983). The families of origin of social workers. *Clinical Social Work Journal, 11*(4), 309-322. Accessed online: http://www.academia.edu/download/31660888/Families_of_Origin_of_Social_Workers.doc

Langevin, R., Glancy, G. D., Curnoe, S., & Bain, J. (1999). Physicians who commit sexual offences: Are they different from other sex offenders?. *The Canadian Journal of Psychiatry*, *44*(8), 775-780. doi: 10.1177/070674379904400803

MacDonald, K., Sciolla, A. F., Folsom, D., Bazzo, D., Searles, C., Moutier, C., ... & Norcross, B. (2015). Individual risk factors for physician boundary violations: the role of attachment style, childhood trauma and maladaptive beliefs. *General hospital psychiatry*, *37*(5), 489-496. doi: 10.1016/j.genhosppsych.2015.06.002

Miller, J. D., Price, J., Gentile, B., Lynam, D. R., & Campbell, W. K. (2012). Grandiose and vulnerable narcissism from the perspective of the interpersonal circumplex. *Personality and Individual Differences*, *53*(4), 507-512. doi: 10.1016/j.paid.2012.04.026

Newcomb, M., Burton, J., Edwards, N., & Hazelwood, Z. (2015). How Jung's concept of the wounded healer can guide learning and teaching in social work and human services. *Advances in Social Work and Welfare Education, 17*(2), 55. Accessed online: https://www.researchgate.net/publication/285591160_How_Jung%27s_concept_of_the_wounded_healer_can_guide_learning_and_teaching_in_social_work_and_human_services

Patton, J. H., Stanford, M. S., & Barratt, E. S. (1995). Factor structure of the Barratt impulsiveness scale. *Journal of Clinical Psychology*, *51*(6), 768-774. doi: 10.1002-1097-4679(199511)51:6<768::AID-JCLP2270510607>3.0.CO;2-1

Pavot, W., & Diener, E. (2009). Review of the satisfaction with life scale. In *Assessing well-being* (pp. 101-117). Springer, Dordrecht.

Rafaeli, E., Bernstein, D. P., & Young, J. (2010). *Schema therapy: Distinctive features*. Routledge. ProQuest Ebook.

Roback, H. B., Strassberg, D., Iannelli, R. J., Finlayson, A. R., Blanco, M., & Neufeld, R. (2007). Problematic physicians: a comparison of personality profiles by offence type. *The Canadian Journal of Psychiatry*, *52*(5), 315-322. doi: 10.1177/070674370705200506

Rodolfa, E., Hall, T., Holms, V., Davena, A., Komatz, D., Antunez, M., & Hall, A. (1994). The management of sexual feelings in therapy. *Professional Psychology: Research and Practice*, *25*(2), 168. doi: 10.1037/0735-7028.25.2.168

Samenow, C. P., Yabiku, S. T., Ghulyan, M., Williams, B., & Swiggart, W. (2012). The role of family of origin in physicians referred to a CME course. *HEC Forum*, 24(2), 115-126. doi: 10.1007/s10730-011-9171-8

Schoenleber, M., Roche, M. J., Wetzel, E., Pincus, A. L., & Roberts, B. W. (2015). Development of a brief version of the Pathological Narcissism Inventory. *Psychological Assessment*, *27*(4), 1520. doi: 10.1037/pas0000158

Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research and Practice*, *26*(5), 499. doi: 10.1037/0735-7028.26.5.499

Spinella, M. (2007). Normative data and a short form of the Barratt Impulsiveness Scale. *International Journal of Neuroscience*, *117*(3), 359-368. doi: 10.1080/00207450600588881

Stake, J. E., & Oliver, J. (1991). Sexual contact and touching between therapist and client: A survey of psychologists' attitudes and behavior. *Professional Psychology: Research and Practice*, *22*(4), 297. doi: 10.1037/0735-7028.22.4.297

Steinberg, L., Sharp, C., Stanford, M. S., & Tharp, A. T. (2013). New tricks for an old measure: The development of the Barratt Impulsiveness Scale–Brief (BIS-Brief). *Psychological Assessment*, *25*(1), 216. doi: 10.1037/a0030550

Strahan, R., & Gerbasi, K. C. (1972). Short, homogeneous versions of the Marlow-Crowne social desirability scale. *Journal of Clinical Psychology*, *28*(2), 191-193. Doi: 10.1002/1097-4679(197204)28:2<191::AID-JCLP2270280220>3.0.CO;2-G

Swiggart, W., Feurer, I. D., Samenow, C., Delmonico, D. L., & Spickard Jr, W. A. (2008). Sexual boundary violation index: a validation study. *Sexual Addiction & Compulsivity*, *15*(2), 176-190. doi: 10.1080/10720160802055939

APPENDIX A

Example of Electronic Search Strategy

(Complete search history available from the author)

Data base: Ovid PsychINFO

Conducted: 25th of August 2018. Limit all to 'human' and 'English language'.

