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Nonsexual multiple role relationships, attachment style, and perception of the counseling situation and the counselor

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**Nonsexual multiple role relationships, attachment style, and perception of the
counseling situation and the counselor**

by

Irina Vladimirovna Diyankova

A dissertation submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Major: Psychology (Counseling Psychology)

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2008

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ABSTRACT

Professional discussion of nonsexual multiple role relationships (NMRR) has been extensive in the last fifteen years. However, only a few investigations have explored clients or former clients' views on NMRR. This analogue experimental study focused on the former clients' views on NMRR with mental health professionals. Additionally, associations between participants' attachment styles and their emotional and cognitive reactions to the counseling situations, as well as their perceptions of the counselor, were explored.

An experimental mixed 2 (multiple roles: accepted, declined) x 2 (gender: male, female) x 2 (type of multiple roles: social, professional) factorial design was used in this analogue study. One hundred-seventeen volunteer participants, all current college students and former counseling clients, completed the experiment in which they were exposed to vignettes, constructed descriptions of client-counselor interactions. Subjects were randomly assigned to one of the two between-subjects experimental conditions (multiple roles accepted vs. multiple roles declined). Each participant was presented with two vignettes describing counseling situations in which multiple roles either developed or did not. One vignette in each set described social interaction, while another one focused on professional interaction. Additionally, participants completed the following measures: the Balanced Inventory of Desirable Responding (BIDR), the Experiences in Close Relationships Scale (ECRS), the Multiple Role Questionnaire (MRQ), the Reaction Questionnaires (RQs), and the Counselor Rating Form – Short Version (CRF-S).

It was found that when multiple roles were accepted by the counselor, participants had more positive emotions and less negative feelings towards the counseling situation, and they perceived the counselor more positively than when multiple roles were declined. The

relationships between subjects' cognitive evaluation of the counseling situation and multiple roles were moderated by the type of multiple roles (social versus professional). Additionally, it was found that attachment anxiety predicted participants' negative emotional reactions to the counseling situation. Attachment avoidance predicted former clients' perceptions of the counselor. Study findings have important clinical implications. For example, former clients seemed to react positively to the multiple roles presented in vignettes. This finding suggests that they may not necessarily be harmed by selected types of NMRR.

CHAPTER 1. INTRODUCTION

The issue of nonsexual multiple role relationships (NMRR) has become one of the most controversial topics in the ethics of counseling. In the professional literature, a multiple or dual role relationship refers to counselor and client having several (not one) concurrent or consequential relationships (APA, 2002). Examples include a counselor and a client socializing, a counselor treating a student of his/hers, or a counselor buying goods from a client.

Even though it is established that having sexual relationships with clients is unethical, as the Ethics Code of Psychologists unambiguously states (APA, 2002), nonsexual involvements with clients outside of one's office are a grey area, where definitive rules do not exist. There are conflicting views among professionals as to whether nonsexual out-of-office relationships are harmful or beneficial for clients. Some practitioners think that these relationships lead to a greater counseling outcome (Lazarus, 1994a, Zur, 2001). Others are concerned about the harmful consequences for clients (Herlihy & Corey, 1992; Kitchener, 1988) and professionals (Knapp & Vandecreek, 2006). Given this ambiguity and diversity of opinions, there arise questions pertinent to how mental health providers can guide themselves and their clients through decisions concerning multiple roles. Some authors suggest avoiding the multiple relationships altogether (Doverspike, 1999). Others claim that avoidance is not possible (Rubin, 2000; Helbok, Marinelli, & Walls, 2006) and may be even destructive to treatment (Younggren & Gottlieb, 2004).

Even though professional discussion has been vigorous (Brown, 1994a, 1994b; Ebert, 1997, 2006; Greenspan, 2002; Lazarus, 1994a, 1994b, 1998; Zur, 2001, 2005) and heated (Zur, 2005), research in this area has been modest to date. Most studies focused on clinicians'

perspectives on multiple roles (Anderson & Kitchener, 1996; Baer & Murdock, 1995; Belz, 1994; Borys & Pope, 1989; DeJulio & Berkman, 2003; Helbok et al., 2006; Lamb, Cantazaro, & Moorman, 2004; Malley, Gallagher, & Brown, 1992; Womontree, 2004), and only few investigations explored clients or former clients' views on dual role relationships (Diyankova & Scott, 2003, 2006; Pulakos, 1994; Ramsdell & Ramsdell, 1993). It seems impossible, however, to resolve the controversial questions of multiple role ethicality without examining the opinions and views of all parties directly involved in the counseling relationship, including clients and former clients. Therefore, this study seeks to contribute to the existing body of literature by exploring former clients' views on nonsexual multiple role relationships with mental health professionals.

In order to fully appreciate the questions asked in this study, it is important to be familiar with the assertions concerning ethics of multiple roles presented by scholars. In the next section, the author summarizes professional discussion in this area.

Ethics of Multiple Roles

In the last fifteen years there has been an ongoing debate about the ethicality and management of multiple roles in counseling and psychotherapy, with some scholars expressing strong opinions on the subject matter (Lazarus, 1994; Meyer, n.d.; Zur, 2005). Given that, at times, views on multiple roles discussed in the literature differed substantially, the author classified them for the ease of understanding, as belonging to one of the following three categories: a conservative approach, a liberal approach, and a feminist approach. Each of these approaches is briefly summarized below.

The conservative approach to the question of multiple roles stipulates a rather strict definition of boundaries in counseling relationships, and it encourages mental health

professionals to strictly adhere to those limits (Gabbard, 1994; Gottlieb, 1994; Gutheil, 1994; Herlihy & Corey, 1992; Kitchener, 1988; Pope & Vasquez, 1991). According to Williams (1997), this approach originated from the psychodynamic view on the boundaries in the counseling relationship. Some of the boundaries discussed in the literature regard time, space, physical touch, more specifically lack of it, out-of-office interactions, self-disclosure, and gifts (Gutheil & Gabbard, 1993). To be an ethical professional in this frame of reference, one has to start and end sessions on time, meet his/her clients in the professional office, be neutral and not disclose information about oneself, abstain from socializing with the clients, preferably not acknowledge them on the street, and never touch patients or accept gifts from them (Williams, 1997).

In relation to NMRR, many authors from this group suggest that they should be avoided whenever possible (Knapp & Vandecreek, 2006). They explain that NMRR often create a conflict of interest in counseling relationship (Kitchener, 1988) that may lead to the lack of therapeutic progress and harm to clients. In addition to the risks that NMRR themselves pose for clients, the dangers that can evolve were described by Atkins and Stein (1993) and by Doverspike (1999). These authors believe that unethical sexual relationships between professionals and clients often start with nonsexual boundary violations or multiple roles.

Writers classified by the author, and noted as follows, as belonging to the *liberal approach* express quite different views on the counseling relationships' boundaries and NMRR. They criticize the clear-cut limits suggested by Gutheil & Gabbard (1993), as well as many other authors, for being too rigid and not inclusive of multiple factors that may influence development of these limits (Bridges, 1999; Lazarus, 1994a). There exist several difficulties concerning the attempts to define an objective set of therapeutic boundaries as

appropriate for every clinical case. They include: (a) diversity of mental health professionals' theoretical orientations and approaches to therapy (Lazarus, 1998; Smith & Fitzpatrick, 1995; Williams, 1997), (b) multicultural factors, such as client's gender, race, and socio-economic status (Brown, 1994a), and (c) individual differences among the clients (Lazarus, 1998).

The authors from this group do not suggest that there should be no boundaries in counseling relationship. Rather they indicate that the therapeutic boundaries are not universal and should not be presented and regarded as such. Additionally, mental health professionals should exercise good clinical judgment and flexibility when establishing boundaries with a particular client.

Overall, NMRR are thought to be healthy and beneficial for clients (Lazarus, 1994a, 1994b, 1998; Rubin, 2000; Williams, 1997; & Zur, 2001). They are viewed as a part of life and, therefore, should be treated as such. Many writers in this group suggest that NMRR are unavoidable in many environments, such as rural communities (Montgomery & DeBell, 1997; Younggren & Gottlieb, 2004) and college campuses (Hyman, 2002). In addition, the standard of strict counselor-client relationship with the exception of any other contact is not compatible with many cultures and cultural groups, such as Asian American, Native American, LGBT, and the Deaf to name just a few (Smith, 1990). In the aforementioned settings and cultures the neutral professional re-enforcing strict and clear-cut boundaries is likely to be regarded as cold and not trustworthy.

Zur (2005) suggests that NMRR facilitate the development of trust in the therapeutic relationship and create an open environment that is less likely, than rigid boundary maintenance, to lead to exploitation of a client. Additionally, Zur suggests that an idea of danger associated with boundary crossings and NMRR is nothing more than a paranoid myth.

The feminist approach (Brown, 1994a; Lerman & Rigby, 1990; Walker, 2002) may be described as more of a middle ground. Feminist therapists stress both the benign nature of NMRR and their potential for harm. These therapists often refer to NMRR as overlapping relationships. Lerman and Rigby (1990) state that overlapping relationships have always been a fact of life, which equally applies to the counseling relationship. However, the same authors recommend avoiding dual role relationships whenever possible, at the same time acknowledging that it is not always possible. Feminist therapists write extensively about power differentials, as well their attempts to equalize power in therapeutic relationships. Given this stand, overlapping relationships may serve clients' interests by equalizing power in relationships (Saks-Berman, 1985).

Walker (2002) calls for flexibility and discussion of clients' boundary-related requests with clients. In her paper, the author gives an example when she refused to shelter one of her clients, because she thought it would slow down her progress in therapy, at the same time, she described her attendance of one of her clients' wedding, because it was not contraindicated therapeutically.

Research on NMRR

It is interesting that the heated debate about the topic of NMRR has not produced much empirical research. The studies, that have been done in this area, have primarily focused on mental health professionals' perspectives, attitudes, and reported behaviors (Borys & Pope, 1989; Baer & Murdock, 1995; DeJulio & Berkman, 2003), while almost ignoring clients' views and attitudes. The findings suggest that there is considerable diversity in practitioners' attitudes towards NMRR and varying degrees of acceptance of behaviors associated with boundary crossings and dual relationships. The few studies, that were conducted on client

populations, also found a diversity of views and attitudes (Diyankova & Scott, 2003; Pulakos, 1994; Ramsdell & Ramsdell, 1993).

It appears that research on NMRR is in its early stages, especially the line of research that investigates clients' perspectives. It seems surprising, given that the question is whether and to what extent are NMRR potentially harmful or beneficial to clients. This author agrees with Ramsdell and Ramsdell (1993) that, although responsibility for determining appropriate professional boundaries cannot be fully accorded to clients, and professionals must remain aware of confusion and vulnerability experienced by clients in pain, it is important and helpful to learn how clients regard and experience NMRR, and what they think about the effects of multiple roles on therapy. Additionally, this author shares feminist perspectives on the counseling relationship regarding power differential and empowerment. It seems therapeutic to equalize power in the counseling relationship and to empower clients to make decisions regarding their lives, including therapy. This cannot be done without soliciting their perspectives on each aspect of therapy and without involving them in the decision-making process.

It is interesting that, although consistently finding variability in clients' views, only a few researchers have attempted to search for the constructs that may explain these differences. For example, Diyankova & Scott (2003) found that gender may contribute to the differences in the college students' perspectives on nonsexual multiple role relationships. Their findings were consistent with those of the other researchers who examined gender differences in the perspectives of mental health professionals (Borys & Pope, 1989; Baer & Murdock, 1995). However, the differences detected were rather small. It seems important to continue exploring the impact of gender on the perception of the multiple roles. Additionally searching

for the other variables that may predict differences in clients' attitudes towards NMRR may be productive. One of the possible factors, that emerges from the literature, is attachment style.

