THE EFFECTS OF COUNSELING PROVIDER ATTACHMENT STYLE AND EMPATHY ON BOUNDARY BEHAVIORS

By
Kayla Marmaros, M.S., Doctoral Candidate

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Doctor of Philosophy in Mental Health Counseling in the Department of Psychology at Pace University, Pleasantville, NY

Summer 2019

FINAL APPROVAL OF COMPLETED DISSERTATION

NAME: Kayla Marmaros

TITLE of Dissertation: The Effect of Counseling Provider Attachment style and Empathy on Boundary Behaviors

DOCTORAL DISSERTATION COMMITTEE:

COMMITTEE CHAIR: Angela Legg PhD

Associate Professor Pace University

COMMITTEE MEMBER: Paul Griffin PhD

Associate Professor Pace University

COMMITTEE MEMBER: Maren Westphal PhD

Associate Professor Pace University

FINAL APPROVAL OF COMPLETED DISSERTATION:

I have read the final version of the doctoral dissertation and certify that it meets the relevant requirements for the Ph.D. degree in Mental Health Counseling.

Angela Legg 6/18/19

Committee Chair's Signature Date

Anthony Mancini 6/18/19

Committee Member's Signature Date

Maren Westphal 6/18/19

Committee Member's Signature Date

ABSTRACT

Counselors are regularly confronted with boundary issues within day to day clinical practice with clients. Despite the code of ethics serving as a general guideline for appropriate counselor behaviors to ensure optimal client care, its ambiguity leads counselors to rely heavily on clinical decision making (Zur, 2007). The balance of staying within treatment boundaries and wanting to best help clients can be a challenge. Nevertheless, boundary transgressions can have consequences for both the counselor and client, at times leading to suspension of professional licenses and client psychological harm. This study examined counselor demographics (gender, practice setting, years of experience, and theoretical orientation), empathy (cognitive and affective), and attachment patterns (anxious and avoidant) in their influence on counselor boundary behaviors within the therapeutic relationship. Findings revealed demographic factors including male providers and those with more years of experience engage in more boundary behaviors. Our study also provided evidence that those who are more anxiously attached and have greater affective empathy may also engage in more boundary behaviors with clients. It was found that counseling providers higher in anxious attachment engage in more self-disclosing type boundary behaviors.

ACKNOWLEDGEMENTS

I would like to express my deepest appreciation to the following integral individuals who have helped me succeed in this venture. First, I sincerely thank my committee chair, Dr. Angela Legg, whose time, insight, infectious passion for research, and deep belief in me kept me motivated and determined in seeing this through. Further gratitude goes to my dedicated committee members Dr. Paul Griffin, whose feedback and push aided both this project as well as my personal and professional development, and Dr. Maren Westphal, whose insight and experience in the counseling profession were invaluable to my study. Additionally, I would like to thank the generous donors for their sponsorship of the Dissertation Grant for the PhD in Mental Health Counseling at Pace University and the grants received to complete this study. A very special acknowledgement goes to my husband, Daniel, whose continued patience, support, and encouragement allowed me to always see the light at the end of the tunnel. Minerva, my fellow clinician, and now forever friend, there was no doing this without you. Last but never least, my biggest thank you is to my family who I would not be here without – Mom, Dad, Jenny, Matt, Greg, and Ryan. Without knowing it, you are my biggest motivation and the reason I dream big and persevere.

LIST OF TABLES

TABLE OF CONTENTS

CHAPTER I: INTRODUCTION

Maintaining boundaries is of notable consideration within the realm of all human relationships, but is of paramount importance in the professional setting (Ghuloum et al., 2011). The nature of the therapeutic relationship, involving emotional sharing and a power differential between counselor and client, makes clinicians more vulnerable to boundary excursions (Barnett, 2008; Ghuloum et al., 2011). In fact, the navigation of boundaries has been reported by social workers as the most challenging aspect within provider-patient relationships (Reamer, 2003). Nonethelss, counseling professionals are regularly confronted with boundary issues throughout the therapy process that can impact their conduct and practice with clients (Afolabi, 2015). Whether being presented with a client gift, or being asked to attend a client's milestone event, ongoing therapeutic encounters require counselors to render judgment calls. Such decisions may challenge the middle ground of attending to client needs and maintaining appropriate treatment boundaries. To rely on the American Counseling Association Code of Ethics (2014) may seem to be the reasonable solution to this dilemma, however, the guidelines for honorable practice do not address every boundary scenario, while others are ambiguous and open to interpretation (Afolabi, 2015). Nonetheless, counselors have a fiduciary responsibility to act ethically and only in the best interest to those they serve professionally (Barnett, 2008; Jones, 2009).

Some therapists may question how much flexibility exists in adhering to boundaries, while others may be of the mindset that few, if any boundaries, should be imposed in the counseling relationship (Larsson, Kaldo, & Broberg, 2009). However, the ways in which counselors manage boundaries have the potential to be harmful to clients, as well as the treatment process (Barnett, 2008; Gutheil & Brodsky, 2011; Jones, 2009). Researchers have proposed boundaries that are too rigidly enforced may prevent a rich and rewarding relationship

from developing (Lazarus, 1994; Zur, 2001). Overstepping boundaries, however, can result in reports of counselor misconduct to professional boards of licensure, litigation and disciplinary cases, and most significantly, unnecessary harm to clients or the therapeutic process (Barnett, 2008). While there are instances when boundary crossings have demonstrated a positive client impact (Pope & Spiegel, 2008), the term "slippery slope" has been used to explain how multiple boundary crossing behaviors can lead to more destructive boundary violations over time (Aravind, Krishnaram, & Thasneem, 2012; Gabbard & Pope, 1989).

It is critical for counselors to possess strong ethical tools throughout the therapy process as numerous opportunities exist for counselors to overstep treatment boundaries. Emotions may run high for both the client and therapist over the course of treatment sessions and may unknowingly influence a counselor's clinical decision-making, despite their intentions. For example, during the termination phase of treatment, therapists who "feel vulnerable or compromised by endings or loss in his or her own life may experience more difficulty to act cogently and ethically" (Mangione, Forti, & Iacuzzi, 2007, p. 28). Therapists may also be at greater risk of engaging in dual-relationships with patients, in both the beginning and ending of treatment, in efforts to build a good therapeutic alliance or as a way to avoid the finality of termination (Mangione et al., 2007). A counselor's desire to meet their own needs may also give rise to certain boundary behaviors, in addition to counselors who take the therapeutic approach of "curing through love" (Goldman, 2009).

There remains a lack of empirical research on boundary divergences within clinician-patient relationships (Ghuloum et al., 2011). However, both sexual and non-sexual boundary violations remain a significant cause for professional discipline by state regulatory boards (Kirkland, Kirkland, & Reaves, 2004). As counselor boundary crossings are increasing in variety

and form, attention to this issue is gaining resurgence within the counseling community (Afolabi, 2015). A unique set of counselor characteristics and factors may influence the way in which boundaries are maintained. The potential consequences of the way in which counselors manage therapeutic boundaries calls for a better understanding of the counselor characteristics/factors that contribute to boundary behaviors.

Statement of the Problem

An ongoing challenge confronted by therapists is how to offer the maximum benefits to clients while appropriately maintaining limits (Audet, 2011). While most counseling professionals believe they have an adequate understanding of boundary issues when working with clients, application of this knowledge remains difficult (Afolabi, 2015). Even minimal crossings done with good intentions may unknowingly impact the client negatively, or lead to additional boundary harmful transgressions (Oparah, 2007). The boundaries dilemma has only become more complex with the advancement in technology and increase of social media outlets, as therapists are faced with increasing opportunities to cross boundaries through new ways of communication and sharing (Gamble, Boyle, & Morris, 2015; Negretti & Wieling, 2001).

While researchers have discussed the problems surrounding therapeutic boundary issues since the 90's, there are few empirical studies examining boundary transgressions (Miller, Bener, Ghuloum, Commons, & Burgut, 2012). The empirical literature that does exist has primarily examined prevalence rates and self-reported client harm resulting from sexual infringements. There is lacking research, however, on the more ambiguous boundary crossings (e.g., giving or accepting a gift, extending a session, lessening a session fee) that occur more frequently throughout day to day practice (Miller et al., 2012). There are more specifically, limited studies that examine counselor charactersitics/traits which contribute to boundary maintenance. Further, the existing clinical literature lacks a thorough, yet somewhat brief, and up-to-date instrument that measures counselor frequency of a wide range of boundary behaviors. Existing boundary measures largely focus on provider's views and experience with *sexual* boundary transgressions between counselor and client (Bayer, Coverdale, & Chiang, 1996; Berkman, Turner, Cooper, Polnerow, & Swartz, 2000; Coverdale, Thomson & White, 1995) with fewer measures

highlighting the variety of non-sexual crossings, including added boundary behaviors pertaining to social media.

Literature Review

Therapist Boundary Behaviors in Counseling

Within the therapeutic relationship, treatment boundaries are viewed as a framework that determine the scope of patient and counselor roles, and encompass the structural elements of therapy, such as session time, place, and fee, as well as the content of therapy, and the therapist-client interaction (Smith & Fitzpatrick, 1995). Therapy content includes components such as language usage, self-disclosure, and physical contact between therapy participants (Pope & Keith-Spiegel, 2008). Psychotherapists commonly agree that boundaries play a critical role throughout the counseling process (Aravind, Krishnaram, & Thasneem, 2012; Dailey, 2017; Gelso & Hayes, 1998; Luchner, Mirsalimi, Moser, & Jones, 2008) as the way in which treatment boundaries are approached may enrich or harm therapy. While both the client and counselor are capable of boundary breaches, it is commonly accepted that counselors are responsible for assuring their proper maintenance (Gutheil & Gabbard, 1992; Simon, 1992). Therefore, in the context in which a patient initiates an exchange it is "the therapist's responsibility to consider and deal with all interactions in support of the treatment. This includes reflecting on self-disclosure, physical contact, language, dress, and gifts within treatment and any interaction outside treatment" (Thomas & Pastusek, 2012, p. 858).

Appropriate counselor treatment boundaries both model and foster client autonomy, build the therapeutic alliance, and provide a sense of safety for the client (Smith & Fitzpatrick, 1995). By upholding this relationship, the therapist creates an environment of trust and openness in

which a client feels comfortable in sharing feelings without feeling judged (Russell & Peterson, 1998; Simon, 1992). As cited in Gross (2005), Langs (1982) shared the establishment of clear boundaries can also help to avoid ambiguous communication between the therapist and client thus decreasing possible misinterpretations of therapist intentions and behaviors. Other researchers have pointed out boundaries ensure that the therapy focus is toward helping the client rather than motivated by therapist needs, or personal motives (Luchner et al., 2008; Smith & Fitzpatrick, 1995). A qualitative research study surveying providers and users of mental health services, highlighted the viewed importance of having clear boundaries within the therapeutic relationship, as clients reported clear boundaries must be established to provide the maintenance of personal safety. In the same study, mental health service providers reported boundaries increase effectiveness of services and prevent client dependency, while also noting the difficulty in discussing and maintaining them with clients (Grant & Mandell, 2016). In a study by Fennig et al. (2005) interviewing 93 therapist and patients on attitudes and incidents towards boundaries and confidentiality, 22.6% reported they had encountered an ethical or boundary situation, mainly a breach of confidentiality (39% of the 22.6%), or violation of boundaries and sex in therapy (39% of the 22.6%).

When counselors step outside the professional limits to which they are bound, enduring negative effects for the client may result. Boundary breaking can create client barriers such as taking away client independence and their freedom to explore (Smith & Fitzpatrick, 1995), can damage the counselor-client relationship, and can result in mistrust of their therapist (Ghoulum et al., 2011). Yet, the clinical realities of practice sometimes present therapists with ethical dilemmas, as the bending of certain boundaries might appear to serve a client in a particular situation. In a 2005 survey of American Group Psychotherapy Association members, 20% of

service providers endorsed extending a short-term group beyond the contracted date at the request of clients, despite ethical concerns. It was also reported that over 1/3rd of therapists reported the experience of a client wanting to continue a relationship in a nonprofessional capacity with them, and 10% of providers themselves reporting experiencing wanting to continue the relationship with them. Additionally, 62% of therapists endorsed that there had been times when they have felt vulnerable to issues about endings due to events in their own lives (Mangione, Fort, & Iacuzzi, 2007). According to the American Counseling Association Code of Ethics (2014), if a provider decides to extend boundaries listed under A.6.a (seeing a client with a previous relationship) and A.6.b (attending milestone, accepting gift, etc.), counselors are required to document the interaction, rationale, potential benefit, and anticipated consequences. If harm occurs as a result, counselors must document evidence of their attempt to rectify the situation.

It can be challenging for a therapist to determine the beneficial or harmful nature of boundary infractions as gray areas exist between healthy and unhealthy boundary transgressions (Glass, 2003; Harper & Steadman, 2003). While some crossings may serve a client therapeutically, what may be good for one client may be harmful for another (Ghuloum et al., 2011). In these instances, even the most competent of counselors are capable of blurring boundaries. Counselors differ "in their ability to perceive that something they might do, or are already doing, could directly or indirectly affect the welfare of others" (Pope & Keith-Spiegel, 2008, p. 640).

Boundary Crossings versus Boundary Violations

Boundary behaviors are counselor actions within the therapeutic relationship that range from those that provide minimal harm to the client to those which can contribute to significant psychological injury, and most catastrophically documented, client suicide (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983). These behaviors have been categorized by Guthiel and Gabbard (1993) into *boundary crossings* and *boundary violations* as a way to classify the degree to which they can affect the client. Boundary crossings have been referred to as counselor actions which deviate from commonly accepted clinical practice which may or may not benefit the client, while boundary violations have been described as those that pose a clear risk to the therapeutic process or harm to the client (Twemlow, 1997).

Boundary *crossings* remain a topic of controversy in regards to their effects on the therapeutic process and client. Guthiel and Gabbard (1993) emphasized that crossing boundaries "may at times be salutary, at times neutral, and at times harmful" depending on the clinical context (p. 188-189). Twemlow (1997) highlights counselor actions viewed as boundary crossings to include: accepting a gift from a patient, reducing session fees, giving free sessions in times of financial strain, attending important client social functions (e.g., wedding), giving client a ride home, and visiting a suicidal patient at home. There are instances when non-sexual boundary infringements have been viewed as enriching psychotherapy by serving the treatment plan and strengthening the counselor-client alliance (Pope & Keith-Spiegel, 2008), however, not paying attention to boundary crossings may increase the risk for committing more serious boundary violations (Thomas & Pastusek, 2012). Twemlow (1997) proposed a developmental continuum of boundary crossings, beginning with early stages consisting of *boundary inattention* leading to *boundary crossings* and occasionally to *boundary violations*.

While researchers inconsistently identify specific incidents as either a boundary crossing or violation, certain severe behaviors have been categorized fairly consistently as violations and those that are always harmful to clients (Twemlow, 1997). Counselors surveyed across the United States, Brazil and Qatar (Miller et al., 2012) widely agree that both sexual and other forms of physical exploitation, as well as selfish misuse of patients, such as seeking personal gains or own validation, are considered boundary violations and are unacceptable (Fitzpatrick & Smith, 1995; Twemlow, 1997). Additional incidents reported as violations have included non-erotic physical contact (e.g., hugs), unethical self-disclosure, dual relationships (Smith & Fitzpatrick,1995), retaining a patient longer than indicated, failure to refer, or failure to seek supervision or consultation (Twemlow, 1997). It has also been suggested that treating outside of one's area of expertise and excessive discussion of client cases in informal settings should also be considered boundary violations (Twemlow, 1997). Another researcher reported secrecy, abuse of professional privilege, and the presence of a double bind, or putting the client in a lose-lose situation, as other violations (Peterson, 1992). Harm to the patient can occur in a variety of forms, outside of sexual contact, when boundaries are allowed to be breached by the patient or crossed by the therapist (Jones, 2009).

The majority of empirical work on boundary violations consists of case studies on counselor-initiated *sexual* violations and client-reports on its effects. In fact, Miller, Commons, and Guthiel (2006), is the first empirical study that gauged counseling provider's perceptions on the severity of a wide range of boundary behaviors. A total of 61 mental health professionals were surveyed; 33 in the United States and 28 in Brazil. The US sample consisted of attendees of the Program in Psychiatry in Law at Harvard University Massachusetts Mental Health Center and the sample in Brazil included weekly meeting attendees at the Institute of Psychiatry at

University of Rio de Janeiro. Both meetings covered professional topics such as boundaries. Responses from clinicians in both groups reported three types of boundary violations including 1.) Core boundary violations (e.g., sexual violations, transgressions involving financial matters, and counselor physical aggression), 2.) Separation of therapists and clients lives (e.g., dual relationships, situations in which the client and therapist encounter each other outside of the clinical setting), and 3.) Disclosure and greeting types of behavior.

Boundary violations have been viewed as part of a process with multiple incidents or red flags leading up to its event (Russell & Peterson, 1998). A study which conducted a 19-year chart review of 120 physicians monitored for boundary violations, including patient non-sexual and sexual offenses, found that physicians with a history of prior boundary violations were more likely to commit violations of a sexual nature (Brooks, Gendel, Early, Gundersen, & Shore, 2012). It has been argued that "it is the result of a series of small decisions that, together, form a pattern that begins to erase the distinction between the one who provides a service and the one who receives the service" (Russell & Peterson, 1998, p. 460). As Gabbard (2008) states, "we can have the most intelligent, articulate rationalization for our departures from ordinary analytic boundaries, but be utterly oblivious to the potential for harm that everyone else around us can see" (p. 879).

Effects of Boundary Behaviors

The outcomes resulting from counselor boundary behaviors can vary widely from therapeutic progress to client detriment. Overall, certain boundary behaviors can have a place in therapeutic technique, however, they also carry the risk of disrupting the working alliance, despite their intentions of improving it. Certain counselor actions may be disturbing to the

patient, could be viewed as intrusive or sexual in nature, and could lead to more harmful behaviors (Glass, 2003). Several studies have gathered and shared client-reported effects of certain boundary behaviors occurring within the therapeutic relationship.

Self-disclosure. The act of therapist self-disclosure, or the revealing of a personal experience or information to a client, is an example of a boundary crossing that may have different client interpretations according to the client-counselor situation (Ghuloum et al., 2011). Previous research has revealed mixed findings when examining counselor self-disclosure and the therapeutic relationship and outcome. Self-disclosure has been found to enhance the therapeutic alliance (Curtis, 1981), while other studies found no link or a negative link between therapist self-disclosure and therapeutic outcome (Braswell, Kendall, Braith, Carey, & Vye, 1985; Kelly & Rodriguez, 2007). One qualitative study revealed four of eight clients interviewed, reported that the experience of therapist self-disclosure reduced the credibility and confidence in their therapist's abilities and professionalism while the other half viewed the self-disclosure as meaningful and as a way to build rapport (Wells, 1994).

Additional studies have found clients to have positive reports of counselor self-disclosure sharing they feel more understood, see their counselors as more genuine and human (Knox, 1997), as well as trusting, interpersonal, and empathetic than therapists who do not use self-disclosure (Simone, McCarthy, & Skay,1998). However, a qualitative study examining client's perception of counselor self-disclosure, revealed that self-disclosure can create boundary issues such as compromising the client's view of both therapist and client roles (Audet, 2011). One study examining therapist-client in-session verbal behaviors reported a negative link between therapist self-disclosure and child behavior change in the classroom (Braswell, Kendall, Braith, Carey, & Vye, 1985). Sessions were audiotaped where therapist self-disclosure was coded based

on frequency of therapist providing information about him/herself or his/her activities either spontaneously or in response to client questions (Braswell et al., 1985).

Practitioners are most concerned for the potential of therapist disclosure to infringe upon client-therapist boundaries and imperil professionalism (Audet, 2011). Additional concerns with therapist self-disclosure is the potential for it to alter the role of the therapist beyond clinical effectiveness (Lazarus & Zur, 2002), creating a friendship dynamic, or altering the focus from client to therapist (Zur, 2004). This was supported by Anderson and Mandell's study (1989) as cited in Simone et al., (1998) that found too much disclosure resulted in role confusion.

Counseling professionals also experience personal struggles throughout their lives, and when stressed, they may "self-disclose inappropriately or use the treatment setting for their benefit" (Gottlieb, Younggren, & Murch, 2009, p. 167). Disclosures by the clinician that have been considered inappropriate include personal life problems or stressors, fantasies or dreams, and social, sexual, or financial circumstances (Gutheil & Gabbard, 1993; Simon, 1991). While around 90% of therapists' report using self-disclosure at some point, (Edwards & Murdock, 1994; Kelly & Rodriguez, 2007), some researchers have argued it is falsely assumed that sharing personal information always demonstrates authenticity, transparency, and benefits the therapeutic relationship (Pope & Keith-Spiegel, 2008). For example, patients with borderline personality disorder have lower ego strength and may feel more threatened by the self-disclosure, as they are unable to understand and integrate it (Simone et al., 1998). Further, inappropriate therapist self-disclosure had been identified as the boundary violation which most frequently precedes therapist-client sex (Simon, 1991).

Physical touch. The use of non-sexual physical contact is sometimes used in therapy as a reassuring gesture and an appropriate response to a particular situation (Simon, 1992). It may be

used, for example, to console grieving clients and express therapist warmth and understanding. A study shared therapist reports of some clients who received counselor touch positively, as it reportedly fostered a bond of trust and greater openness (Horton, Clance, Sterk-Elifson, & Emshoff, 1995). However, such self-report studies have been critiqued in that they usually reflect rationalization by therapists. Twemlow (1997) explains even "a touch liked by the patient does not mean in the long run that such contact is considered helpful to therapy" (p. 359).

The appropriateness of counselor physical touch can vary accordingly depending on the context it is used in, client characteristics, such as cultural background (Ghuloum et al., 2011), as well as different client diagnoses. For example, a hug to a 5-year old client may mean something very different if the child has an Autism diagnosis or has experienced sexual trauma (Thomas & Pustusek, 2012). This can also be particularly damaging to those clients who are victims of sexual abuse with the potential to reignite trauma, destroy trust, or the gesture may be interpreted as sexual in nature. Physical touch can also be problematic with eating-disorder patients, who are generally overinvolved with their bodies and body sensation. Eating disorder patients "often suffer from distorted body image and tend to somaticize psychic reactions. Their hunger for physical and emotional nurturance is so great that a hug threatens to be too gratifying or too frightening" (Gusella, 2003, p. 362). Nevertheless, in a past survey 44% of therapists reported hugging as "unquestionably ethical" in many situations (Pope, Tabachnick, & Keith-Spiegel, 1987).

Dual relationships. Dual relationships, or an additional counselor-client relationship that co-exists with a professional one, can lead to role confusion within the counseling relationship (Afolabi, 2015; Ringstad, 2008). This type of external relationship can include an alliance that may be of a business, social, familial, or sexual nature (Nigro, 2004). Kitson and Sperlinger

(2007) report the diverse and sometimes subtle ways in which dual relationships can occur in practice may be difficult for healthcare providers to recognize easily. Infact, amid the infractions for APA membership termination among therapists, the most common deals with the issue of dual relationships (Sonne, 1994). This was echoed by a national survey of state counseling licensing boards that identified ethical complaints of dual relationships as the most violated standard of professional ethics (Neukrug, Milliken, & Walden, 2001).

In Pope and Vetter's (1992) national survey of the challenges faced by psychologists, those of "blurred and dual" relationships were reported by respondents to be the second most troubling ones faced in their day to day practice. While some non-sexual dual relationships may appear to be more harmless that others, the Division of Clinical Psychology (1995) states that "all carry risks" (p. 14). Koocher & Keith-Speigel (1998) report loss of objectivity and exploitation being two potential negative outcomes of role blending that accompanies dual relationships. The blurring of boundaries in dual relationships can leave both persons in the relationship feeling vulnerable (Russell & Peterson, 1998) while compromising the effectiveness of therapeutic relationship. Authors have suggested the potential development of a dual relationship may be at a greater risk when therapy comes to an end, as a way for counselors to avoid its finality (Mangione et al., 2007).

Researchers have argued that it is best to avoid all forms of dual relationships due to potential consequences including differing role expectations, client exploitation, and conceivable impaired judgment when one individual is more powerful in one role and less in another (Kitchener, 1988). Studies old and new have found sexual dual role relationships to be linked with negative outcomes and the possible cause of harm to client's emotional and social well-being (Eichenberg, Becker-Fischer & Fischer, 2010).

Sexual Contact. The most intrusive and damaging boundary violation reported is therapist-client sexual contact (Somer & Nachmani, 2005). A past study revealed that 1% to 12% of therapists experienced sexual intercourse with at least one client (Williams, 1992) and clients who engaged in a sexual relationship with their therapists have suffered "tragic consequences" (Angel, 2010). One study found 90% of the 559 participants who had been involved sexually with a therapist were adversely affected by reports of negative feelings about the experience, a negative effect on personality, and less sexual intimacy with their current partner (Bouhoustos et al., 1983). A more recent study shared 86.5% of study participants reported consequences from sexual contact with therapists and 93.3% of these reported feelings of isolation and distrust, fear, depression, guilt, shame, post-traumatic stress disorder, and suicidal tendencies (Eichenberg, Becker-Fischer & Fischer, 2010). Female clients who reported sexual involvement with male professionals have shared resulting feelings of greater mistrust and anger towards men and therapists (Feldman-Summers & Jones, 1984). Sexual contact is said to cause disruption to the therapeutic process, as at therapy termination these clients have been found to be left with a greater number of psychological and psychosomatic symptoms (Smith & Fitzpatrick, 1995). Ultimately, a counseling professional's judgment and objectivity can be affected when sexual and professional roles intertwine, and furthermore poorly influence decisions and actions (Barnett, 2008, p. 8).

Predictors of Boundary Behaviors

The counseling literature is limited in empirical investigation of counselors who blur treatment boundaries, while most studies have focused on those clinicians who have committed sexual boundary violations. Research on this matter became popular in the 80's and 90's as sexual misconduct was becoming the number-one liability concern for mental health providers

(Gabbard, 1994). Several researchers at the time developed typologies of therapists who engaged in sexual boundaries with patients (Pope & Bouhuoutsos, 1986; Twemlow & Gabbard, 1989). Gabbard (1994) proposed such therapists fell in one of four pathologies to include 1) psychotic disorders, 2) predatory psychopathy and paraphilia's, 3) masochistic surrender (clinician's with self-destructive tendencies and allow themselves to be controlled by client), or 4) love sickness (vulnerable clinicians who idealize and fall in love with their patients).

A national survey of U.S. psychiatrists at the time revealed 84 (6.4%) of 1,136 participants reported sexual contact with their own patients. It was found that 88% of sexual contact occurred between male psychiatrists and female clients. Reasons for becoming sexually involved with patients included, engaging in sexual contact for love or pleasure (73%), or to enhance the patient's self-esteem or provide an emotional experience (19%), "loss of control", "exploitation", "judgement lapse", "impulsivity", "therapist enhancement", and "personal needs". Offenders also reported being in love with the patient (62%) and the majority of responders also reported believing the patient was in love with them (92%) (Gartrell, Herman, Olarte, Feldstein, & Localio, 1986).

A separate longitudinal study found two repeatedly sexually violating psychiatrists to have elevated scores on MMPI's Psychopathic Deviancy and Hypomania scales, gathered at the beginning of their residency training (Garfinkel, Bagby, Waring, & Dorian, 1997). Additional case reports described sexually violating therapists to also resembled the antisocial type, typically as male staff who tended to be exploitative in all their relationships and lacked empathy (Averill et al., 1989), were overly confident, had a dismissive attitude towards consultation, craved admiration (Brodsky, 1989), or were categorized as antisocial or borderline individuals (Stone, 1975).