SEARCH:

(predict* OR assess* OR character* OR risk factor* OR antecedent* OR context* or quanti*).mp. [mp=title, abstract, heading word, table of contents, original title, key measures]

Result: 1589327

AND

(ethical behaviour OR therapeutic boundar* OR boundary crossing* OR boundary violation* OR ethical judgment OR ethical decision making).mp. [mp=title, abstract, heading word, table of contents, original title, key measures]

Result: 3245

AND

(Choice or choos* or deci* or select or opt or interest* or influence* or motivat*)[mp=title, abstract, heading word, table of contents, original title, key measures]

Result: 566563

Total: 293

APPENDIX B

PARTICIPANT INFORMATION SHEET

PROJECT TITLE: Investigating Issues Relevant to Professional Boundaries in Therapeutic Practice
PRINCIPAL INVESTIGATOR: Mr Edward Dickeson
STUDENT'S DEGREE: Master of Psychology (Clinical)

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?
This project aims to investigate factors that might influence ethical decision-making by therapeutic practitioners, particularly with regard to client/worker relationships. Outcomes from the project may improve our professions' knowledge and understanding of ethical issues that arise in therapeutic practice.

Who is undertaking the project?
This project is being conducted by Mr Ned Dickeson from the University of Adelaide and will form the basis of a Master's degree in Clinical Psychology. The project is being supervised by Associate Professor Rachel Roberts from the University of Adelaide and Dr Matthew Smout from the University of South Australia.

Why am I being invited to participate?
Invitations are being sent to therapeutic service providers across Australia representing a variety of disciplines and work settings. As a provider of therapeutic client services, you have valuable insight and experience with issues related to ethics in therapeutic practice.

What am I being invited to do?
You are being invited to complete a one off, anonymous, online survey. You will be asked to give your opinion about a series of questions regarding ethics in therapeutic practice. You will also be asked to complete questionnaires designed to measure features of personality.

How much time will my involvement in the project take?
The survey will take approximately 35 minutes to complete.

Are there any risks associated with participating in this project?
The survey will include questions about ethical dilemmas that arise in therapeutic work. Some participants may worry that they could experience personal or professional ramifications, such as loss of reputation, based on how they respond to the questions. Please note that ethics approval was granted for this project contingent on the assured anonymity of all participants. Every possible effort will be made to fulfil this requirement including the deletion of any potentially identifying data following study completion in December, 2019.

The survey does include some questions about adverse childhood events and participants may find thinking about these events distressing. You do not have to answer these questions. If you do find the questions distressing you can contact the following support services:

Lifeline - crisis support and suicide prevention services (24-hours)
Phone: 13 11 14

Blue Knot Helpline - supporting adult survivors of childhood trauma and abuse (9 to 5 AEST)
Phone: 1300 657 380

What are the potential benefits of the research project?
Ethical conduct is a vital component of therapeutic service delivery. A better understanding of what factors influence a practitioner's decision-making process when faced with ethical dilemmas may contribute towards a reduction in the occurrence of ethical transgressions.

Can I withdraw from the project?
If you choose to participate, you can withdraw from the study at any time. However, given that participation will be anonymous, it will not be possible to have your specific data deleted once it has been entered into the survey.

What will happen to my information?
Participants will not be asked to provide their names, place of work or any other potentially identifying information. The utmost care will be taken to ensure that no personally identifying details are revealed. All collected data will be kept electronically on password protected computers. Access to the data will be reserved to the researchers, and kept for a minimum of seven years.

Results of the project will be written up and submitted as thesis component of a Master of Psychology degree and may be published in an academic journal article.

All records containing personal information will remain confidential and no information which could lead to the identification of any individual will be released. Individuals' responses will be kept confidential by the researcher and not be identified in the reporting of the research. If you wish to receive a copy of the research report, you may request it by contacting the researchers.

Your information will only be used as described in this participant information sheet and it will only be disclosed according to the consent provided, except as required by law.

Who do I contact if I have questions about the project?
Project Manager (primary contact): Mr Edward Dickeson
[redacted]

Internal Supervisor: A/Prof. Rachel Roberts
[redacted]

External Supervisor: Dr Matthew Smout
[redacted]

What if I have a complaint or any concerns?
If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or

your rights as a participant, please contact the University of Adelaide ethics subcommittee chairperson:
Professor Paul Delfabbro
[redacted]
Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If I want to participate, what do I do?
By clicking on the 'Next', you will be led directly to the beginning of the questionnaire. By doing so, you are indicating your understanding of the information provided on this sheet and providing consent to participate in the study.