Attachment Style

Attachment theory, stemming from the original works of Bowlby & Ainsworth (Bretherton, 1992), postulates that when under stress human beings, babies as well as adults, seek proximity to and protection from the secure person. This behavior has been named attachment and a secure person has been labeled an attachment figure (Ainsworth, 1989; Lopez & Brennan, 2000). Due to the different childhood experiences with primary caregivers the types of attachment behaviors that people exhibit differ significantly along two dimensions, anxiety and avoidance (Bartholomew & Horowitz, 1991). Persons who are low on both anxiety and avoidance are called securely attached. This style is considered to be healthy. It has been related to such desirable aspects of mental functioning, as flexibility and open-mindedness in information processing, accurate and highly differentiated assessments of others, balanced self-views that derive from both interpersonal and achievement sources, and seeking social support when stressed (Lopez & Brennan, 2000). The other three styles, anxious-ambivalent, avoidant, and dismissing stem from different combinations of avoidance and anxiety (Bartholomew & Horowitz, 1991) and have been related to a variety of psychological problems (e.g., Wei, Mallinckrodt, Larson, & Zakalik, 2005).

Beginning from Bowlby's (1988) seminal paper, multiple researchers have examined the connection between attachment style and counseling relationship. Slade (1999) described two major factors tying attachment style with counseling. First, client's attachment organization has a profound effect on his or her feelings about and expectations of his/her therapist.

Second, the model of successful treatment involves client's capacity to use a therapist as a secure base or, in other words, to be securely attached.

Mallinckrodt and colleagues conducted a number of empirical studies examining associations between counseling relationships and client's attachment style. Mallinckrodt, Gantt, and Coble (1995) found strong relationships between attachment style and working alliance as perceived by a therapist. Mallinckrodt, Porter, and Kivighan (2005) showed a significant association between client's attachment style and depth of in-session exploration. Additionally, Woodhouse, Schlosser, Crook, Ligiero, and Gelso (2003) detected a relationship between client's attachment style and transference as perceived by a therapist. All the aforementioned findings suggest that attachment style may significantly impact counseling relationship. As such, attachment seems to be relevant to the exploration of former clients' reactions to multiple roles.

Rationale for the Study

This study seeks to contribute to the existing body of research by examining several aspects of former clients' perspectives on NMRR. First, the effect of acceptance or decline of multiple roles in the counseling situation on the participants' perceptions of the situation and the counselor will be explored. This line of inquiry continues the work by Diyankova and Scott (2006). These researchers used vignettes that described counseling situations with acceptance or decline of multiple role relationships on the counselor's part and, in addition, specified positive or negative client's reactions to these situations. No main effects of multiple roles on participants' perceptions of the counseling situation and counselor were found. However, the researchers discovered that an interaction between multiple roles and clients' reactions to them, as presented to participants in vignettes, explained part of the

variance in participants' perceptions of the counseling situation and of the counselor described in the vignettes.

One of the criticisms associated with this study pertained to the notion that participants' responses to the vignettes were confounded by the clients' reactions to the multiple roles described in the vignette. It remains to be seen, what will happen if vignettes just describe acceptance or decline of multiple roles and omit clients' reactions to them. The present study will use the vignettes modified in the suggested direction, that is by presenting acceptance or decline of multiple roles without specifying client's reaction to it. There exists some indirect evidence that suggests that former clients may react more positively to the acceptance rather than decline of multiple roles (Diyankova & Scott, 2003; Pulakos, 1994).

Secondarily, the author plans to assess whether former clients' perceptions of NMRR differ depending on the dimensions of their attachment style. Several researchers have found association between attachment style and the counseling relationship (e.g., Mallinckrodt, Gantt, & Coble, 1995), which led the investigator to hypothesize that attitudes towards multiple roles and perceptions of the situations involving multiple roles may be influenced by attachment style as well.

Moreover, the author wonders if acceptance or decline of multiple roles in a counseling situation will have a different effect on the participants' attitudes towards multiple roles depending on subjects' attachment styles. Slade (1999) proposed that individuals high on attachment anxiety and low on avoidance may become dependent upon and demanding towards their counselor. She indicated that they were likely to challenge the boundaries of the relationship. It is possible, however, that dependence and challenge to the boundaries may stem from low attachment avoidance. Continuing this line of reasoning, the interaction

between attachment avoidance and multiple roles may partially predict participants' reactions to the vignettes. For example, low attachment avoidance may be associated with more negative reactions to the absence of multiple roles (i.e., a therapist setting boundaries) and more positive responses to the presence of multiple roles than high avoidance. The latter may be associated with the preference of staying within the boundaries of the counseling relationship and may result in more positive reactions towards absence (decline) of multiple roles. However, given a lack of research on attachment style and multiple roles, it is difficult to make specific predictions. So, this study seeks to explore whether attachment style dimensions explain any of the differences in participants' perceptions of the counseling situation and the counselor.

Third, this study seeks to control for gender effects, as the previous research showed that a small proportion of the variance in perspectives on multiple role relationships was explained by sex (Baer & Murdock, 1995; Borys & Pope, 1989; Diyankova & Scott, 2003). Finally, previous research suggested that part of the variance in self-report measures may be explained by the social desirability bias, especially when these measures assess negative affect (Bartz, Blume, & Rose, 1996). Additionally, Holtgraves (2004) showed that social desirability operates as an editing process of the self-report. Moreover, Paulhus (1984) discussed the importance of controlling impression management when using self-report measures. Given these important findings and the fact that participants are asked to report their positive and negative emotions, as well as their positive and negative perceptions of the counselor, control for social desirability seems important.

The major dependent variable dimensions of interest in this study are participants' views on NMRR in counseling. Three different aspects of these views will be studied. Two of them

are more situational and pertain to participants' immediate reactions to the situation of multiple roles in the form of their feelings and thoughts. The third one is likely a more stable construct which refers to general attitudes towards NMRR. In addition, the author is interested in how the counselor described in vignettes is perceived by the study participants depending on whether he is involved or not involved in the multiple role relationships with clients. The question of whether participants' reactions to the multiple roles will be extended to include their perception of the counselor seems important. If reactions to the multiple role situations are associated with the counselor perception, the importance of addressing nonsexual multiple roles in the context of the counseling relationship in a competent and flexible manner becomes even more salient.

Research Questions

Four groups of research questions stem from the study rationale. The questions are grouped around the dependent variables of interest.

Emotional reactions to the counseling situation

Will participants have more positive emotional reactions to the situations involving acceptance of multiple roles by the counselor as compared to the decline? Will participants have more negative emotional reactions to the decline or acceptance of multiple roles? Will participants' emotional reactions to the counseling situation be affected by attachment anxiety and/or attachment avoidance?

Cognitive evaluation of the counseling situation

Will participants perceive more positive or negative outcomes of the counseling situation depending on the acceptance or decline of multiple roles? Will participants' cognitive evaluation of the situation be affected by attachment anxiety or attachment avoidance?

Perception of the counselor

Will the counselor, presented in the counseling vignettes, be more positively viewed by the study participants when he accepts multiple roles than when he declines them? Will attachment anxiety and/or avoidance have an effect on the participants' perceptions of the counselor?

General attitude towards multiple roles

Will attachment anxiety have an effect on participants' general attitudes towards multiple roles? To what degree will attachment avoidance be associated with participants' general attitudes towards multiple roles?

CHAPTER 2. LITERATURE REVIEW

Multiple Role Relationships in Counseling: Definitions and Ethical Standards

There are varied definitions of a multiple role (or dual role) relationship in counseling and psychotherapy, however, most of them are similar. The most prominent definition of multiple role relationships appeared in the 2002 American Psychological Association Code of Ethics and Professional Standards:

A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in relationship with a person closely associated with or related to the person with whom they have the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person (American Psychological Association, 2002; p. 6).

Pope and Vasquez (1991) gave a simpler definition. They characterized the dual relationship in psychotherapy as a situation, when a therapist is concurrently involved in a second relationship with his or her client. The other relationship, which is often referred to as secondary, may be of social, financial, or professional nature.

Multiple role relationships in counseling encompass a broad category of relationships which include, but are not limited to, such situations as: (a) having sex or interactions of sexual nature with a client, (b) dating a client, (c) having sexual relationship with a former client, (d) entering into business relationships with a client, (e) service and product bartering with a client, (f) delivery of professional services to close friends and family members, (g) socializing with clients, (h) entering into therapeutic relationships with employees, (i) accepting acquaintances as clients, (j) accepting gifts from clients and asking them for favors (Koocher & Keith-Spiegel, 1998).

Often multiple role relationships are discussed as synonymous with boundary crossings and violations (Barnett, 1996). However, these concepts are overlapping, but not the same. Moreover, there exist multiple definitions of therapeutic boundaries (Bridges, 1999; Gutheil & Gabbard, 1993; Johnston & Farber, 1996; Smith & Fitzpatrick, 1995). Smith and Fitzpatrick (1995) describe therapeutic boundaries as “a therapeutic frame which defines a set of roles for the participants in the therapeutic process” (p. 499). According to Gutheil and Gabbard (1993), where the boundary lies depends on the limits that are introduced in the relationship by a psychologist and his/her client. But responsibility for defining the limits rests with professional. Gutheil and Gabbard describe some common domains for the limits in counseling practice: role, time, place and space, money, gifts, clothing, self-disclosure, and physical contact. Most scholars, when discussing the issues of therapeutic boundaries, recognize that there should be definite boundaries in therapeutic relationship. What professionals disagree about is: what are these boundaries, how flexible they should be, and how universal are they.

According to Gutheil and Gabbard (1993), boundary crossing is a descriptive term, neither laudatory nor pejorative. Violation of a therapeutic boundary represents harmful crossing, a boundary transgression. The concepts of therapeutic boundaries and their violations are tightly connected with that of multiple role relationships. As Barnett (1996) states, “all dual relationships with patients in some way reflect a crossing of certain pre-established boundaries” (p. 138). However, when we speak about multiple role relationships, the continuity of a secondary relationship is often implied. Therefore, boundary crossings or violations are happening in multiple role relationships on a continuous basis.

Different multiple role relationships are not equivalent in an ethical sense, or in terms of potential for harm to a client, a therapist, or a counseling relationship. As noted in the most recent American Psychological Association (APA) Code of Ethics and Professional Standards (2002), psychologists acknowledge that sexual relationships with current and former clients, clients' relatives and significant others, as well as acceptance of former sexual partners as clients, are unethical and harmful for clients (ethical principles 10.05 - 10.06). However, there is little agreement about the wide range of other than sexual multiple role relationships. These relationships were termed nonsexual multiple role relationships (NMRR), and they are in the focus of this study.

The APA Code of Ethics gives very vague guidelines for the NMRR situations, involving mental health professionals and their clients. However, principles 3.05 and 3.06 to some degree address the ethicality of NMRR. These principles convey two major points. First, secondary relationships that are not expected to cause harm are not unethical. Second, psychologists should avoid multiple role relationship, if it could be anticipated to cause harm to a client or lead to a professional's impairment. The phrase "reasonably expected" is used throughout the text. Many questions arise after reading the aforementioned guidelines. For example, is it always or even often possible to foresee harm, exploitation, or impairment stemming from NMRR? What is the meaning of 'reasonably expected'? The ambiguity associated with NMRR is reflected in the ethics codes of other therapeutic disciplines (American Association for Marriage and Family Therapy, 2001; American Counseling Association, 2005; National Association of Social Workers, 1999). The only exception to this trend seems to be the Feminist therapy code of ethics (Feminist Therapy Institute, 1987), which does not present NMRR on the ethical-unethical dichotomy, but rather views it as a

fact of life to be dealt with. Feminist guidelines are formulated in a mild and moderate language. Thus, the Feminist therapy code of ethics suggests that the practitioner should be aware of the complex nature and overlapping interests inherent in multiple role relationships. Additionally, a therapist is responsible for prevention of possible abuse and harm to a client if involved in these relationships (Feminist Therapy Institute, 1987).

The ambiguity and confusion of most Ethics Codes has led to publication of multiple ethical decision-making and risk management models and guidelines. Some of them addressed general issues (Atkins & Stein, 1993; Doverspike, 1999; Younggren & Gottlieb, 2004), while others focused on specific situations: multiple roles in rural communities (Stockman, 1990), NMRR in LGBT community (Kessler, 2005), and NMRR in pastoral counseling (Montgomery & DeBell, 1997). These papers provide more clarification and give concrete suggestions related to management of NMRR. Unfortunately, often guidelines depend on the views of the author more than on empirical or clinical evidence.