Specific risk factors to the degeneration of treatment boundaries has been speculated and discussed by researchers to include those who treat patients in private practice settings (due to little overhead), those providers with little social support, and most recently theorized; counselors high in covert narcissism, or having a high sensitivity to the reactions and needs of others and the tendency to deflect attention from self to others (Luchner, Mirsalimi, Moser, & Jones, 2008). Empirical evidence has suggested the prompting of boundary transgressions may also be triggered by the combination of low levels of differentiation (greater dependability on others to function) combined with high stress (Baer & Murdock, 1995), as well as mismanaged client transference (Schoener, Milgrom, Gonsiorek, Luepker, & Conroe, 1990; Smith & Fitzpatrick, 1995; Twemlow & Gabbard, 1989) such as in those counselors who are experiencing divorce, or marriage separation themselves and may be more at-risk of sharing their own problems (Gabbard, 1991; Twemlow & Gabbard, 1989).

A more recent study revealed healthcare professionals mandated to an ethics course after a reported boundary problem were more likely to be insecurely attached and have experienced a childhood trauma (MacDonald et al., 2015). With notable flaws in this study not having a comparison group, further exploration is warranted on attachment styles and boundaries. It has been postulated that the “thinness” or “thickness” of boundaries is a dimension of personality (Hartmann, 1991; Hartmann, Elkin, & Garg, 1991), and therefore future research should further examine counselor characteristics which may influence boundary behaviors (Simone et al., 1998).

Theoretical Orientation.

Effecting a variety of in-session behaviors, a counselor's theoretical orientation has been found by several studies to be related to the degree to which she or he endorsed involvements with a client as being ethical. Psychiatrists, psychologists, and social workers have equivalent rates of counselor-client sexual contact (Goldman, 2009), however, repeated survey studies have found psychodynamic therapists to have endorsed fewer behaviors as ethical than therapists of other theoretical orientations (Borys & Pope, 1989; Holroyd & Brodsky, 1977; Pope, Tabachnick, & Keith-Spiegel, 1987), such as cognitive, behavioral, eclectic and humanistic groups (Baer & Murdock, 1995). In concordance, as cited in Alpert & Steinberg (2017), Celenza (2007) found psychodynamic and analytic therapists to have lower prevalence rates of misconduct than therapists of other orientations. Borys & Pope (1989) reasoned the training in psychodynamic therapy probably places more emphasis on establishing clear roles in treatment, the blurring of boundaries, and the therapist's desires in order to avoid exploitation of clients to meet therapists needs.

Contrarily, the humanistic treatment approach which emphasizes authentic and empathic fellowship (Bohart & Watson, 2011; Heinonen & Orinsky, 2013), considers the dangers of being inflexible when boundaries are applied strictly in person-centered counseling. Accordingly, such therapists have been found to tend to allow the greatest flexibility regarding personal questions (Glickauf-Hughes & Chance, 1995), increasing their risk for boundary dilemmas.

Similarly, the treatment approach of a cognitive-behavioral therapist places emphasis on the counseling partnership, and as a collaborative one (Gottlieb, Younggren, and Murch, 2009; Heinonen & Orinsky, 2013) and commonly use personal disclosures to normalize humanness and model new perspectives and behaviors to the client (Goldfried, Burckell, & Eubanks-Carter,

2003). The practices of cognitive behavioral therapists can potentially create opportunity for boundary problems, such as modeling and self-disclosure, with few guidelines when it comes to deciding how much information to share and under what circumstances. In addition, out of office sessions, involving behavioral interventions may create vulnerabilities for practitioners (Gottlieb, Younggren, & Murch, 2009). In Baer & Murdok's (1995) study surveying APA members on attitudes towards counselor behavior with clients, therapists of a cognitive orientation were second to highest in rating more social behaviors and more dual relationship behaviors as ethical than theoretical orientations of behaviorist, eclectic, humanistic, and psychodynamic/analytic. Professionals' *attitude* alone has been found to predict behaviors with clients. For example, professionals' attitude about non-erotic contact with clients has been found to be predictive of his or her attitude towards and the likelihood to have sexual contact with clients (Borys, 1988).

Counselor years of experience

Researchers have revealed mixed opinions and findings in the way that therapist's years of experience affect their view on or experience with boundary behaviors. Twemlow (1997) presented a developmental model of the typical boundary transgressor, suggesting boundary inattention may occur in naïve therapists. Gusella (2003) remarks these therapists often cannot find the right words to say and employ a hug as a way of saying it all, "but the hug can be confusing. It may convey something other than the message the therapist intends" (p. 362). Student therapists' who characteristically blur personal boundaries experience termination with heightened anxiety and tend to move psychologically closer to other patients, and tend to abandon their therapeutic role because of personal conflicts. In contrast, experienced therapists have been found to make a greater differentiation between their personality and the therapeutic role they hold (Greene & Geller, 1980). For example, Robitschek and McCarthy (1991) found as

male counselors increased in experience, they reported less frequent self-disclosure. This is in alignment with other study findings that examined clergy behavior within their congregations and found more experience in the field led to the development of thicker boundaries with their religious followers (Bleiberg & Skufca, 2005).

Contrarily, a study surveying a broad range of UK clinical psychologists surrounding attitudes towards clinical dual relationships found counselors who viewed dual relationships as less professionally appropriate to be female, younger, and more recently qualified counselors (fewer year of experience). These counselors were also found to have received more supervision, described their main theoretical orientation as psychodynamic, had experienced personal therapy, and had worked in urban settings (Kitson & Sperlinger, 2007). When examining all variables (years of experience, psychodynamic theoretical orientation, practice in rural or urban setting, if had personal experience or not, if live in same of different area of clients, gender), years of experience accounted for the largest amount of variance (4.8%) of the attitude score towards boundaries, followed by whether orientation was psychodynamic or not (4.3%), while other variables did not contribute a large amount to the variance of the attitude scores but were significant. Researchers proposed the possibility that "as clinical psychologists become more experienced, they are more likely to engage in dual relationships because they have encountered more ethical dilemmas at first hand and they come to see themselves beyond questioning, regardless of what they do" (Kitson & Sperlinger, 2007, p. 291). It was also suggested that this may be linked to a third variable such as training. Nonetheless, more empirical investigation is warranted in examining years of experience and its effect on boundary behaviors.

Gender

In previous case studies of counselor-client sexual contact, providers were consistently male. Baer and Murdock (1995) also found male therapists to rate non-erotic dual relationships with clients as more ethical than female therapists, such as providing therapy to a relative, friend, or lover of an ongoing client. However, females had a higher mean rating (rated as more ethical) of behaviors on the incidental subscale, such as accepting a gift or invitation to a special occasion. Female therapists in helping professions tend to emphasize relational factors in their approach (Zur, 2007). Generally, women tend to express more emotions than their male counterparts and take more responsibility when it comes to maintaining relationships (Bleiberg & Skufca, 2005). In a 2001 study interviewing clients who saw both male and female therapists, reported female therapists to be seen "too soft" at times or not direct enough, but also more focused on feelings, and more comforting and caring (Gehart & Lyle, 2001), as the tradition female role encourages (Gilligan, 1982). One particular study examining boundaries among clergy found that female clergy scored higher than males on the boundary questionnaire (Hartmann, 1991), indicating thinner mental and interpersonal boundaries (Bleiberg & Skufca, 2005).

Practice Setting

There are multiple practice settings for which counselor-client treatment occur. Settings vary among psychiatric and general hospitals, outpatient clinics, non-profit agencies, schools, and prisons, to the clients' home, and private and public workplaces. Because of the different environments and treatment procedures in each of these settings, the boundary rules governing traditional assessment and treatment are not always easily applied (Walker & Clark, 1999). This

can result in the absence of clear rules or guidelines (Ghuloum et al., 2011), and an increased risk for boundary problems between provider and client.

Those counseling professionals in private practice settings, specifically, have little oversight and more room to freely engage in boundary behaviors. In fact, researchers share older case studies that found that those boundary-violating practitioners are typically middle-aged males treating client's in private practice (Luchner, Mirsalimi, Moser, & Jones, 2008; Goldman, 2009). One study revealed those mental health professionals who view dual relationships as less professionally appropriate are more likely to not work for themselves or on a solo basis (Epstein, Simon, & Kay, 1992). Being in private practice has also been correlated to engaging in less consultation on average (2.34 hours a month) than counselors practicing in other settings (schools, colleges, hospitals, residential settings, and community agencies) as well as less peer and group supervision than colleagues in other settings (Lawson, 2007). It is possible that a lack of consultation may influence clinical decision-making and engagement in boundary behaviors. Furthermore, private providers have been found to prefer to rely on their own professional experience rather than on evidence-based research or advice from colleagues when making their own clinical decisions (Stewart & Chambless, 2007) which also have the potential to lead to boundary behaviors. For example, Stewart and Chambless (2008) found that psychologists in private practice waited a median of 12 sessions before acknowledging treatment failure or considering consultation with colleagues, as 36% waited longer than 19 sessions and 10% more than 30 sessions.

While there do not appear to be clear definitions and/or clear agreement of what differentiates healthy boundaries from boundary violations (Glass, 2003; Luchner et al., 2008), this may be due in large part to the fact that boundaries are defined differently by each

practitioner based on a variety of individual, social, cultural, theoretical, and administrative factors (Luchner et al, 2008; Zur, 2007). Ultimately, there is a value in understanding interpersonal qualities in understanding ethical judgments (Baer & Murdock, 1995). Specifically, it is enlightening to examine counselor attachment, as it influences the way in which interpersonal behavior take place, and the impact of counselor empathy, regarded as a therapist characteristic found to impact treatment outcome. Whereas a body of anecdotal research and case studies exists regarding demographic, and work-related antecedents of boundary behaviors, fewer studies have examined individual differences and personality predictors. It is of importance to better understand the impact of counselor personality traits which may influence counselor boundary behaviors above other characteristics.

Counselor Attachment

Attachment Theory

Individual attachment styles have been studied as a way to inform our understanding of interpersonal relationships. Attachment theory, developed by John Bowlby (1969), proposes a child's early relationship with his or her caregiver during emotional and interpersonal development, shapes expectations about the self and others, and can influence later relationships in adult life (Trusty, Ng, & Watts, 2005). An individual's developed mental representation, or *internal working model about the self and others* (Ainsworth & Bowlby, 1991; Bowlby, 1973; Taylor, Rietzschel, Danqua, & Berry, 2015) can affect the ways in which one relies upon themselves and others, in addition to how one interacts with the world in an emotionally engaged way (Cassedy et al., 2015). Several studies have highlighted the impact of early attachment styles, as attachment patterns in infancy were found to be associated with the development of social competency, self-reliance, and emotional regulation in adulthood (Sroufe, 2005; Waters,

Merrick, Treboux, Crowell, & Albersheim, 2000).

The ways that attachment styles have been assessed and classified have progressed over time (Mikulincer & Shaver, 2007). Three different patterns of attachment were first identified and classified on the basis of the child's experiences in his early caregiving environment and the parent-child emotional bond (Ainsworth & Bowlby, 1991). Later, an extension of these three categories was proposed by Bartholomew and Horowitz (1991) suggesting a four-category adult attachment structure. This model categorizes attachment styles by one's view of the self and others in combination with the varying levels of two fundamental dimensions of attachment patterns; avoidance and anxiety (Brennan, Clark, & Shaver, 1998). Anxiety resembles a fear of relationship rejection or abandonment, whereas avoidance reflects a discomfort in close relationships and reluctance to depend on others. High anxiety individuals often adopt 'hyper-activating' strategies, or display certain behaviors to gain self-reassurance and closeness within their relationships, whereas highly avoidant individuals tend to avoid close relationships and minimize the importance of affect through 'deactivating' strategies.

Researches have classified combinations of avoidance and anxiety as one way to measure attachment where those with high anxiety and low avoidance are considered 'anxious-preoccupied', low anxiety and highly avoidant individuals are classified as 'dismissing-avoidant', and those who are high in both avoidance and anxiety are considered to have a 'fearful' attachment style and tend to desire close relationships but avoid them due to fear of rejection (Bartholomew & Horowitz, 1991; Bucci, Roberts, Danquah, & Berry, 2015). Ultimately, individuals who exhibit low attachment anxiety and avoidance simultaneously are considered to have a 'secure' attachment style, whereas individuals with high levels of anxiety and/or avoidance are regarded as having an insecure attachment (Besser & Priel, 2009; Taylor et

al., 2015). Current researchers tend to conceptualize attachment on a continuum of anxiety and avoidance, and avoid categorizing "style" as attachment patterns can go undetected or misrepresented (Fraley, Heffernan, Vicary, & Brumbaugh, 2011; Fraley, Waller, & Brennan, 2000).

Attachment styles have been influential in informing clinical practice (Taylor et al., 2015; Wallin, 2007) as researchers continue to explore the function of the therapeutic relationship from an attachment theory perspective (Parpottas & Draghi-Lorenz, 2015). The counselor-client working alliance involves an emotional bond that includes dimensions of respect, trust, and confidence and influences attainment of client goals and engagement in therapeutic tasks (Bucci, Seymour-Hyfe, Harris, & Berry, 2016). Numerous studies have explored *client* attachment styles in relation to perceived reports on the counselor-client alliance, while less have examined the role of the *therapist's* attachment patterns in therapy (Parpottas & Draghi-Lorenz, 2015). Yet, therapists too, can also bring early relational experiences to counseling sessions which can affect the working alliance and counselor-client interactions (Parpottas & Draghi-Lorenz, 2015). In addition to the influencing nature of attachment style on one's personal relationships, it has also been found to affect how one approaches professional relationships (Sroufe, 2005). Therefore, it becomes important to understand the influence of therapist attachment styles on the therapeutic process and outcome (Parpottas & Draghi-Lorenz, 2015, p. 45).

Counselor Attachment Style in the Therapeutic Relationship

Within the therapeutic context, the role of a therapist serves as a temporary attachment figure to clients (Yusof & Carpenter, 2016) so counselors must provide a 'secure base' in order for clients to feel safe during times of distress (Degnan, Seymour-Hyde, Harris, & Berry, 2016).

However, "therapists' different abilities to co-create a secure base are likely to depend on their own attachment security" (Yusof &, Carpenter, 2016, p. 61). Generally, study findings have revealed those counseling professionals with more secure attachment styles have more favorable therapeutic relationship attributes (Black, Hardy, Turpin, Parry, 2005; Bruck, Arnold, Aderholt, & Muran, 2006; Dunkle & Friedlander, 1996). One study revealed when insecurely attached clinical psychologists were compared to securely-attached clinical psychologists, the former scored higher on a self-reliance and angry withdrawal scales, as well as experienced more early loss events and had more un-empathetic parental responses. Another study found when comparing to secure psychologists, insecure psychologists reported feeling less supported at work, perceived that work interfered in their personal life, and experienced more professional problems (Leiper & Casares, 2000). Insecurely attached psychotherapists, who had higher ratings in the scale need for approval, also reported having more problems delivering therapy than securely attached therapists (Black, Hardy, Turpin, & Parry, 2005).

Research findings have also indicated a counselor's attachment style can impact the counselor-client therapeutic alliance (Bucci et al., 2016), the care that counselors provide clients (Cassedy et al., 2015) as well as the treatment outcome (Bucci et al., 2016). For example, individuals who scored high on avoidance are less likely to elicit disclosures from other people (Mikulincer & Dhaver, 2007), and clients working with anxiously attached therapists reported decline in global functioning (Bruck et. al., 2006). A review by Degnan and colleagues (2016) examined the influence of therapist attachment related patterns on alliance and therapeutic outcome across 36 empirical studies, and revealed inconsistent findings. Three of the seven studies reviewing the effect of therapist secure attachment on the alliance found a positive influence of therapist attachment security on the quality of the alliance (Black et al., 2005;

Bruck, Arnold, Aderholt, & Muran, 2006; Dunkle & Friedlander, 1996), discovering therapists to be directly related to improved client outcomes, client interpersonal problems and client target complaints following therapy (Bruck et al., 2006). Other studies, however, failed to identify an existing relationship between securely attached therapists and alliance (Ligiero & Gelso, 2002), especially when rated by clients (Dinger, Strack, Sachsse & Schauenburg, 2009; Petrowski, Nowacki, Pokorny, & Buchheim, 2011).

It has been postulated that therapists with attachment insecurities (those higher on anxiety or avoidance, or both) may lack skills that form a good therapeutic alliance (Mikulincer & Shaver, 2007). For example, when working with an anxiously attached counselor, clients perceived the counselor-client alliance as more negative (Dinger et al., 2009; Sauer, Lopez, & Gormley, 2003). Yet, insecurely attached therapists may be unaware of their effects on the counseling alliance as Sauer et al. (2003) shared clients had rated the counseling alliance as more negative than therapists had, when working with an anxiously attached therapist. The *client's* perspective of the working alliance, however, was found to be the best predictor of outcome while the therapist's perception being the worst (Horvath & Bedi, 2002; Horvath & Luborsky 1993). As fewer findings have documented attachment anxiety to be positively related to client-rated alliance (Sauer et al., 2003) at certain stages of therapy, researchers reasoned that preoccupied-anxious counselors may "make extra efforts to ensure that the client feels good about the therapeutic relationship in attempts to fulfil their own attachment needs" (Degnan, Seymour-Hyge, Harris, & Berry, 2016, p.58).

Anxiety, Avoidance, and Counselor Boundary Behaviors

There has not been direct research that examines attachment related anxiety and attachment related avoidance in direct relation to counselor boundary behaviors. Research on attachment patterns, however, can provide a convincing link between attachment-related anxiety and attachment-related avoidance and counselor boundary behaviors.

Past research examining attachment styles in adult friendships revealed individuals high in anxious attachment struggle with self-other boundaries. Findings show the anxiously-attached group scored high on elaboration, self-disclosure (showing a tendency to disclose inappropriately), emotional expressiveness, frequency of crying, reliance on others, use of others as a secure base, crying in the presence of others, and caregiving, in addition to high-ratings on level of romantic involvement and low on coherence and balance of control in friendships (Bartholomew & Horowitz, 1991). Such behaviors in the counseling context, however, may constitute as or reflect boundary crossings, such as self-disclosing inappropriately, giving hugs, or establishing a dual relationship in efforts to provide gained esteem for the counselor and a closer connection to clients. This same study revealed friends of highly anxious individuals described them as with less overall warmth and more overall dominant than the anxious individuals reported themselves (Bartholomew & Horowitz, 1991).

In alignment with attachment theory, the counselor high in attachment anxiety resembles a preoccupation with the clinical relationship, fears rejection or abandonment from their client, and therefore seeks reassurance, approval, and closeness within the therapeutic relationship, known as “hyper-activating” strategies (Dinger et al., 2009). Marmarosh (2017) revealed dialogue to resemble that of an anxious therapist in the face of client termination. The session demonstrated these therapists may be more prone to avoid termination, and anxiously pre-plan to

continue treatment in the future with their client. The counselor may be overly sensitive to the ending and depending on the type of termination, feel a sense of abandonment, or perceive that he or she is deserting the client. If the anxious therapist is overly concerned with avoiding conflict and reducing guilt, he or she may overly focus on the positive aspects of the termination or completely avoid the ending to the treatment (Marmarosh, 2017). As further suggested by research, it is possible that because anxiously attached trainee therapists are attuned to their own issues and anxieties, they may be therefore more attuned to their client's emotions and vulnerabilities than avoidant therapists (Trusty et al., 2005).

An empirical study looking at the manner in which clergy (primarily rabbis) connect with significant others (attachment style) was investigated in relation to how they set boundaries. As measured by The Boundary Questionnaire (Hartmann, 1991), individuals with very thick boundaries hold distinct and separate perceptions, thoughts, and feelings, and tend to think in terms of black and white. These individuals are described to be precise in their organization of time and space, and are less likely to enter inappropriate relationships impulsively. Conversely, individuals with very thin boundaries are described to more easily become over-involved in relationships, tending to follow their feelings and impulses when both establishing and ending relationships. It was found that clergy who had a combination of thin outer boundaries (our awareness of our encounters with other individuals, groups, organizations, nations), and thick inner boundaries (our awareness of our encounters with our dreams, thoughts, and feelings), and vice versa scored with higher levels of attachment related anxiety than individuals who had a consistently thin or thick inner and outer boundaries (Bleiberg, J. R., & Skufca, 2005).

Highly avoidant therapists, however, are inclined to minimize interpersonal connection as well as dependency and are therefore likely to downplay the importance of the therapy

relationship through deactivating attachment behaviors (Marmarosh, 2017). In a study examining attachment styles in adult friendships, those participants classified as "dismissive" (higher in avoidance) scored low on emotional expressiveness, frequency of crying, and warmth, and scored lower than the secure and preoccupied groups on scales representing closeness in personal relationships: self-disclosure, intimacy, level of romantic involvements, capacity to rely on others, and use of others as a secure base (Bartholomew & Horowitz, 1991). The avoidant therapist may engage in fewer boundary behaviors, as they may not be able to tolerate the emotional needs and feelings of the client and avoid addressing client emotional reactions. Marmarosh (2017) shared Holmes (1997) rationale stating because those higher in avoidance are likely to suppress their emotions leading to less empathy for others that they may even end treatment too soon to avoid longings for the relationship. Therefore, it is reasonable to assume a counselor with high attachment related anxiety, or a preoccupation with the therapeutic relationship, could create friction with therapeutic boundaries (Taylor, et al., 2015) while a therapist with high attachment related avoidance may cross less boundaries in order to avoid additional interpersonal connection all together.

Empathy

An abundance of psychological research indicates that empathy, the ability to understand or share what another is feeling, is facilitative to successful human relationships (Baron-Cohen & Wheelwright, 2004; Mesurado & Richaud, 2017; Neumann, Chan, Wang, & Boyle, 2016). Research studies demonstrate a lack of empathy to be associated with aggression (Baron-Cohen & Wheelwright, 2004; Eisenberg, Eggum, & Diunta, 2010; Gini, Albiero, Benelli, & Altoe, 2007; Mitsopoulou & Giovazoliasm, 2015). Within the context of healthcare, numerous studies

exhibit the value of empathetic healthcare providers and positive patient outcome. One study revealed empathetic providers were perceived to be more trustworthy by their patients, which resulted in both increased patient satisfaction, and compliance (Kim, Kaplowitz, & Johnston, 2004). Similarly, another research study reported a positive relationship between nurse-expressed empathy and patient-perceived empathy, as well as a reported decrease in patient anxiety and depression as feelings of being understood by the nurse increased (Olson, 1995).

Empathy has also been found to lead to altruistic-motivation, or a desire to help people in prosocial ways. As explained by the empathy-altruism hypothesis (Batson & Shaw, 1991), "empathy evokes an altruistic motive, the ultimate goal of which is to protect or promote the welfare of the person for who empathy is felt" (Stocks, Lishner, Decker, 2009, p. 649). For example, empathy has been identified as a positive predictor of defending bullying behavior among schoolmates (Gini, Albiero, Benelli, & Altoe, 2007; Nickerson, Mele, & Princiotta, 2008). Another study revealed empathy-induced participants spent more time on an online charity task, donating rice to the United Nations World Food Programme (Farrelly & Bennett, 2018).

In contrast, other researchers have identified and reported drawbacks to empathy. Empathy has been found as a primary conduit for the development of secondary stress disorders (Decety & Lamm, 2006; Rothschild, 2006), a cause for healthcare provider burnout (Bloom, 2017, p. 25), as bias in nature, interferes with judgement and decision-making, and argued to be a bad moral compass (Bloom, 2017). Moreover, findings have revealed "even when put to good use" too much empathy can be a bad thing (Bloom, 2017, p. 25), Specifically, within the psychotherapy context, Satran (1991) reports too much empathy can be hazardous. West (2015)

comments specifically on the potential for creating a negative stress response when a counseling professional has an inability to separate a client's pain from oneself.

Defining Empathy

As a construct, empathy has been defined and conceptualized in various ways over the last 90 years (Gerdes & Segal, 2011). Researcher have referred to empathy as a personality trait, an attitude or state of being, an experiential process (Trusty, et al., 2005), a raw identification, a resonation, or as something simply received by others (Gladstein, 1983). However, contemporary views of empathy collectively agree it is a complex and multidimensional construct encompassing both cognitive and affective processes (Gerdes & Segal, 2011; Rameson & Lieberman, 2009; Telle & Pfister, 2016; Trusty et al., 2005). Together, these components of empathy jointly inform individuals of the internal states of others (Decety & Jackson, 2004), and are important in predicting prosocial behavior (Mesurado & Richaud, 2017). However, each component has a separate function (Santamaria-Garcia et al., 2017) and exist in varying amounts among individuals.

Cognitive empathy, also referred to as theory of mind or mentalizing, refers to *understanding* another's situation or what is perceived to be the emotions of another person. Specifically, cognitive empathy requires a perspective-taking ability, in order to be able to put oneself in another's shoes (Mesurado & Richaud, 2017) and to predict and understand the behavior of others (Hatcher, Favorite, Hardy, Goode, DeShetler, & Thomas, 2005). For example, a study examining mother-daughter altercations, found daughters who received a cognitive empathy manipulation, were better able to "distance themselves from the emotional heat" of the conflict and listen to their mothers' point of view, leading to fairer outcomes. Ultimately,

cognitive empathy led to lower conflict escalation and promoted other-oriented listening during mother-daughter discord (Van Lissa, Hawk, & Meeus, 2017). The cognitive dimension of empathy also requires interpersonal awareness and interpersonal sensitivity, allowing one's ability to make a good judgement about someone else (Carney & Harrigan, 2003). Moreover, a cross-sectional study of college students found that perspective-taking was negatively correlated with aggression and positively correlated with problem-solving (Richardson, Hammock, Smith, Gardner, & Signo, 1994), while empathic concern (part of affective empathy) was significantly correlated with compliance in conflicts with friends.

Affective empathy allows an observer to identify emotionally with another by internalizing and *experiencing* or *feeling* the perceived emotions of another individual. In resonating with another, affective empathy can come in various forms. The empathizer can either feel empathic concern (associated with prosocial behaviors), emotional contagion (feeling what the individual is feeling), or personal distress, referred to as self-centered feelings of discomfort and anxiety in response to another's suffering (Eisenberg, Eggum, & Giuntam, 2010).

Individuals vary in the extent to which they experience either concern or distress and discomfort in response to other people's negative experiences (Davis, Luce, & Kraus, 1994). For example, those that experience intense emotions, but are well-regulated, are more likely to experience prosocial empathic concern (Eisenberg, Eggum, & Giuntam 2010) and less likely to experience personal distress (Thomas, 2013). An emotional response such as empathic concern has been shown to lead to altruistic motivation, arising from feeling compassion for the other person and wanting to reduce his or her stress (Verhofstadt et al., 2016). High levels of empathic personal distress have also been linked to aversive outcomes such as the inability of professionals to relate well with those whom they serve (Riggio & Taylor, 2000), and the

frequency of clinical errors and speed of recognizing errors in practicing professionals (Larson, Fair, Good & Baldwin, 2010; West et al., 2006). Experiencing personal stress from affective empathy has been shown to result in a self-focused reaction to another's pain, involving withdrawal and avoidance (Batson & Shaw, 1991; Decety & Lamm, 2009). Self-oriented distress is followed by either refraining to help and escaping the situation if possible, or helping the other person (Batson, 1991; Verhofstadt et al., 2016). Experiencing empathic personal distress can also lead to helping behaviors, although for largely egotistic reasons (Batson, 1991). In this case, the greater the personal distress the observer experiences, the greater their motivation to have it reduced.

Empathy within Counseling

Counselor empathy has long been regarded as an essential component to the counseling process and influential to therapy outcome (Gerdes & Segal, 2011; Gladstein, 1983; Moyers & Miller, 2013; Norcross & Wampold, 2011; Rogers, 1957). Rogers (1957) described psychotherapist empathy as "necessary and sufficient conditions of therapeutic personality change (p. 95). In addition to counselor attributes of congruence and unconditional positive regard, empathy is considered a core condition which fosters the counselor-client relationship (Clark, 2010; Feller & Cottone, 2003). Referred to as empathic responding (Rogers, 1979), responsive communication (Barrett-Leanard, 1986), or communicative attunement (Bohart & Greenberg, 1997), a counselor's display of empathic understanding has been found to create a supportive emotional climate facilitating trust, open-communication, increased compliance, and therapy satisfaction among clients (Bohart, Elliot, Greenberg, & Watson, 2002; Clark, 2010).