Yours sincerely,

Mr Edward Dickeson, A/Prof. Rachel Robert, Dr Matthew Smout

APPENDIX C

Boundary Violations Propensity Questionnaire

The following 17 scenarios describe difficult situations that might occur in a human services context. For each scenario, indicate how likely you would be to make the same decision as the worker. Answer as honestly as you can. Thank you.

1	2	3	4	5	6
Definitely not	Probably not	Possibly	Probably	Very probably	Definitely

1. The worker learns that a client has brought alcohol into a residential substance addiction treatment program. This normally results in the client being exited from the program as it puts other clients at risk of relapse. The worker decides not to report the breach because they think that overall the program is helping the client. How likely would you be to make the same decision as the worker?
2. A client has become increasingly flirtatious with the worker. The worker has great rapport with the client and anticipates that if they informed their supervisor of the flirting, the supervisor would assign a new worker. The worker puts strong boundaries in place with the client but avoids mentioning the matter in their case notes or when talking to their supervisor. How likely would you be to make the same decision as the worker?
3. The client has had thoughts of suicide. In addition to the contact details of an emergency crisis line, the worker feels obliged to also give their personal phone number for the client to use if they need additional support. How likely would you be to make the same decision as the worker?
4. After achieving significant improvements with the client's depression, the worker and client conclude their counselling sessions. Three months later, by chance on the weekend, the worker sees the former client in a shopping centre. Wanting to encourage the client's progress, the worker invites the former client for a coffee. The worker offers to "do this again" if the client needs further support. How likely would you be to make the same decision as the worker?
5. The client offers a personal gift that is more expensive than permitted by the organisation's code of conduct. The worker feels uncomfortable, but decides to accept

the gift as they feel declining would be damaging to the therapeutic relationship. How likely would you be to make the same decision as the worker?

6. The client, a qualified tradesperson, is unable to afford the consultation fee. The worker agrees to be compensated with some maintenance on the office building so that the client can continue to access the service. How likely would you be to make the same decision as the worker?
7. A client is intoxicated and angry. He starts breaking things and throwing furniture around the empty waiting room. The rest of the staff follow the emergency procedure and lock themselves in the back rooms, waiting for the police to arrive. The worker hopes to minimise the trouble the client will face if they are arrested by the responding police officers. The worker enters the waiting room and tries to calm the client down. How likely would you be to make the same decision as the worker?
8. The client reveals to the worker that she has a new boyfriend. The worker knows this man as a previous client and that he has history of violent offending. The worker decides to immediately inform the client of her boyfriend's violent offences. How likely would you be to make the same decision as the worker?
9. The worker has a colleague who has a reputation for being rude and belittling towards clients. An upset client comes to the worker and says the same colleague insulted them but they doubt anybody will believe them if they make a complaint. The worker assures the client that they are not the first person to have had this problem with the colleague. How likely would you be to make the same decision as the worker?
10. The worker's supervisor voices concern that the worker is becoming over-involved with their client's life. The worker thinks the supervisor is being lazy and uncaring. The worker disregards most of their supervisor's objections. How likely would you be to make the same decision as the worker?
11. The worker discovers that a colleague is dating one of the service's clients. They choose to say nothing. How likely would you be to make the same decision as the worker?

APPENDIX D

Sexual Boundary Violation Index

Please circle the response that best characterizes your behaviours.