Debate on the Ethicality of NMRR

During the past two decades, professionals' awareness of the importance and complexity of NMRR has been increasing. Many prominent psychotherapy scholars and practitioners have written about this issue (Bennett, Bricklin, & VandeCreek, 1994; Borys, 1994; Brown, 1994b; Ebert, 1997, 2006; Gottlieb, 1994; Gutheil, 1994; Lazarus, 1994a, 1994b, 1998; Lazarus & Zur, 2002; Pope & Vasquez, 1991; and Zur, 2001, 2005). The category of nonsexual dual relationship was singled out of the broader category of dual relationship in the reports of the APA Ethics Committee. The issue of nonsexual dual relationship raises many difficult questions, most of which thus far have not received definite answers. Among the salient questions are the following:

- What is the balance between harm and benefits in NMRR?
- How should mental health professionals address NMRR and respond to multiple roles, when they develop in counseling relationship?

Among authors writing about multiple relationships, there exists disagreement about harmfulness and/or beneficence, and, as a result, appropriateness of multiple role relationships in therapy and counseling, and the ways of resolving them. Despite this apparent disagreement all authors recognize existence of multiple role relationships and potential for harm that is inherent in them. The investigator has classified the views on NMRR, expressed in the professional literature, in three major groups, namely a conservative approach (Kitchener, 1988; Herlihy & Corey, 1992, 1997; Knapp & Vandecreek, 2006), liberal views (Lazarus, 1994a, 1994b, 1998; Zur, 2001, 2005), and a feminist perspective (Brown, 1994a; Greenspan, 2002; Walker, 2002). However, there is one author, Bruce Ebert (1997, 2006), who seems to share both liberal and conservative views. His writings will be discussed separately.

Conservative approach

Professionals in this group view NMRR as potentially harmful. They focus on the problems associated with nonsexual multiple role relationships and on their potential for abuse, maltreatment of a client and impairment of a mental health professional (Gabbard, 1994; Gottlieb, 1994; Kitchener, 1988; Kitchener & Harding, 1990; Pope & Vasquez, 1991). Although this group acknowledges that not all nonsexual multiple role relationships are harmful, they think that the risk of exploiting a client and abusing therapist's power is inherent in those relationships. "It is crucial to clarify our relationship to each patient and to

avoid sexual and nonsexual dual relationships, which prevent that clarity and place the patient at great risk for harm" (Pope & Vasquez, 1991, p. 129).

Herlihy and Corey (1992) assert that dual relationships can be problematic along a number of dimensions: (a) they are pervasive, (b) they can be difficult to recognize, (c) they are sometimes unavoidable, (d) they can be very harmful, but are not always harmful, (e) they are the subject of the conflicting advice from expert sources.

Kitchener (1988) identified three potential factors in a dual role relationship that may result in a professional causing harm to a client. They are: incompatibility of expectations between roles, divergence of the obligations associated with the roles, and power and prestige of professional. Gottlieb (1994) supports Kitchener's notion of incompatibility of expectations between roles. He thinks that a conflict between role expectations is the main issue concerning NMRR.

When speaking about the harm that dual relationships can cause, Pope and Vasquez (1991) also note that these relationships: erode and distort the professional nature of therapeutic relationship, create conflicts of interest, and thus compromise the disinterest (not lack of interest) necessary for professional judgment, and cannot be equal, because of the existing power imbalance in therapeutic relationship.

Gabbard (1994) expresses concern that the clients may not feel free to express their negative emotions, such as anger, to their therapist who is also their friend or with whom they have other than therapeutic relationships. Another common concern is associated with NMRR eventually developing into a sexual relationship (Knapp & Vandecreek, 2006). The concept of the slippery slope has been used to describe this process. "When boundary violations begin to occur, a clinician may start sliding down the slippery slope toward sexual

misconduct” (Doverspike, 1999, p. 12). Further, the author states that although a mandatory ethical obligation would be to abstain from having sex with a client, a more aspirational standard should be maintenance of clear boundaries with clients.

In general, the authors in this group seem to pay much more attention to potential of harm inherent in NMRR than benefit, and they suggest avoiding multiple roles whenever possible.

Liberal view

In the last two decades multiple authors have expressed their concerns with prohibitions that exist in the area of multiple role relationships (Lazarus, 1994, 1998; Lazarus & Zur, 2002; Williams, 1997; Zur, 2001, 2005). They think that, as a result of evolving ethical standards (as well as legal practices), psychologists and other mental health providers are becoming more rigid in maintaining their boundaries with the clients. They assert that this tendency is harmful, first of all, for the clients: "... practitioners who hide behind rigid boundaries, whose sense of ethics is uncompromising, will, in my opinion, fail to really help many of the clients who are unfortunate enough to consult them." (Lazarus, 1994a, p. 260) They also believe that currently many professionals try to avoid multiple role relationships or occasional involvements with the clients from which their clients can benefit.

Moreover, Rubin (2000) states that clinicians have to move the focus of their attention from the term "multiple relationships" to the term "multiple levels of involvement". He argues that all therapists have multiple levels of involvement with their clients, and that this is neither avoidable nor has to be avoided. He suggests that harm potential is not inherent in the NMRR. More specifically, Rubin thinks that it is a failure to acknowledge and balance multiple levels of involvement with each other, as well as a complex set of motivations, feelings and behaviors that come with them, that presents potential danger for a client. A

criticism of this view is that it may not be realistic to expect that mental health professionals and their clients will be able to recognize and balance these complex motivations.

Zur (2001) states that nonsexual multiple role relationships are a part of community living. He says that normally people are connected and interdependent in a healthy way. So, why would not we expect the same from a counselor and a client? Also, multiple role relationships are unavoidable elements in the rural and small town life. Additionally, Zur thinks that NMRR serve as a reflection of the shared culture in many groups and communities, such as the gay, the physically challenged, and some ethnic minorities. Moreover, he states that NMRR may facilitate therapeutic alliance, trust in counseling relationship, and effectiveness of counseling because both partners will come to know and trust each other better through the out-of-office involvements.

In his latest paper on NMRR, Zur (2005) criticized the conservative approach to the multiple roles that has dominated the profession. He stated that so called dangers associated with NMRR are exaggerated. Zur focused on several myths in this area. One is the portrayal of NMRR as synonymous with inevitable exploitation and harm. The second myth is that of the slippery slope, which has been used and abused extensively in the last decades. Zur seems very passionate when he states: "It is insulting for educated psychotherapists to be repeatedly lectured on the paranoid notion of the slippery slope... Nevertheless if repeated enough by enough experts , ethicists, and attorneys, it becomes the dumbed-down professional standard" (p. 268-269). He suggests that multiple myths surrounding NMRR are fueled by psychoanalytic theory and risk management approach. Zur asserts that it is very disturbing that risk management and fear of speaking up are guiding professional decisions in this area, instead of clinical considerations and caring attitude towards clients.

In addition to and consistent with Zur, Williams (1997) thinks that standards of strict boundary maintenance and avoiding multiple role relationships stem from the psychodynamic perspective. These standards, in his opinion, fail to encompass practices of humanistic and cognitive-behavioral therapies.

In general, the authors from the liberal group think that nonsexual dual role relationships may be healthy and beneficial for the clients in many cases. They tend to focus on the positive sides of these relationships, and they do not consider these relationships to be inherently unethical. However, even they acknowledge that nonsexual multiple role relationships may be harmful in some cases and situations, and that psychologists have to be sensitive to the potential consequences of their actions.

Bruce Ebert

This author wrote extensively about ethics in counseling with the later works being focused on multiple role relationships (Ebert, 1976, 1992, 1997, 2006). His position related to NMRR is difficult to classify, because it seemed to change throughout the years, and his current view encompasses both conservative and liberal assertions. Therefore, his position is considered as a special case.

In an earlier paper Ebert (1997) expressed an opinion that the implied prohibition of the dual relationships was too conservative. Even though the APA Ethics Codes never prohibited all multiple role relationships per se, the author was concerned with the broad interpretations of the guidelines advocated by some professionals, as well as their influence on the regulatory boards and ethics committees decisions. The situation seemed especially alarming in the light of the following APA's (1986) ruling: "[it] is clear that 'dual relationships', such as social contact with patients, are to be avoided" (p. 695). The author stated that it was

impossible to avoid all multiple relationships and that there were many examples of these types of relationships that were harmless.

Ebert (1997) described several major problems associated with the promoted prohibitions and conservative attitudes towards NMRR, such as interference with the constitutionally protected right to privacy, restriction of the First Amendment right to association, and lack of initial intentions of APA standards to prohibit all multiple role relationships. From Ebert's perspective, poorly defined and vague standards for ethical and unethical conduct in the area of NMRR, as well as overly broad understanding and application of the existing guidelines, facilitated the movement of ethics committees and professional boards towards more restrictive and arbitrary judgments. In general, Ebert seemed to advocate a liberal approach to multiple role relationships and his paper has been reprinted in the Lazarus and Zur's (2002) volume, one that expresses rather open-minded views and attitudes towards NMRR.

In 2006, Ebert published a monograph completely devoted to the challenges of multiple role relationships. In this book, the author expressed much more cautious views on NMRR. In fact, in one part of the monograph he dissociated himself from the Lazarus and Zur (2002) work by stating that "there is a strong likelihood that, if a professional follows the advice of the authors, that professional is likely to become the object of a disciplinary action" (p. 17). In general, the author uses the language and concepts of the conservative writers, such as the "slippery slope". In one of the chapters he focuses on the possible negative consequences of NMRR for a professional, such as criminal complaints or complaints to one's employer. The author still thinks that there are many types of NMRR that are ethical. However, he advises, "when in doubt, be conservative and do not engage in [NMRR]" (p. 24).

Feminist perspective

There is an emerging third voice in the discussion of NMRR that belongs to the feminist therapists (Brown, 1994a; Greenspan, 2002; Lerman & Rigby, 1990; Walker, 2002). This group takes a multicultural approach to NMRR by considering multiple perspectives on the issues, such as that of a client, of a therapist, of a person living in the rural area, or of an ethnic minority individual. Their approach to the challenges of NMRR is complex and diversified. These authors stress both the benign nature of NMRR and their potential for harm. Feminist therapists often refer to NMRR as overlapping relationships. Lerman and Rigby (1990) state that overlapping relationships have always been a fact of life, whether in psychotherapy or outside of it. The Feminist therapy code of ethics (Feminist Therapy Institute, 1987) supports this idea through the guidelines accepting of NMRR.

As a first step in approaching the feminist outlook, it is important to understand their concept of boundaries. In general, feminist therapists view boundaries in a way that differs from the mainstream approach to psychotherapy. Thus, Greenspan (2002) thinks that the concept of boundaries itself is reflective of the male psychodynamic approach that does not hold true for women and for therapists of the other theoretical orientations. Greenspan states that fluid and permeable boundaries are more natural for women who feel safe in the situation of interconnectedness as opposed to distance and separation.

Brown (1994a) says that universal boundaries are a myth. Given the heterogeneity of human experiences, it seems naïve to expect that one mold will fit all. This author states that “appropriate boundaries in therapy are a reflection of race, class, culture, setting, and most importantly, the specific and unique relational matrix among and between the human beings in therapy room” (p. 31). Here, the client’s perspective is brought in the focus of attention

through the notion of individual differences in the perception of boundaries and their violations. Brown claims that a client is an important source of authority on whether the boundaries are appropriate and whether violation has occurred.

Most feminist professionals agree that NMRR are unavoidable in many situations (Adleman & Barret, 1990; Biaggio & Greene, 1995; Lerman & Rigby, 1990; Walker, 2002). This opinion is especially relevant for the professionals who live or work in the small rural communities (Gates & Speare, 1990), within ethnic minority groups (Biaggio & Greene, 1995) or among sexual minorities (Smith, 1990). This view is shared by both the liberal and conservative authors in the area of NMRR. However, feminist therapists take the argument one step further, when Biaggio and Greene (1995) say that mental health professionals do not always have control over, or even an ability to anticipate, the ways in which their lives may overlap with those of their clients.

Some feminist authors (Greenspan, 2002; Lerman & Rigby, 1990) think that potential for harm attributed to NMRR should be re-addressed. They assert that it is abuse of power, not multiple roles, that is responsible for the negative consequences of NMRR. And, this abuse may happen even with the strictest maintenance of boundaries. Greenspan (2002) states that the best way to prevent abuse from happening is to equalize power in relationships by giving up the expert role, and by being flexible and empathic with one's clients, as well as by acknowledging interconnectedness which includes integration of different roles, not avoidance of multiple roles. Other authors acknowledge potential problems of the NMRR. For example, Biaggio and Greene (1995) suggest that a secondary relationship may develop in two problematic ways: by not meeting therapist's needs or by not meeting client's needs.