Multiple studies have alluded to the idea that empathy is a core condition of effective therapy (DePue & Lambie, 2014) as it serves as an important mechanism of change. One study revealed improved therapeutic outcomes when clients experienced counselor empathy in their approach (Gerdes & Segal, 2011), and patients who perceived their counselors as empathetic were found to have better therapeutic outcome, patient compliance, and satisfaction through increased counselor trust (Elliot, Bohart, Watson, & Greenberg, 2011; Kim, Kaplowitz, & Johnston, 2004). Additionally, client perception of therapist empathy was associated with significant decreases in negative self-treatment at the conclusion of therapy and significant improvement in attachment insecurity (Watson, Steckley, & McMullen, 2014). Positive effects of counselor empathy have been seen across clientele, as a study specifically looking at substance abuse clients revealed high empathy-counselors achieved higher success rates. Low counselor empathy resulted in higher dropout and relapse rates, weaker therapeutic alliance, and less client change (Moyers & Miller, 2013).

However, just like too little empathy, too much empathy has been suggested to be hazardous within psychotherapy (Satran, 1991). Modell (1986) "underscores a "dark side" of empathy where patients who feel relentlessly drenched with the therapist's empathy have difficulty feeling separate and finding their own way in life" (Satran, 1991, p. 740). Elliot and colleagues (2011) state that not all clients respond favorably to explicit empathic expressions and shared Beutler, Crago, & Arizmendi's (1986) review that "patients who are highly sensitive, suspicious, poorly motivated, and reactive against authority perform relatively poorly with therapists who are particularly empathic, involved, and accepting" (p. 279). Elliot and colleagues (2011) also shared an additional study by Mohr and Woodhouse (2000) that found some clients prefer business-like therapists instead of a warm and empathetic delivery. Certain fragile clients

may find the usual expressions of empathy too intrusive, while hostile clients may find empathy too directive, and other clients may find an empathic focus on feelings too foreign (Elliot et al., 2011). Moreover, clinicians themselves operating at high levels of empathy or affective sharing may come with a personal cost, as studies have revealed a positive link to emotional and physical counselor burnout (Eisenberg, 2000). In fact, Gerdes and Segal (2011) shared many social workers who have a very strong capacity to share in their clients' feelings have trouble detaching from their clients and ultimately take on many of the same burdens they are trying to ease. Researchers report such a degree of enmeshment is not constructive and has the potential to "prevent clear and constructive action" (Gerdes & Segal, 2011, p. 145).

The accurate expression of empathy, specifically, can either facilitate or hinder the counseling process (DePue & Lambie, 2014). Within counseling, counselor empathy is demonstrated through both nonlinguistic and paralinguistic behaviors (Elliot, Bohart, Watson, & Greenberg, 2011). Rogers (19464) contends empathy can only be accurately expressed when counseling professionals can enter the client's inner world, communicate the understanding of this world to the client and check the accuracy of the understanding (as cited in Giordano, Stare, Clarke, 2015; Macaulay, Toukmanian, & Gordon, 2007; Neukrug, Bayne, Nganga, & Pusateri, 2013). In order for counselor empathy to benefit the therapeutic process, clients must take notice of and feel it is exhibited by the counselor (Macaulay, Toukmanian, & Gordon, 2007).

For an appropriate empathic response to occur, the other's emotional state must 1) be identified or registered in awareness, 2) be understood on some level, and 3) connect with the empathic person's knowledge or experience of appropriate responses (Carré et al., 2013). An empathic person's ability to respond appropriately also requires 'theory of mind', or the

recognition that others have different thoughts and perceptions from one's own and that those other thoughts and perceptions are based on different experiences (Frith & Frith, 2010).

Empathy and Boundary Behaviors

Psychological health providers require ongoing empathy throughout their daily practice in order to understand and connect with their clients. Despite the likely presence of empathy among most counseling providers, clinicians differentiate from each other in how much empathy they convey in treatment sessions (Moyers & Miller, 2013). As therapists naturally derive satisfaction from helping clients, deeply empathizing with a client's difficult experience along with the strong desire to heal them can subsequently lead to boundary dilemmas.

While there are no direct studies examining the impact of counselor empathy on boundary behaviors, there is strong empirical and theoretical support that empathy is a motivator for helping others in distress (Mark, Ijzendoorn, & Bakermans-Kranenburg, 2002; Mikulincer et al., 2001). Specifically, it is possible that the "empathy-prosocial behavior in connection with a situation of need and/or negative emotions of the target" (Stocks, Lishner & Decker, 2009; Telle & Pfister, 2016, p. 154) may be expressed in the form of boundary crossings in the clinical context. This could be as subtle as a counselor going the extra mile to provide their personal email, or giving their client a ride home, to an extreme such as engaging in a personal relationship with them. One particular case study demonstrated a therapist's empathy and altruistically motivated actions for her suffering client resulted in multiple boundary crossings. The over identification with her client's experiences led the therapist agreeing to see this client for sessions inside the client's car, allowing the client to lay her head on the therapist, and finally visiting the client's home (Seelig, 2017).

It is also possible for counselor empathy to lead to prosocial behaviors in an attempt to relieve their own pain felt from the situation. One study found that children witnessing harm upon another person and seeing this person's distress, resulted in self-distress behavioral action to help stop the harm in the other to reduce their own personal distress (Deschamps, Schutter, Kenemams, & Matthys, 2015). While empathy is required to some extent for certain boundary crossings, it comes with important qualifiers (Hermansson, 1997). It is possible too much empathy leads counselors to engage in boundary behaviors in order to relieve their own distress felt from the client's situation.

Duan and Hill (1996) speculated that different types of empathy may be hindering or helpful to clients at different times. Elliot and colleagues (2011) shared Hill et al. (1992) and Thompson & Hill (1991) found when clients had negative in-session reactions to their therapists, the therapist's awareness or understanding of the reaction led to interventions that were perceived as less helpful than when the awareness was absent. Between intellectual (cognitive), emotional (affective), and communicative (nonverbal) empathy, Ridgway and Sharpley (1990) found emotional (affective) empathy to be the only type of empathy significantly related to high counseling skill (including attending, responding to feelings, and strategies/influencing skills). Affective empathy was found to be significantly related to high counseling skills only when the counselor trainee also experienced a low sense of meaning and purpose in life.

As the cognitive dimension of empathy involves someone's ability to make a good judgement about another (Carney & Harrigan, 2003), those counselors high in this domain are possibly better able to think before acting, not letting the emotions of others strongly steer their decision-making within the therapeutic relationship. On the other hand, while affective empathy has been viewed to be especially important in order to build the therapeutic bond, provide safety

for clients (Hatcher et al., 2005), and help clients increase self-awareness (Gladstein, 1983; Macaulay et al., 2007), too much affective sharing can contribute to counselors' emotional and physical burnout (Eisenberg, 2000; Gerdes & Segal, 2011) and affect clinical decision-making. Moreover, the descriptors "enmeshed" (Lopez, 1995) and overly expressive (Bartholomew & Horowitz, 1991) have been used to characterize attachment anxiety, as thought to be manifested through high levels of emotional empathy. Individuals high in empathic concern may result in frequent boundary crossings intended to help the client, or self, feel better.

Despite the common use of the word empathy within in clinical work and psychology, the complicated set of affective, cognitive, and self-regulatory components is not as well-understood by practitioners, which may result in very different motivational and behavioral outcomes with clients (Thomas, 2013, p. 365). Decety (2011) suggested that useful research regarding empathy may require deconstruction of the larger construct and specific investigation of component parts (Thomas, 2013).

Purpose and Rationale

The purpose of this study was to investigate counselor characteristics which contribute to frequency of therapist boundary behaviors within the context of counseling. Specifically, this study further explored briefly discussed/studied therapist demographics in relation to counselor boundaries (gender, theoretical orientation, years of experience, practice setting). Newly explored variables included counselor empathy (cognitive and affective), a characteristic thought to be required for boundary crossings (Hermansson, 1997), and an integral component to successful therapeutic outcomes (Rogers, 1957). (Gerdes & Segal, 2011; Moyers & Miller, 2013; Norcross & Wampold, 2011), as well as counselor attachment style, largely influential to the

therapist-client interaction and outcome (Parpottas & Draghi-Lorenz, 2015; Yusof & Carpenter, 2015). Correlates were thought to contribute to a better understanding of what kind of counselors engage in boundary behaviors more frequently with clients. In addition, this study was completed to identify implications for training programs, such as increasing counselor awareness in how demographics, but also certain personal characteristics contribute to boundary behaviors with clients. An additional purpose of the study was to create a comprehensive boundary measure that gauged counselor-endorsed frequency of a wide-range of boundary behaviors.

Proposed Hypotheses

Within the counseling literature, there are limited studies that examine predictors of counselor boundary behaviors. However, some studies have discussed or examined counselor demographics in relation to views on ethical behaviors, stances on dual relationships, and use of self-disclosure within the therapeutic relationship (Baer & Murdock, 1995; Bleiberg & Skufca, 2005; Borys, 1988; Kitson & Sperlinger, 2007; Robitschek & McCarthy 1991). The more common demographics explored include theoretical orientation, and counselor years of experience, with few but some that examined counselor gender, and practice setting in their direct relation to boundary behaviors.

Several studies have found psychodynamic-oriented counselors endorse counseling boundaries as less ethical than other orientations (Baer & Murdock, 1995; Borys & Pope, 1989; Holroyd & Brodsky, 1977; Pope, Tabachnick, & Keith-Spiegel, 1987), and have lower prevalence rates of misconduct than therapists of other orientations (Celenza, 2007). Other authors have suggested cognitive behavioral therapists have a greater opportunity to encounter boundary dilemmas due to the nature of their techniques, such as exposure, self-disclosure, and a

heavy focus on the therapeutic relationship (Goldfried, Burckell, & Eubanks-Carter, 2003; Gottlieb, Younggren, and Murch, 2009; Heinonene & Orinsky, 2013). Therefore, hypothesis 1a states:

> ***Hypothesis 1a****:* Providers with a cognitive-behavioral orientation will positively predict having engaged in more boundary behaviors with their client than other orientations.

Counselor years of experience in relationship to how boundaries are held has yielded mixed discussion and findings. Researchers have raised concerns that novice therapists may be more at risk for boundary behaviors (Twemlow, 1997; Gusella, 2003), as other study findings report those providers further along in their career engage in more boundary crossings (Kitson & Sperlinger, 2007.). The literature found counselors who viewed dual relationships as less professionally appropriate to be female, younger, and more recently qualified counselors (Kitson & Sperlinger, 2007). Due to the rigidity and nerves of a novice counselor, as well as consistent supervision being held, it is thought newer counselors engage in less boundary behaviors. As it was found that those counseling providers with more years of experience view dual relationships as more appropriate (Kitson & Sperlinger, 2007), hypothesis 1b states:

> ***Hypothesis 1b*****:** Providers with more years of experience will predict having engaged in more boundary behaviors with their clients than providers with fewer years of experience.

Overall, while case studies have reported the typical boundary transgressor to be male, this is largely when it comes to sexual advances. Because of the caregiving and nurturing gender role of women, it is thought that female providers might cross more day-to-day boundaries with

their clients, specifically as increasing number of women therapists in helping professions tend to emphasize relational factors in their approach (Zur, 2007). Past research revealed female clergy scored higher than males on the boundary questionnaire (Hartmann, 1991), indicating thinner mental and interpersonal boundaries (Bleiberg & Skufca, 2005). Hypothesis 1c states:

> ***Hypothesis 1c:*** Female providers will positively predict having engaged in more boundary behaviors with their clients than male providers.

Older case studies of boundary-violating physicians have demonstrated a pattern with such behaviors taking place by practitioners in private practice (Goldman, 2009; Luchner, Mirsalimi, Moser, & Jones, 2008). One study revealed those mental health professionals who view dual relationships as less professionally appropriate are more likely to not work for themselves or on a solo basis (Epstein, Simon, & Kay, 1992). Additionally, clinicians in private practice tend to have little overhead and have been found to engage in less consultation and supervision than other settings (schools, colleges, hospital, residential settings, and community agencies) (Lawson, 2007). Therefore, hypothesis 1d states:

> ***Hypothesis 1d:*** Health care providers in private practice will positively predict having engaged in more boundary behaviors with their clients than other practice settings.

As counselors high in attachment anxiety resemble a preoccupation with the clinical relationship, and fear rejection or abandonment from their client, they adopt “hyper-activating” strategies, such as seeking reassurance, approval, and closeness within the therapeutic relationship (Dinger et al., 2009). Conversely, individuals high in avoidance are prone to using “deactivating” strategies and distance themselves in relationships by minimizing their important

and avoiding intimacy (Marmarosh, 2017). Therefore, the following attachment hypotheses are made for the relationship between attachment-related anxiety and boundary behaviors and attachment-related avoidance and boundary behaviors:

Hypothesis 2a: Attachment-related anxiety will positively predict engagement in boundary behaviors.

Hypothesis 2b: Attachment-related avoidance will negatively predict engagement in boundary behaviors.

Hypothesis 2c. Counselor attachment style will incrementally predict boundary behaviors over and above counselor demographic factors.

Counselor empathy has not been studied in direct relation to counselor boundary behaviors. However, researchers have suggested boundary crossings require empathy to some extent (Hermansson, 1997). High empathic concern and affective sharing can lead to both prosocial behaviors and a degree of enmeshment that is not constructive and prevents clear and constructive action (Gerdes & Segal, 2011). Cognitive empathy, rather, involves perspective taking, interpersonal awareness and interpersonal sensitivity, allowing one's ability to make a good judgement about someone else (Carney & Harrigan, 2003) and presumably their needs. Therefore, the following hypotheses are made for the relationship between counselor empathy and boundary behaviors:

Hypothesis 3a: Overall empathy will positively predict boundary behaviors.

Hypothesis 3b: Counselors higher in affective empathy will predict engagement in more boundary behaviors, however, cognitive empathy will show no predictive relationship with boundary behaviors.

Hypothesis 3c: Counselor empathy will incrementally predict boundary behaviors over and above counselor demographic factors.

CHAPTER II: DEVELOPMENT OF SCALE

Background of Existing Scales

The existing research on counselor boundaries lacks a brief, yet comprehensive and current version of a counselor boundary measure. Past measures surrounding topics of clinician boundaries have focused solely on sexual transgressions within the therapeutic relationship such as in the Exploitation Index (Epstein & Simon, 1990) and the Boundary Violations Index (Swiggart et al., 2008). Others include a limited list of boundary behaviors, focusing mostly on dual relationships, such as in the 20-vignette Ethical Assessment Survey (EAS) (Baer & Murdock, 1995), and the 15-item Predictors of Psychotherapeutic Benefit Measure (Jones, Botsko, & Gorman, 2003). The Psychologist Ethical Practices Survey (Helbok, Marinelli, Walls, & Richard, 2006) was developed for a study that examined ethical dilemmas and problems that confront psychologists across rural and urban communities. However, this measure includes an overwhelming 120-items. Despite the benefit of including a wide range of boundary behaviors, additional lengthy measures are Pope, Tebachnick and Speigal's Ethics Attitudes and Behaviors Survey (1987) and the more recent Cross-Cultural Perceptions of Boundaries questionnaire (Miller et al., 2012) both containing 80+ items.

Kendall, Fronek, and Ungerer (2011) recently developed the Boundaries In Practice Scale incorporating multiple boundary domains across health disciplines, however, the 19-vignette-style and multiple questions (Part A, B, and C) attached to each is not so straight forward. Moreover, the scale is only for use upon permission for release from the author. Additional

existing boundary measures examine patient-physician boundaries within a medical context (Jain et al., 2012), student-teacher relationship boundaries (Plaut & Baker, 2011), and boundaries between hospice palliative care volunteers and patients (Claxton-Oldfield, Gibbon, & Schmidt-Chamberlain, 2011). Lastly, the Boundaries Questionnaire (Hartmann, 1989) was developed to measure "thin" or "thick" mental and interpersonal boundaries with a heavy focus on intrapsychic elements such as dreams, unusual experiences, as opposed to measuring the act of crossing of particular boundary with a client.

The purpose of creating a new boundary behaviors measure for this study was to develop an instrument that focused on interpersonal boundaries specific to the counselor-client relationship and included a wide range of mild to severe boundary behaviors, while remaining relatively brief in length. As opposed to measuring clinician's attitudes towards boundary behaviors, this particular instrument was created to measure the self-reported frequency with which counselors engage in these boundary behaviors across all of their clients.

Method and Results

Creation of Initial Scale

Preliminary data was gathered for a 58-item self-constructed online distributed survey. Measure items were determined and included after reviewing and gathering of a large list of clinical boundary problems accrued from the existing counseling literature, as well as fellow clinicians, as can be seen in table 1. Some items from the literature were re-worded to include a specific example for the participant, inspired by clinical situations counselors shared. In efforts to make a concise and valid final version measure, researchers included three questions for each item listed: the perceived acceptability of each behavior (endorsed as 'never', 'sometimes',

'frequently', 'always'), the perceived frequency of each behavior in the counseling field (endorsed as 'rarely', 'occasionally', 'frequently', 'always'), and the perceived severity of each behavior listed by asking participants whether they considered each boundary behavior as a boundary crossing, boundary violation, or neither. This allowed researchers to gather as much data as possible to later determine which questions were unnecessary/irrelevant to include in the final measure.

Table 1.
Scale Items Sources

Citation/Source	Boundary Behaviors from Counseling Literature used in initial Pre-Survey	Items Worded Differently in initial Pre-Survey
Twemlow, 1997	Accepting a gift from a patient	1. Accepting gift from client
	Reducing session fees	17. Lessening session fees in times of client financial hardship
	Giving free sessions in times of financial strain	
	Attending important client social functions (e.g., wedding)	23. Attending client milestone (e.g., graduation/wedding)
	13. Giving client a ride home	
	14. Visiting a suicidal patient at home	
	Retaining patient longer than indicated	18. Retaining a patient for treatment longer than needed
	4. Failure to seek supervision or consultation	
	Failure to refer, Treating outside of one's area of expertise	9. Failure to refer out when needed
Miller, 2005	Dual relationships	24. Holding a dual relationship with client (e.g., they are also your dentist, friend, son's teacher, etc.)
		16. Participating in same social activity as client (e.g., book club)
		38. Using client family member/friend who is a provider you need (an orthodontist/mechanic etc.)

Citation/Source	Boundary Behaviors from Counseling Literature used in initial Pre-Survey	Items Worded Differently in initial Pre-Survey
Miller, 2005 (*Cont*.)	Dual relationships	25. Accepting client friend request on Facebook
	Situations in which the client and therapist encounter each other outside of the clinical setting / Responding to patients greeting in public (Thomas, 2013)	19. Running into patient outside of therapy and saying hi
	Self-disclosure	2. Self-disclosing personal information/experiences
		28. Sharing upcoming travel plans with patient when they ask
		49. Talking about similar past personal experiences
		48. Talking about past client similar challenges
	Greeting behavior	46. Greeting client with kiss on cheek
		5. Giving client hug
	Sexual violations	34. Therapist-client sexual contact
	Transgressions involving financial matters	17. Lessening session fees in times of client financial hardship
Peterson, 1992	Compromise role reversal	54. Sharing struggles of your own with client
	Secrecy	21.Not sharing diagnosis with client (secrecy)
		51. Lying to client when feeling as if it will benefit them
	Abuse of professional privilege	34. Therapist-client sexual contact
	58. Putting the client in a lose-lose situation	
Smith & Fitzpatrick, 1995	Non-erotic physical contact (e.g., hugs)	3. Counselor physical contact (putting hands on shoulder, hand over hand)
		5. Giving client a hug

Citation/Source	Boundary Behaviors from Counseling Literature used in initial Pre-Survey	Items Worded Differently in initial Pre-Survey
Smith & Fitzpatrick, 1995 (*Cont*.)	Physical explotation, Selfish misuse of patients, seeking personal gains/validation	34. Therapist-client sexual contact
	Unethical self-disclosure	54. Sharing struggles of your own with client
Glass, 2003	Violations of Confidentiality	31. Breaking confidentiality 30. Not reporting abuse right away because your client says will make the situation worse
	Discussing certain adolescent treatment issues with parents (Thomas, 2013)	22.Not sharing concerns of risky behavior with client's parents 42.Talk with family members about client conversations because you are concerned
	Telephone therapy with a patient who has moved away or feels too sick to come to session	56. Having a phone/video session
Gabbard, 2008	Embarks on romantic relationship after treatment termination	8. Keeping a personal relationship after treatment termination
	Physician-patient relationship ongoing (Malmquist & Notman, 2001)	7. Responding to client's email after termination
Sude, 2013	Text messaging with clients at higher risk for boundary concern	35. Texting with client outside of session about a clinical matter
Koocher, 2009	Counselors should decide how much time they will be available through TM and communicate the decision to clients	36. Responding to client concern via telephone outside of office hours
Barnett, Lazarus, Vasquez, and Moorehead-slaughter, 2008	Extend time of psychotherapy session	11. Extending session beyond time allotted
	Sharing personal information	20. Having pictures of family members in counseling office
	Gift giving	15. Giving a client a gift
Ashby et al., 2015	Googling patients	45. Looking up client or client family members on social media

Citation/Source	Boundary Behaviors from Counseling Literature used in Pre-Survey	Items Worded Differently in initial Pre-Survey
Colleagues/Professionals in field	12. Giving out personal phone number 26. Providing client with false hope 29. Engaging in foul language/swear words in conversation with client 32. Texting on phone while in session with client 33. Not planning for session 12. Giving out personal phone number 26. Providing client with false hope 29. Engaging in foul language/swear words in conversation with client 32. Texting on phone while in session with client 33. Not planning for session 52. Expressing emotion with client (crying) 6. Speaking to client about clinical issues outside of session 10. Transfer client to unknown therapist at termination 27. Giving client food to try during session 37. Leaving session at same time as client – walk out to cars together 39. Start seeing client's siblings/friend/cousin as patient 40. Find ways to agree with majority of what client says/avoid confrontation 41. Provide client with personal email 43. Do work for clients (i.e., call a psychiatrist to make them appt.) 44. Share opinion (i.e., "you should divorce him)	

Citation/Source	Boundary Behaviors used from Counseling Literature used in Pre-survey	Items Worded Differently in initial Pre-Survey
Colleagues/Professionals in field *(Cont.)*	47. Introducing client to significant other 50. Taking food/trying food from client 53. Flirting with client 57. Letting client dictate session	

Participant Recruitment and Procedure

An IRB was drafted and approved from Pace University in order to create and distribute the online Qualtrics survey. Survey participants included mental health counselors, marriage and family therapists, social workers, psychologists, and student trainees working one-on-one with clients for at least 3-months. Participants were recruited from counselor listservs to include the American Counseling Association (ACA), Counselor Education and Supervision Network (CESNET), and the professional provider database, Psychology Today. Additional participants were students in Master level and doctorate level Mental Health Counseling program at Pace University. Participants were provided with a link to a Qualtrics online survey. Once participants read and provided consent, participants were first asked demographic and descriptive information to include: profession in the counseling field, months/years in practice, if currently seeing clients, and practice location/setting. Participant gender, age, and ethnicity were unintentionally left out of this demographic section but were included in the final version.

A total of 151 participants completed the survey and rated 58 boundary behavior items in terms of how acceptable they viewed them, how frequent they believe them to happen in the counseling field, and were provided with definitions to define each behavior as either a *boundary crossing*, a *boundary violation*, or neither. A total of 122 participants indicated an average of 125.02 months in practice (10.41 years) with a 9.5 year range on either side (SD = 102.74). Remaining participant demographics are listed in table 2.

Table 2

Participant Demographic Information Boundary Behavior Survey: Study 1

	N (%)
Profession	
Licensed Mental Health Counselor (or eligible)	95 (66)
Student / Trainee in Internship	26 (18.1)
Licensed Clinical Social Worker (or eligible)	13 (9.0)
Licensed Psychologist (or eligible)	7 (4.9)
Licensed Marriage Family Therapist (or eligible)	3 (2.1)
Seeing Clients	
Yes	109 (79.6)
Not currently, but have in past	24 (17.5)
No	4 (2.9)
Practice Setting	
Private practice	51 (42.9)
Agency	25 (21.0)
Multiple settings	14 (11.2)
Higher level care	13 (10.9)
College / school	11 (9.2)
Hospital	3 (2.5)
Community mental health	2 (1.7)

Note. Valid percentages were used to account for missing data

Data Item Reduction

Scale items were reduced from 58-items to 40-items after running and analyzing participant boundary data through the Statistical Package for Social Sciences (SPSS). A factor analysis was conducted to examine patterns of responses with the intention to categorize items into similar categories, however yielded little useful information due to the response scales approximating categorical data. Three items were immediately removed based off participant feedback that the items were too vague and required additional information in order to answer the question appropriately (item numbers: 10, 42, 58). Following, the process for reducing items first entailed combining or eliminating overlapping items which fell under a common category and yielded similar frequencies. Each boundary behavior's frequencies, means, and standard deviations were examined for both the endorsed acceptability of the behavior as well as perceived frequency in the counseling field. A total of five items were combined (item numbers: 5, 35, 36, 41, 51) and one item dropped for redundancy (item number: 26). Table 4 includes scale item reduction details.

Remaining scale items were theorized into eight overarching boundary behavior categories, as seen in table 4, to include items of counselor self-disclosure, active behavior (counselor-initiated behavior), passive behavior (client-initiated behavior), physical contact, professional violations, post-termination, immediacy behaviors (counselor expressions of warmth), and dual relationships. Items in each category were removed if they met at least 2/3 of the following criteria: 1.) had at least 60% of participants endorsing the behavior as "neither" a crossing nor violation, 2.) was not foundational to the counseling literature, and/or 3.) had little variability in participant responses when rating the acceptability (endorsed as 'never', 'sometimes', 'frequently', or 'always') of the particular behavior. After analyzing data for both

‘acceptability’ and ‘frequency’ questions, participant response variability was similar among both groups, but perceived acceptability of a behavior was thought to be more informative when analyzing individual differences among counselors.

This process was completed by first analyzing each boundary behavior item’s category descriptives (endorsed as a ‘crossing’, ‘violation’, or ‘neither’) to determine participant’s general view on severity of each behavior. In order to get a better visual of those items highly endorsed as ‘neither’, items were put in rank order from highest to lowest percentage responses on ‘neither’. Those with at least 60% responses under ‘neither’ were ultimately cut from the final version of the boundary survey, as the majority of participants did not recognize such items as a boundary behavior. It was then determined if the particular item was foundational to the counseling literature based upon how often this behavior had been mentioned in the counselor boundary literature, or if was highlighted solely by a counseling colleague. Frequency tables were then created to analyze the variability in participant responses regarding endorsed ‘frequency’ of how often these behaviors are thought to occur in practice and ‘acceptability’, or how acceptable they are viewed to be. Items with little response variability were dropped, as such items wouldn’t be informative in determining individual differences that contribute to endorsement of boundary behaviors. See Table 3 for the scale item reduction and reasons for exclusion.

The final boundary measure solely included participant endorsed ‘frequency’ of how often counseling professionals engage in these behaviors across clients and how they would hypothetically respond to the situation if haven’t yet had the opportunity to do so. The final measure excluded ‘acceptability’, in addition to categorization of ‘boundary crossing’, boundary ‘violation’, or ‘neither’ as these questions were initially asked to help zone in on items that

majority of counseling professionals considered to be boundary behaviors to begin with and views on their severity. The focus for the final measure was solely capturing counselor endorsed frequency of engagement in boundary behaviors. Additionally, items were organized to reflect contrast between similar items of different severity (i.e., self-disclosing personal information and self-disclosing personal struggles) so that the intention behind items was clearer. A 7-point Likert-scale was used (1= never and 7= always) so counseling professionals have the opportunity to answer questions more precisely.