0 = Never 1 = Rarely 2 = Sometimes 3 = Often

1 I have told patients personal things about myself in order to impress them.
2 I have accepted social invitations from particular patients outside of scheduled clinic visits.
3 I have used language other than clinical language to discuss my patient's physical appearance or behaviours I may consider seductive.
4 I have found myself comparing the gratifying qualities I observe in a patient with the less gratifying qualities in my significant other.
5 I have thought that my patient's problem would be helped if he/she had a romantic involvement with me.
6 I have found myself trying to influence other employees in my workplace over whom I have supervisory influence, to support political causes, or positions in which I have personal interest.
7 I have felt a sense of excitement or longing when I think of a patient or anticipate his/her visit.
8 I have found myself talking about my personal life or problems with a patient and expected sympathy.
9 When a patient has acted in a manner I consider seductive, I have experienced this as a gratifying sign of my own sex appeal.
10 I have engaged in a personal relationship with a patient either while I was treating him/her, or after treatment was terminated.
11 I think about what it would be like to be sexually involved with a patient.
12 I have initiated or engaged in a personal relationship with an employee that I supervise.
13 I take great pride in the fact that such an attractive, wealthy, powerful, or important patient is seeking my help.
14 I have found myself talking about my personal life or problems with patients.
15 I have resisted or refused consultation with appropriate professionals, when others have told me I have problems that cause difficulty in my work or personal relationships.
16 I have initiated or engaged in a personal relationship with a person over whom I have power, authority, or decision-making ability.
17 I have asked one or more patients to do personal favours for me.
18 I have found myself trying to influence my patients to support causes, business deals, or positions in which I have personal interest.
19 I have initiated business deals with patients.
20 I have solicited gifts, bequests, or favours from patients for personal benefit or to benefit a business with which I am or plan to be involved.
21 I have recommended treatment procedures or referrals that I did not believe to be necessarily in my patient's best interests.
22 I have found myself fantasizing or daydreaming about a patient.
23 I have made exceptions for patients, e.g., scheduling, benefits, and/or fees, because I found the patient attractive, appealing or impressive.

24 I have made exceptions for some patients because I was afraid he/she will otherwise become extremely angry or self - destructive.
25 I have sought social contact with patients outside of scheduled clinic visits.

APPENDIX E

Boundaries in Practice Scale (Sample only)

Consider each of the following situations and select the appropriate response from the four choices. Please imagine you are the person in each scenario.

Never ethical	Ethical under some conditions	Ethical under most conditions	Always ethical
0	1	2	3

1 A mother of a client is very distressed. She is a nice woman and you really like her. She asks you to have dinner with her one night. She needs some cheering up so you invite her home for dinner. How ethical is this decision?

4 You have been under a lot of personal stress and the client asks you what is wrong. You find yourself telling the client about your problems. How ethical is this decision?

7 You are working with a client who has a family situation similar to your own. You can really understand what this person is going through. You offer advice based on your own personal experience. How ethical is this decision?

9 You are meeting a group of friends at a nightclub. You feel sorry for one of your young clients and feel a night out would do them good. You invite them to come along. How ethical is this decision

APPENDIX F

Marlowe-Crowe Social Desirability Scale short form

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you.

1	**I'm always willing to admit it when I make a mistake.**	(true)
2	**I always try to practice what I preach.**	(true)
3	**I never resent being asked to return a favour.**	(true)
4	**I have never been irked when people expressed ideas very different from my own.**	(true)
5	**I have never deliberately said something that hurt someone's feelings.**	(true)
6	**I like to gossip at times.**	(false)
7	**There have been occassions when I took advantage of someone.**	(false)
8	**I sometimes try to get even rather than forgive and forget.**	(false)
9	**At times I have really insisted on having things my own way.**	(false)
10	**There have been occassions when I felt like smashing things.**	(false)

APPENDIX G

Circumplex Scale of Interpersonal Problems (Sample only)

The following is a list of personal problems people commonly report in their lives. These include thoughts, feelings, and behaviours that may cause emotional distress, disrupt relationships, or interfere with goals and activities. Read each statement carefully, and indicate how much you experience each problem using the scale below to record your answers.

Not a Problem	Minor Problem	Moderate Problem	Serious Problem
0	1	2	3

Domineering	Bossing around other people too much Verbally or physically abusing others
Self-Centred	Acting rude and inconsiderate toward others Acting selfishly with others
Cold/Distant	Pushing away other people who get too close Difficulty showing love and affection to others
Inhibited	Difficulty making friends Having trouble fitting in with others
Non-Assertive	Lacking Self-Confidence Getting easily embarrassed in front of others
Exploitable	Letting other people boss me around too much Acting overly submissive with others
Self-Sacrificing	Putting other people’s needs before my own too much Giving too much to others
Intrusive	Being overly affectionate with others Difficulty keeping personal matters private from others

APPENDIX H

Brief Pathological Narcissism Inventory (Sample only)

Please indicate how much each of the following statements is typical of you. Use the scale provided.

Not at All Like Me					Very Much Like Me
0	1	2	3	4	5

Narcissistic Grandiosity	Grandiose Fantasy	I often fantasize about being recognised for my accomplishments I often fantasize about performing heroic deeds
	Exploitative	I can make anyone believe anything I want them to I can read people like a book.
	Self-sacrificing-self-enhancement	I like to have friends who rely on me because it makes me feel important. I try to show what a good person I am through my sacrifices
Narcissistic Vulnerability	Contingent self-esteem	When people don't notice me, I start to feel bad about myself I am preoccupied with thoughts and concerns that most people are not interested in me.
	Hiding the self	I can't stand relying on other people because it makes me feel weak When others get a glimpse of my needs, I feel anxious and ashamed
	Devaluing	When others don't meet my expectations, I often feel ashamed about what I wanted Sometimes I avoid people because I'm concerned that they'll disappoint me
	Entitlement Rage	I get annoyed by people who are not interested in what I say or do It irritates me when people don't notice how good a person I am

APPENDIX I

Barratt Impulsiveness Scale Brief Version

People differ in the way they act and think in different situation. This is a test to measure some of the ways in which you act and think. Read each statement and mark the appropriate option beneath it. Do not spend too much time on any statement. Answer quickly and honestly.