Moreover, there exists heterogeneity within the feminist group in regards to the views on and approach towards the NMRR. Some clinicians are more cautious and conservative in dealing with multiple roles. For example, Sears (1990) shares her experiences of being the only Native American lesbian therapist within a three state area. She chose to be conservative and explicit with her clients in relation to managing boundaries and multiple roles. The author acknowledges that this choice limited the number of lesbian and Native American friends she has. On the other hand, Smith (1990) argues against strict guidelines that limit relationships between a mental health professional and his/her client.

In addition, the feminist authors suggest several ways in which therapists can protect their clients from exploitation and harm in NMRR: by equalizing power (Greenspan, 2002), by being flexible and discussing client's requests with clients (Walker, 2002), by reaching their own emotional well-being through continuous self-care and self-monitoring (Smith, 1990), and by empowering their clients and staying connected to them (Greenspan, 2002).

NMRR in special situations

The previous discussion focused on NMRR and counseling in general. However, there exist several special cases that merit consideration when exploring the ethicality of multiple roles. Thus, several authors have focused on counseling situations that make NMRR difficult or impossible to avoid. For example, Stockman (1990) discussed the issues of NMRR in rural practice. The author suggested that if a professional wants to be helpful to and respected in the rural community, he or she should not avoid secondary (to the counseling) interactions and relationships with potential, current and former clients. He suggests that rural residents harbor resentment towards "outsiders-rescuers". The author proceeds to give extensive recommendations to the professionals related to managing multiple roles in the most

beneficial and least harmful ways. Questions of ethicality are not being raised because multiple role relationships are a fact of life in the rural areas.

Helbok, Marinelli, and Walls (2006) conducted national survey of ethical practices in rural and urban communities. They found that rural practitioners encounter more types of multiple role situations in their work with the clients. Also, they are more often involved in the secondary relationship as compared with their urban counterparts. Helbok et al. also analyzed participants' responses to the open-ended questions. Many rural practitioners noted that it was impossible to avoid multiple roles in their environment and that ethical codes should be changed to reflect this reality.

Kessler (2005) stated that due to the cohesive nature of sexual minorities communities, LGBT therapists and LGBT clients are likely to communicate with each other outside of counseling. The author cited research suggesting that up to 95% of LGBT therapists encountered clients socially in the community (Morrow, 2000 as cited in Kessler, 2005). He proceeded to offer a number of practical recommendations to the mental health professionals including: preparation of the client for NMRR potential; analysis of the impact of shared involvement in LGBT community on counseling process; and incorporation of the LGBT community realities into the existing ethical decision-making models.

Kertesz (2002) stated that the communal nature of the Latin culture directly influenced therapeutic work. He noted that it was quite typical and ethical for therapists from Latin countries to have multiple involvements with their clients. Moreover, counselor's rejection of client's invitation for a social event or celebratory occasion may lead to a negative interruption of therapy because it would be perceived as an offense. In spite of these generally favorable views on NMRR, the author stated that caution should be exercised by a

therapist when approaching secondary relationships. It is not acceptable for a mental health professional to satisfy his/her own needs at the client's expense. Additionally, a great degree of flexibility and clear-cut contracts are needed to successfully negotiate multiple roles.

An additional special situation is presented in university counseling center settings. Harris (2002) considered multiple role relationships in the context of the university counseling center, the situation especially applicable to the current study on the student population. He said that, in the context of the university campus, NMRR became almost unavoidable. According to Malley, Gallagher, and Brown (1992), multiple role relationships refer to one of the major categories of ethical problems encountered by the university counseling centers' staff. Harris analyzed a clinical example from his practice in which he frequently had lunch served by his client in one of the campus restaurants. He stated that this secondary relationship, instead of negatively affecting counseling process, benefited it.

Iosupovici and Luke (2002) also shared their experiences and observations related to the multiple roles in the environment of the university counseling center. They emphasized such positive aspects of NMRR as client empowerment and increased trust. Additionally, they noted that counselor's integration into the university community is an expectation in the majority of the college centers. The authors suggest including explanation about NMRR in the informed consent and noting outside encounters and interactions in the clinical records. They further propose that NMRR should be studied from both client and therapist perspectives and that clinical records that note multiple roles would make these investigations much easier.

Discussions, prior noted in this section, reflect the conflict between mainstream professional ideas about the boundaries in therapeutic relationships and cultural norms of a

particular community. More specifically, it seems that the professional community so far has attempted to establish the boundaries that are based in the individualistic culture. However, these limits may not be appropriate for the members of the more communal cultures and subcultures.

It seems that the debate on ethicality of NMRR evolves around the ethical principles of beneficence, do good, and nonmaleficence, do no harm. Some practitioners insist that benefits of NMRR outweigh risks, while others think that risks are greater than benefits, yet third group stresses both and calls for flexibility. What is interesting is that this discussion is based mostly on opinions and some clinical evidence. However, there is a lack of empirical research supporting either of these views.

Research on NMRR

In spite of the extensive discussions focused on nonsexual multiple role relationships, only few empirical studies were done in this area. Moreover, almost all prior investigations focused on mental health professionals' perspectives on NMRR.

Clinicians' views on NMRR

Several studies on counselors' perspectives on NMRR were done in a similar manner using a self-report instrument for therapists developed by Borys and Pope (1989), who utilized and adopted items from Pope, Tabachnick, and Keith-Spiegel's (1987) study. The instrument was later modified by Baer and Murdock (1995).

Pope, Tabachnick, and Keith-Spiegel (1987) explored ethical beliefs and behaviors of psychologists using a self-report attitude survey about ethical behaviors with a large national sample. There were several interesting findings concerning NMRR. First, many behaviors constituting NMRR, or leading to their development, were assessed as ethical by a

substantial portion of professionals. Thus, from the perspective of a small portion of psychotherapists, the following behaviors were either always ethical or ethical under many circumstances: providing therapy to one of the friends (8.1 %) , accepting client's gift (11.9 %), accepting goods rather than money as payment (27.8 %), providing therapy to one's student or supervisee (13%), accepting a client's invitation to a party (17.5 %), asking favors from clients (15.5 %), inviting clients to a party or social event (7.6 %), becoming social friend with a former client (28.7 %). However, a substantial proportion of respondents were unsure of the ethicality of some behaviors: accepting goods rather than money as a payment (21.6 %), accepting a client's gift worth at least \$50 (15.8 %), going into business with a former client (17.5 %), asking favors from the clients (12.3 %), and becoming social friends with a former client (13.4 %). These results suggest that there is substantial variation among professionals' views concerning NMRR.

An additional national study of psychologists, psychiatrists, and social workers' perspectives on ethics of dual role relationships (Borys & Pope, 1989) also revealed clinicians' ambiguity about these issues. Although there were no differences in perspectives among professions, the views on ethicality of multiple roles relationships differed substantially. For example, 44.9 % of clinicians consider accepting gift worth over \$50 to be unethical, whereas 37 % consider it to be ethical under rare conditions, 13.1 % think that this is ethical under some conditions. One more example of ethical ambiguity concerns providing therapy to a current student or supervisee: 44.4 % consider this practice to be unethical, whereas 31 % think it's ethical under rare conditions, 16 % consider it to be ethical under some conditions, 5.4 % think this is ethical under most conditions.

In addition, DeJulio and Berkman (2003) study of attitudes and behaviors of social workers supported the results of previous studies (Borys & Pope, 1989). They used Ethical Assessment Survey (EAS) developed by Borys and Pope (1989) and modified by Baer and Murdock (1995). The results showed that there was variability and ambiguity among clinicians' views on NMRR. For example, 18.9 % of participants thought that disclosing details of current personal stresses to clients was ethical under some conditions, while 42.9 % thought that it was never ethical. Concerning provision of therapy to current student or supervisee, 59.9 % of respondents thought that it was unethical; 23.2 % thought it was ethical under rare conditions; 9.9 % of respondents thought that it was ethical under some conditions; and 4.5 % of survey participants thought that it was ethical under most conditions or always.

Baer and Murdock (1995) focused on the family systems concept of differentiation of self from the family of origin and its connection with views on NMRR. They hypothesized that psychologists' personal differentiation (awareness of boundaries in the family relationships) and level of stress would be correlated with their views on ethicality of NMRR. Using the Ethical Assessment Survey, they found that respondents who were low in differentiation and high in stress viewed NMRR as more ethical than those who were low in differentiation and low in stress. Contrary to their predictions, Baer and Murdock found that therapists, who were high in differentiation and low in stress, rated items of the questionnaire as more ethical than did therapists who were high in differentiation and high in stress.

Additional data pertinent to NMRR was provided by Anderson and Kitchener (1996) in their exploratory study of nonsexual post-therapy relationships between psychologists and clients. They found that there was little consensus among psychologists, who participated in

the study, regarding whether or not nonsexual post-therapy relationships were ethical.

Psychologists, participants in this study, were asked to identify reasons for viewing NMRR with former clients as either ethically problematic or not problematic. Among the reasons, contributing to perception of relationships as problematic, were the following: (a) dual role relationships exist, (b) special knowledge about former client can impact relationship, (c) a former client could not return to therapy with his or her therapist, (d) a power differential still exists, (e) exploitation occurred or could occur resulting in harm, and (f) a former client's internalized image of a therapist can be negatively impacted.

Among the reasons, named in favor of NMRR with former clients, were the following: (a) clear roles of new relationships were discussed and kept, (b) the therapy relationship is over, therefore no dual roles, (c) sufficient time has passed since termination, (d) unplanned and brief meeting or contact occurred, (e) confidentiality can be maintained, and (f) compartmentalization is natural in real life.

A number of the studies conducted were methodologically weak. Therefore, it is very difficult to generalize their results to mental health professionals overall. For example, Womontree (2004) surveyed a small sample (N=56) of the rural mental health care providers in regards to the number of ethical practices including multiple roles. The questionnaire was developed by the researcher. The results indicated that within this small and non-randomly selected sample, professionals with three or more children were statistically more likely to experience dual role relationships. Lamb, Catanzaro, & Moorman (2004) also surveyed psychologists. Participants were asked about the most frequent outside relationships that they had to negotiate with their clients, supervisees, and students. They were provided with seven types of possible relationship: (a) social interactions and events, (b) business or financial

associations, (c) collegial or professional relationships, (d) collegial or professional roles with social component, (e) supervisory or evaluative interactions, (f) religious affiliations, and (g) workplace contacts. No other categories, including “the other”, were offered. On the basis of frequencies of psychologists’ reports, conclusions about the most frequently encountered interactions and the need for negotiation in relationships were made. Thus, the most frequent and “needy” one was social interactions and the least frequent and “needy” one was business associations. Overall, the study had weak methodology, a low response rate of 31%, and poorly described statistical analysis.

In general, the prior noted studies reflect clinicians’ ambiguity about NMRR. However, there is a general trend that can be discerned. More clinicians rate different situations representing NMRR or boundary crossings as being unethical or ethical under rare conditions than being always ethical or ethical under most conditions. However, research also shows that clinicians engage in the NMRR with their clients and often have to navigate their way in these interactions. There are significant gaps in this type of research, however. For example, the proportion of professionals that deal with the NMRR and the frequency of these situations are not reliably known. There is no comprehensive data about the types of decisions clinicians make pertinent to NMRR and about the ways in which these decisions are being made. It would be interesting to learn how individual differences and varied theoretical orientations relate to the actual decisions that professionals make in this area of ethical ambiguity. Even though we have a paucity of data pertinent to mental health professionals and NMRR, there is even less known about the client’s perspective on multiple roles.

Clients' perspective on NMRR

Only a few studies of clients' perspectives on NMRR have been found by the author. Thus, Ramsdell and Ramsdell (1993) surveyed former clients of the large metropolitan counseling center. The researchers developed a list of twenty one behaviors comprising different forms of social and physical contact, such as client visiting at the counselor's home, attending a movie or other event together, and counselor sharing personal information. They asked participants how often these behaviors actually occurred in their counseling experiences and what effect the actual or presumable interactions described in the list have had or may have had on therapy.