Table 3

Scale Item Reduction

	Acceptability M (SD)	Frequency M (SD)	Crossing N (%)	Violation N (%)	Neither (%)	Reason for exclusion
1. Accepting gift from client	1.95 (.39)	1.73 (.65)	96 (63.6%)	1 (.7%)	54 (35.8%)	
2. Self-disclosing personal information/experiences	2.14 (.39)	2.19 (.69)	70 (47.0%)	1 (.7%)	78 (52.3%)	
3. Counselor physical contact (putting hands on shoulder, hand over hand)	1.82 (.54)	1.70 (.71)	81 (53.6%)	23 (15.2%)	7 (31.1%)	
4. Failing to seek supervision or consultation	1.39 (.67)	2.10 (.87)	27 (18.1%)	87 (58.4%)	35 (23.5%)	
5. Giving client hug	1.89 (.45)	1.70 (.68)	84 (57.1%)	14 (9.5%)	49 (33.3%)	Combined item (#3) as example, Similar frequencies
6. Speaking to client about clinical issues outside of session	1.62 (.64)	1.66 (.71)	65 (43.9%)	40 (27.0%)	43 (29.1%)	
7. Responding to clients email after termination	2.13 (.70)	1.87 (.79)	54 (36.2%)	13 (8.7%)	82 (55.0%)	
8. Keeping a personal relationship after treatment termination	1.17 (.43)	1.50 (.71)	65 (44.2%)	75 (51%)	7 (4.7%)	
9. Failure to refer out when needed	1.28 (.56)	1.88 (.83)	16 (10.8%)	116 (78.4%)	16 (10.8%)	
10. Transfer to client to unknown therapist at termination	1.86 (.63)	2.09 (.83)	36 (24.2%)	34 (22.8%)	79 (53%)	Participant feedback, unclear on ‘unknown’
11. Extending session beyond time allotted	2.10 (.43)	2.24 (.78)	62 (41.6%)	6 (4%)	81 (54.4%)	
12. Giving out personal phone number	1.53 (.67)	1.73 (.76)	87 (59.2%)	35 (23.8%)	25 (17%)	
13. Give your patient a ride home	1.24 (.43)	1.25 (.51)	70 (47.6%)	72 (49.0%)	5 (3.4%)	
14. Visiting suicidal patient at home	1.64 (.69)	1.37 (.58)	74 (50.7%)	35 (24.0%)	37 (25.3%)	
15. Giving client a gift	1.62 (.53)	1.47 (.61)	87 (60%)	26 (17.9%)	32 (22.1%)	
16. Participating in same social activity as client (i.e. book club)	1.33 (.53)	1.41 (.61)	80 (54.4%)	54 (36.7%)	13 (8.8%)	

Scale Item Reduction

	Acceptability M (SD)	Frequency M (SD)	Crossing N (%)	Violation N (%)	Neither (%)	Reason for exclusion
17. Lessening session fees in times of client financial hardship	2.34 (.70)	2.13 (.70)	36(24.3%)	5(3.4%)	107(72.3%)	
18. Retaining a patient for treatment longer than needed	1.35 (.59)	1.93 (.79)	39 (26.4%)	83 (56.1%)	26 (17.6%)	
19. Running into patient outside of therapy and saying hi	2.00 (.74)	2.05 (.76)	61 (41.5%)	18 (12.2%)	68 (46.3%)	
20. Having pictures of family members in counseling office	2.04 (.88)	2.18 (.87)	54 (36.5%)	2 (1.4%)	92 (62.2%)	
21. Not sharing diagnosis with client (secrecy)	1.71 (.70)	1.76 (.82)	30 (20.5%)	86 (58.9%)	30 (20.5%)	Combine with item (#51) as example, Similar frequencies
22. Not sharing concerns of risky behavior with clients parents because client asked you not to	1.71 (.59)	1.84 (.72)	41 (28.5%)	6 (45.8%)	37 (25.7%)	
23. Attending client milestone (i.e., graduation/wedding)	1.71 (.59)	1.58 (.68)	96 (65.3%)	24 (16.3%)	27 (18.4%)	
24. Holding a dual relationship with client (i.e., they are also your dentist, friend, son's teacher, etc.)	1.36 (.51)	1.50 (.68)	65 (44.2%)	75 (51%)	7 (4.8%)	
25. Accepting client friend request on Facebook	1.09 (.30)	1.50 (.68)	49 (33.3%)	97 (66.0%)	1(.7%)	
26. Providing client with false hope	1.28 (.52)	1.65 (.69)	40 (27.4%)	75 (51.4%)	31 (21.2%)	Redundancy with item (#37), similar frequencies
27. Giving client food to try/share during session	1.62 (.53)	1.52 (.61)	67 (45.6%)	15 (10.2%)	65 (44.2%)	
28. Sharing upcoming travel plans with patient when they ask	1.97 (.49)	1.87 (.70)	77 (52.4%)	3 (2.0%)	67 (45.6%)	Combined with item (#2) as example, Similar frequencies

Scale Item Reduction

	Acceptability M (SD)	Frequency M (SD)	Crossing N (%)	Violation N (%)	Neither (%)	Reason for exclusion
29. Engaging in foul language/swear words in session with client	1.97 (.64)	1.91 (.79)	51 (34.7%)	6 (4.1%)	90 (61.2%)	Not foundational, Over 60% 'neither'
30. Not reporting abuse right away because your client says/fear will make their situation worse	1.20 (4.2)	1.55 (.66)	17 (11%)	121 (83.4%)	7 (4.8%)	
31. Breaking confidentiality	1.44 (.42)	1.50 (.60)	25 (17.2%)	102 (70.3%)	18 (12.4%)	
32. Texting on phone while in session with client	1.11 (.33)	1.30 (.53)	48 (32.7%)	73 (49.7%)	26 (17.7%)	Not foundational, Low Variability
33. Not planning for session	1.72 (.67)	2.04 (.84)	41 (28.5%)	26 (18.1%)	77 (53.5%)	
34. Therapist-client sexual contact	1.03 (.20)	1.27 (.50)	5 (3.4%)	141 (95.9%)	1 (.7%)	
35. Texting with client outside of session about a clinical matter	1.57 (.56)	1.72 (.68)	64 (43.5%)	44 (29.9%)	39 (26.5%)	Combined item (#6), Similar frequencies
36. Responding to client concern via telephone outside of office hours	2.03 (.50)	1.90 (.67)	70 (47.9%)	7 (4.8%)	69 (47.3%)	Combined with item (#6)
37. Leaving session at same time as client – walk out to cars together	1.79 (.64)	1.62 (.71)	60 (41.1%)	1 (.7%)	85 (58.2%)	
38. Using client/family member/friend who is a provider you need (an orthodontist/mechanic, etc.)	1.40 (.64)	1.40 (.58)	91 (61.9%)	38 (25.9%)	18 (12.2%)	
39. Start seeing client's siblings/friend/cousin as a patient	1.89 (.67)	1.92 (.73)	66 (46.2%)	26 (18.2%)	51 (35.7%)	
40. Find ways to agree with majority of what client says/avoid confrontation	1.54 (.56)	1.92 (.79)	57 (39.0%)	36 (24.7%)	53 (36.3%)	
41. Provide client with personal email	1.28 (.48)	1.58 (.73)	90 (61.6%)	36 (24.7%)	20 (13.7%)	Combined item (#9) Similar frequencies
42. Talk with family members about client conversations because you are concerned	1.45 (.56)	1.77 (.73)	46 (31.7%)	78 (53.8%)	21 (14.5%)	Participant feedback, Age dependent
43. Do work for clients (i.e., call a psychiatrist to make them appt.)	1.85 (.57)	1.85 (.71)	65 (44.2%)	10 (6.8%)	72 (49.0%)	

Scale Item Reduction

	Acceptability M (SD)	Frequency M (SD)	Crossing N (%)	Violation N (%)	Neither (%)	Reason for exclusion
44. Share opinion (i.e., "you should divorce him")	1.37 (.57)	1.75 (.81)	72 (50.0%)	54 (37.5%)	18 (12.5%)	
45. Look up client or client family members on social media	1.32 (.55)	1.82 (.84)	77 (52.7%)	52 (35.6%)	17 (11.6%)	
46. Greeting client with kiss on cheek	1.12 (.33)	1.31 (.62)	46 (31.3%)	93 (63.3%)	8 (5.4%)	Not foundational, Low variability
47. Introducing client to significant other	1.25 (.43)	1.24 (.46)	63 (43.2%)	68 (46.6%)	15 (10.3%)	Not foundational, Low variability
48. Talking about past client similar challenges	1.85 (.57)	1.79 (.70)	57 (38.8%)	24 (16.3%)	66 (44.9%)	
49. Talking about similar past personal experiences	1.96 (.38)	1.84 (.66)	75 (51.0%)	3 (2.0%)	69 (46.9%)	
50. Taking food/trying food from client	1.64 (.48)	1.55 (.63)	74 (50.3%)	10 (6.8%)	63 (42.9%)	Combined with item (#27), Similar frequencies
51. Lying to client when feeling as if it will benefit them	1.28 (.47)	1.56 (.72)	58 (39.5%)	66 (44.9%)	23 (15.6%)	
52. Expressing emotion with client (crying)	2.02 (.63)	1.87 (.67)	49 (33.6%)	7 (4.8%)	90 (61.6%)	
53. Flirting with client	1.04 (.20)	1.40 (.60)	16 (10.9%)	127 (86.4%)	4 (2.7%)	Not foundational, Low variability
54. Sharing struggles of your own with client	1.64 (.51)	1.61 (.63)	83 (57.6%)	27 (18.8%)	34 (23.6%)	
55. Write note of clearance to help client out (i.e. writing plane note for service dog, bariatric surgery)	2.07 (.75)	2.03 (.81)	32 (22.1%)	19(13.1%)	94 (64.8%)	
56. Having a phone/video session	2.37 (.73)	2.14 (.80)	24 (16.4%)	2(1.4%)	120 (82.2%)	Not foundational, Heavily viewed as 'neither'

Scale Item Reduction

	Acceptability M (SD)	Frequency M (SD)	Crossing N (%)	Violation N (%)	Neither (%)	Reason for exclusion
57. Letting client dictate session	2.30 (.65)	2.37 (.72)	27 (18.6%)	6 (4.1%)	112 (77.2%)	Not foundational, Heavily viewed as 'neither'
58. Putting the client in a lose-lose situation	1.13 (.33)	1.32 (.55)	27 (18.6%)	91 (62.8%)	27 (18.6%)	Participant feedback, too vague

Table 4

Categories of Boundary Behaviors

Self-Disclosure	Active Behavior	Passive Behavior	Physical Contact	Professional Violations	Post-Termination	Immediacy Behaviors	Dual Relationships
Talking about similar past experiences	Giving a client a gift	Letting client dictate session	Counselor physical contact (give hug, hand over hand)	Failing to seek supervision or consultation	Keeping a personal relationship after termination	Giving out personal telephone/email	Accepting client social media request
Cry in session with client	Giving your patient a ride home	Accepting gift from client	Therapist-client sexual contact	Not reporting abuse right away because your client says will make their situation worse	Transfer client to unknown therapist at termination	Extending session times beyond allotted	Holding a dual relationship with client (i.e., they are also your dentist, friend, son's teacher, etc.)
Sharing struggles of own with client	Visiting suicidal patient at home	Having pictures of family members in counseling office	Greeting with a kiss	Write note of clearance to help client out (i.e., writing plane note for service dog, bariatric surgery)		Responding to/talking with client about clinical matters outside of session (via phone or text)	Using client family member/friend who is a provider you need (a dentist/mechanic etc.)
Sharing personal opinion	Flirting with client	Not planning for session		Failure to refer out when needed		Running into patient outside of therapy and saying hi	Participating in same social activity as client (i.e., book club, gym)
Self-disclose personal information (i.e., travel plans)	Lessening session fees	Find ways to agree with majority of what client says/avoid confrontation		Retaining a patient for treatment longer than needed		Do work for clients (i.e. call a psychiatrist to make them appt.)	Attending client milestone (i.e., graduation/wedding)

Categories of Boundary Behaviors

Self-Disclosure	Active Behavior	Passive Behavior	Physical Contact	Professional Violations	Post-Termination	Immediacy Behaviors	Dual Relationships
Introducing client to significant other	Sharing food in session	Engaging in foul language/ swear words in conversation with client		Breaking confidentiality			Looking up client or client family members on social media
Talking about past client similar challenges	Walking out to cars together			Start seeing client's siblings/friend/cousin as a patient Lying to client when feel will benefit with them (i.e., not sharing diagnosis with client) Providing client with false hope Providing phone/video session			

CHAPTER III: METHOD

Participants

Participants included counseling professionals recruited from counseling groups on online social media outlet, Facebook ('Professional Mental Health Counselors, Social Workers, and Psychologist' group, 'New York Mental Health Counselors Association'), as well as the counseling online listservs American Counseling Association (ACA) and Counselor Education and Supervision Network (CESTNET), as well as counseling providers advertised on Psychology Today. Each was provided with a Qualtrics survey link and estimated time of survey 8-10 minutes. The final sample included 342 participants (85.9% female, 13.2% male, and .9% were categorized as 'other' including 'non-binary' and 'demi-girl' responses). The age of participants ranged from 27 to 51 years (M= 39.32, SD = 12.24) including Licensed Mental Health Counselors (68.6%), Licensed Clinical Social Workers (13.2%), Licensed Marriage and Family Therapists (3.2%), Licensed Psychologists (5.6%), and counselor trainees eligible for licensure (9.4%). Most participants reported currently seeing therapy clients (82.4%) with the remaining who had practiced in the past (17.65), all with at least 3 months of face-to-face contact. The majority of participants reported their ethnicity as White and European American (72.5%), followed by Black and African American (9.5%), Hispanic or Latino (5.9%), Asian or Asian American (5.3%), Multiracial (44%), with remaining participants categorized as 'other' (2.4%) (Those who reported religions such as 'Jewish' and other responses not indicating specific ethnic group). See Table 5 and 6 for further descriptive information on practice setting, years of experience, and theoretical orientation (those categorized as 'other' included participants who endorsed counseling *techniques* rather than orientation, such as motivational interviewing,

or theories or approaches that fell under no particular orientation such as social learning, positive psychology, and trauma-informed).

Table 5

Participant Demographic Information: Study II

	N (%)
Gender	
Female	292 (85.9)
Male	45 (13.2)
Other	3 (.9)
Currently Seeing Clients	
Yes	280 (82.4)
Not currently, but have in past	60 (17.6)
Profession	
Licensed Mental Health Counselor	234 (68.6)
Licensed Clinical Social Worker	45 (13.2)
Student/Trainee	32 (9.4)
Licensed Psychologist	19 (5.6)
Licensed Marriage Family Therapist	11 (3.2)
Ethnicity	
White and European American	245 (72.5)
Black and African American	32 (9.5)
Hispanic or Latino	20 (5.9)
Asian and Asian Americans	18 (5.3)
Multiracial	15 (4.4)
Other	8 (2.4)
Theoretical Orientation	
CBT	159 (46.6)
Humanistic	88 (25.8)

Psychodynamic	46 (13.5)
Multimodal	12 (3.5)
Other	11 (3.2)
Attachment	8 (2.3)
Solution Focused	8 (2.3)
Family Systems	7 (2.1)
Play	2 (.6)
Grief Therapist	
No	326 (95.3)
Yes	16 (4.7)
Practice Setting	
Private practice	123 (36)
Community Mental Health	72 (21.1)
Agency	51 (14.9)
Multiple Settings	41 (12)
Higher Level Care	30 (8.8)
School	25 (7.3)

Note. Valid percentages were used to account for missing data

Table 6

Participant Demographic Information Cont.: Study II

	Mean	SD	Min	Max	Skew	Kurtosis
Age	39.32	12.24	21	74	.86	-.06
Years of Experience	9.19	9.32	0	48	1.84	3.28

Measures

Demographics. A demographics questionnaire was provided gathering basic profile (gender, age, ethnicity) and work-related information (if currently seeing clients or had in past for at least 3-months, profession within the field, years of experience, theoretical orientation, indicate if grief therapist, and practice setting).

Attachment Style. Individual attachment style was measured using the 36-item Experiences in Close Relationship –Revised Scale (ECR-R; Fraley, Waller, & Brennan, 2000) The ECR-R is 36-item self-report measure encompassing two subscales of anxiety (18 items) and avoidance (18 items) and rated on a Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). Sample items from the subscale of anxiety include: "I am afraid that I will lose my partner's love," "I worry a lot about my relationships," and "my desire to be very close sometimes scares people away." Example questions for the subscale of avoidance include: "I prefer not to show a partner how I feel deep down," "I am nervous when others get too close to me," and "I feel comfortable sharing my private thoughts and feelings with my partner". Fairchild & Finney (2006) confirmed the ECR-R to have high internal consistency on both anxiety ($\alpha = .917$) and avoidance subscales ($\alpha = .927$). Validity of the ECR-R was tested through examination of the ECR-R and the Relationship Questionnaire (RQ; Bartholomew & Harowitz, 1991) by Sibley, Fischer, and Liu (2005). The RQ is a self-report questionnaire which measures four categories of adult attachment (secure, preoccupied, fearful, and dismissing) on a 9-point Likert scale. The avoidance measures for the ECR-R and RQ were moderately positively correlated, $r = .45$ as were the anxiety measures for the ECR-R and RQ, $r = .69$ (Sibley et al, 2005). For the current dataset, internal consistency was found to be good with Cronbach's alpha coefficients with $\alpha = .88$ on the Anxiety dimension and $\alpha = .92$ on the Avoidance dimension. The anxious attachment

scale items had a (*M*= 2.99, *SD*= .98) with a min-max of 1.00-6.22, skewness of .61, and kurtosis of -.16. Avoidance attachment had a (*M*= 2.99, *SD*= 1.01) with a min-max of 1.11-6.22, skewness of .35, and kurtosis of -.24. Individual descriptive item statistics are presented in table 7.

Empathy. Participant empathy was measured through the 20-item self-report measure, The Basic Empathy Scale for Adults (BES-A) (Carré, Stefaniak, D'ambrosio, Bensalah, & Besche-Richard, 2013). It is a self-report survey adapted from The Basic Empathy scale originally designed to measure both cognitive and affective components of empathy in adolescents (Jolliffe & Farrington, 2006*).* Validated for use with adults (Carré et al., 2013), the BES-A has been validated to be used as a 2-factor model (cognitive and affective empathy) or a 3-factor model, incorporating 3 types of empathy (emotional contagion, cognitive empathy, and *emotional disconnect*). The 2-factor model will be used based off of interested variables. The BES-A is rated on a 5-point Likert scale ranging from 1 ("strongly disagree") to 5 ("strongly agree") with higher scores indicating greater empathy. There are 9 items for cognitive empathy (e.g., *I can usually understand how they feel),* and 11 items for affective empathy (e.g., *I don't become sad when I see other people cry*). Internal consistency was found to be good with Cronbach's alpha coefficients ranging from α= .69 to α= .82 in a population of French adults (Carré et al., 2013). Adequate test-retest reliability was demonstrated with correlations ranging from .56 to .74 over a seven-week period (Carré et al., 2013). For the current dataset, the internal consistency was found to be appropriate with Cronbach's alpha coefficients for overall empathy α= .79, cognitive empathy α= .73, and affective empathy α= .81. For the current dataset, there was a grand empathy (*M*= 3.82, *SD*= .362) with a response minimum of 3.05 and response maximum of 4.95, skewness of .51, and a kurtosis of .14. Items that made up affective empathy had overall (*M*=

3.47, *SD* =.54) with a min-max of 2.18-4.91, skewness of .20, and a kurtosis -.22. The cognitive empathy dimension has overall (*M*= 4.23, *SD*= .37) with a min-max 3.11-5., skewness of .14, and kurtosis of -.31. Individual descriptive item statistics are presented in table 8.

Counselor Boundaries. Counselor boundaries was measured through the self-constructed, 40-item Counseling Practice Questionnaire (CPQ), to assess counselor's reported frequency or hypothetical frequency of varying boundary behaviors presented within the therapeutic context. The (CPQ) asks participants to endorse how frequently or hypothetically how frequently they engage in each of these behaviors within the therapeutic relationship, on a 7-point Likert scale, scale range 1= never to 7= always. A higher score indicates a participant who engages in more boundary behaviors than a participant with a lower score. There are 6 subscales to include 5-items of *'Self-disclosure'* (a= .77) described as personal information counselor reveals to/shares with the client (e.g., 'Sharing a struggle of own with client'), 5-items of *'Dual relationships'* (a= .67), which represent the counselor having an additional social role in the client's life besides counselor (e.g., 'participate in same social events'), 5-items of '*Reciprocal Behavior' (a= .71),* which resembles giving and receiving type actions between counselor and client (e.g., 'accepting gift'), 5-items of '*Over and Beyond' (a= .66),* describing counselor extension of their work role beyond what is expected (e.g., 'giving patient ride home'), 5-items of '*Availability' (.68),* or an action where the counselor is making themselves more available to client (e.g., 'speaking clinical matters outside session'), and 3-items of *Personal Motives (.59)* which describe actions for self versus caregiving (e.g., 'retain patient longer than needed', 'do not plan for session'). For the current dataset (N= 342), internal consistency was found to be good (α= .88) with a grand boundary behavior (*M*= 2.07, *SD*= .54) and a min-max of 1.03- 3.93, skewness of .69, and kurtosis of .25. Individual descriptive item statistics are presented in table 9.

Table 7

Experiences in Close Relationships Scale Item Information

	M	SD	Min	Max	Skewness	Kurtosis
ECR Items						
1. I'm afraid that I will lose the love of others	3.26	1.84	1	7	.56	-.76
2. I often worry that other people will not want to stay with me	3.01	1.83	1	7	.67	-.63
3. I often worry that other people don't really love me	2.76	1.77	1	7	.87	-.27
4. I worry that other people won't care about me as much as I care about them	3.40	1.83	1	7	.43	-.87
5. I often wish that other people's feelings for me were as strong as my feelings for him or her	3.31	1.89	1	7	.45	-.95
6. I worry a lot about my relationships	3.14	1.72	1	7	.61	-.46
7. When other people are out of my sight, I worry that they might become interested in someone else	2.12	1.41	1	7	1.31	1.06
8. When I show my feelings for other people, I'm afraid they will not feel the same about me	2.96	1.65	1	7	.61	-.46
9. I rarely worry about people leaving me	4.48	1.91	1	7	-.24	-1.19
10. Other people make me doubt myself	3.34	1.75	1	7	.37	-.79
11. I do not often worry about being abandoned	4.68	2.04	1	7	-.48	-1.09
12. I find that people don't want to get as close as I would like	2.66	1.66	1	7	.81	-.32
13. Sometimes people change their feelings about me for no apparent reason	2.34	1.55	1	7	1.18	.67
14. My desire to be very close sometimes scares people away	1.98	1.32	1	7	1.58	2.09
15. I'm afraid that once someone gets to know me, he or she won't like who I really am	2.64	1.79	1	7	.89	-.34

Experiences in Close Relationships Scale Item Information

	M	SD	Min	Max	Skewness	Kurtosis
16. It makes me mad that I don't get the affection and support I need from my people	2.62	1.71	1	7	.84	-.37
17. I worry that I won't measure up to other people	3.23	1.95	1	7	.46	-1.04
18. People only seem to notice me when I'm angry	1.95	1.32	1	7	1.55	2.05
19. I prefer not to show people how I feel deep down	3.31	1.79	1	7	.40	-.81
20. I feel comfortable sharing my private thoughts and feelings with other people	3.38	1.67	1	7	.46	-.56
21. I find it difficult to allow myself to depend on other people	4.27	1.76	1	7	-.13	-.94
22. I am very comfortable being close to other people	2.97	1.54	1	7	.53	-.34
23. I don't feel comfortable opening up to other people	2.89	1.62	1	7	.77	-.07
24. I prefer not to be too close to other people	2.46	1.42	1	7	.85	-.01
25. I get uncomfortable when another person wants to be very close	2.73	1.54	1	7	.74	-.10
26. I find it relatively easy to get close to other people	3.26	1.47	1	7	.34	-.43
27. It's not difficult for me to get close to other people	3.11	1.48	1	7	.52	-.14
28. I usually discuss my problems and concerns with other people	3.33	1.67	1	7	.43	-.59
29. It helps to turn to others in times of need	2.27	1.39	1	7	1.08	.81
30. I tell other people just about everything	4.56	1.74	1	7	-.30	-.88
31. I talk things over with other people	2.94	1.44	1	7	.59	-.31
32. I am nervous when people get too close to me	2.49	1.35	1	7	.82	-.08
33. I feel comfortable depending on other people	4.11	1.59	1	7	.13	-.71
34. I find it easy to depend on other people	4.39	1.55	1	7	-.07	-.71
35. It's easy for me to be affectionate with other people	2.99	1.57	1	7	.57	-.28

Experiences in Close Relationships Scale Item Information

	M	SD	Min	Max	Skewness	Kurtosis
36. People really understand me and my needs	3.93	1.41	1	7	.40	-.31

Note. Items 20, 22, 26, 27, 28, 29, 30, 31, 33, 34, 35, 36 responses reverse coded.