Rarely/Never	Occasionally	Often	Always/Nearly Always
1	2	3	4

1 I plan tasks carefully.

2 I do things without thinking.

3 I don't "pay attention."

4 I am self-controlled. (R)

5 I concentrate easily. (R)

6 I am a careful thinker. (R)

7 I say things without thinking. (R)

8 I act on the spur of the moment. (R)

APPENDIX J

Satisfaction with Life Scale

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item. Please be open and honest in you responding.

Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

1 In most ways my life is close to ideal

2 The conditions of my life are excellent

3 I am satisfied with my life

4 So far, I have gotten the important things I want in life

5 If I could live my life over, I would change almost nothing

APPENDIX K

Brief Experiential Avoidance Questionnaire

Please indicate the extent to which you agree or disagree with each of the following statements

Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1	2	3	5	6	7

1	The key to a good life is never feeling any pain
2	I'm quick to leave any situation that makes me feel uneasy
3	When unpleasant memories come to me, I try to put them out of my mind
4	I feel disconnected from my emotions
5	I won't do something until I absolutely have to
6	Fear or anxiety won't stop me from doing something important
7	I would give up a lot not to feel bad
8	I rarely do something if there is a chance that it will upset me
9	It's hard for me to know what I'm feeling
10	I try to put off unpleasant tasks for as long as possible
11	I go out of my way to avoid uncomfortable situations
12	One of my big goals is to be free from painful emotions
13	I work hard to keep out upsetting feelings
14	If I have any doubts about something, I just won't do it
15	Pain always leads to suffering

APPENDIX L

Interpersonal Reactivity Index

(Only Empathic concern (EC) Personal distress (PD) subscales were used in this project.)

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale. Read each item carefully before responding. Answer as honestly as you can. Thank you.

Answer Scale:

A	B	C	D	E
DOES NOT DESCRIBE ME WELL				DESCRIBES ME VERY WELL

I often have tender, concerned feelings for people less fortunate than me. (EC)

Sometimes I don't feel very sorry for other people when they are having problems. (EC) (-)

In emergency situations, I feel apprehensive and ill-at-ease. (PD)

When I see someone being taken advantage of, I feel kind of protective towards them. (EC)

I sometimes feel helpless when I am in the middle of a very emotional situation. (PD)

When I see someone get hurt, I tend to remain calm. (PD) (-)

Other people's misfortunes do not usually disturb me a great deal. (EC) (-)

Being in a tense emotional situation scares me. (PD)

When I see someone being treated unfairly, I sometimes don't feel very much pity for them. (EC) (-)

I am usually pretty effective in dealing with emergencies. (PD) (-)

I am often quite touched by things that I see happen. (EC)

I would describe myself as a pretty soft-hearted person. (EC)

I tend to lose control during emergencies. (PD)

When I see someone who badly needs help in an emergency, I go to pieces. (PD)

APPENDIX M

Adverse Childhood Experiences Questionnaire

While you were growing up, during the first 18 years of life:

YES or NO

1. Did a parent or other adult in the household often or very often push, grab, slap, or throw something at you? OR ever hit you so hard that you had marks or were injured?
2. Did a parent or other adult in the household often or very often swear at you, insult you, put you down, or humiliate you? OR act in a way that made you afraid you might be physically hurt?
3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? OR Attempt or actually have oral, anal or vaginal intercourse with you?
4. Did you often or very often feel that you didn't have enough to eat, had to wear dirty cloths, and had no one to protect you? OR Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
5. Did you often or very often feel that no one in your family loved you or thought you were important or special OR your family didn't look out for each other, feel close to each other, or support each other?
6. Were your parents ever separated or divorced?
7. Was a household member depressed or mentally ill, or did a household member attempt suicide?
8. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? OR Sometimes often or very often, kicked, bitten, hit with a fist, or hit with something hard? OR ever repeatedly hit for at least a few minutes or threatened with a gun or knife?
9. Did you live with anyone who was a problem drinker or alcoholic or used street drugs?
10. Did a household member ever go to prison?