The results showed that none of the respondents acknowledged having sexual multiple roles with their counselors. Only small percentage of participants acknowledged sharing meal with the counselor or being held by them. Approximately 30% of participants said that they hugged their counselor, another 25% acknowledged that they were hugged by their counselor, while 40-45% of participants said that hugging may benefit therapy. Two thirds of participants said that their counselor shared personal information with them and the same number suggested that this behavior may benefit therapy.

In general, there was a great variability in the former client's responses to the questions related to the potential effects of behaviors constituting NMRR. The findings of this study support the notion that it is impossible to develop a uniform code of conduct for all counselors with all clients and suggest that there is a need for continued professional discretion in these ambiguous areas. However, caution should be exercised in interpreting the results of this study due to the very low response rate (27%) and non-representative sample (mostly white educated females who were clients in the same counseling center).

Pulakos's (1994) study is somewhat related to the prior discussion. She studied clients' perspectives on incidental encounters with their therapists. Results showed that 79 % of clients who met their therapists in public were satisfied with their response. However, 21 % of clients wanted a different response from their therapists. In all of the cases they wanted their therapist to be more involved. For example, when therapists ignored them, clients wanted acknowledgement or engagement in conversation; if the therapist gave a brief acknowledgement, the client wanted engagement in the conversation. In no cases did the clients want less than therapists offered. The feelings reported by most clients were confidence, surprise, awkwardness, enjoyment, curiosity, and anxiety.

Diyankova and Scott (2003), in their study of college students' views on nonsexual multiple role relationships, found that most students viewed most behaviors of professionals representing boundary crossing or dual roles as either acceptable under rare circumstances or sometimes acceptable. Also, they found small sex and ethnic differences in reaction to and acceptance of NMRR. The results suggested that men and minorities are slightly more accepting of multiple roles than women and Caucasian individuals.

Diyankova and Scott (2006) explored the former clients' perspectives on NMRR in concrete counseling situations through an analogue experiment. They proposed that clients' subjective perceptions of and reactions to the situations involving NMRR would be one of the possible factors influencing perceived ethicality of NMRR, perception of the counselor, and reactions to the counseling. Seventy three college students, all former counseling clients, participated in this study. The results showed that presence or absence of NMRR were not the critical factors in the former clients' reactions to the counseling situation or their perception of the counselor. However, former clients' reactions to the situation and

perception of the counselor changed depending on whether absence or presence of multiple role relationships had positive or negative impact on the client (in the vignette), as expressed by the client's emotional reactions.

This study has several important implications for the clinical practice. First, the results suggest that mental health professionals do not need to categorically and rigidly avoid all nonsexual multiple role relationships with their clients. A position of cautious openness suggested by feminist clinicians (Greenspan, 2002) may be the most appropriate for making decisions in the situations involving NMRR. Second, counselors should be sensitive to their clients' unique perceptions of the multiple role relationships and openly explore these views and attitudes in session when appropriate as was suggested by Walker (2002).

A number of questions were not addressed by the prior cited research. For example, the role of social desirability in the clients' and former clients' responses to the surveys is unclear. Also, individual differences may explain some variability in participants' attitudes towards multiple roles. One of the possible factors here may be attachment style, a concept which is reviewed in the following section.

Attachment Style

The concept of attachment

Attachment theory originated from the works of John Bowlby and Mary Ainsworth in 1960s and 1970s (Bretherton, 1992). Originally it focused on the observation and explanation of the proximity seeking behavior in infants. The researchers postulated that human babies possess a wide range of species-specific behaviors that promote physical closeness to their caregiver, such as smiling and crying (Ainsworth, 1989). Depending on the type of care provided by an adult, an infant may behave in a variety of different ways. Ainsworth (1978

as cited in Lopez & Brennan, 2000) classified attachment behavior in three categories: secure, anxious-ambivalent, and avoidant.

Secure infants were found to exhibit distress when separated from their mothers, but they were easily comforted upon reunion, and were able to resume their independent behavior soon after. Anxious-ambivalent children demonstrated considerable distress when separated from their mothers. They were not easily comforted upon mother's return. Additionally, they often behaved in angry and protesting ways. Avoidant infants appeared to be unaffected by the departure of their mother, and did not seek proximity when she returned. These differences were labeled attachment styles. Ainsworth (1989) noted that human children use attachment behaviors to seek closeness to their caregivers when threatened. Therefore, the function of these behaviors may be seen as obtaining a sense of security and safety.

Attachment behaviors were hypothesized to extend into adulthood, and influence an individual's functioning in a variety of close relationships, such as romantic, friendships, and familial relationships (Ainsworth, 1989).

Since the original work of Bowlby and Ainsworth, much theorizing and research has been done on attachment. Unfortunately, researchers use different language and definitions, when investigating attachment. Some scientists focus on the categories or attachment styles (Horowitz, Rosenberg, & Bartholomew, 1993), others use attachment dimensions (Lopez, 2001; Tyrell, Dozier, Teague, & Fallot, 1999), yet others use both (Dozier & Tyrell, 1998; Sharfe & Bartholomew, 1994). Different categories and dimensions of attachment are being proposed. For example, Main (1990) described one primary dimension of attachment (security-insecurity) and one secondary dimension (deactivation-hyperactivation). Later, Bartholomew and Horowitz (1991) proposed working model of self and working model of

other as two major underlying dimensions of attachment. One more construct came from Brennan, Clark, and Shaver (1998), who found anxiety and avoidance to be two underlying dimensions of attachment in adults. The current study will focus on attachment avoidance and attachment anxiety dimensions proposed by Brennan et al., as the author believes that continuous variables more accurately represent real-life phenomena.

As Crowell and Treboux (1995) noted, multiple measures of adult attachment, stemming from the seemingly common theoretical background, assess the construct in a variety of different ways, and even appear to address different concepts, at times. This situation creates confusion for those, consuming literature on attachment. Unfortunately, it is impossible to entirely avoid this confusion in the following literature review. However, the author will try to clarify relationships between the constructs used in the current study and those described by the other researchers whenever possible.

Bartholomew and Horowitz (1991) have developed and tested a two-dimensional model of adult attachment, which is commonly used in the current research (e.g. Mallinckrodt, 2000). Drawing on Bowlby's (1980) concept of internal working models, they proposed that a combination of an *internal working model of self* and an *internal working model of other* constitutes an attachment style. An internal working model of self incorporates individual's sense of worth and lovability. It can be either positive or negative. An internal working model of other contains individual's core expectations of the availability and trustworthiness of his or her close others. It can also be either positive or negative. The combinations of these dimensions produce four types of attachment: secure, preoccupied, dismissing and fearful. Secure style is characterized by positive model of self and positive model of other. Preoccupied attachment style comprises negative self model and positive other model.

Dismissing style has to do with positive self model and negative other model. And, fearful type comprises both negative models of self and other.

Developing the two-dimensional model of attachment further, Scharfe and Bartholomew (1994) suggested that internal model of self was strongly related to anxiety, while an internal model of other was associated with avoidance. Following this logic, Brennan, Clark, and Shaver (1998) combined 60 known measures of adult attachment to examine if there were, indeed, two underlying dimensions of attachment. They administered 323 items to over a thousand participants. The data were factor analyzed, and resulted in two higher order factors representing anxiety and avoidance. From this study, Brennan and colleagues created the 36-item Experiences in Close Relationships Scale (ECRS), a self-report measure, that assesses an individual's position on the two attachment dimensions. This measure has been validated, and it is commonly used in research on attachment (Lopez, 2001; Mohr, Gelso, & Hill, 2005; Wang & Mallinckrodt, 2006; Wei, Mallinckrodt, Larson, & Zakalik, 2005). The present study will use this measure for evaluation of participants' attachment styles (see Appendix D).

Adult attachment behaviors have been researched extensively in the last twenty years (e.g., Hazan & Shaver, 1987; Bartholomew & Horowitz, 1991; Lopez, 2001). They have been linked to the various aspects of and problems in human functioning. Thus, Lopez (2001) found that adult attachment anxiety was significantly positively correlated with emotional reactivity, need for social approval and self-concealment. Attachment avoidance was negatively correlated with emotional reactivity and positively correlated with self-concealment. Additionally, attachment behaviors have been related to counseling relationship

(Bowlby, 1988; Ainsworth, 1989; Dozier & Tyrell, 1998; Mallinckrodt, 1991, 2000), as described in the following section.

Attachment style and counseling relationship

Bowlby (1988) suggested that therapist's role in counseling is similar to that of a parent, who provides child with a secure base. The safety of the therapeutic relationship is postulated to enable a client to explore past and present painful experiences. Ainsworth (1989) agrees that a therapist may be viewed as an attachment figure and that counseling relationship may involve, and, in part, may be based on attachment system. Lopez and Brennan (2000) further developed this line of thinking. They suggested that an effective therapeutic relationship activates client's attachment system, and it concurrently facilitates an insight into client's attachment organization and strategies, as well as their origins and problematic functions.

Slade (1999), in her review of attachment organization and counseling relationship, noted two major factors. First, a client's attachment organization has a profound effect on his or her feelings about and expectations of a therapist. Therefore, if a client has a dismissive attachment style, he or she would expect a therapist to be emotionally unavailable and rejecting. Second, a model of successful treatment involves client's capacity to use therapist as a secure base. The latter presents a significant issue when treating people with insecure attachment style, because they are likely to experience an emotionally available, responsive, and empathic therapist as incapable of providing the safe base.

Dozier and Tyrell (1998) reviewed literature examining how clients' internal working models of attachment relate to treatment process and outcome. First, they concluded that the evidence, connecting working models with treatment process and outcome, was limited. However, they cited results of existing studies showing relationships between security –

insecurity dimension of attachment and cooperativeness in treatment process as rated by therapists. Additionally, they found that deactivation-hyperactivation dimension of attachment was significantly negatively correlated with help-seeking, self-disclosure, and general treatment use. From the descriptions of the dimensions provided by the authors it seems that security-insecurity closely corresponds to attachment anxiety while deactivation-hyperactivation appears to be associated with attachment avoidance.

Slade (1999) discussed an influence of attachment style on counseling process. Thus, she noted that individuals with the dismissing styles, those low on anxiety and high on avoidance, tend to deny the importance of relationships, as well as emotions. In counseling, they frequently struggle, and they find the process to be demanding and hard. Adults with preoccupied attachment style, manifested by high anxiety and low avoidance, often may come across as extremely needy and dependent. They may be very demanding of their attachment figures. Given these tendencies, the preoccupied individuals may become dependent upon and demanding towards their therapist. It is not unusual for them to request extra-appointments and call their therapists between sessions. According to the author, these patients are more likely to challenge parameters of counseling relationship.

Mallinckrodt (2000) compared the counseling relationship to one that activates the attachment system. He concluded that, although there exist therapeutic approaches, to which attachment theory may not be applicable, attachment contributes to the majority of the types of counseling relationships. Moreover, this author thinks that the majority of clients come to therapy in distress, which activates their attachment system. Additionally, the majority of therapists serve as a secure base to their clients due to the professional role expectations, such as to be understanding, accepting, and supportive.

Mallinckrodt (2000) applied Bartholomew and Horowitz's (1991) model (see discussion of the model on p. 36) to the counseling relationship. He argued that working models are activated under stress. The specific affective response, expressed by a client, stems from his or her interpretation and appraisal of an event. The latter are, in turn, determined by client's internal working models. Given that clients' internal working models are quite different, it is understandable, why a similar relationship event may cause two contrasting reactions from two different individuals. The conceptual ideas discussed above gave rise to the number of studies exploring impact of attachment style on counseling in general and counseling relationship in particular.

Horowitz, Rosenberg, and Bartholomew (1993) explained the relationship between attachment style and interpersonal problems. They looked at both self- and other-reports. Researchers used the model of Bartholomew and Horowitz (1991) and classified their subjects' attachment styles as secure (low anxiety and low avoidance), dismissing (low anxiety and high avoidance), fearful (high anxiety and high avoidance) and preoccupied (high anxiety and low avoidance). They found that secure individuals reported high warmth in friendship relationships which was confirmed by the other-reports. Dismissing individuals were described as struggling with the problems of coldness. Participants with fearful attachment reported relatively more problems than other individuals related to lack of assertiveness and social inhibition. This pattern was confirmed by the friends' reports. Finally, preoccupied group showed elevation on the expressiveness scale, which was confirmed by the friends' reports. Additionally, partners of these individuals described them as autocratic and competitive. Both dimensions refer to dominance.