Table 8

Basic Empathy Scale Item Information

	M	SD	Min	Max	Skewness	Kurtosis
BES Items						
1. My friends' emotions don't affect me much	3.67	.94	1	5	-.84	-.11
2. After being with a friend who is sad about something, I usually feel sad	3.19	.97	1	5	-.27	-1.21
3. I can understand my own friends' happiness when they do well at something	4.54	.62	1	5	-1.97	8.19
4. I get frightened when I watch characters in a good scary movie	3.78	1.10	1	5	-.10	.216
5. I get caught up in other people's feelings easily	2.91	1.10	1	5	.32	-1.12
6. I find it hard to know when my friends are frightened	4.20	.68	1	5	-1.08	2.91
7. I don't become sad when I see other people crying	3.66	.95	1	5	-.84	.113
8. Other people's feelings don't bother me at all	4.15	.70	1	5	-1.08	2.54
9. When someone is feeling 'down' I can usually understand how they feel	4.29	.58	1	5	-.77	3.49
10. I can usually work out when my friends are scared	3.94	.69	1	5	-.79	2.01
11. I often become sad when watching sad things on TV or in films	3.75	1.00	1	5	-.91	.129
12. I can often understand how people are feeling even before they tell me	4.08	.73	2	5	-.89	1.33
13. Seeing a person who has been angered has no effect on my feelings	3.87	.78	2	5	-.95	.934
14. I can usually work out when people are cheerful	4.20	.64	1	5	-.55	1.37
15. I tend to feel scared when I am with friends who are afraid	2.57	.93	1	5	-.65	-.47
16. I can usually realize quickly when a friend is angry	4.31	.59	1	5	-.82	3.28

Basic Empathy Scale Item Information

	M	SD	Min	Max	Skewness	Kurtosis
17. My friend's unhappiness doesn't make me feel anything	4.08	.54	1	5	-.85	5.33
18. I am usually not aware of my friends' feelings	4.21	.79	1	5	-1.74	4.97
19. I have trouble figuring out when my friends are happy	4.34	.59	1	5	-.68	2.52

Note. Items 1, 6, 7, 8, 13, 18, 19, 20 responses reverse coded to ensure higher numbers reflected more empathy

Table 9

Counseling Practice Questionnaire Scale Item Information

	M	SD	Min	Max	Skewness	Kurtosis
CPQ Items						
1. Accept gift from client	2.69	1.48	1	7	.90	-.01
2. Give client a gift	1.83	1.17	1	7	1.69	2.63
3. Self-disclose personal information (e.g., sharing upcoming travel plans)	3.42	1.40	1	7	.30	-.52
4. Share struggles of own with client	2.56	1.45	1	7	.692	-.49
5. Use non-romantic physical contact (e.g., hug, putting hands on shoulder, hand over hand)	2.55	1.49	1	6	.82	-.41
6. Therapist-client sexual contact	1.01	.12	1	3	14.83	230.39
7. Fail to seek supervision/consultation to keep client disclosure private	1.40	.97	1	7	3.35	13.02
8. Break confidentiality (beyond reporting abuse, neglect, or harmful behavior)	1.34	.88	1	7	4.46	24.30
9. Speak to/respond to client about clinical issues outside of session (via text, phone)	2.90	1.65	1	7	.60	-.66
10. Respond to client email after treatment termination	2.82	1.91	1	7	.94	-.31
11. Keep a personal relationship after treatment termination	1.23	.60	1	5	3.19	11.51
12. Do not refer out client when better suited with more qualified provider for problem	1.79	1.55	1	7	2.26	4.21
13. Extend session beyond time allotted	3.33	1.41	1	7	.37	-.67
14. Give out personal phone number/email	1.59	1.29	1	7	2.55	6.14
15. Leave session at same time as client – walk out to cars together	1.64	1.09	1	6	2.05	4.02
16. Visit patient at home (e.g., suicidal client, client unable to get to session)	1.98	1.63	1	7	1.72	1.88

Counseling Practice Questionnaire Scale Item Information

	M	SD	Min	Max	Skewness	Kurtosis
17. Give your patient a ride home	1.27	.88	1	7	4.42	21.59
18. Participate/stay in same social activity (e.g., book club, gym class)	1.42	.91	1	7	2.82	9.03
19. Lessen session fees in times of financial hardship	3.31	1.84	1	7	.24	-1.07
20. Retain a patient for treatment longer than needed	1.68	1.05	1	6	1.83	3.17
21. Run into patient outside of therapy and say hi	2.77	1.69	1	7	.73	-.46
22. Having pictures of family members in office	1.96	1.68	1	7	1.78	2.08
23. Do not share concerns of risky behavior with clients parents because client asked you not to	2.55	1.65	1	7	.96	.14
24. Attend client milestone (e.g., graduation/wedding/recital)	1.95	1.31	1	7	1.33	.85
25. Hold dual relationship with client (also your friend, dentist, child's teacher)	1.34	.79	1	6	2.89	9.13
26. Look up client or client family members on social media/google	1.96	1.24	1	7	1.37	1.41
27. Accept client friend request on personal social media account	1.10	.49	1	7	7.95	79.21
28. Share food during session	1.63	1.05	1	7	2.01	4.39
29. Do not report abuse right away because your client says will make their situation worse	1.34	.90	1	7	3.47	14.83
30. Do not plan for session	2.55	1.44	1	7	.76	-.11
31. Use client's family or friend as provider (dentist, mechanic, car salesman)	1.25	.68	1	5	3.15	10.26
32. See client's family member or friend as a new patient	2.28	1.43	1	6	.89	-.27
33. Find ways to agree with majority of what client says/avoid confrontation	2.14	1.13	1	6	.98	.48
34. Do extra client tasks/extra work for them (e.g., call a psychiatrist to make them appt.)	2.05	1.32	1	7	1.4	1.48

Counseling Practice Questionnaire Scale Item Information

	M	SD	Min	Max	Skewness	Kurtosis
35. Share personal opinion (e.g., "you should divorce him")	2.18	1.13	1	7	1.2	1.73
36. Talk about past client's similar challenges	2.54	1.54	1	7	.89	-.22
37. Talk about similar past personal experiences	2.54	1.27	1	7	.92	.59
38. Omit information from client when feel will benefit client (i.e., do not share diagnosis)	2.57	1.52	1	6	.66	-.77
39. Cry in session with client	2.12	1.26	1	6	1.08	.47
40. Write note of clearance to help client out when asked but not necessarily needed (i.e., service dog letter)	2.01	1.42	1	7	1.49	1.53

Procedure

The primary researcher will submit the research proposal to Institutional Review Board (IRB) through Pace University for the approval to conduct this study. Through the means of posting on counseling listservs: American Counseling Association, CESNET, and Psychology Today, participants will include licensed mental health counselors, social workers, psychologists, marriage and family therapists, and student trainees, required to have worked with patients with one-on-one face contact for a minimum of three months. Each participant will be provided a questionnaire that includes a cover letter describing the purpose of the study, a statement of informed consent, and a copy of the following four measures: Demographic Questionnaire, The Basic Empathy Scale for Adults (BES-A), Experiences in Close Relationships Revised (ECR-R), and a self-constructed counselor boundary behaviors measure, Counseling Practice Questionnaire (CPQ) asking participants to self-report their personal frequency or hypothetical frequency of boundary behaviors done throughout their practice with clients. The demographic questionnaire that reflects demographic and descriptive information will include gender, age, ethnicity, if they currently see clients, months/years in practice, practice location/setting, participant's primary theoretical orientation, and will ask if they primarily practice grief therapy. Upon completion, the online survey will end and participant's answers/data will automatically be recorded on Qualtrics.

Statistical Analyses

The principle variables of interest in this analysis were counselor attachment (attachment related anxiety, attachment related avoidance) and empathy (cognitive and affective), while other independent variables included demographic factors such as counselor theoretical orientation,

counselor years of experience, gender, therapy type, and practice setting. The principle dependent variable was counselor-endorsed frequency of boundary behaviors in practice.

Descriptive statistics were analyzed to calculate the mean values and standard deviations for all independent and dependent variables. Pearson's correlations were calculated for all variables to explore the magnitude and direction of all interrelationships. Based on the above hypotheses, a number of relationships will be of primary interest. First, correlations were conducted to determine the demographic variables relationship to boundary behaviors.

Hierarchical regressions were performed to analyze the contributions of the independent variables to boundary behaviors. Based on the hypotheses that counselor empathy and attachment style provides incremental predictive value in the prediction of more boundary behaviors over and above demographic variables, the regression model looked at demographic variables in step one, counselor attachment anxiety and avoidance while controlling for demographics in step two, and counselor empathy while controlling for demographics and attachment anxiety and avoidance in step three.

CHAPTER IV: RESULTS

Factor Analysis

An exploratory factor analysis was conducted to determine what, if any, underlying structure exists for the self-created Counseling Practice Questionnaire (40-boundary behavior items). Principal components analysis was conducted utilizing a Varimax rotation, initially identifying 11 components. Four criteria were used to determine the appropriate number of components to retain: eigenvalue, variance, scree plot, and counseling theory. After examining the above criteria, 6 components were retained. Cronbach's alpha statistic was calculated to establish the internal consistency of scale items. All 40 items together had a Cronbach alpha of $\alpha = .88$.

After rotation, the first component accounted for 19.89 % of response variance, second 5.31%, third 4.95%, fourth 4.43%, fifth 4.06 %, sixth 3.86%, totaling 42.5%. Component 1 was named *Self-disclosure*. Items loading on this component (5-items) are described as personal information/opinion counselor reveals to/shares with the client (e.g., 'Sharing a struggle of own with client', 'sharing past personal experience'). Component 2, *Dual Relationships,* includes 5-items which represent the counselor having an additional social role in the client's life besides counselor (e.g., 'participate in same social events', 'keep personal relationship after treatment termination'). Component 3 *Reciprocal Behavior*, encompasses 6-items which resembles giving and receiving type actions between counselor and client (e.g., 'accepting gift', 'non-romantic physical contact', 'sharing food'). Component 4, *Over and Beyond,* has 5-items which describe counselor extending their work role beyond what is expected (e.g., 'giving patient ride home', 'attending client milestone'). Component 5, *Availability,* has 5-items which describe an action where the counselor is making themselves more available to client (e.g., 'speaking clinical

matters outside session', 'responding to email after treatment termination') Lastly, Component 6, *Personal Motive Behaviors*, includes 4-items which describe actions counselors engage in for self versus caregiving nature for client (e.g., 'retain patient longer than needed', 'do not plan for session'). Table 10 presents descriptive and alphas and Table 11 displays the factor loadings.

Table 10

Descriptive Statistics for Boundary Behavior Subscales

	No. of Items	N	Min	Max	Mean	Std. Deviation	Skewness	Kurtosis	Alpha
Self-Disclosure	5	342	1.00	5.80	2.65	.98	.81	.61	.77
Dual Relationships	5	342	1.00	5.00	1.58	.65	1.82	4.50	.67
Reciprocal Behaviors	6	342	1.00	5.33	2.26	.87	.77	.27	.71
Over and Beyond	5	342	1.00	7.00	2.13	.89	1.74	4.56	.66
Availability	5	342	1.00	6.20	2.45	1.05	.79	.17	.68
Personal Motives	4	342	1.00	5.00	2.08	.83	.84	.37	.59

Table 11

Factor Loadings for Boundary Behavior Category Items

	Factor Loadings						
Items	Self-Disclosure	Dual Relationships	Reciprocal Behaviors	Over and Beyond	Availability	Personal Motives	Non-Component Items
3. Self-disclose personal information (e.g., sharing upcoming travel plans)	.622						
4. Share struggles of own with client	.794						
36. Talk about past client's similar challenges	.559						
35. Share personal opinion (e.g., "you should divorce him")	.539						
37. Talk about similar past personal experiences	.794						
11. Keep a personal relationship after treatment termination		.518					
18. Participate/stay in same social activity (e.g., book club, gym class)		.688					
25. Hold dual relationship with client (also your friend, dentist, child's teacher)		.629					
31. Use client's family or friend as provider (dentist, mechanic, car salesman)		.775					
32. See client's family member or friend as a new patient		.459					

Factor Loadings for Boundary Behavior Category Items

Items	Self-Disclosure	Dual Relationships	Reciprocal Behaviors	Over and Beyond	Availability	Personal Motives	Non-Component Items
1.Accept gift from client			.481				
2. Give client a gift			.500				
5. Use non-romantic physical contact (e.g., hug, putting hands on shoulder, hand over hand)			.729				
21. Run into patient outside of therapy and say hi			.583				
28. Share food during session			.523				
39. Cry in session with client			.320				
13. Extend session beyond time allotted				.301			
16. Visit patient at home (e.g., suicidal client, client unable to get to session)				.731			
17. Give your patient a ride home				.709			
24. Attend client milestone (e.g., graduation/wedding/recital)				.354			
34. Do extra client tasks/work for them (e.g., call a psychiatrist to make them an appt.)				.608			
9. Speak to/respond to client about clinical issues outside of session (via text, phone)					.609		
10. Respond to client email after treatment termination					.556		
14. Give out personal phone number/email					.703		

Factor Loadings for Boundary Behavior Category Items

Items	Self-Disclosure	Dual Relationships	Reciprocal Behaviors	Over and Beyond	Availability	Personal Motives	Non-Component Items
15. Leave session at same time as client – walk out to cars together					.472		
19. Lessen session fees in times of financial hardship					.561		
20. Retain a patient for treatment longer than needed						.512	
26. Look up client or client family members on social media/google						.496	
30. Do not plan for session						.704	
33. Find ways to agree with majority of what client says/avoid confrontation						.644	
6. Therapist-client sexual contact							--
7. Fail to seek supervision/consultation to keep client disclosure private							--
8. Break confidentiality (beyond reporting abuse, neglect, or harmful behavior)							--
12. Do not refer out client when better suited with more qualified provider for problem							--
22. Having pictures of family members in office							--

Factor Loadings for Boundary Behavior Category Items

Items	Self-Disclosure	Dual Relationships	Reciprocal Behaviors	Over and Beyond	Availability	Personal Motives	Non-Component Items
23. Do not share concerns of risky behavior with clients parents because client asked you not to							--
27. Accept client friend request on personal social media account							--
26. Look up client or client family members on social media/google							--
29. Do not report abuse right away because your client says will make their situation worse							--
38. Omit information from client when feel will benefit client (i.e., do not share diagnosis)							--
40. Write note of clearance to help client out when asked but not necessarily needed (e.g., service dog letter)							--

Note. Any items that do not fall in categories go into overall composite

Preliminary Analyses

Descriptive statistics (means, standard deviations, correlations) for all of the study variables are displayed in Table 12. A number of significant correlations were found.

As shown in Table 12, anxious attachment and overall empathy were significantly positively correlated (r =.21), while avoidant attachment and overall empathy were significantly negatively correlated (r = -.11). Moderately correlated was a significant positive relationship between anxious attachment and affective empathy (r= .30).

Overall boundaries and gender were negatively correlated when males coded as 0 and females as 1 (r = -.14). Counselor years of experience and practice setting were demographics that correlated to overall boundaries, as well as the most boundary behavior subscales. Counselor years of experience was significantly positively correlated to overall boundaries (*r*= .33) as well as boundary behavior subscales *Self-Disclosure* (*r*= .17), *Dual Relationships* (*r*= .24), *Reciprocal Behaviors* (*r*= .39), *Over and Beyond* (*r* =.14), and *Availability* (*r*= .35). Practice setting was significantly positively correlated to overall boundaries (r =.17) and boundary subscales of *Self-Disclosure* (r= .14), *Dual Relationships* (r = .18), *Availability* (r= .35), while negatively correlated to *Over and Beyond* (r = -.11).

Finally, no significant correlations were found between empathy and overall boundaries, anxious attachment and overall boundaries, or avoidant attachment and overall boundaries.

Table 12

Means, Standard Deviations, and Intercorrelations for Study Variables

Measure	N	M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1. Gender	340	-	-	-																
2. Age	339	39.32	12.24	-.02	-															
3. Years of Experience	342	9.20	9.32	-.13*	-.03	-														
4. Theoretical Orientation	341	--	--	-.01	.05	-.09	-													
5. Practice Setting	342	--	--	-.05	-.07	.33*	.03	-												
6. Overall Empathy	342	3.82	.36	.20**	-.07	-.14*	-.05	-.06	-											
7. Affective Empathy	342	3.47	.54	.21**	-.06	-.15*	-.05	-.01	.89**	-										
8. Cognitive Empathy	342	4.23	.37	.07	-.05	-.03	-.03	-.10	.59**	.15**	-									
9. Anxious Attachment	342	3.00	.98	.09	.04	-.20**	-.09	-.11*	.21**	.30**	-.07	-								
10. Avoidant Attachment	342	3.30	1.00	.07	.04	-.18**	.06	-.13*	-.11*	-.07	-.10	.35**	-							
11. Overall Boundaries	342	2.07	.54	-.14**	.02	.33**	-.10	.17**	.06	.08	-.02	.10	-.07	-						
12. Self-Disclosure	342	2.65	.98	-.14**	.01	.17**	-.03	.14**	.06	.06	.03	.08	-.14**	.71**	-					
13. Dual Relationships	342	1.50	.61	-.14**	.04	.24**	-.13*	.18**	.01	.02	.00	.03	-.03	.66**	.39**	-				
14. Reciprocal Behavior	342	2.26	.87	-.02	-.06	.39**	-.11*	.10	.09	.10	.01	.08	-.14*	.75**	.50**	.44**	-			
15. Over and Beyond	342	2.13	.89	-.03	.03	.14**	-.05	-.11*	.08	.09	.01	.06	-.01	.68**	.34**	.35**	.44**	-		
16. Availability	342	2.45	1.05	-.01	-.04	.35**	-.04	.35**	.04	.03	.04	-.02	-.06	.73**	.34**	.48**	.45**	.41**	-	
17. Personal Motives	342	2.10	.83	-.04	.04	.08	-.15**	.05	.04	.11*	-.12*	.20**	.00	.58**	.34**	.33**	.28**	.35**	.29**	-

Note. Gender coded as 1= female 0 = male
Theoretical orientation coded as 1= Cognitive Behavioral Therapy 0 = All other (Psychodynamic, Humanistic)
Practice setting coded as 1= private practice 0 = all others (Community Mental Health, Hospital, School, Higher level care (hospital, residential, intensive outpatient), school, multiple settings

Hypothesis Testing

The relationship between theoretical orientation and boundary behaviors

Hypothesis 1a predicted that therapists identifying with a cognitive behavioral theoretical orientation would positively predict having reported to engage in more boundary behaviors than all other theoretical orientations reported. Cognitive behavioral theoretical orientation explained .7% of the variance in boundary behaviors, F (1, 339) = 3.3, p = .067, R^2 = 0.7%. Individual predictor variable results are reported in Table 13 showing that contrary to the hypothesis, while not statistically significant, a Cognitive Behavioral theoretical orientation shows counseling professionals having engaged in less boundary behaviors.

Table 13

Summary of Regression Analysis of CBT Theoretical Orientation Prediction of Boundary Behaviors

Predictor	*B* (95% CI)	*SE B*	Beta	*t*	*p*
Cognitive Behavioral Therapy	-0.1 [-0.22, 0.01]	.05	-0.09	-1.8	.067

Note. Theoretical orientation coded as 1= Cognitive Behavioral Therapy 0 = All other (Psychodynamic, Humanistic)

Theoretical Orientation Exploratory Hypotheses

For exploratory purposes, the predictive relationship between cognitive behavioral theoretical orientation and all boundary behavior subscales were examined. Individual predictor variable results are reported in table 14 revealing that cognitive behavioral orientation significantly negatively predicts dual relationships, reciprocal behaviors, and personal motives.

As two additional exploratory hypotheses, we compared the reported frequency of boundary behaviors of psychodynamic and humanistic theoretical orientations. Psychodynamic orientation explained .4% variance of boundary behaviors, F (1, 339) = 2.21, p = .137, R^2 = 0.004. Humanistic orientation explained -.1% variance of boundary behaviors, F (1, 339) = .062, p = .429, R^2 = -0.001. Individual predictor variable results are reported in table 15 and 16 demonstrating null findings when examining the relationship between theoretical orientation and boundary behaviors.

Table 14

Summary of Regression Analysis of CBT Prediction of Boundary Behavior Subscales

	B (95% CI)	SE *B*	Beta	*t*	*p*
Overall Boundaries	-.09 [-.19, .01]	.05	-.09	-1.84	.067
Self-Disclosure	-.01 [-.07, .04]	.03	-.03	-.50	.620
Dual Relationships	-.11 [-.19, -.02]	.04	-.13	-2.43	.016
Reciprocal Behaviors	-.07 [-.13, -.01]	.03	-.11	-2.12	.035
Over and Beyond	-.03 [-.09, .03]	.03	-.05	-.84	.401
Availability	-.02 [-.07, .03]	.03	-.04	-.78	.435
Personal Motives	-.09 [-.15, -.03]	.03	-.15	-2.74	.007

Table 15

Summary of Regression Analysis of Psychodynamic Theoretical Orientation Prediction of Boundary Behaviors

Predictor	*B* (95% CI)	*SE B*	Beta	*t*	*p*
Psychodynamic Orientation	0.13 [-0.04, 0.30]	0.09	0.08	1.49	.137

Note. Theoretical orientation coded as 1= Psychodynamic, 0 = All other (Cognitive Behavioral, Humanistic)

Table 16

Summary of Regression Analysis of Humanistic Theoretical Orientation Prediction of Boundary Behaviors

Predictor	*B* (95% CI)	*SE B*	Beta	*t*	*p*
Humanistic Orientation	.05 [-0.08, 0.19]	0.07	0.04	0.79	.429

Note. Theoretical orientation coded as 1= Humanistic, 0 = All other (Cognitive Behavioral, Psychodynamic)

The relationship between years of experience and boundary behaviors

Hypothesis 1b predicted that providers with fewer years of experience will engage in fewer boundary behaviors with their clients than those with more years of experience. Years of experience explained 10.6% of the variance in boundary behaviors, F (1, 340) = 41.48, $p < .001$, R^2= 0.106. Individual predictor variable results are reported in table 17 showing that years of experience significantly predicted boundary behaviors in a positive direction. As predicted, counseling professionals with less years of experience engage in fewer boundary behaviors. For exploratory purposes, years of experience was examined in relation to all boundary behavior subscales. Individual predictor variable results are reported in table 18 revealing that more years of experience significantly predicted subscales of overall boundaries, self-disclosure, dual relationships, reciprocal behaviors, over and beyond, and availability.

Table 17

Summary of Regression Analysis of Counseling Professional Years of Experience Prediction of Boundary Behaviors

Predictor	*B* (95% CI)	SE *B*	Beta	*t*	*p*
Years of Experience	.02 [0.01, 0.03]	0.00	.33	6.44	<.001

Table 18

Summary of Regression Analysis of Years of Experience Prediction of Boundary Behavior Subscales

	B (95% CI)	SE *B*	Beta	*t*	*p*
Overall Boundaries	.02 [.01, .03]	.00	.33	6.44	.000
Self-Disclosure	.02 [.01, .03]	.01	.17	3.21	.001
Dual Relationships	.02 [.01, .02]	.00	.25	4.65	.000
Reciprocal Behaviors	.04 [.03, .05]	.01	.39	7.76	.000
Over and Beyond	.01 [.00, .02]	.01	.14	2.63	.009
Availability	.04 [.03, .05]	.01	.35	6.86	.000
Personal Motives	.01 [-.00, .02]	.01	.08	1.40	.163

The relationship between provider gender and boundary behaviors

Hypothesis 1c stated female providers will positively predict having engaged in more boundary behaviors with their clients than male providers. Gender explained 1.7% of the variance in boundary behaviors F (1, 338) = 7.01, p = .008, R^2= 0.17. Men reported engaging in boundary behaviors (N = 45, M = 2.28, SD= *.56*) more often than women (N = 292, M = 2.03, SD =*.54*). Overall, male providers reported engaging in more boundary behaviors compared to female providers. For exploratory purposes, all boundary behavior subscales were examined in relation to gender. Individual predictor variable results are reported in table 19 revealing that gender significantly predicted overall boundary behaviors, self-disclosure, and dual relationships. Results show male counseling providers engage in overall boundaries, self-disclosure, and dual relationships more than female providers.

Table 19

Summary of Regression Analysis of Gender Prediction of Boundary Behavior Subscales

	B (95% CI)	SE *B*	Beta	*t*	*p*
Overall Boundaries	-.21 [-.37, -.05]	.08	-.14	-2.65	.008
Self-Disclosure	-.38 [-.66, -.10]	.14	-.14	-2.64	.009
Dual Relationships	-.23 [-.41, -.06]	.09	-.14	-2.60	.010
Reciprocal Behaviors	-.05 [-.31, .21]	.13	-.02	-0.37	.712
Over and Beyond	-.06 [-.32, .20]	.13	-.03	-0.48	.635
Availability	-.28 {-.58, .02]	.15	-.10	-1.82	.069
Personal Motives	-.09 [-.33, .14]	.12	-.04	-0.78	.436

Note. Gender was coded as 1 = female, 0 = male

The relationship between practice setting and boundary behaviors

Hypothesis 1d stated providers in private practice will positively predict having engaged in more boundary behaviors with their clients than other practice settings. Private practice setting explained 2.5% of the variance in boundary behaviors, F (1, 340) = 9.90, p = .002, R^2= 0.25. Individual predictor variable results are reported in table 20 showing private practice setting significantly predicted boundary behaviors in a positive direction. Counseling providers working in private practice reported engaging in more boundary behaviors (N = 123, M = 2.19, SD =.55) than those working in other settings such as community mental health center, higher level care (including Inpatient, Hospital, and Residential), School, Multiple Settings (N = 219, M = 2.00, SD = .53).

Table 20

Summary of Regression Analysis of Practice Setting Prediction of Boundary Behaviors

Predictor	*B* (95% CI)	*SE B*	Beta	*t*	*p*
Private Practice verses Other	.19 [.07, .31]	.06	.17	3.15	.002

Note. Practice setting coded as private practice = 1, all others = 0 (Community Mental Health, Hospital, School, Higher level care (hospital, residential, intensive outpatient), school, multiple settings

The relationship between attachment-related anxiety and attachment-related avoidance and boundary behaviors

It was hypothesized (2a) that those higher in attachment-related anxiety report engaging boundary behaviors more frequently. A linear regression found attachment related anxiety explained 0.6% of the variance in boundary behaviors, F (1, 340) = 3.21, p = .074, R^2= .006. An additional attachment hypothesis (2b) predicted attachment-related avoidance will negatively predict boundary behaviors. Attachment related avoidance explained 0.2% of the variance in boundary behaviors, F (1, 340) = 1.65, p = .20, R^2 = .002. Neither attachment related anxiety or avoidance significantly predicted engagement in boundary behaviors. Separate analyses were done for each individual predictor, but results are reported together in table 21.

Table 21

Summary of Regression Analyses Attachment-related Anxiety and Avoidance Prediction of Boundary Behaviors

Predictor	*B* (95% CI)	*SE B*	Beta	*t*	*p*
Attachment anxiety	.05 [-.005, .113]	0.30	.097	1.79	.074
Attachment avoidance	-.04 [-.096, .020]	.029	-.069	-1.28	.200

Note. Results from two separate linear regressions

Lastly, hypothesis 2c predicted counselor attachment style will incrementally predict boundary behaviors over and above counselor demographic factors. To further examine the relationship between demographics, counselor attachment style, and boundary behaviors, a hierarchical multiple regression was performed in two steps with boundary behaviors as the dependent variable. As shown in Table 22, the first step included the demographic variables of practice setting (private practice versus others), theoretical orientation (cognitive behavioral therapists versus others, psychodynamic versus others, humanistic versus others), gender, and years of experience. The second step controlled for all of the demographic variables in step one and added avoidant attachment and anxious attachment. The hierarchical multiple regression revealed that in step one demographic variables did significantly contribute to the regression model, F (6, 332) = 8.983, $p < .001$ which accounted for 12.4% of the variance in boundary behaviors. In this step years of experience was a significant predictor of boundary behaviors, β = .31, $p < .001$ as well as gender, β = -.11, p = .041. Results indicate counseling professionals with more years of experience engage in more boundary behaviors as well as males engage in more boundary behaviors. In step 2, introducing avoidant and anxious attachment to the regression model explained an additional 2.8% of the variance in boundary behaviors. This change in R^2 was significant, F (8, 330) = 8.338, p = < .001. In this second step, years of experience, β = .33, $p < .001$ and gender, β = -.11, p = .028 remained significant predictors of boundary behaviors, with anxious attachment emerging as a significant predictor of boundary behaviors, β = .19, $p < .001$ suggesting those counseling professionals higher in anxiety related attachment engage in more boundary behaviors.

Table 22

Summary of Hierarchical Regression Analysis for Demographics, Counselor Attachment Style, and Boundary Behaviors (N= 339)

Variable	B (95% CI)	SE	β	R^2	ΔR^2
Step 1				.12**	.12**
Practice Setting (Private vs. other)	.08 [-.05, .20]	.06	.07		
Theoretical Orientation (CBT vs. other)	.03 [-.14, .19]	.09	.02		
Theoretical Orientation (Psychodynamic vs. other)	.14 [-.07, .35]	.11	.09		
Theoretical Orientation (Humanistic vs. other)	.14 [-.05, .32]	.09	.11		
Gender	-.16 [-.31, -.01]	.08	-.11*		
Years of Experience	.02 [.01, .02]	.00	.31**		
Step 2				.15**	.03**
Practice Setting (Private vs. other)	.08 [-.04, .20]	.06	.07		
Theoretical Orientation (CBT vs. other)	.04 [-.13, .20]	.08	.03		
Theoretical Orientation (Psychodynamic vs. other)	.15 [-.06, .36]	.10	.09		
Theoretical Orientation (Humanistic vs. other)	.11 [-.07, .30]	.09	.09		
Gender	-.17 [-.31, -.02]	.08	-.11*		
Years of Experience	.02 [.01, .03]	.00	.33**		
Avoidance Attachment	-.03 [-.08, .03]	.03	-.05		
Anxious Attachment	.10 [.04, .16]	.03	.19**		

Note. **$p < .01$ *$p < .05$, Adjusted R^2 used for less biased estimate

Attachment Exploratory Hypothesis

Past research reveals those with anxious attachment engage in more self-disclosure, and particularly, inappropriate self-disclosure in adult relationships (Bartholomew, 1983). For exploratory purposes, the hypothesis that counselors who are high in anxious attachment will report having had more self-disclosure boundary behaviors, (measured by the self-disclosure subscale on the Counseling Practice Questionnaire) was examined.

Given the earlier relationships discovered with private practice setting, gender, and years of experience, these variables were entered into the model as control variables. A hierarchical multiple regression was performed in two steps with self-disclosure as the dependent variable. As shown in Table 23, the first step included the demographic variables mentioned above while the second step controlled for all of the demographic variables in step one and added anxious attachment. The hierarchical multiple regression revealed that in step one demographic variables significantly contributed to the regression model, F (3, 336) = 6.03, p = .001 which accounted for 4.3% of the variance in self-disclosure. In this step gender, β = -.12, p = .02 and years of experience, β = .12, p = .03 were significant predictor of self-disclosure. When anxious attachment was added in step 2, it significantly explained an additional 1.5% variance of self-disclosure, F (4, 335) = 5.93, p <.001, R^2 = .055.