Mikulincer and Nachshon (1991) investigated relationships between attachment style and trait-like self-disclosure willingness and flexibility. The latter may be viewed as very important factors contributing to effective counseling relationship and outcome. The authors classified participants into three attachment styles: secure (low anxiety and low avoidance), ambivalent (high anxiety and low avoidance), and avoidant (high anxiety and high avoidance). They found that avoidant individuals had a clear lack of desire to make intimate self-disclosures, even in response to others' disclosures. Additionally, their liking of another person was not affected by how much they disclosed.

The pattern that emerged for the ambivalent individuals was especially interesting. Mikulincer and Nachshon (1991) reported that ambivalent individuals showed a combination of secure and avoidant self-disclosure patterns. Similar to secure persons, they demonstrated high self-disclosing behavior, reciprocity in descriptive and evaluative disclosure and strong liking of those, who are highly willing to disclose. However, similar to avoidant persons, they showed a lack of disclosure flexibility, manifesting in misunderstanding when self-disclosure was appropriate or inappropriate, as well as lack of topical reciprocity.

The researchers have provided an interesting explanation of this pattern, that has implications for this study. They think that what an ambivalent person is looking for when self-disclosing is an immediate breaking of boundaries, which meets their needs for security. By disclosing personal information these individuals may facilitate merging with others and reduce the fear of being unloved. Given these findings, we may expect ambivalent or preoccupied individuals to be more accepting of and seeking out the nonsexual multiple role relationships.

The investigator, however, suggests an alternative explanation for Mikulincer and Nachshon's (1991) findings. It is possible that attachment avoidance may explain willingness to disclose, with individuals high on attachment avoidance abstaining from revealing personal information, and individuals low on attachment avoidance freely disclosing. Attachment anxiety, in turn, may predict disclosure flexibility.

Malinckrodt and colleagues (1991, 1995, 2000, 2005) conducted a number of investigations relating attachment style to counseling relationship. Mallinckrodt (1991) explored client's representations of childhood emotional bonds with their parents and formation of working alliance with their therapist. He collected data from more than 100 client-counselor dyads at three counseling centers. The author hypothesized that early parental bonds, more specifically parental care and overprotection, would be associated with current working alliance in therapy. Partial support for this hypothesis was found for the counselor-rated working alliance but not for the client-rated alliance.

In addition, Mallinckrodt found that emotionally expressive, warm, and nurturing binds of clients with their fathers were related to positive ratings of the working alliance by their counselors. Additionally, he reported that the more reportedly intrusive were clients' fathers, the more positively working alliances were rated by the counselors. This study provided first, although not substantial, evidence of relationships between working alliance and attachment.

In 1995 Mallinckrodt, Gantt, and Coble developed an instrument for evaluation of a client's attachment to a counselor, *the Client Attachment to Therapist Scale (CATS)*. The factor analysis of this measure led to differentiation of three subscales, namely secure (low anxiety and low avoidance), preoccupied-merger (high anxiety and low avoidance), and avoidant-fearful (high anxiety and high avoidance).

Analysis of relationships between the scale and other measures yielded interesting results. It was found that clients with high scores on the secure subscale tended to report positive working alliances and were relatively free of object relations deficits. Clients in the preoccupied-merger group rated the bonds aspect of working alliance positively, but not the goals and tasks aspects. Also, they showed deficits related to insecure attachment. Clients, who scored high on the avoidant-fearful subscale, showed more negative therapeutic alliances and broad deficits in object relations, such as alienation, social incompetence, and egocentricity.

Another interesting finding of the Mallinckrodt et al. (1995) study pertains to the relationships between attachment to therapist style and length of therapy. It was found that the longer a client and a counselor met, the more securely a client was attached to his/her therapist, meaning the less attachment anxiety and avoidance was experienced.

Mallinckrodt, Porter, and Kivighan (2005) expanded on Mallinckrodt et al. (1995) study by adding variables of adult romantic attachment and session depth. Their results supported some of the findings discussed above. Thus, the researchers found that security in client's attachment to therapist was associated with clients perceiving working alliance as positive. Additionally, they showed that anxious attachments in romantic relationships were significantly negatively associated with the tasks and goals components of therapeutic alliance, but not the bond component (as measured by the Working Alliance Inventory). Also, this study data supported Bowlby's (1988) hypothesis that clients may use therapists as a secure base. Mallinckrodt et al. showed that client's secure attachment (low anxiety and low avoidance) to therapist was associated with deeper explorations in session. On contrary,

avoidant-fearful attachment (high anxiety and high avoidance) to therapist was negatively related to session depth.

Several other researchers reported findings in line with Mallinckrodt and colleagues studies. Thus, Eames and Roth (2000) looked at the association between client's attachment style and working alliance, as it develops in the first five sessions and as reported by both a client and a therapist. They found that secure attachment (low anxiety and low avoidance) was correlated with the significantly higher alliance ratings by a therapist at session five. Avoidant style (high anxiety and high avoidance) was related to significantly lower alliance ratings by clients at sessions three and five and therapists at session two. An anxious-ambivalent tendency (high anxiety and low avoidance) was associated with improvement in alliance ratings over time. Additionally, this attachment style was associated with the highest number of alliance ruptures.

Woodhouse, Schlosser, Crook, Ligiero, and Gelso (2003) studied relationships between client attachment to therapist and therapist perception of transference in 51 client-therapist dyads. They found that both secure (low anxiety and low avoidance) and anxious-preoccupied (high anxiety and low avoidance) attachments to therapist were positively related to the amount of transference and negative transference as perceived by therapist.

Despite essentially the same findings for both groups, the authors provide very different explanations for them. Thus, they suggest that anxiously attached individuals may have a tendency to negatively distort the image of therapist. However, securely attached people were said to be capable of deeper exploration of the difficult (negative) material. It is unclear why explanations were so contrasting. An alternative explanation to these findings, suggested by the author of the current manuscript, is that attachment avoidance may explain the amount of

negative and positive transference towards therapist. Thus, individuals low on attachment avoidance may approach therapist with more openness independent of the level of their anxiety. It seems as if more research is needed to explain this data. Additionally, Woodhouse et al. (2003) found that security of attachment to therapist was positively associated with time in treatment. The latter findings agree with the original results of Malinckrodt et al. (1995).

Mohr, Gelso, and Hill (2005) have examined both client and counselor attachment styles and their relationship to session evaluation and countertransference. In agreement with Mallinckrodt et al. (2005), they found that clients high on fearful attachment (high anxiety and high avoidance) gave low ratings of the counseling session depth. Tyrell, Dozier, Teague, and Falot (1999) investigated the relationships between attachment styles of patients with serious mental illnesses, attachment styles of their case managers and therapeutic outcomes. They found that better outcomes occurred when clients were matched with case managers who were dissimilar to them on the avoidance dimension of attachment.

It appears that many studies done in this area are consistent in their findings and are in agreement with the theoretical postulates. Thus, most of them suggest that attachment style is related to different aspects of counseling relationship (Malinckrodt et al., 1995; Mohr et al., 2005), as well as counseling process and outcome (Mallinckrodt et al., 2005; Mohr et al., 2005).

Given that no research on attachment and nonsexual multiple role relationship was identified, the author made inferences from the prior noted body of research, as well as theoretical writings. First, it is possible that individuals with high attachment anxiety are more likely to seek and pursue relationships outside of the counseling office, while persons with the attachment pattern manifesting in high avoidance may be likely to abstain from any

secondary relationship (Slade, 1999). Second, based upon the ideas of Malinckrodt et al. (1995, 2005), the author predicts that multiple roles may elicit very different responses in clients depending on their attachment orientations. So, the question may not be whether multiple role relationships are ethical or unethical per se, but rather when and with whom multiple roles may be beneficial and when and with whom they are harmful. The first step in responding to this question may entail exploration of clients' views on and reaction to NMRR depending on their attachment style.

Gender and NMRR

There is not much data available on the associations between gender and multiple role relationships. However, the findings across the studies are somewhat consistent.

Borys and Pope (1989) found that a higher proportion of male than of female therapists were initiators of nonsexual dual relationships. Researchers measured therapists' views and behaviors along three dimensions: incidental involvements, social/financial involvements, and dual professional roles. Results on these three factors were somewhat different. Thus, concerning incidental involvements (accepting gifts, attending client's special occasions), male therapists who reported a predominantly female client population viewed such involvements as significantly more ethical than did respondents in all other therapist-client gender pairings. Interestingly, female therapists reported having engaged in such involvements with a significantly greater proportion of clients than did their male counterparts. Social and financial involvements, as well as professional/dual involvements, were viewed by female therapists as significantly less ethical than by male therapists. Also, female therapists reported that they engaged in secondary social and professional relationships with smaller proportion of their clients than did male therapists.

Baer and Murdock (1995) used the Ethical Assessment Survey, that was a slightly modified version of the Therapeutic Practices Survey developed by Borys and Pope (1989). They found that male therapists viewed professional/dual involvements as more ethical than did female therapists. Researchers neither found significant differences on two other factors (incidental and social involvements) nor interaction between genders.

Diyankova and Scott (2003) found that female potential clients had significantly lower degree of acceptance of NMRR than did male clients. In all the cited studies the reported differences were statistically significant, however, their clinical meaning is questionable, because in most cases they were rather small.

Thus, the prior literature suggests the importance of conducting a study that incorporates such variables as attachment style, gender, and multiple roles in an investigation of clients or prior clients' reactions to the counseling situation that presents a potential for development of NMRR.

CHAPTER 3. MATERIALS AND METHODS

Research Design

An experimental mixed 2 (multiple roles: present, absent) x 2 (gender: male, female) x 2 (type of multiple roles: social, professional) factorial design was used. There was one manipulated treatment factor (multiple roles), one blocking variable (gender), and one within-subjects factor (type of multiple roles). Additionally, three quantitative covariates: attachment avoidance, attachment anxiety, and impression management were used in this study. This design produced two between subjects experimental conditions: multiple roles present and multiple roles absent; and two within-subjects experimental conditions: social interaction and professional interaction.

Participants

Power analysis to determine sample size

Several types of analysis were planned for this study. Analysis requiring the most participants was the analysis of the potential three-way interactions. Therefore, sample size was computed using a power-based sample size formula for planning a value of correlation: $N = (Z_{\alpha/2} + Z_{\beta})^2 / \rho^2 + 3$ (Cohen, 1988).

The researcher decided that $\rho = .3$ was an acceptable planning value of correlation. Even though $\rho = .1$ would have allowed detection of a smaller effect size, this effect size would not have as much clinical significance. Two estimates of the sample size were computed. It was found that $N_1 = 85$ for the power of .80, and $N_2 = 139$ for the power of .95. Therefore, the researcher decided to obtain sample greater than 85 and preferably close to 139. For more details on computation see Appendix A.

Selection criteria

Participants were selected on the basis of their previous counseling experience. Most of the participants had at least four counseling sessions with the same counselor after the age of 15. There were several reasons for establishing this criterion. First, the author believes that the counseling relationship is a very special type of human relationship that is different from the majority of other social relationships. In counseling, two adults maintain a focused and close relationship for the purposes of addressing the concerns of only a client participant. From the author's perspective, only persons, who have experienced such a relationship before, would be able to fully appreciate and understand the questions that will be posed in the study. Second, participants need to have access to the recollections of their own experiences of the counseling relationship so that they can reflect on it. Those individuals who have been in the counseling relationship closer to adulthood would be more capable of doing this. Finally, the author believes that at least four sessions with the same counselor are usually needed to develop a strong counseling relationship.

Characteristics of the primary study sample

The primary study sample consisted of 117 volunteer participants. One of the individuals did not receive counseling prior to the study and, therefore, did not meet eligibility criteria for participation. In addition, two other subjects were identified as response outliers on multiple measures. Thus, these three participants were excluded from the subsequent analysis. The final sample consisted of 114 students, all former counseling clients, recruited from Psychology Department Research Pool, as well as from the upper level psychology classes. Demographic characteristics of this sample are presented in the Table 1.

Table 1. Demographic characteristics of the sample (N=114)

| Variable | n | % |
|------------------------|-----|------|
| Gender | | |
| Male | 44 | 38.6 |
| Female | 70 | 61.4 |
| Ethnicity | | |
| Caucasian | 106 | 93.0 |
| African American | 2 | 1.8 |
| Latino/Latina | 3 | 2.6 |
| Asian/Pacific Islander | 1 | .9 |
| Multiracial | 1 | .9 |
| International | 1 | .9 |
| Age | | |
| 18-19 years old | 49 | 43.0 |
| 20-24 years old | 59 | 51.8 |
| 25-30 years old | 5 | 4.4 |
| 31-40 years old | 0 | 0.0 |
| 41-55 years old | 1 | .9 |
| 56 and older | 0 | 0.0 |
| Marital status | | |
| Single | 97 | 85.1 |
| Married | 8 | 7.0 |
| Divorced/separated | 2 | 1.8 |
| Living with a partner | 2 | 1.8 |
| Single with children | 1 | .9 |
| Other | 4 | 3.5 |
| Socio-economic status | | |
| Low | 13 | 11.4 |
| Middle | 91 | 79.8 |
| High | 9 | 7.9 |

All study participants had received counseling prior to their participation in the study. Information about the type of counseling received, number of sessions attended during the longest experience, age during the most recent counseling episode, perceived success of counseling, and perceived quality of the counseling relationship was collected. It is summarized in the Table 2.

Table 2. Counseling experience of the sample (N=114)

| Variable | n | % |
|---|-----|------|
| Type of counseling | | |
| Individual | 57 | 50.0 |
| Family | 11 | 9.6 |
| Group | 2 | 1.8 |
| Individual and group | 28 | 24.6 |
| Individual and group | 9 | 7.9 |
| Individual, family, and group | 7 | 6.1 |
| Number of sessions (longest experience) | | |
| One | 3 | 2.6 |
| 2-3 | 15 | 13.2 |
| 4-6 | 27 | 23.7 |
| 8-10 | 30 | 26.3 |
| 11-20 | 17 | 14.9 |
| More than 20 | 22 | 19.3 |
| Age (most recent experience) | | |
| 10 years or younger | 3 | 2.6 |
| 10-14 years | 6 | 5.3 |
| 15 years or older | 105 | 92.1 |
| Success of the counseling experience | | |
| Not very successful | 11 | 9.6 |
| Moderately unsuccessful | 11 | 9.6 |
| Neither successful nor unsuccessful | 11 | 9.6 |
| Moderately successful | 48 | 42.1 |
| Successful | 33 | 28.9 |
| Nature of the counseling relationship | | |
| Negative | 9 | 7.9 |
| Neutral | 43 | 37.7 |
| Positive | 62 | 54.4 |

As can be seen from the table, 92% of individuals (n=105) were in counseling at or after the age of 15; 88.6 % (n=101) of individuals have received individual counseling either on its own or in combination with the other forms of treatment; and 88.4% (n=96) have attended four or more counseling sessions during their longest counseling experience.

Instruments

The summary of all instruments and variables is presented in Table 3.

Materials and independent measures

Case vignettes.

The manipulated independent variable labeled “multiple roles” was presented through the vignettes, or case descriptions (see Appendix B). Originally, two sets of vignettes were developed for the purposes of this study. Each set consisted of four vignettes describing a situation involving nonsexual multiple roles in the counseling relationship. Two out of the four vignettes in each set were modified versions of the cases used in Diyankova and Scott (2006) study. Set A introduced one level of the multiple roles variable, multiple roles accepted, and described situations in which the counselor accepted multiple roles either offered by the client or presented by the situation. Set B introduced the second level of this variable, multiple roles declined, and described situations in which counselor declined multiple roles either offered by the client or presented by the situation. The vignettes were similar in length (ranging from 217 to 285 words). They depicted the essential elements of the counselor-client interaction in a similar sequence and differed only in respect to acceptance of multiple roles by the counselor.

A pilot study was conducted for the purposes of the development and validation of the vignettes. Based upon pilot subjects’ reactions to the questions posed in the Vignette Feedback Questionnaire (see Appendix C), the two most impact producing and realistic vignettes were chosen for each of the two experimental sets. One vignette described a situation involving client inviting therapist to attend her art show. The other vignette depicted a client and a counselor becoming a student and an instructor outside of counseling.

Table 3. Summary of the instruments and variables used in the primary study

| Variables | Instruments |
|---|---|
| Independent Variables | |
| 1. Multiple roles (present vs. absent) | Case vignettes |
| 2. Type of multiple roles (social vs. professional) | Case vignettes |
| 3. Attachment avoidance | The Experiences in Close Relationships Scale (ECRS; Brennan et al., 1998) |
| 4. Attachment anxiety | The Experiences in Close Relationships Scale (ECRS; Brennan et al., 1998) |
| Covariates | |
| 1. Gender (control) | Demographic Questionnaire |
| 2. Impression management (control) | The Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1989) |
| Dependent Variables | |
| 1. index of positive feelings (IPF) IPF1 – for vignette 1 IPF2 – for vignette 2 IPF – combined index for vignettes 1 & 2 | Reaction Questionnaire (part 1) |
| 2. index of negative feelings (INF) INF1 – for vignette 1 INF2 – for vignette 2 INF – combined index for vignettes 1 & 2 | Reaction Questionnaire (part 1) |
| 3. Cognitive Evaluation (CE) CE1 – for vignette 1 CE2- for vignette 2 CE- combined index for vignettes 1& 2 | Reaction Questionnaire (part 2) |
| 4. General attitude towards multiple roles (MRQ) | Multiple Role Questionnaire (MRQ; Diyankova & Scott, 2003) |
| 5. Counselor Rating (CRF) | Counselor Rating Form – Short version (CRF-S; Corrigan & Schmidt, 1983) |

Experience in Close Relationships Scale (ECRS).

The Experiences in Close Relationship Scale (Brennan, Clark, & Shaver, 1998) was used to measure participants' attachment style in respect to attachment avoidance and attachment anxiety (see Appendix D). It is a 36-item self-report measure of adult attachment. The responses to ECRS questions are recorded on a 7-point Likert-type scale ranging from *disagree strongly (1)* to *agree strongly (7)*. The ECRS comprises two subscales. The Avoidance subscale (18 items) measures fear of intimacy, discomfort with closeness, and self-reliance (e.g., "I try to avoid getting too close to my partner"). The Anxiety subscale (18 items) measures preoccupation with abandonment, fear of rejection, and jealousy (e.g., "I worry about being alone"). Scores for both subscales are calculated as an average across 18 questions comprising each factor and range from 1 to 7.

The scale was developed from over 1000 undergraduate student responses to 323 items representing more than 60 adult attachment scales. The items were drawn from the self-report measures of adult attachment available at the time. A principal component analysis of the items produced two major factors that accounted for 62.8 % of the variance. The factors were named *Avoidance* and *Anxiety*. The correlation between factors was .12, suggesting that dimensions underlying attachment style are nearly orthogonal. Brennan et al. (1998) created two 18-item subscales from the 36 items with the highest absolute-value correlations with one of the aforementioned factors. These new subscales, Avoidance and Anxiety, were almost unrelated to each other ($r = .11$) and each was highly correlated with its parental factor ($r = .95$ for both subscales).

Brennan et al. (1998) provided the following estimates of internal reliability (coefficient alpha): .94 and .91, for the Avoidance and Anxiety subscales, respectively. The authors also

described evidence of the scales' validity. They analyzed relationships between ECRS subscales and measures of touch and post-coital emotions. As was expected, significant differences among the four attachment groups were found. Thus, individuals low on both anxiety and avoidance experienced significantly more positive and less negative post-coital emotions than the other three groups. Individuals scoring high on avoidance subscale of ECRS reported more touch aversion than those scoring low.

The Balanced Inventory of Desirable Responding (BIDR).

BIDR (see Appendix E) is a 40-item self-report measure developed by Paulhus (1984, 1991). It evaluates systematic over-report of desirable experiences, under-report of undesirable experiences, and tendency to present one's personality in an overly positive light. The measure is useful in identifying individuals who distort their responses and for evaluating the honesty of their responses. It measures two major forms of socially desirable responding: Impression Management (IM) and Self-Deceptive Enhancement (SDE), which are factor-derived, relatively homogeneous subscales. For the purposes of our study only Impression Management subscale scores were used, as suggested by Paulhus (1984), to control for social desirability of responses to self-report questionnaires.

The Impression Management subscale consists of 20 items assessed on a Likert-type scale ranging from (1) not true to (7) very true. Each response of 6-7 is given a score of 1, whereas each response of 1-5 is given a score of 0. Therefore, the possible range of scores is 0-20.

Reliability and validity data for the BIDR is adequate (Paulhus, 1991). For the IM scale alpha coefficients, representing internal consistencies, ranged from .75 to .86. A 5-week test-retest reliability coefficient of .65 was reported. Evidence of concurrent validity for the entire scale comes from correlations of .71 with the Marlowe-Crowne scale and .80 with the

Multidimensional Social Desirability Inventory by Jacobson, Kellog, Cauce, and Slavin.

Paulhus reported high correlations between the IM scale and the L-scale of the MMPI and Eysenck's Lie scale.

Dependent measures

Reaction Questionnaire (RQ).

There are two parts of the RQ (see Appendix F). The first part of the RQ (questions 1-18) is intended to measure participants' emotional reactions to the vignette, while the second part (questions 20 - 27) assesses their cognitive attitudes towards situations described in the vignette. In the primary study participants filled one questionnaire for each of the two presented vignettes.

The first part was developed for the purposes of investigating former and current clients' emotional reactions to the case vignettes in the earlier study done by Diyankova and Scott (2006). It consists of 19 self-report items intended to assess emotional domains of participants' reactions to the clinical case vignettes. Participants were asked to indicate to what extent they experienced each of the feelings reflected in 18 items after reading each of the two vignettes. Item 19 was added for the purposes of the future scale development. When participants felt something not included in the previous 18 items, they were asked to report this on item 19.

Each of the eighteen items is assessed on the Likert-type scale ranging from (1) not at all to (5) to a great extent. Nine items evaluate positive feelings and nine other items assess negative feelings. Nine negative ratings from the first RQ were averaged across feelings for computation of the Index of Negative Feelings for vignette 1 (INF1), whereas nine negative ratings from the second RQ were averaged across feelings for computation of the Index of

Negative Feelings for vignette 2 (INF2). The same operation was performed on the positive ratings for computation of the Indices of Positive Feelings (IPF1 and IPF2). Additionally, in the later phases of analyses INF1 and INF2 were combined to produce general Index of Negative Feelings (INF), while IPF1 and IPF2 were combined to produce general Index of Positive Feelings (IPF). The possible range of scores for each of the aforementioned indices was 1-5. According to Diyankova & Scott (2006), Index of Positive Feelings and Index of Negative Feelings were moderately negatively correlated ($r = -.54$), suggesting that these subscales measure related but different phenomena.

Part 2 of the Reaction Questionnaire (questions 20-27) was developed for the purposes of this study. It assessed participants' Cognitive Evaluation of the impact of multiple roles presented in the vignette on the client and on the counseling process. Participants were asked to respond on the 7-point Likert-type scale ranging from 1 (not at all) to 7 (very much). Four questions (20, 23, 24, and 27) evaluated perceptions of the positive impact of multiple roles. Additional four questions (21, 22, 25, and 26) assessed perceptions of the negative impact. A Cognitive Evaluation score was calculated as the difference between perceptions of positive impact and perceptions of negative impact (range: -6 to 6).

Multiple Roles Questionnaire (MRQ).

This 21-item self-report measure was developed by Diyankova and Scott in 2003 (see Appendix G). Each item on the MRQ is assessed on a 7 point Likert-type scale ranging from strongly disagree (1) to strongly agree (7). A score for each factor (description of the factors see below) is derived by summing up the item responses on this factor. The total score is calculated by summing up the scores on the first factor with the recoded scores on the second factor. Scoring is reversed on the second factor so that total scores convey a consistent

meaning, degree of acceptance. The total score represents the degree of acceptance of NMRR (larger score describes higher degree of acceptance) and range from 21 to 147.