Table 23

Regression Analysis Summary for Counselor Anxious Attachment and Counselor Self-Disclosure (N= 339)

Variable	B (95% CI)	SE	β	R^2	ΔR^2
Step 1				.04**	.04**
Practice Setting (Private vs. other)	.19 [-.04, .42]	.12	.09		
Gender	-.32 [-.61, -.04]	.14	-.12*		
Years of Experience	.01 [.00, .03]	.00	.31*		
Step 2				.06*	.02*
Practice Setting (Private vs. other)	.20 [-.02, .43]	.12	.10		
Gender	-.34 [-.62, -.06]	.14	-.13*		
Years of Experience	.02 [.00, .03]	.01	.10**		
Anxious Attachment	.13 [.02, .23]	.05	.13*		

Note. $^{**}p < .01$ $^{*}p < .05$
Adjusted R^2 used for less biased estimate

The relationship between counselor empathy and boundary behaviors

Hypothesis 3a predicted a significant relationship between overall empathy and boundary behaviors, however, this was not found (see table 12). Hypothesis 3b predicted that those higher in affective empathy would predict engagement in boundary behaviors and cognitive empathy would not predict engagement in boundary behaviors. A linear regression found empathy explained .3% of the variance in boundary behaviors, F (2, 339) = 1.45, p = *.236*, R^2= .003. Individual predictor variable results are reported in table 24. Neither affective nor cognitive empathy significantly predicted boundary behaviors when looked at in isolation.

Table 24

Summary of Regression Analyses Affective and Cognitive Empathy Prediction of Boundary Behaviors

Predictor	*B* (95% CI)	*SE B*	Beta	*t*	*p*
Affective empathy	.09 [-.02, .20]	.06	.09	1.65	.101
Cognitive empathy	-.05 [-.21, .10]	.08	-.04	-0.68	.496

Note. Results from two separate linear regressions

To examine hypothesis 3c, that counselor empathy will incrementally predict more boundary behaviors over and above attachment and counselor demographic factors, a hierarchical regression was performed in three steps with boundary behaviors as the dependent variable. As shown in Table 25, the first step included the demographic variables of practice setting (private versus others), gender, and years of experience. The second step controlled for all of the demographic variables in step one and added avoidant and anxious attachment. The third step controlled for all the demographic variables in step one and attachment variables in step two and added cognitive and affective empathy. The hierarchical multiple regression revealed that in step one demographic variables significantly contributed to the regression model, F (3, 336) =

15.78, p <.001 which accounted for 11.6% of the variance in boundary behaviors. Both gender, β = -.101, p = .05 and years of experience, β = .295, p <.001 significantly predicted boundary behaviors in this step. Introducing avoidant and anxious attachment to the regression model in step 2 explained an additional 2% of the variance in boundary behaviors. This change in R^2 was significant, F (5, 334) = 12.362, p = .002. In this second step, gender, β = -.11, p = .031, and years of experience, β = .32, p < .001, remained significant predictors of boundary behaviors, with anxious attachment emerging as a significant predictor of boundary behaviors, β = .196, p < .001. Introducing affective and cognitive empathy to the regression model did not substantially increase predictive ability as it explained an additional 1.1% of the variance in boundary behaviors. This change in R^2 was not significant F (7, 332) = 9.53, p = .109, but still fit the model data. Despite a non-significant change in R^2, affective empathy did significantly predict boundary behaviors over and above attachment style and provider demographics when looked at without cognitive empathy in the model.

Table 25

Summary of Hierarchical Regression Analysis for Demographics, Counselor Attachment, and Counselor Empathy Prediction of Boundary Behaviors

Variable	B (95% CI)	SE	*B*	R^2	ΔR^2
Step 1				.12**	.12**
Practice Setting (Private vs. Other)	.08 [-.04, .20]	.06	.07		
Gender	-.15 [-.30, -.00]	.08	-.10*		
Years of Experience	.02 [.01, .02]	.06	.07**		
Step 2				.14*	.02*
Practice Setting (Private vs. Other)	.08 [-.04, .20]	.06	.07		
Gender	-.16 [-.31, -.02]	.08	-.11*		
Years of Experience	.02 [.01, .03]	.00	.30**		
Avoidant Attachment	-.03 [-.09, .03]	.03	-.06		
Anxious Attachment	.11 [.05, .17]	.03	.20**		
Step 3				.15	.01
Practice Setting (Private vs. other)	.08 [-.04, .20]	.06	.07		
Gender	-.19 [-.34, -.04]	.08	-.13**		
Years of Experience	.02 [.01. 03]	.00	.33**		
Avoidant Attachment	-.02 [-.08, .04]	.03	-.04		
Anxious Attachment	.09 [.02, .15]	.03	.16**		
Cognitive Empathy	-.00 [-.15, .15]	.08	-.00		
Affective Empathy	.12 [.07, .23]	.06	.12*		

Note. $^{**}p < .01$ $^{*}p < .05$
Adjusted R^2 used for less biased estimate

CHAPTER V: DISCUSSION

Summary of results

Therapeutic boundaries are widely regarded by counseling professionals as a crucial part of the therapeutic context (Aravind, Krishnaram, & Thasneem, 2012; Dailey, 2017; Gelso & Hayes, 1998; Luchner, Mirsalimi, Moser, & Jones, 2008). The ways in which providers maintain boundaries can benefit or harm the therapeutic relationship and/or therapeutic outcome (Smith & Fitzpatrick, 1995). Past research and case studies have looked at the influence of counselor demographics (counselor gender, practice setting, counselor theoretical orientation, and years of experience) in relation to boundary behaviors, mainly of a dual relationship nature (Averill et al., 1989; Baer & Murdock, 1995; Goldman, 2009; Kitson & Sperlinger, 2007; Robitschek & McCarthy, 1991; Stewart and Chambless, 2008). However, few studies examine counselor demographics across a wide range of boundary behaviors, and even fewer assessing counselor *personality* characteristics and their influence on boundary behaviors. Nonetheless, both counselor empathy (Moyer & Miller, 2013; Norcross & Wampold, 2011; Rogers, 1957) and counselor attachment patterns have been found to be influential to the counselor-client dyad as well as the therapeutic process (Black, Hardy, Turpin, & Pary, 2005; Bucci et al., 2016).

The first goal of this study was to add more empirical evidence to the limited literature on boundary behaviors within the counseling context. This study set out to further examine counselor demographic variables shown to influence boundary behaviors, in addition to, counselor personality characteristics. Specifically, counselor empathy (affective and cognitive), as well as counselor attachment patterns (attachment anxiety and attachment avoidance) were explored in their relationship to boundary behaviors. Lastly, as existing boundary scales have notable limitations, another goal was to create a comprehensive yet concise boundary behavior

scale to include a wider range of boundary behaviors that counseling professionals encounter throughout day to day practice.

Indeed, this study yielded some interesting and important findings. First, the 40-item Counseling Practice Questionnaire (CPQ) was developed and used to measure counselor boundary behaviors. Although it requires continued validation analysis, it shows promising potential to measure counselor boundary engagement. It is a rather useful measure when looking at a wide range of boundary behaviors, to include minor boundary behaviors that arise in day-to-day practice to more severe counselor actions. Further, the measure revealed six boundary subscales which could be used for future research specific to one boundary area, such as self-disclosure or dual relationships. The Counseling Practice Questionnaire (CPQ) can also be used as an educational instrument to increase counselor awareness in counselor training programs and ethics courses.

Study findings revealed counselor demographics such as gender, years of experience, and practice setting yielded statistically significant relationships with overall boundary behaviors. Specifically, male counseling professionals, those with more years of clinical experience, and those providers working in private practice reported engaging in more boundary behaviors, when examined at the bivariate level. Contrary to what was hypothesized, however, theoretical orientation showed a non-significant relationship with boundary behaviors. When demographics were analyzed holistically, years of experience and counselor gender remained statistically significant predictors of boundary behaviors, whereas practice setting no longer predicted boundary behaviors. One possible reason private practice setting did not predict boundary behaviors, despite previous research suggesting this pattern (Epstein, Simon, & Kay, 1992), is due to the strength of the prediction between years of experience and boundary behavior

endorsement. Perhaps providers with more years of experience are also more likely to work in private practice settings. Additional possible explanations are described in further detail below.

While both counselor attachment and counselor empathy were not significantly predictive of boundary behaviors at the bivariate level, counselor attachment anxiety and affective empathy emerged as predictors of greater engagement in boundary behaviors after controlling for counselor demographics. Pandey and Elliot (2010) explain bivariate results only paint a partial picture of the relationship between predictor-outcome variables. Further, they share Bertan & Holder's (1988) words that "the whole regression can be greater than the sum of parts" (p. 371). As cited in Pandey and Elliot (2010), researchers including Courville & Thompson (2001) and Shieh (2006) report a predictor variable that shows a non-significant correlation to the outcome variable can sometimes improve the variance in a multiple regression model. Ultimately, this study supports the idea that individuals higher in attachment-related anxiety and affective empathy may cross more boundaries with their clients, when controlling for other predictive variables such as gender and years of experience.

Demographics and Boundary Behaviors

Gender. Contrary to our hypothesis, the data revealed male counseling providers to cross more counseling boundaries than female counseling providers. While past research/case studies identified males to engage in more boundary behaviors, most of these studies focused solely on sexual transgressions or other types of dual relationships within the counseling relationship (Baer & Murdock, 1995; Borys & Pope, 1989; Gartrell, Herman, Olarte, Feldstein, & Localio, 1986). We assumed when examining a wider range of boundary behaviors, including subtle day-to-day crossings, females would report more possibly due to gender role characteristics to include acts

characterized by nurturance and warmth (e.g., extending session, saying hi outside of therapeutic setting, crying in session, accepting gift). However, it is possible that it may be more important to females to protect their boundaries in interpersonal relationships. Past research revealed female psychiatrists endorsed fewer boundary violations than male psychiatrists (Epstein, Simon, & Kay, 1992). Our study finding that male providers engage specifically more in self-disclosure behaviors (sharing personal information/opinion in session) as well as dual relationship behaviors (having an additional role in client's life besides provider) also aligns with other past research findings. Baer and Murdock (1995) found male therapists to rate non-erotic dual relationships with clients as more ethical than female therapists, such as providing therapy to a relative, friend, or lover of an ongoing client. Past research studies have also found male therapists to engage in more dual relationships than female providers (Holroyd & Brodsky, 1977; Borys & Pope, 1989; Bouhoutsos et al., 1983). Additionally, a dissertation on therapist self-disclosure found male therapists to be significantly more willing to disclose than female therapists (Bianco, 2007), as other past research found that male counselors to report more self-disclosure with male clients (Anderson & Mandell, 1989).

Practice Setting. Our findings showed those counseling providers practicing in a private practice setting versus other settings as a whole (Community Mental Health, Higher level care (Inpatient, Hospital, and Residential), School, Multiple Settings) engage in more boundary behaviors. Past case studies of sexual boundary-breaking providers provide some support to our current findings, as Goldman (2009) shares the consistent profile of the transgressor involves those who were working in solo practice setting at the time. A survey of clinical psychologists also revealed those who view dual relationships as less professionally appropriate were those providers not

practicing as a solo provider (Kitson & Sperlinger, 2007). It has also been suggested providers working in private practice settings may be at greater risk of engaging in boundary behaviors because of the isolated environment and little oversight (Luchner, Misralimi, Moser, & Jones, 2008) so engage more feely in any desired behaviors.

It is important to mention, however, private practice setting was found as a significant predictor of boundary behavior only when examined in a bivariate manner, and not a significant predictor when examined among other significant demographic predictors (gender, years of experience). It is also possible that there is a different relationship to boundary behaviors between solo private practitioners and group private practitioners which we did not differentiate in our data collection. Solo providers are the ones solely responsible for any outcomes associated with boundary crossings and may be extra careful. Borys and Pope's (1989) finding support this idea as solo private practitioners rated social/financial involvements with clients as significantly less ethical than did group private practitioners.

Years of Experience. Our study reveals of all demographics, counselor years of experience had the greatest predictive value to boundary behaviors. Findings revealed more years of experience significantly predicted all boundary subscales, except *Personal Motives*, suggesting the majority of boundary behaviors increase as counseling professional's advance in experience. This finding adds to the current literature's mixed findings on this topic. However, Kitson and Sperlinger's (2007) research supported our findings, as they found counselors with more years of experience view dual relationships as more professionally appropriate than recently qualified counselors. Similarly, their study revealed counselor years of experience accounted for the largest amount of variance (4.8%) of attitude scores towards boundaries, when considering all demographics (years

of experience, theoretical orientation, rural or urban practice setting, gender, had been in therapy, if live in different area of clients). This finding was also supported by a national study of psychologists, psychiatrists, and social worker's attitudes on dual relationships, as they found respondents with 30 more years of experience rated dual professional roles as significantly more ethical than those with less than 10 years of experience (Borys & Pope, 1989). As previously suggested by other researchers. it is possible that those counseling professionals with more experience come across more boundary situations and become less sensitive in how they handle them, and question themselves less as time goes on (Kitson & Sperlinger, 2007). Lastly, it can also be argued that those with more years of experience no longer require counseling supervision hours that is required to attain licensure, which aids in appropriate clinical decision-making.

Theoretical Orientation. Although different theoretical orientations encompass a variety of therapeutic techniques and impact the way sessions are structured, the present study found a counselor's theoretical orientation only weakly predicted counselor boundary behaviors. While it was noted that cognitive behavioral counselors cross slightly more boundaries, no theoretical orientations examined (CBT, Psychodynamic, Humanistic) showed a consistent relationship with boundary behaviors. As cognitive behavioral therapists only have a few practices which may resemble boundary behaviors (exposure therapy and practicing outside of the office, use of self-disclosure), they may not be enough to be a strong predictor. It is also considered that because professional boundaries are a resurging topic in the media and counseling, counseling professionals may have developed a heightened awareness leading to extra cautious behavior, regardless of theoretical orientation. Lastly, boundary behaviors may more heavily depend on counselor ethics training verses an adopted theoretical orientation.

Attachment-related anxiety and attachment-related avoidance and boundary behavior

Although attachment showed no significant relationship to counselor boundary behaviors at the bivariate level, attachment anxiety emerged as significant predictor of boundary behaviors when controlling for demographics. At this multivariate level, it is possible attachment anxiety acts as a suppressor variable; a predictor that does not correlate with the outcome variable in isolation, but is correlated with one or more predictors that are correlated with the outcome variable. As cited in Pandey and Elliot (2010), Tzelgov and Henik (1991) explain "these variables are called suppressors because they suppress outcome-irrelevant variance in other predictors, causing the suppressed variables to obtain a substantial regression weight" (p. 29). In this study, anxious attachment correlated with years of experience at the bivariate level, such that less experienced counselors also reported higher levels of anxious attachment. Thus, after partialing out this connection in a regression framework, anxious attachment then emerges as significant predictor of boundary behaviors. Although counselors with more years of experience also endorsed engaging in more boundary behaviors, those counselors who report especially low anxious attachment styles may refrain from these boundary crossings despite their years of experience. Similarly, younger counselors may generally prefer to maintain stricter boundaries but this relationship may attenuate for less experienced counselors who also report higher levels of anxious attachment.

Counseling providers higher in anxiety attachment engaging in more boundary behaviors makes intuitive sense and could be explained by attachment research. The counselor high in attachment anxiety resembles a preoccupation with the clinical relationship, fears rejection or abandonment from their client, and therefore seeks reassurance, approval, and closeness within the therapeutic relationship, known as "hyper-activating" strategies (Bartholomew & Horowitz,

1991; Bucci, Roberts, Danquah, & Berry, 2015; Dinger et al., 2009). Such actions in the therapeutic context may resemble certain boundary behaviors. Counselors who are higher in this specific attribute may tend to engage in more boundary behaviors to stay close to and satisfy the client to fulfill their own anxious driven relationship needs, possibly without even realizing. As an exploratory finding, it was particularly interesting to find those higher in attachment anxiety reported more boundary behaviors specifically of a self-disclosure nature within the therapeutic relationship. Our research finding aligns with past research that shows those with higher attachment anxiety profiles tend to self-disclose more in personal relationships (Bartholomew, 1983).

Contrary to our hypothesis, there was no significant finding of avoidant attachment as a predictor of boundary behaviors. This may be explained by the idea that counselors entering the counseling profession most likely score lower on avoidance as the profession itself involves working directly with individuals, forming some type of therapeutic relationship, and confronting intimate therapeutic issues.

Empathy and Boundary Behaviors

Contrary to our hypothesis, overall empathy did not show significant predictive value to engagement in boundary behaviors. Although a past research study noted a *lack* of empathy among a boundary-breaking provider, this was when reviewing a single case study involving a sexual transgression (Averill et al., 1989). Therefore, it was thought that when examining empathy among a wider range of boundary behaviors, that high levels of empathy might lead to crossing more boundaries in order to ameliorate counselor/client distress (e.g., extending a session, lessening a session fee, or accepting an invitation to a client wedding). There are several

possible reasons this finding was not found. As researchers argue empathy requires a self-other distinction (Wondra & Ellsworth, 2015), one explanation may be lower empathy individuals may not have enough empathy to distinguish between self-other boundaries, while those with more empathy do. Lastly, as it has been shown that those with higher levels of overall empathy also have better emotional regulation skills (Panfile & Laible, 2012) it is possible that these providers can still care for a client and can also maintain sound and ethical decision making.

Results revealed no relationship between empathy (overall, cognitive, and affective) and boundary behaviors at the bivariate level. However, when controlling for demographic factors, different facets of empathy (e.g., affective vs. cognitive) do offer more insight into specifically what forms of empathy may predict engagement in boundary behaviors. Within the multiple regression framework, after controlling for practice setting, gender, and years of experience, affective empathy emerged as a significant predictor of boundary behaviors. Cognitive empathy remained a non-predictor. Similarly, anxious attachment failed to correlate with boundary behaviors in isolation. However, affective empathy acts as a suppressor variable, whose bivariate relationship to boundaries was non-significant, but gained regression weight when it suppressed outcome-irrelevant variance in other predictors at the multiple regression level. Specifically, this can happen when the variable is correlated strongly with another predictor variable (Pandey & Elliot, 2010; Tzelgov & Henik, 1991). In this particular study, affective empathy had a significant positive relationship with gender and a significant negative relationship to years of experience. Specifically, females tend to report more affective empathy and those with fewer years of experience also report more affective empathy. While it was instead found that those with greater years of experience and males endorsed boundary behaviors, those counselors who report on the upper end of affective empathy may engage in boundary behaviors despite years of

experience or gender. When cognitive empathy was removed from the model all together, affective empathy added statistically significant predictive ability of boundary behaviors.

This is an important finding as clinicians operating at high levels of empathy or affective sharing may come with a personal cost, as studies have revealed a positive link to emotional and physical counselor burnout (Eisenberg, 2000). Gerdes and Segal (2011) shared many social workers who have a very strong capacity to share in their clients' feelings have trouble detaching from their clients and ultimately take on many of the same burdens they are trying to ease. These researchers report such a degree of enmeshment is not constructive and has the potential to "prevent clear and constructive action" (Gerdes & Segal, 2011, p. 145).

Ultimately, the non-significant relationship between cognitive empathy and boundary behaviors may be what prevented the emergence of a predictive relationship between overall empathy and boundary behaviors. It is quite possible cognitive empathy is only predictive of boundary behaviors when looked at a specific level of empathy, particularly an interaction. In this sense, it may be the case that those counseling providers high in affective empathy may emotionally entangle themselves in client emotions leading them to do excessive actions typically outside of counseling norms. However, the presence of cognitive empathy and its associating characteristics may overpower or attenuate the effects of affective empathy. This idea is supported by several studies when looked at with medical provider's performing patient procedures involving pain. Specifically, studies have showed the affective aspect of empathy can be modified by higher order executive functioning to make the individual less dependent on their affective empathy inputs (Cheng et al., 2007; Decety, Yang, & Cheng, 2010). As cognitive empathy requires perspective-taking, interpersonal awareness and interpersonal sensitivity, which foster one's ability to make a good judgement about someone else (Carney & Harrigan,

2003), perhaps it is these properties that help individuals distance themselves from the emotional heat of a situation (Van Lissa, Hawk, & Meeus, 2017)

Strengths and Limitations

Strengths of this study included the large sample size, or number of counseling professionals captured who participated in this study, yielding stronger results. In addition, while the majority of participants were mental health counselors, the study included a wide range of counseling professionals (mental health counselors, psychologists, social workers, marriage and family therapists, and students in training) who all work one-on-one with clients, and therefore results better generalize to the counseling helping population as a whole. The boundary behavior scale created served as a strength as preliminary stages of validation demonstrated excellent internal consistency (a= .88) and added to the current literature of boundary scales. A unique feature of this scale was that it explored a broader range of boundary behaviors than previous scales while keeping it relatively short.

The results of this study could be generalized to a greater population if it included more male counseling professionals, as well as a more diverse ethnic background as the majority of participants were white females. The potential for a selection effect could have occurred when examining gender and boundary behaviors. Perhaps men who naturally engage in more boundary behaviors were more likely to opt to take the boundary survey compared to male providers who hold stricter boundaries (e.g., so strict that they may not even want to report the types of behaviors they engage in with their clients so opted out to take the survey. However, past counseling research examining ethics/boundaries among counseling professionals also report a predominantly female sample (Borys, 1988), as high as 80.1% (Nigro, 2001). The American

Psychological Association (2016) also reported the majority of psychology workforce encompasses 84% of white providers.

An additional limitation included all participant responses on each scale used were based on self-report. While the participants were guaranteed anonymity, there remains the possibility that their responses were influenced by social desirability such as choosing favorable/positive responses on boundary behavior, empathy, and attachment items. In addition, data collection was based off retrospective accounts where counseling professional participants were asked to reflect back on how frequently they cross certain boundaries, which can produce inaccurate information due to not remembering or remembering incorrectly. This could have also potentially been bettered captured by an observational design involving recording the occurrence of boundary crossings in session in real time or soon after they happened. However, the possible ethical implications of conducting such a study would be a tough hurdle to overcome. A true experiment on this subject matter would also be ethically questionable given that not all boundary behaviors are good or benign.

Future Directions

The topic of counseling boundary behaviors, however, is far from complete and researchers interested in continuing to study this area have many avenues to explore. First, the self-created 40-item Counseling Practice Questionnaire requires further validation to be used among researchers in this area. Ultimately, the 6 boundary subscales could be used for future research specific to one boundary area. The Counseling Practice Questionnaire as a whole can also be used as an educational instrument in counselor training programs and ethics courses.

Further study is also warranted to examine how counselor attachment styles and different types of empathy may interact in relation to boundary behaviors to better understand their combined effects on how boundaries are managed. Particularly interesting is the idea that cognitive empathy may serve as a buffer in lessening affective empathy's effects, and particularly in the context of boundary behaviors. Additional research would be interesting to look at the client perspective of boundary behaviors to get an inside view as to which boundary behaviors they view as facilitative or unhelpful in certain situations. While this study took a particular interest in counselor empathy and attachment in relation to boundary behaviors, there are other traits and characteristics that could have been explored, such as mindfulness, and counselor training. It is possible that differences in training models and advisors influence how providers view and maintain boundary behaviors. Mindfulness, in particular, has been shown to improve counseling professional's self-awareness, promote cognitive flexibility, increase empathy, and develop resiliency (Trammel, 2015). Specifically, when used by service providers, mindfulness "may also aid in the ethical decision-making process by helping calm reactive emotional states elicited when faced with complex issues in practice. As a result, its utility in practice is that it clarifies dilemmas and allows for a more intentional response, with the potential to help social workers avoid boundary violations that occur in our profession" (Trammel, 2015, p. 165). Ultimately, self-awareness is important to practicing a 'healthy' empathy and also identifying personal attachment needs that may be affecting our practice with clients.

As a variety of boundary violations continue to be reported, the topic of boundary behaviors is gaining resurgence in the counseling community (Afolabi, 2015). Therefore, a greater focus on boundary behaviors would be a critical component to add into counselor education programs, as well as supervision models. It would be helpful for counselors to be

aware of self-attributes, so they may be able to identify motivations behind their boundary behaviors and that their intent is the benefiting of the clients. Counselor education programs review how counselor *biases* have the potential to pollute the client experience (Abbott, 2003), however, an increased focus on counselor personality should be highlighted as well, especially in relation to boundary behaviors. While current educational models exist for avoiding exploitive dual relationships (Gottlieb, 1993), and others which contemplate how personal values reconcile with ethical decision making (Kocet & Herlihy, 2014), these models do not account for the influence of counselor personality traits, such as attachment and empathy. Nonetheless, empathy is a trait that is viewed as essential for benefits of the counseling relationship and therapeutic outcomes, largely lacking discussion of what too much could do.

Implications for Mental Health Counselors

While this study identified significant predictors for engagement in boundary behaviors, it is important to note that certain boundary crossings have been seen as beneficial to clients in the appropriate context (Pope & Spiegel, 2008), and is important to keep in mind holding a too rigid framework may also be harmful and take away from the counseling relationship (Lazarus, 1994; Zur, 2001). Therefore, counseling providers should be aware that operating at either extremity of the spectrum can create problems within the therapeutic relationship, and therefore engaging in certain boundary behaviors may be beneficial in certain client contexts. Nevertheless, when considering boundary decisions, it is helpful for counselors to first be aware of predictive demographic factors and one's own interpersonal factors and how they are playing out in the therapy room.

According to our study findings, counseling professionals who are male, and those with

more years of experience should keep in mind the increased risk they have in boundary behavior engagement and to be especially speculative when making boundary decisions. In addition, those who are have anxious attachment patterns and high in affective empathy should also be aware of their increase susceptibility to greater engagement in boundary behaviors. As mentioned earlier, it's possible these demographic factors and attributes may serve providers well at times in engaging in appropriate boundary behaviors that positively build the therapeutic alliance, however, the pattern of engaging in excess also have harmful potential and are a pattern all providers should recognize.

With the specific finding revealing male professionals and anxiously attached professionals engage in more self-disclosure, these particular professionals should place heightened awareness of incidents in when they are sharing, why they are sharing, and the content of self-disclosure that is used with clients. It is critical to carefully consider the clinical context before sharing, client diagnosis, being attune with inner desires or purpose of sharing, and distinguishing the need of the client versus the need of the counselor. As male professionals also reported engaging in more dual relationship boundary behaviors, these providers should also adopt increased self-awareness on actions that may lead to even minor forms of dual relationships with clients. Even while this not may be the intention of the provider, clients may interpret additional relationships as inappropriate or misleading.

Most importantly, the goal for any clinical practitioner is to minimize any potential harm done to clients or the treatment process (West, 2002). In doing so, it becomes crucial for providers to make time to self-reflect enough to identify emotions, feelings, and unconscious needs that can lead to excessive or inappropriate boundary behaviors, as is protective for both client and the counseling professional. Therefore, it is up to counseling professionals to consult

and seek supervision throughout ones counseling career, even and especially beyond required years. This consultation becomes important in recognizing own attachment needs as well as managing personal emotions that may pop up throughout treating clients with heartfelt stories that may trigger a counselor's past or high levels of emotional empathy. In fact, a study surveying clinical psychologists on dual relationships found professionals who view dual relationships as less appropriate are those who have experience personal therapy themselves and received more supervision (Kitson & Sperlinger, 2007). Having an outlet, time to process this, and time for self away from work is likely essential in de-tangling from client's emotions and keeping boundary behaviors at bay. Lastly, it is particularly important for counseling professionals to lay out boundaries in the beginning of the treatment to inform clients of their separate roles and responsibilities, as well as to hold themselves accountable to these lines.

Conclusion

Boundary behaviors have potential to blur lines between the counseling provider and client, and negatively impact the client, therapist themselves, and/or the treatment process. It is crucial for both novice and more seasoned practicing counselors to take note of factors that contribute to increased boundary behaviors. Our study reveals demographic, such as gender and years of experience, as well as interpersonal factors, such as levels of anxious attachment and affective empathy, play a role in how counseling providers maintain boundaries. Although there may be times when crossing a boundary may serve as an appropriate or even helpful avenue, there are also times when these are not well-received by clients, or even damaging to the therapeutic relationship and/or process. It is helpful for counseling professionals to recognize how often they are engaging in boundary behaviors to further explore and identify why and if it

is for the client's best interest only. Initiating such topics of conversation in clinical supervision, or seeking a supervisor, would be helpful to assess the impact of one's own personal characteristics on clinical decision making and client care.

Although at first glance overall empathy and attachment do not seem to drive a direct connection to engagement in boundary behaviors, further analyses suggest one's affective empathy and attachment anxiety could result in more boundary behaviors. It is important counseling providers are both mindful of and in tune with how emotionally involved they are with client's situations. Lambert and Glaser (2018) highlight the importance of R. C. Fox's (1959) original term of 'detached concern' when working with patients. Much research urges clinicians working with others to adopt 'detached concern', or a professional balance between concern and distance to serve as an emotional buffer in order to handle emotional stress (R.C. Fox, 1959). Perhaps this may aid in better preventing multiple boundary behaviors with potential negative effects for provider, client, and the treatment process.

REFERENCES

Afolabi, O. E. (2015). Dual relationships and boundary crossing: A critical issues in clinical psychology practice. International Journal of Psychology and Counselling, 7(2), 29-39.

Ainsworth, M. S., & Bowlby, J. (1991). An ethological approach to personality development. *American psychologist*, *46*(4), 333.

Alpert, J. L., & Steinberg, A. L. (2017). Sexual boundary violations: A century of violations and a time to analyze. *Psychoanalytic Psychology*, *34*(2), 144.

American Counseling Association. (2014) ACA Code of Ethics. Alexandria, VA: Author.

American Psychological Association. (2017, May). *Demographics of the U.S. Psychology Workforce*. Retrieved from https://www.apa.org/workforce/publications/16-demographics/report.pdf

Audet, C. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers?. *Counselling Psychology Quarterly*, *24*(2), 85-100. doi:10.1080/09515070.2011.589602

Angel, K. (2010). The history of 'female sexual dysfunction' as a mental disorder in the 20th century. *Current Opinion in Psychiatry*, *23*(6), 536-541. doi:10.1097/YCO.0b013e32833db7a1

Aravind, V. K., Krishnaram, V.D., & Thasneem, Z. (2012). Boundary crossings in clinical settings. *Indian journal of psychological medicine*, *34*(1), 21.

Ashby, G. A., O'Brien, A., Bowman, D., Hooper, C., Stevens, T., & Lousada, E. (2015). Should psychiatrists 'Google' their patients?. *BJPsych bulletin*, *39*(6), 278-283.

Averill, S. C., Beale, D., Benfer, B., Collins, D. T., Kennedy, L., Myers, J., ... & Zoble, E. (1989). Preventing staff-patient sexual relationships. *Bulletin of the Menninger Clinic*, *53*(5), 384.

Baer, B. E., & Murdock, N. L. (1995). Nonerotic dual relationships between therapists and clients: The effects of sex, theoretical orientation, and interpersonal boundaries. Ethics & Behavior, 5(2), 131-145. doi: 10.1207/s15327019eb0502_2

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: a test of a four-category model. Journal of personality and social psychology, 61(2), 226.

Barrett-Lennard, G. T. (1986). The Relationship Inventory now: Issues and advances in theory, method, and use.

Batson, C. D. (1991). The Altruism Question: Toward a Scientifique Answer.

Barnett, J. E. (2008). Mentoring, boundaries, and multiple relationships: Opportunities and challenges. *Mentoring & Tutoring: Partnership in Learning*, *16*(1), 3-16.

Batson, C. D., & Shaw, L. L. (1991). Evidence for altruism: Toward a pluralism of prosocial motives. *Psychological inquiry*, *2*(2), 107-122.

Bayer, T., Coverdale, J., & Chiang, E. (1996). A national survey of physicians' behaviors regarding sexual contact with patients. *Southern medical journal*, *89*(10), 977-982.

Barnett, J. E., Lazarus, A. A., Vasquez, M. J., Moorehead-Slaughter, O., & Johnson, W. B. (2007). Boundary issues and multiple relationships: Fantasy and reality. *Professional Psychology: Research and Practice*, *38*(4), 401a.

Baron-Cohen, S., & Wheelwright, S. (2004). The empathy quotient: an investigation of adults with Asperger syndrome or high functioning autism, and normal sex differences. *Journal of autism and developmental disorders*, *34*(2), 163-175.

Berkman, C. S., Turner, S. G., Cooper, M., Polnerow, D., & Swartz, M. (2000). Sexual Contact with Clients: Assessment of Social Workers' Attitudes and Educational Preparation. *Social Work*, *45*(3), 223–235.

Bertrand, P. V., & Holder, R. L. (1988). A quirk in multiple regression: the whole regression can be greater than the sum of its parts. *Journal of the Royal Statistical Society: Series D (The Statistician)*, *37*(4-5), 371-374.

Besser, A., & Priel, B. (2009). Emotional responses to a romantic partner's imaginary rejection: The roles of attachment anxiety, covert narcissism, and self-evaluation. Journal Of Personality, 77(1), 287-325. doi:10.1111/j.1467-6494.2008.00546.x

Bianco, J. A. (2007). Therapists' willingness to self-disclose as a function of theoretical orientation and client diagnosis. Columbia University.

Black, S., Hardy, G., Turpin, G., & Parry, G. (2005). Self-reported attachment styles and therapeutic orientation of therapists and their relationship with reported general alliance quality and problems in therapy. Psychology and Psychotherapy: Theory, research and practice, 78(3), 363-377.

Bleiberg, J. R., & Skufca, L. (2005). Clergy dual relationships, boundaries, and attachment. *Pastoral psychology*, *54*(1), 3-22.

Bloom, P. (2017). Empathy and its discontents. *Trends in cognitive sciences*, *21*(1), 24-31.

Bohart, A. C., Elliott, R., Greenberg, L. S., & Watson, J. C. (2002). Empathy.

Bohart, A. C., & Greenberg, L. S. (1997). *Empathy reconsidered: New directions in psychotherapy*. American Psychological Association.

Bohart, A. C., & Watson, J. C. (2011). Person-centered psychotherapy and related experiential approaches. In S. B. Messer & A. S. Gurman (Eds.), *Essential psychotherapies: Theory and practice. 3rd ed.* (pp. 1–38). New York, NY: Guilford Press.

Borys, D. S. (1988). *Dual relationships between therapist and client: A national survey of clinicians' attitudes and practices* (Doctoral dissertation, ProQuest Information & Learning).

Borys, D. S., & Pope, K. S. (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. *Professional Psychology: Research and Practice*, *20*(5), 283-293. doi:10.1037/0735-7028.20.5.283

Bouhoutsos, J., Holroyd, J., Lerman, H., Forer, B. R., & Greenberg, M. (1983). Sexual intimacy between psychotherapists and patients. *Professional Psychology: Research and Practice, 14*(2), 185-196. doi:10.1037/0735-7028.14.2.185

Bowlby, J. (1969). Attachment and loss: Vol. 1. Loss. *Nueva York: Basic Books*.

Bowlby, J. (1973). Attachment and loss, Vol. II. *Separation. Basic Books.*

Braswell, L., Kendall, P. C., Braith, J., Carey, M. P., & Vye, C. S. (1985). 'Involvement' in cognitive-behavioral therapy with children: Process and its relationship to outcome. *Cognitive Therapy and Research*, *9*(6), 611-630. doi:10.1007/BF01173021

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview.

Brodsky, A. M. (1989). Sex between patient and therapist: Psychology's data and response. *Sexual exploitation in professional relationships*, 15-25.

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.

Bruck, E., Arnold, W., Aderholt, S., & Muran, J. C. (2006). Predictive validity of patient and therapist attachment and introject styles. American Journal of Psychotherapy, 60(4), 393.

Bucci, S., Seymour-Hyde, A., Harris, A., & Berry, K. (2016). Client and therapist attachment styles and working alliance. Clinical Psychology & Psychotherapy, 23(2), 155-165. doi:10.1002/cpp.1944

Bucci, S., Roberts, N. H., Danquah, A. N., & Berry, K. (2015). Using attachment theory to inform the design and delivery of mental health services: A systematic review of the literature. Psychology and Psychotherapy: Theory, Research And Practice, 88(1), 1-20. doi:10.1111/papt.12029

Carney, D. R., & Harrigan, J. A. (2003). It takes one to know one: Interpersonal sensitivity is related to accurate assessments of others' interpersonal sensitivity. *Emotion*, *3*(2), 194.

Carré, A., Stefaniak, N., D'ambrosio, F., Bensalah, L., & Besche-Richard, C. (2013). The Basic Empathy Scale in Adults (BES-A): Factor structure of a revised form. *Psychological assessment*, *25*(3), 679.

Cassedy, H. F., Enander, R. A., Robinson, R. C., Evans, H. M., Frank, B., Tucker, C., & ... Stringer, C. A. (2015). Attachment theory as a model of doctor–patient interaction. Journal of Applied Biobehavioral Research, 20(4), 151-178. doi:10.1111/jabr.12036

Cheng, Y., Lin, C. P., Liu, H. L., Hsu, Y. Y., Lim, K. E., Hung, D., & Decety, J. (2007). Expertise modulates the perception of pain in others. *Current Biology*, *17*(19), 1708-1713.

Clark, A. J. (2010). Empathy: An integral model in the counseling process. *Journal of Counseling & Development, 88*(3), 348-356.

Claxton-Oldfield, S., Gibbon, L., & Schmidt-Chamberlain, K. (2011). When to Say "Yes" and When to Say "No" Boundary Issues for Hospice Palliative Care Volunteers. *American Journal of Hospice and Palliative Medicine®, 28*(6), 429-434.

Coverdale, J. H., Thomson, A. N., & White, G. E. (1995). Social and sexual contact between general practitioners and patients in New Zealand: attitudes and prevalence. *Br J Gen Pract, 45*(394), 245-247.

Curtis, J. M. (1981). Effect of therapist's self-disclosure on patients' impressions of empathy, competence, and trust in an analogue of a psychotherapeutic interaction. *Psychological Reports, 48*(1), 127-136. doi:10.2466/pr0.1981.48.1.127

Dailey, A. C. (2017). Violating boundaries. *Studies In Gender And Sexuality, 18*(1), 13-18. doi:10.1080/15240657.2017.1276781

Davis, M. H., Luce, C., & Kraus, S. J. (1994). The heritability of characteristics associated with dispositional empathy. *Journal of Personality, 62*(3), 369-391.

Decety, J. (2011). Dissecting the neural mechanisms mediating empathy. *Emotion review, 3*(1), 92-108.

Decety, J., & Jackson, P. L. (2004). The functional architecture of human empathy. *Behavioral and cognitive neuroscience reviews, 3*(2), 71-100.

Decety, J., & Lamm, C. (2006). Human empathy through the lens of social neuroscience. *The scientific World journal, 6*, 1146-1163.

Decety, J., & Lamm, C. (2009). Empathy versus personal distress: Recent evidence from social neuroscience. In J. Decety & W. Ickes (Eds.), *The social neuroscience of empathy.* (pp. 199–213). Cambridge, MA: MIT Press.

Decety, J., Yang, C. Y., & Cheng, Y. (2010). Physicians down-regulate their pain empathy response: an event-related brain potential study. *Neuroimage*, *50*(4), 1676-1682.

Degnan, A., Seymour-Hyde, A., Harris, A., & Berry, K. (2016). The role of therapist attachment in alliance and outcome: A systematic literature review. *Clinical Psychology & Psychotherapy*, *23*(1), 47-65. doi:10.1002/cpp.1937

DePue, M. K., & Lambie, G. W. (2014). Impact of a university-based practicum experience on counseling students' levels of empathy and assessed counseling competencies. *Counseling Outcome Research and Evaluation*, *5*(2), 89–101. https://doi.org/10.1177/2150137814548509

Deschamps, P. H., Schutter, D. G., Kenemans, J. L., & Matthys, W. (2015). Empathy and prosocial behavior in response to sadness and distress in 6- to 7-year olds diagnosed with disruptive behavior disorder and attention-deficit hyperactivity disorder. *European Child & Adolescent Psychiatry*, *24*(1), 105-113. doi:10.1007/s00787-014-0535-x

Dinger, U., Strack, M., Sachsse, T., & Schauenburg, H. (2009). Therapists' attachment, patients' interpersonal problems and alliance development over time in inpatient psychotherapy. Psychotherapy: Theory, Research, Practice, Training, 46(3), 277-290. doi:10.1037/a0016913

Division of Clinical Psychology. (1995). Professional practice guidelines. Leicester: British Psychological Society.

Duan, C., & Hill, C. E. (1996). The current state of empathy research. *Journal of counseling psychology*, *43*(3), 261.

Dunkle, J. H., & Friedlander, M. L. (1996). Contribution of therapist experience and personal characteristics to the working alliance. Journal Of Counseling Psychology, 43(4), 456-460. doi:10.1037/0022-0167.43.4.456

Edwards, C. E., & Murdock, N. L. (1994). Characteristics of therapist self-disclosure in the counseling process. *Journal Of Counseling & Development*, *72*(4), 384-389. doi:10.1002/j.1556-6676.1994.tb00954.x

Eichenberg, C., Becker-Fischer, M., & Fischer, G. (2010). Sexual assaults in therapeutic relationships: prevalence, risk factors and consequences. *Health*, *2*(09), 1018.

Eisenberg, N. (2000). Emotion, regulation, and moral development. *Annual review of psychology*, *51*(1), 665-697.

Eisenberg, N., & Eggum, N. D. Di Giunta, L. (2010). *Empathy-Related Responding: Associations with Prosocial Behavior, Aggression, and Intergroup Relations. Social Issues and Policy Review*, *4*(1), 143-180.

Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy*, *48*(1), 43.

Epstein, R. S., Simon, R. I., & Kay, G. G. (1992). Assessing boundary violations in psychotherapy: Survey results with the Exploitation Index. *Bulletin of the Menninger Clinic*, *56*(2), 150–166.

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.

Farrelly, D., & Bennett, M. (2018). Empathy leads to increased online charitable behaviour when time is the currency. *Journal of Community & Applied Social Psychology*, *28*(1), 42–46. https://doi-org.rlib.pace.edu/10.1002/casp.2339

Feldman-Summers, S., & Jones, G. (1984). Psychological impacts of sexual contact between therapists or other health care practitioners and their clients. *Journal of consulting and clinical psychology*, *52*(6), 1054.

Feller, C. P., & Cottone, R. R. (2003). The importance of empathy in the therapeutic alliance. *The Journal of Humanistic Counseling*, *42*(1), 53-61.

Fennig, S., Secker, A., Treves, I., Ben Yakar, M., Farina, J., Roe, D., & Fennig, S. (2005). Ethical dilemmas in psychotherapy: Comparison between patients, therapists and laypersons. *Israel Journal of Psychiatry and Related Sciences*, *42*(4), 251.

Fraley, R. C., Waller, N. G., & Brennan, K. A. (2000). An item response theory analysis of self-report measures of adult attachment. *Journal of personality and social psychology*, *78*(2), 350.

Fraley, R. C., Heffernan, M. E., Vicary, A. M., & Brumbaugh, C. C. (2011). The experiences in close relationships—Relationship Structures Questionnaire: A method for assessing attachment orientations across relationships. *Psychological Assessment*, *23*(3), 615-625. doi:10.1037/a0022898

Frith, U., & Frith, C. (2010). The social brain: allowing humans to boldly go where no other species has been. *Philosophical Transactions of the Royal Society of London B: Biological Sciences*, *365*(1537), 165-176.

Gabbard, G. O. (1991). Psychodynamics of sexual boundary violations. *Psychiatric Annals*, *21*(11), 651-655.

Gabbard, G. O. (1994). Psychotherapists who transgress sexual boundaries with patients. *Bulletin Of The Menninger Clinic*, *58*(1), 124-135.

Gabbard, G. O. (2008). Boundaries, Technique, and Self-Deception: a Discussion of Arnold

Gabbard, G. O. (2010). *Long-term psychodynamic psychotherapy: A basic text*. Arlington, VA: American Psychiatric Publishing, Inc.

Gabbard, G. O., & Pope, K. S. (1989). Sexual intimacies after termination: Clinical, ethical, and legal aspects. *Sexual exploitation in professional relationships*, 115-127.

Gamble, N., Boyle, C., & Morris, Z. A. (2015). Ethical practice in telepsychology. Australian Psychologist, 50(4), 292-298. doi:10.1111/ap.12133

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.

Gartrell, N., Herman, J., Olarte, S., Feldstein, M., & Localio, R. (1986). Psychiatrist–patient sexual contact: Results of a national survey: I. Prevalence. *The American journal of psychiatry*.

Gehart, D. R., & Lyle, R. R. (2001). Client experience of gender in therapeutic relationships: An interpretive ethnography. *Family Process*, *40*(4), 443–458. https://doi-org.rlib.pace.edu/10.1111/j.1545-5300.2001.4040100443.x

Gelso, C. J., & Hayes, J. A. (1998). *The psychotherapy relationship: Theory, research, and practice*. Hoboken, NJ, US: John Wiley & Sons Inc.

Gerdes, K. E., & Segal, E. (2011). Importance of empathy for social work practice: Integrating new science. *Social Work*, *56*(2), 141-148. doi:10.1093/sw/56.2.141

Gini, G., Albiero, P., Benelli, B., & Altoè, G. (2007). Does empathy predict adolescents' bullying and defending behavior? *Aggressive Behavior: Official Journal of the International Society for Research on Aggression*, *33*(5), 467-476.

Ghuloum, S., Bener, A., Commons, M. L., Miller, P. M., Burgut, F. T., & Bhugra, D. (2011). Perceptions of boundaries and cultural influences in Qatar. *International Journal Of Social Psychiatry*, *59*(3), 199-206. doi:10.1177/0020764011431799

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.

Giordano, A. L., Stare, B. G., & Clarke, P. B. (2015). Overcoming Obstacles to Empathy: The Use of Experiential Learning in Addictions Counseling Courses. *Journal Of Creativity In Mental Health*, *10*(1), 100-113. doi:10.1080/15401383.2014.947011

Gladstein, G. A. (1983). Understanding empathy: Integrating counseling, developmental, and social psychology perspectives. Journal Of Counseling Psychology, 30(4), 467-482. doi:10.1037/0022-0167.30.4.467

Glass, L. L. (2003). The gray areas of boundary crossings and violations. *American Journal Of Psychotherapy*, *57*(4), 429-444.

Glickauf-Hughes, C., & Chance, S. E. (1995). Answering clients' questions. *Psychotherapy: Theory, Research, Practice, Training*, *32*(3), 375.

Goldfried, M. R., Burckell, L. A., & Eubanks-Carter, C. (2003). Therapist self-disclosure in cognitive-behavior therapy. *Journal of clinical psychology*, *59*(5), 555-568.

Goldman, D. (2009). "Love Cure", Contemporary Pyschoanalysis, 45:2, 281-286, DOI: 10.1080/00107530.2009.10746001

Gottlieb, M. C. (1993). Avoiding exploitive dual relationships: A decision-making model. *Psychotherapy: Theory, research, practice, training*, *30*(1), 41.

Gottlieb, M. C., Younggren, J. N., & Murch, K. B. (2009). Boundary management for cognitive behavioral therapies. *Cognitive and Behavioral Practice*, *16*(2), 164-171.

Grant, J. G., & Mandell, D. (2016). Boundaries and relationships between service users and service providers in community mental health services. *Social Work in Mental Health*, *14*(6), 696-713.

Greene, L. R., & Geller, J. D. (1980). Effects of therapists' clinical experience and personal boundaries on termination of psychotherapy. *Academic Psychiatry*, *4*(1), 31-35.

Gross, S. M. (2005). Student Perspectives on Clinical and Counseling Psychology Practica. *Professional Psychology: Research And Practice*, *36*(3), 299-306. doi:10.1037/0735-7028.36.3.299

Gusella, J. (2003). The Therapist's Voice. *Eating disorders*, *11*(2), 149-154., p. 362).

Gutheil, T. G., & Brodsky, A. (2011). *Preventing boundary violations in clinical practice*. Guilford Press.

Gutheil, T. G., & Gabbard, G. O. (1992). Obstacles to the dynamic understanding of therapist-patient sexual relations. *American Journal Of Psychotherapy*, *46*(4), 515-525.

Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *The American journal of psychiatry*.

Harper, K., & Steadman, J. (2003). Therapeutic boundary issues in working with childhood sexual-abuse survivors. *American Journal Of Psychotherapy*, *57*(1), 64-79.

Hartmann, E. (1989). Boundaries of dreams, boundaries of dreamers: Thin and thick boundaries as a new personality measure. *Psychiatric Journal of the University of Ottawa*.

Hartmann, E. (1991). *Boundaries in the mind: A new psychology of personality*. New York, NY, US: Basic Books.

Hartmann, E., Elkin, R., & Garg, M. (1991). Personality and dreaming: The dreams of people with very thick or very thin boundaries. *Dreaming, 1*(4), 311-324. doi:10.1037/h0094342

Hatcher, S. L., Favorite, T. K., Hardy, E. A., Goode, R. L., DeShetler, L. A., & Thomas, R. M. (2005). An Analogue Study of Therapist Empathic Process: Working With Difference. *Psychotherapy: Theory, Research, Practice, Training, 42*(2), 198-210. doi:10.1037/0033-3204.42.2.198

Heinonen, E., & Orlinsky, D. E. (2013). Psychotherapists' personal identities, theoretical orientations, and professional relationships: Elective affinity and role adjustment as modes of congruence. *Psychotherapy Research, 23*(6), 718-731.

Helbok, C. M., Marinelli, R. P., & Walls, R. T. (2006). National survey of ethical practices across rural and urban communities. *Professional Psychology: Research and Practice, 37*(1), 36.

Hermansson, G. (1997). Boundaries and boundary management in counselling: The never-ending story. *British Journal Of Guidance & Counselling, 25*(2), 133-146. doi:10.1080/03069889700760131

Holroyd, J. C., & Brodsky, A. M. (1977). Psychologists' attitudes and practices regarding erotic and nonerotic physical contact with patients. *American Psychologist, 32*(10), 843-849. doi:10.1037/0003-066X.32.10.843

Holmes, J. (1997). 'Too early, too late': Endings in psychotherapy - an attachment perspective. British Journal Of Psychotherapy, 14(2), 159-171. doi:10.1111/j.1752-0118.1997.tb00367.x

Horton, J. A., Clance, P. R., Sterk-Elifson, C., & Emshoff, J. (1995). Touch in psychotherapy: A survey of patients' experiences. *Psychotherapy: Theory, Research, Practice, Training*, *32*(3), 443-457. doi:10.1037/0033-3204.32.3.443

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross, J. C. Norcross (Eds.), Psychotherapy relationships that work: Therapist contributions and responsiveness to patients (pp. 37-69). New York, NY, US: Oxford University Press.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. Journal Of Consulting And Clinical Psychology, 61(4), 561-573. doi:10.1037/0022-006X.61.4.561

Jones, M. A., Botsko, M., & Gorman, B. S. (2003). Predictors of psychotherapeutic benefit of lesbian, gay, and bisexual clients: The effects of sexual orientation matching and other factors. *Psychotherapy: Theory, Research, Practice, Training*, *40*(4), 289.

Jones, A. L. (2009). Catalyst for self-analysis. Psyccritiques, 54(12), doi:10.1037/a0014286

Kelly, A. E., & Rodriguez, R. R. (2007). Do therapists self-disclose more to clients with greater symptomatology?. *Psychotherapy: Theory, Research, Practice, Training*, *44*(4), 470

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.

Kim, S. S., Kaplowitz, S., & Johnston, M. V. (2004). The effects of physician empathy on patient satisfaction and compliance. *Evaluation & the health professions*, *27*(3), 237-251.

Kirkland, K., Kirkland, K. L., & Reaves, R. P. (2004). On the Professional use of disciplinary data. *Professional Psychology: Research and Practice*, *35*(2), 179.

Kitchener, K. S. (1988). Dual role relationships: What makes them so problematic?. *Journal Of Counseling & Development*, *67*(4), 217-221. doi:10.1002/j.1556-6676.1988.tb02586.x

Kitson, C., & Sperlinger, D. (2007). Dual relationships between clinical psychologists and their clients: A survey of UK clinical psychologists' attitudes. *Psychology and Psychotherapy: Theory, Research and Practice*, *80*(2), 279-295.

Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of counseling psychology*, *44*(3), 274.

Kocet, M. M., & Herlihy, B. J. (2014). Addressing value- based conflicts within the counseling relationship: A decision- making model. Journal of Counseling & Development, 92(2), 180-186.

Koocher, G. P. (2009). Any minute now but far far away: Electronically mediated mental health. *Clinical Psychology: Science and Practice*, *16*(3), 339-342.

Koocher, G. P., & Keith-Spiegel, P. (1998). Ethics in psychology: Professional standards and cases. Oxford University Press. *New York*.

Larson, M. J., Fair, J. E., Good, D. A., & Baldwin, S. A. (2010). Empathy and error processing. *Psychophysiology*, *47*(3), 415-424.

Larsson, B. M., Kaldo, V., & Broberg, A. G. (2009). Similarities and differences between practitioners of psychotherapy in Sweden: A comparison of attitudes between psychodynamic, cognitive, cognitive–behavioral, and integrative therapists. *Journal Of Psychotherapy Integration*, *19*(1), 34-66. doi:10.1037/a0015446

Lawson, G. (2007). Counselor wellness and impairment: A national survey. *The Journal of Humanistic Counseling, Education and Development*, *46*(1), 20-34.

Lazarus, A. A. (1994). How certain boundaries and ethics diminish therapeutic effectiveness. *Ethics & behavior*, *4*(3), 255-261.

Lazarus, A. A., & Zur, O. (2002). *Dual relationships and psychotherapy*. Springer Publishing Company.

Leiper, R., & Casares, P. (2000). An investigation of the attachment organization of clinical psychologists and its relationship to clinical practice. *British Journal Of Medical Psychology, 73*(4), 449-464. doi:10.1348/000711200160651

Ligiéro, D. P., & Gelso, C. J. (2002). Countertransference, attachment, and the working alliance: The therapist's contribution. *Psychotherapy: Theory, Research, Practice, Training*, *39*(1), 3.

Lopez, F. G. (1995). Contemporary attachment theory: An introduction with implications for counseling psychology. *The Counseling Psychologist*, *23*(3), 395-415.

Luchner, A. F., Mirsalimi, H., Moser, C. J., & Jones, R. A. (2008). Maintaining boundaries in psychotherapy: Covert narcissistic personality characteristics and psychotherapists. *Psychotherapy: Theory, Research, Practice, Training*, *45*(1), 1-14. doi:10.1037/0033-3204.45.1.1

Macaulay, H. L., Toukmanian, S. G., & Gordon, K. M. (2007). Attunement as the core of therapist-expressed empathy. *Canadian Journal Of Counselling, 41*(4), 244-254.

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': Corrigendum. *General Hospital Psychiatry, 37*(5), 488. doi:10.1016/j.genhosppsych.2015.06.001

Mangione, L., Forti, R., & Iacuzzi, C. M. (2007). Ethics and Endings in Group Psychotherapy: Saying Good-bye and Saying it Well. *International Journal Of Group Psychotherapy*, *57*(1), 25-40. doi:10.1521/ijgp.2007.57.1.25

Mark, I. L. V. D., IJzendoorn, M. H. V., & Bakermans-Kranenburg, M. J. (2002). Development of empathy in girls during the second year of life: Associations with parenting, attachment, and temperament. *Social development*, *11*(4), 451-468.

Marmarosh, C. L. (2017). Fostering engagement during termination: Applying attachment theory and research. *Psychotherapy*, *54*(1), 4-9. doi:10.1037/pst0000087

Mitsopoulou, E., & Giovazolias, T. (2015). Personality traits, empathy and bullying behavior: A meta-analytic approach. *Aggression and violent behavior*, *21*, 61-72.

Mesurado, B., & Richaud, M. C. (2017). The relationship between parental variables, empathy and prosocial-flow with prosocial behavior toward strangers, friends, and family. *Journal Of Happiness Studies*, *18*(3), 843-860. doi:10.1007/s10902-016-9748-

Mikulincer, M., Gillath, O., Halevy, V., Avihou, N., Avidan, S., & Eshkoli, N. (2001). Attachment theory and reactions to others' needs: Evidence that activation of the sense of attachment security promotes empathic responses. *Journal Of Personality And Social Psychology, 81*(6), 1205-1224. doi:10.1037/0022-3514.81.6.1205

Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change*. Guilford Press.

Miller, P. M., Bener, A., Ghuloum, S., Commons, M. L., & Burgut, F. T. (2012). Differences and similarities in cross-cultural perceptions of boundaries: A comparison of results from two studies. *International Journal Of Law And Psychiatry*, *35*(5-6), 398-405. doi:10.1016/j.ijlp.2012.09.004

Miller, P. M., Commons, M. L., & Gutheil, T. G. (2006). Clinicians' perceptions of boundaries in Brazil and the United States. *Journal of the American Academy of Psychiatry and the Law Online*, *34*(1), 33-42.

Moyers, T. B., & Miller, W. R. (2013). Is low therapist empathy toxic?. *Psychology Of Addictive Behaviors*, *27*(3), 878-884. doi:10.1037/a0030274

Negretti, M. A., & Wieling, E. (2001). The use of communication technology in private practice: Ethical implications and boundary dilemmas in therapy. *Contemporary Family Therapy: An International Journal, 23*(3), 275-293. doi:10.1023/A:1011178915547

Neukrug, E., Bayne, H., Dean-Nganga, L., & Pusateri, C. (2013). Creative and Novel Approaches to Empathy: A Neo-Rogerian Perspective. *Journal Of Mental Health Counseling*, *35*(1), 29-42

Neukrug, E., Milliken, T., & Walden, S. (2001). Ethical complaints made against credentialed counselors: An updated survey of state licensing boards. Counselor Education and Supervision, 41(1), 57–70. https://doi.org/10.1002/j.1556-6978.2001.tb01268.x

Neumann, D. L., Chan, R. C., Wang, Y., & Boyle, G. J. (2016). Cognitive and affective components of empathy and their relationship with personality dimensions in a Chinese sample. *Asian Journal of Social Psychology*, *19*(3), 244-253.

Nickerson, A. B., Mele, D., & Princiotta, D. (2008). Attachment and empathy as predictors of roles as defenders or outsiders in bullying interactions. *Journal of school psychology*, *46*(6), 687-703.

Nigro, T. (2003). Dual relationships activities: Principal component analysis of counselors' attitudes. *Ethics & Behavior*, *13*(2), 191–201. https://doi-org.rlib.pace.edu/10.1207/S15327019EB1302_05

Nigro, T. (2004). Counselors' experiences with problematic dual relationships. *Ethics & Behavior*, *14*(1), 51-64. doi:10.1207/s15327019eb1401_4

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy*, *48*(1), 98-102. doi:10.1037/a0022161

Olson, J. K. (1995). Relationships between nurse-expressed empathy, patient-perceived empathy and patient distress. *Image: the Journal of Nursing Scholarship*, *27*(4), 317-322.

Oparah, B. (2007). Therapeutic relationship versus boundary transgressions: lessons for helping professionals. *IFE PsychologIA: An International Journal*, *15*(1), 77-86.

Pandey, S., & Elliott, W. (2010). Suppressor variables in social work research: Ways to identify in multiple regression models. *Journal of the Society for Social Work and Research*, *1*(1), 28-40.

Panfile, T.M., & Laible, D.J. (2012). Attachment security and child's empathy: The mediating role of emotion regulation. *Merrill-Palmer Quarterly*, *58*(1), 1-21. https://doi-org.rlib.pace.edu/10.1353/mpq.2012.0003

Parpottas, P., & Draghi-Lorenz, R. (2015). Effects of therapists' attachment organization on the process and outcome of therapy: A review of the empirical literature. *Counselling Psychology Review*, *30*(4), 44-56

Peterson, M. (1992). At personal risk. *Boundary violations in professional-client relationships. WW Norton&Company. New York.*

Petrowski, K., Nowacki, K., Pokorny, D., & Buchheim, A. (2011). Matching the patient to the therapist: the roles of the attachment status and the helping alliance. *The Journal of nervous and mental disease*, *199*(11), 839-844.

Plaut, S. M., & Baker, D. (2011). Teacher–student relationships in medical education: Boundary considerations. *Medical teacher*, *33*(10), 828-833.

Pope, K. S., & Keith-Spiegel, P. (2008). A practical approach to boundaries in psychotherapy: Making decisions, bypassing blunders, and mending fences. *Journal Of Clinical Psychology*, *64*(5), 638-652. doi:10.1002/jclp.20477

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist, 42*(11), 993-1006. doi: 10.1037/0003-066X.42.11.993

Pope, K. S., & Vetter, V. A. (1992). Ethical dilemmas encountered by members of the American Psychological Association: A national survey. *American Psychologist*, *47*(3), 397.

Rameson, L. T., & Lieberman, M. D. (2009). Empathy: A social cognitive neuroscience approach. *Social And Personality Psychology Compass, 3*(1), 94-110. doi:10.1111/j.1751-9004.2008.00154.x

Reamer, F. G. (2003). Boundary issues in social work: Managing dual relationships. *Social work*, *48*(1), 121-133.

Richardson, D. R., Hammock, G. S., Smith, S. M., Gardner, W., & Signo, M. (1994). Empathy as a cognitive inhibitor of interpersonal aggression. *Aggressive behavior*, *20*(4), 275-289.

Ridgway, I. R., & Sharpley, C. (1990). Multiple measures for the prediction of counsellor trainee effectiveness. *Canadian Journal of Counselling and Psychotherapy/Revue canadienne de counseling et de psychothérapie*, *24*(3).

Riggio, R. E., & Taylor, S. J. (2000). Personality and communication skills as predictors of hospice nurse performance. *Journal of business and Psychology*, *15*(2), 351-359.

Ringstad, R. (2008). The ethics of dual relationships: Beliefs and behaviors of clinical practitioners. *Families In Society*, *89*(1), 69-77. doi:10.1606/1044-3894.3711

Robitschek, C. G., & McCarthy, P. R. (1991). Prevalence of counselor self-reference in the therapeutic dyad. *Journal of Counseling & Development*, *69*(3), 218-221.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21(2), 95-103. doi:10.1037/h0045357

Rogers, C. R. (1979). The foundations of the person-centered approach. *Education*, *100*(2).

Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. WW Norton & Co.

Russell, C. S., & Peterson, C. M. (1998). The management of personal and professional boundaries in marriage and family therapy training programs. *Contemporary family therapy*, *20*(4), 457-470.

Santamaría-García, H., Baez, S., García, A. M., Flichtentrei, D., Prats, M., Mastandueno, R., ... & Ibáñez, A. (2017). Empathy for others' suffering and its mediators in mental health professionals. *Scientific reports*, *7*(1), 6391.

Satran, G. (1991). Some limits and hazards of empathy. *Contemporary Psychoanalysis*, *27*(4), 737–748. https://doi.org/10.1080/00107530.1991.10746727

Sauer, E. M., Lopez, F. G., & Gormley, B. (2003). Respective contributions of therapist and client adult attachment orientations to the development of the early working alliance: A preliminary growth modeling study. Psychotherapy Research, 13(3), 371-382. doi:10.1093/ptr/kpg027

Schoener, G. R., Milgrom, J. H., Gonsiorek, J. C., Luepker, E. T., & Conroe, R. M. (1990). *Psychotherapists' sexual involvement with clients: Intervention and prevention*. Minneapolis, MN, US: Walk-in Counseling Ctr.

Seelig, B. J. (2017). Altruism and Boundary Violation. *Psychoanalytic Inquiry*, *37*(7), 474-486.

Simon, R. I. (1991) Psychological Injury caused by boundary violation precursors to therapist-patient sex. Psychiatric Annals, 21(10), 614-619. doi:10.3928/0048-5713-19911001-09

Simon, R. I. (1992). Treatment boundary violations: Clinical, ethical, and legal considerations. *Bulletin Of The American Academy Of Psychiatry & The Law*, *20*(3), 269-288.

Simone, D. H., McCarthy, P., & Skay, C. L. (1998). An investigation of client and counselor variables that influence likelihood of counselor self-disclosure. *Journal Of Counseling & Development*, *76*(2), 174-182. doi:10.1002/j.1556-6676.1998.tb02390.x

Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research And Practice*, *26*(5), 499-506. doi:10.1037/0735-7028.26.5.499

Somer, E., & Nachmani, I. (2005). Constructions of Therapist-Client Sex: A Comparative Analysis of Retrospective Victim Reports. *Sexual Abuse: Journal Of Research And Treatment*, *17*(1), 47-62. doi:10.1177/107906320501700106

Sonne, J. L. (1994). Multiple relationships: Does the new ethics code answer the right questions?. *Professional Psychology: Research And Practice*, *25*(4), 336-343. doi:10.1037/0735-7028.25.4.336

Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment & human development*, *7*(4), 349-367.

Stewart, R. E., & Chambless, D. L. (2007). Does psychotherapy research inform treatment decisions in private practice?. *Journal of clinical psychology*, *63*(3), 267-281.

Stewart, R. E., & Chambless, D. L. (2008). Treatment failures in private practice: How do psychologists proceed?. *Professional Psychology: Research and Practice*, *39*(2), 176.

Stocks, E. L., Lishner, D. A., & Decker, S. K. (2009). Altruism or psychological escape: Why does empathy promote prosocial behavior*? European Journal of Social Psychology, 39*(5), 649-665. doi:10.1002/ejsp.561

Stone, M. H. (1975). Management of unethical behavior in a psychiatric hospital staff. *American journal of psychotherapy*, *29*(3), 391-401.

Sude, M. (2013). Text messaging and private practice: Ethical challenges and guidelines for developing personal best practices. *Journal of Mental Health Counseling*, *35*(3), 211-227.

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.

Taylor, P. J., Rietzschel, J., Danquah, A., & Berry, K. (2015). The role of attachment style, attachment to therapist, and working alliance in response to psychological therapy. Psychology And Psychotherapy: Theory, Research And Practice, 88(3), 240-253. doi:10.1111/papt.12045

Telle, N., & Pfister, H. (2016). Positive empathy and prosocial behavior: A neglected link. *Emotion Review*, *8*(2), 154-163. doi:10.1177/1754073915586817

Thomas, J. (2013). Association of personal distress with burnout, compassion fatigue, and compassion satisfaction among clinical social workers. *Journal of Social Service Research*, *39*(3), 365-379.

Thomas CR, Pastusek A. Boundary Crossings and Violations: Time for Child Psychiatry to Catch Up. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2012;51(9):858-860. doi:10.1016/j.jaac.2012.06.011.

Trusty, J., Ng, K., & Watts, R. E. (2005). Model of Effects of Adult Attachment on Emotional Empathy of Counseling Students. Journal Of Counseling & Development, 83(1), 66-77. doi:10.1002/j.1556-6678.2005.tb00581.x

Twemlow, S. W. (1997). Exploitation of patients: Themes in the psychopathology of their therapists. *American Journal Of Psychotherapy*, *51*(3), 357-375.

Twemlow, S. W., & Gabbard, G. O. (1989). The lovesick therapist. *Sexual exploitation in professional relationships*, 71-87.

Tzelgov, J., & Henik, A. (1991). Suppression situations in psychological research: Definitions, implications, and applications. *Psychological Bulletin*, *109*(3), 524.

Van Lissa, C. J., Hawk, S. T., & Meeus, W. H. (2017). The effects of affective and cognitive empathy on adolescents' behavior and outcomes in conflicts with mothers. *Journal of experimental child psychology*, *158*, 32-45.

Verhofstadt, L., Devoldre, I., Buysse, A., Stevens, M., Hinnekens, C., Ickes, W., & Davis, M. (2016). The role of cognitive and affective empathy in spouses' support interactions: An observational study. *PloS one*, *11*(2), e0149944.

Walker, R., & Clark, J. J. (1999). Heading off boundary problems: Clinical supervision as risk management. *Psychiatric Services*, *50*(11), 1435-1439.

Wallin, D. J. (2007). Attachment in Psychotherapy. New York, NY, US: Guilford Press.

Waters, E., Merrick, S., Treboux, D., Crowell, J., & Albersheim, L. (2000). Attachment security in infancy and early adulthood: A twenty-year longitudinal study. Child Development, 71(3), 684-689. doi:10.1111/1467-8624.00176

Wells, T. L. (1994). Therapist self-disclosure: Its effects on clients and the treatment relationship. *Smith College Studies in Social Work, 65*(1), 23-41.

West, A. L. (2015). Associations among attachment style, burnout, and compassion fatigue in health and human service workers: A systematic review. *Journal of Human Behavior in the Social Environment*, *25*(6), 571-590.

West, C. P., Huschka, M. M., Novotny, P. J., Sloan, J. A., Kolars, J. C., Habermann, T. M., & Shanafelt, T. D. (2006). Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study. *Jama*, *296*(9), 1071-1078.

Williams, M. H. (1992). Exploitation and inference: Mapping the damage from therapist-patient sexual involvement. *American Psychologist, 47*(3), 412-421. doi:10.1037/0003-066X.47.3.412

Wondra, J. D., & Ellsworth, P. C. (2015). An appraisal theory of empathy and other vicarious emotional experiences. Psychological Review, *122*(3), 411-428. https://doi-org.rlib.pace.edu/10.1037/a0039252

Yusof, Y., & Carpenter, J. (2015). The impact of family therapists' adult attachment styles on their career choice and approach to therapy: An interpretive phenomenological analysis. Journal Of Social Work Practice, 29(4), 395-412. doi:10.1080/02650533.2014.922059

Yusof, Y., & Carpenter, J. (2016). Family therapists' adult attachment styles and the therapeutic alliance. *Journal Of Family Therapy*, *38*(1), 59-81. doi:10.1111/1467-6427.12079

Zur, O. (2007). A Decision-Making Process For Boundary Crossing and Dual Relationships. In *Boundaries in Psychotherapy: Ethical and Clinical Explorations* (pp. 69-80). Washington, DC, US: American Psychological Association. doi:10.1037/11563-004

Zur, O. (2001). Out-of-office experience: When crossing office boundaries and engaging in dual relationships are clinically beneficial and ethically sound. *Independent Practitioner*, *21*(1), 96-100.

Appendix A

Demographics for Study I: Boundary Pre-Survey

1. Which of the following describes your profession within the counseling field?

Licensed (or eligible for license) Mental Health Counselor

Licensed (or eligible for license) Social Worker

Licensed (or eligible for license) Psychologist

Licensed (or eligible for license) Marriage and Family Counselor

Student Counselor Trainee in Practicum/Internship

2. Are you currently seeing clients?

Yes

No

Not currently, but have in the past

3. How long have you been seeing clients?

_____

4. In what clinical setting do you see clients? (i.e., private practice, residential, agency, etc.)

Appendix B

Demographics for Study II: Counselor Characteristics and Boundary Behaviors

1. What is your gender?
    a. Male b. Female
2. Age: _____
3. Ethnicity: _____
4. Which of the following describes your profession within the counseling field?
    a. Licensed (or eligible for license) Mental Health Counselor
    b. Licensed (or eligible for license) Social Worker
    c. Licensed (or eligible for license) Psychologist
    d. Licensed (or eligible for license) Marriage and Family Counselor
    e. Student Counselor Trainee
5. Are you currently seeing clients?
    a. Yes b. Not currently, but have in the past
6. How many years of clinical experience do you have working face to face with clients?

    _____ years

7. Which theoretical orientation do you align with **most?**
    a. Psychodynamic
    b. Cognitive Behavioral
    c. Humanistic
    d. Other: _____*(Please note a specific orientation not listed you **most** align with other than eclectic)*

8. Are you primarily a grief therapist/majority of clients seen are grieving?
    a. Yes
    b. No
9. What practice setting do you work in?
    a. Private practice
    b. Community mental health
    c. Higher level care (inpatient, hospital, residential)
    d. School
    e. Agency
    f. Multiple settings

Appendix C

Boundary Behavior Pre-survey (58-items)

For each item, choose how acceptable and frequent you think these counselor behaviors are and happen within a counseling context. According to the definitions below, categorize each behavior as a boundary crossing, violation, or neither.

Boundary crossing: Counselor actions which deviate from commonly accepted clinical practice which may or may not benefit the client.

Boundary violation: Counselor actions which deviate from commonly accepted clinical practice that pose a clear risk to the therapeutic process or harm to the client.

1	***Accepting gift from client***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
2	***Self-disclosing personal information/experiences***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
3	***Counselor physical contact (putting hands on shoulder, hand over hand)***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
4	***Failing to seek supervision or consultation***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
5	***Giving client hug***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
6	***Speaking to client about clinical issues outside of session***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
7	***Responding to clients email after termination***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	

8	***Keeping a personal relationship after treatment termination***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
9	***Failure to refer out when needed***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
10	***Transfer client to unknown therapist at termination***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
11	***Extending session beyond time allotted***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
12	***Giving out personal phone number***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
13	***Give your patient a ride home***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
14	***Visiting suicidal patient at home***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
15	***Give a client a gift***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
16	***Participating in same social activity as client (i.e., book club)***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
17	***Lessening session fees in times of client financial hardship***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
18	***Retaining a patient for treatment longer than needed***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
19	***Running into patient outside of therapy and saying hi***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
20	***Having pictures of family members in counseling office***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*

		Categorization:	*Crossing*	*Violation*	*Neither*	
21	***Not sharing diagnosis with client (secrecy)***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
22	***Not sharing concerns of risky behavior with clients parents***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
23	***Attending client milestone (i.e., graduation/wedding)***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
24	***Holding a dual relationship with client (i.e., they are also your dentist, friend, son's teacher, etc.)***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
25	***Accepting client friend request on Facebook***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
26	***Providing client with false hope***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
27	***Giving client food to try/share during session***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
28	***Sharing upcoming travel plans with patient when they ask***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
29	***Engaging in foul language/swear words in conversation with client***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
30	***Not reporting abuse right away because your client says will make their situation worse***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
31	***Breaking confidentiality***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
32	***Texting on phone while in session with client***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	

33	***Not planning for session***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
34	***Therapist-client sexual contact***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
35	***Texting with client outside of session about a clinical matter***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
36	***Responding to client concern via telephone outside of office hours***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
37	***Leaving session at same time as client – walk out to cars together***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
38	***Using client family member/friend who is a provider you need (an orthodontist/mechanic etc.)***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
39	***Start seeing client's siblings/friend/cousin as a patient***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
40	***Find ways to agree with majority of what client says/avoid confrontation***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
41	***Provide client with personal email***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
42	***Talk with family members about client conversations because you are concerned***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
43	***Do work for clients (i.e. call a psychiatrist to make them appt.)***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
44	***Share opinion (I.e. "you should divorce him")***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
45	***Looking up client or client family members on social media***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*

		Categorization:	*Crossing*	*Violation*	*Neither*	
46	***Greeting client with kiss on cheek***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
47	***Introducing client to significant other***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
48	***Talking about past client similar challenges***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
49	***Talking about similar past personal experiences***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
50	***Taking food/trying food from client***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
51	***Lying to client when feeling as if it will benefit them***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
52	***Expressing emotion with client (i.e. crying)***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
53	***Flirting with client***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
54	***Sharing struggles of your own with client***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
55	***Write note of clearance to help client out (i.e., writing plane note for service dog, bariatric surgery)***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
56	***Having a phone/video session***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
57	***Letting client dictate session***	Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*
		Frequency:	*Rarely*	*Occasionally*	*Frequently*	*Always*
		Categorization:	*Crossing*	*Violation*	*Neither*	
58		Acceptability:	*Never*	*Sometimes*	*Frequently*	*Always*

	Putting the client in a lose-lose situation	Frequency:	*Rarely Occasionally Frequently Always*
		Categorization:	*Crossing Violation Neither*

Appendix D

Basic Empathy Scale (20 items)

(Carré, Stefaniak, D'Ambrosio, Bensalah, & Besche-Richard, 2013)

Please rate each statement on a 5-point scale with 1=strongly agree, 2=agree, 3=undecided, 4=disagree and 5=strongly disagree. Circle the number that best describe you.

1.	My friends' emotions don't affect me much	1	2	3	4	5
2.	After being with a friend who is sad about something, I usually feel sad	1	2	3	4	5
3.	I can understand my friend's happiness when they do well at something	1	2	3	4	5
4.	I get frightened when I watch characters in a good scary movie	1	2	3	4	5
5.	I get caught up in other people's feelings easily	1	2	3	4	5
6.	I find it hard to know when my friends are frightened	1	2	3	4	5
7.	I don't become sad when I see other people crying	1	2	3	4	5
8.	Other people's feeling don't bother me at all	1	2	3	4	5
9.	When someone is feeling 'down' I can usually understand how they feel	1	2	3	4	5
10.	I can usually work out when my friends are scared	1	2	3	4	5
11.	I often become sad when watching sad things on TV or in films	1	2	3	4	5
12.	I can often understand how people are feeling even before they tell me	1	2	3	4	5
13.	Seeing a person who has been angered has no effect on my feelings	1	2	3	4	5
14.	I can usually work out when people are cheerful	1	2	3	4	5
15.	I tend to feel scared when I am with friends who are afraid	1	2	3	4	5
16.	I can usually realize quickly when a friend is angry	1	2	3	4	5

17.	I often get swept up in my friends' feelings	1	2	3	4	5
18.	My friend's unhappiness doesn't make me feel anything	1	2	3	4	5
19.	I am not usually aware of my friends' feelings	1	2	3	4	5
20.	I have trouble figuring out when my friends are happy	1	2	3	4	5

Appendix E

The Experiences in Close Relationships-Revised Scale (36-items)

(Fraley, Waller, & Brennan, 2000)

The statements below concern how you feel in emotionally intimate relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by clicking a number to indicate how much you agree or disagree with the statement

1 2 3 4 5 6 7

Strongly Disagree Strongly Agree

1. I'm afraid that I will lose the love of others._____

2. I often worry that other people will not want to stay with me._____

3. I often worry that other people don't really love me._____

4. I worry that other people won't care about me as much as I care about them._____

5. I often wish that other people's feelings for me were as strong as my feelings for him or her._____

6. I worry a lot about my relationships._____

7. When other people are out of my sight, I worry that they might become interested in someone else._____

8. When I show my feelings for other people, I'm afraid they will not feel the same about me._____

9. I rarely worry about people leaving me._____

10. Other people make me doubt myself._____

11. I do not often worry about being abandoned._____

12. I find that people don't want to get as close as I would like._____

13. Sometimes people change their feelings about me for no apparent reason._____

14. My desire to be very close sometimes scares people away._____

15. I'm afraid that once someone gets to know me, he or she won't like who I really am._____

16. It makes me mad that I don't get the affection and support I need from my people._____

17. I worry that I won't measure up to other people._____

18. People only seem to notice me when I'm angry._____

19. I prefer not to show people how I feel deep down._____

20. I feel comfortable sharing my private thoughts and feelings with other people.

21. I find it difficult to allow myself to depend on other people._____

22. I am very comfortable being close to other people._____

23. I don't feel comfortable opening up to other people._____

24. I prefer not to be too close to other people._____

25. I get uncomfortable when another person wants to be very close._____

26. I find it relatively easy to get close to other people._____

27. It's not difficult for me to get close to other people._____

28. I usually discuss my problems and concerns with other people._____

29. It helps to turn to others in times of need._____

30. I tell other people just about everything._____

31. I talk things over with other people._____

32. I am nervous when people get too close to me._____

33. I feel comfortable depending on other people._____

34. I find it easy to depend on other people._____

35. It's easy for me to be affectionate with other people._____

36. People really understand me and my needs.____

Appendix F

Counseling Practice Questionnaire (40-items)

Across clients, how frequently do you engage in these counselor behaviors? If you haven't had any opportunity yet to engage in this behavior, how frequently do you think you might engage in this behavior if you did have the opportunity? Click your estimated frequency for each behavior.

	Counselor Behaviors	Frequency Never Occasionally Frequently Always						
1	***Accept gift from client***	1	2	3	4	5	6	7
2	***Give client a gift***	1	2	3	4	5	6	7
3	***Self-disclose personal information (e.g., sharing upcoming travel plans)***	1	2	3	4	5	6	7
4	***Share struggles of own with client***	1	2	3	4	5	6	7
5	***Use non-romantic physical contact (e.g., hug, putting hands on shoulder, hand over hand)***	1	2	3	4	5	6	7
6	***Therapist-client sexual contact***	1	2	3	4	5	6	7
7	***Fail to seek supervision/consultation to keep client disclosure private***	1	2	3	4	5	6	7
8	***Break confidentiality (beyond reporting abuse, neglect, or harmful behavior)***	1	2	3	4	5	6	7
9	***Speak to/respond to client about clinical issues outside of session (via text, phone)***	1	2	3	4	5	6	7
10	***Respond to client email after treatment termination***	1	2	3	4	5	6	7
11	***Keep a personal relationship after treatment termination***	1	2	3	4	5	6	7

	Counselor Behaviors	**Frequency**						
		Never		Occasionally		Frequently		Always
12	***Do not refer out client when better suited with more qualified provider for problem***	1	2	3	4	5	6	7
13	***Extend session beyond time allotted***	1	2	3	4	5	6	7
14	***Give out personal phone number/email***	1	2	3	4	5	6	7
15	***Leave session at same time as client – walk out to cars together***	1	2	3	4	5	6	7
16	***Visit patient at home (e.g., suicidal client, client unable to get to session)***	1	2	3	4	5	6	7
17	***Give your patient a ride home***	1	2	3	4	5	6	7
18	***Participate/stay in same social activity (e.g., book club, gym class)***	1	2	3	4	5	6	7
19	***Lessen session fees in times of financial hardship***	1	2	3	4	5	6	7
20	***Retain a patient for treatment longer than needed***	1	2	3	4	5	6	7
21	***Run into patient outside of therapy and say hi***	1	2	3	4	5	6	7
22	***Having pictures of family members in office***	1	2	3	4	5	6	7
23	***Do not share concerns of risky behavior with clients parents because client asked you not to***	1	2	3	4	5	6	7
24	***Attend client milestone (e.g., graduation/wedding/recital)***	1	2	3	4	5	6	7
25	***Hold dual relationship with client (also your friend, dentist, child's teacher)***	1	2	3	4	5	6	7
26	***Look up client or client family members on social media/google***	1	2	3	4	5	6	7

	Counselor Behaviors	Frequency						
		Never	Occasionally		Frequently			Always
27	***Accept client friend request on personal social media account***	1	2	3	4	5	6	7
28	***Share food during session***	1	2	3	4	5	6	7
29	***Do not report abuse right away because your client says will make their situation worse***	1	2	3	4	5	6	7
30	***Do not plan for session***	1	2	3	4	5	6	7
31	***Use client's family or friend as provider (dentist, mechanic, car salesman)***	1	2	3	4	5	6	7
32	***See client's family member or friend as a new patient***	1	2	3	4	5	6	7
33	***Find ways to agree with majority of what client says/avoid confrontation***	1	2	3	4	5	6	7
34	***Do extra client tasks/extra work for them (e.g., call a psychiatrist to make them appt.)***	1	2	3	4	5	6	7
35	***Share personal opinion (e.g., "you should divorce him")***	1	2	3	4	5	6	7
36	***Talk about past client's similar challenges***	1	2	3	4	5	6	7
37	***Talk about similar past personal experiences***	1	2	3	4	5	6	7
38	***Omit information from client when feel will benefit client (i.e., do not share diagnosis)***	1	2	3	4	5	6	7
39	***Cry in session with client***	1	2	3	4	5	6	7
40	***Write note of clearance to help client out when asked but not necessarily needed (i.e., service dog letter)***	1	2	3	4	5	6	7