Twenty one items of the scale were factor-analyzed on the sample of 899 undergraduate students. As a result of exploratory factor analysis, two factors were extracted that account for 42 % of the variance. These factors were: positive attitude towards NMRR (11 items) and negative attitude towards NMRR (9 items). Total score was calculated by summing up responses on these two factors.

Scale internal consistency estimates for the respective two factors, based upon a sample of undergraduate students (N=872) were: $\alpha_1=0.861$ (positive attitude to NMRR), $\alpha_2=0.814$ (negative attitude to NMRR). A validation study of this scale has not yet been conducted.

Counselor Rating Form – Short Version (CRF-S).

CRF-S is a 12-item self-report measure evaluating client's perception of counselor's attractiveness, expertness, and trustworthiness. It is a shorter version of a 36-item instrument measuring client's perception of the counselor (CRF; Barak & LaCrosse, 1975) constructed by Corrigan and Schmidt (1983). In hopes of improving CRF they selected the best items with the highest loadings on the suggested three factors. The CRF-S showed improved reliabilities, reduction in educational level required for comprehension, and slightly greater use of the full 7-point range in the ratings of each item.

The CRF-S consists of three factor-derived subscales, attractiveness, expertness and trustworthiness. Each scale consists of four items. Each item is an adjective describing one of the positive characteristics of the counselor (e.g., experienced, friendly, or warm). Participants are asked to indicate to which extent the counselor under consideration possesses this characteristic using a 7- point Likert-type scale ranging from 1 (not very) to 7 (very).

Corrigan and Schmidt (1983) reported high inter-item reliabilities for each of the three subscales ranging from .82 to .94 for their two validation samples ($N_1=133$ and $N_2=155$). Epperson and Pecnik (1985) reported high internal consistencies for each of the three subscales (.76 - .87) obtained on the sample of 213 college students.

The CRF-S was validated through a number of studies (Corrigan & Schmidt, 1983; Epperson & Pecnik, 1985; Tracey, Glidden, & Kokotovic, 1988). Corrigan and Schmidt have tested the factor-structure of the CRF-S on the samples of college students ($N_1=133$) and community clients ($N_2=155$). They performed a series of confirmatory factor analyses and concluded that three orthogonal factors of attractiveness, expertness, and trustworthiness explained observed variance in responses the best. Additionally, Tracey et al. have found that a two-step hierarchical-factor model with three independent first-order factors and an independent second-order general factor provided the best fit for the data from their two samples, clinical ($N_1=191$) and non-clinical ($N_2=111$). An independent second-order factor is worth further discussion, as it will be used in this study.

Tracey et al. (1988) reported that the second order factor represented global positive evaluation of the counselor without reference to a specific dimension. Furthermore, they found that of all the factors this one had the most sound factor structure. This factor seems to be the most relevant to the current project as participants may not have enough information about the counselor in the vignette to be able to differentiate among the three dimensions. However, they may be able to form a general impression. The possible score range was 12-84.

Other measures

Counseling Experience Scale. This scale was developed for the purposes of the study. It contains six questions (see Appendix J) pertaining to the participants' previous counseling experience, such as type of counseling, duration, perceived success, and nature of the relationship with the counselor.

Demographic Questionnaire. This questionnaire developed by the author contains six questions gathering demographic information about participants' characteristics, such as age, gender, ethnicity, family status, and socio-economic status (see Appendix K).

Vignette Feedback Questionnaire. Sixty four questions related to the realism and quality of the vignettes were developed for the pilot study (Appendix C). Responses to these questions were used to select and modify vignettes to be used in the primary study.

Variables

For the brief summary of variables and measures, please, see Table 3.

Independent variables

There are 4 independent variables in this study: multiple roles, type of multiple role situation, attachment avoidance, and attachment anxiety. *Multiple roles*, the first independent variable in this study, is a between subjects manipulated factor with two levels, multiple roles accepted and multiple roles declined. This variable was presented through the case vignettes.

The second variable, *type of multiple role situation*, is a within-subjects factor with two levels, social interaction and professional interaction. It is an exploratory variable that will allow preliminary analysis of possible differences in former clients' views depending on the type of multiple roles. This variable was presented through the case vignettes as well.

Vignette 1 described social interaction outside of counseling (client invited psychologist to

attend her art show). Vignette 2 focused on professional interaction outside of therapy (counselor and client found themselves in the professor – student relationship outside the sessions).

The third and fourth variables were quantitative predictors. *Attachment avoidance*, a continuous variable, was measured by the Avoidance subscale of the Experiences in Close Relationships scale (ECRS; Brennan, Clark, & Shaver, 1998). *Attachment anxiety*, also a continuous variable, was measured by the Anxiety subscale of the Experiences in Close Relationships scale.

Covariates/control variables

The study had two control variables. *Gender* was a blocking factor. It was measured through the self-report. The second variable, *Impression Management*, was used to control for the social desirability response bias. It was measured by the Impression Management subscale of the Balanced Inventory of Desirable Responding (Paulhus, 1984).

Dependent variables

Originally, there were eight dependent variables in this study. Six of them were paired: Index of Negative Feelings for vignette 1 (INF1) with Index of Negative Feelings for vignette 2 (INF2), Index of Positive Feelings for vignette 1 (IPF1) with Index of Positive Feelings for vignette 2 (IPF2), and Cognitive Evaluation 1 (CE1) with Cognitive Evaluation 2 (CE2). Each of the participants had scores on both of the variables from the pair. In the subsequent analysis, INF1 and INF2 were combined to produce general Index of Negative Feelings (INF), while IPF1 and IPF2 were combined in general Index of Positive Feelings (IPF). For more detailed description of the process and rationale behind this transformation see section *Variable Transformation* in chapter 4.

Indices of Negative Feelings (INF1, INF2, and INF) measured participants' negative emotional reactions to the case vignettes. Higher scores represent higher presence/intensity of negative feelings. *Indices of Positive Feelings (IPF1, IPF2, and IPF)* evaluated participants' positive emotional reactions to the study vignettes. Higher scores on these indices mean higher presence/intensity of positive emotions in response to the vignettes. Both sets of indices were measured by the first part of Reaction Questionnaire. The *Cognitive Evaluation* variables (*CE1* and *CE2*) assessed participants' perceptions of the positive and negative impact of the multiple role situation with the positive scores reflecting prevalence of positive judgments and negative scores indicating prevalence of negative assessments. Two aforementioned variables were measured by the second part of the Reaction Questionnaire.

The fifth dependent variable, *general attitude towards nonsexual multiple role relationships*, was measured by the Multiple Roles Questionnaire (MRQ) with the larger total score representing more positive attitude towards NMRR.

The sixth variable, *Counselor Rating (CRF)*, evaluated participant's perception of the counselor described in the vignettes as measured by the Counselor Rating Form – Short Version (CRF-S; Corrigan & Schmidt, 1983). The higher scores reflect more positive perception of the counselor.

Operational Hypotheses

Operational hypotheses have been developed on the basis of study research questions described in the introduction portion on pp. 11-12. For the rationale behind these hypotheses, please, refer to pp. 8-11.

Emotional reactions to the counseling situation

It was hypothesized that participants would have higher scores on the Index of Positive Feelings (IPF) when multiple roles were accepted than when multiple roles were declined. Additionally, it was predicted that participants would have lower scores on the Index of Negative Feelings (INF) when multiple roles were accepted than when they were declined. Even though predictions for both variables were in the same direction, the author planned to analyze these variables separately, as her previous research showed differential patterns of responses for these two variables (Diyankova & Scott, 2006). Finally, it was hypothesized that the scores on both IPF and INF might be predicted by attachment anxiety, attachment avoidance or an interaction between the two.

Cognitive evaluation of the counseling situation

It was predicted that participants would have higher scores on the Cognitive Evaluation (CE) when multiple roles were accepted, than when multiple roles were declined. Additionally, it was hypothesized that differences in participants' scores on the CE might be partially explained by their scores on attachment anxiety, attachment avoidance, or the interaction between the two. However, this part of the hypothesis was exploratory, because it was difficult to predict the magnitude and direction of the differences, as there was no previous research, to the best of the author's knowledge, on the relationships between attachment dimensions and perception of the counseling situations involving multiple roles.

Perception of the counselor

It was predicted that participants would have higher scores on the Counselor Rating (CRF) when multiple roles were accepted, than when multiple roles were declined.

Additionally, it was hypothesized that the CRF scores might be predicted by attachment anxiety, attachment avoidance, or both.

General attitude towards multiple roles

It was hypothesized that the variance in MRQ scores would be explained by attachment avoidance, attachment anxiety, or a combination of the two.

Procedures

Pilot study

The major purposes of the pilot study were to develop and test the clinical case vignettes. Feedback from four practicing mental health professionals and ten individuals, who had been in counseling or were currently undergoing it, was solicited. The author was interested in: how believable and realistic were the vignettes, how authentic were the descriptions of client and psychologist, and how much more or less detail may be needed to enhance the clarity of the vignettes. To obtain responses to these questions, the Vignette Feedback Questionnaire was developed (see Appendix C). Additionally, the author wished to assess the impact vignettes had on individuals. So, seven additional participants, all former counseling clients, were asked to fill out the Reaction Questionnaire for each vignette they read. Finally, the Experiences in Close Relationships Scale was administered to all participants, who were former counseling clients, to assess the variability of responses and to ascertain the feasibility of including the scale in the primary study.

Participants' responses were analyzed for the common themes. The vignettes were modified accordingly. Additionally, two vignettes from each set were deleted to make the primary study more manageable. For more detailed description see Chapter 4.

Primary study

The study application was submitted to the Iowa State University Institutional Review Board (IRB) for approval. As indicated in Appendix M, IRB approval was granted on November 27, 2006 (IRB ID: 06-569).

Potential participants, undergraduate students at Iowa State University, were selected either through the mass testing conducted by Psychology Department or self-selected to participate on the basis of announced criteria. The major eligibility criterion was previous experiences of being a client in psychological counseling. Additional, desirable criteria, were as follows: most recent counseling experience at the age of 15 or later, and attended 4 or more sessions with the same counselor. Eligible participants were contacted via e-mail and/or phone and offered an opportunity to participate in the study.

Individuals, who volunteered to participate, were invited to come to the study sessions conducted in the university classrooms. Participants were randomly assigned to one of the two between-subjects experimental conditions (multiple roles accepted vs. multiple roles declined). Additionally, the order of vignettes presentation was randomized (in some of the packets vignette 1 was presented first, while in the other packets vignette 2 was presented first). After randomization process was completed, an informed consent form (see Appendix K) was presented to the volunteer participants, their questions were answered, and their consent to participate was obtained. Next, the research packets were distributed.

The packets had the following arrangement of materials and measures:

1. Cover sheet (with instructions)
2. Demographic Questionnaire
3. Balanced Inventory of Desirable Responding (BIDR)

4. Experiences in Close Relationships Scale (ECRS)
5. Multiple Role Questionnaire (MRQ)
6. Vignette instructions and introduction
7. Vignette (# 1 or 2)
8. Vignette Reaction Questionnaire (RQ)
9. Vignette (# 2 or 1)
10. Vignette Reaction Questionnaire (RQ)
11. Counselor Rating Form – Short Version (CRF-S)
12. Counseling Experience Scale (CES)

Please, see Appendices B-J for the copies of all the data collection materials.

Participants were instructed to work with the materials in the presented order without going back and forth between questionnaires. After participants finished working with their packets, they were asked to hand them in to the research assistant. After this they were given a copy of the debriefing statement. Also, participants' questions and concerns were addressed.

Analyses of Data

The author analyzed the data obtained in the pilot studies, both quantitatively and qualitatively. Descriptive statistics and independent samples t-tests were used to understand participants' response patterns. Additionally, general themes discussed by participants in both pilot studies were analyzed.

For the primary study data analysis, the author conducted five separate ANCOVAs using SPSS 14.0. Multiple Roles and Gender were entered as factors. Attachment Anxiety, Attachment Avoidance were entered as continuous independent variables, and Impression Management was entered as a covariate. Main effects for multiple roles and attachment were

analyzed. Additionally, interactions among attachment anxiety, attachment avoidance, and multiple roles were explored. The author also used multiple regression analyses on Counselor Rating and on Attitude towards Multiple Roles for exploratory purposes.

CHAPTER 4. RESULTS

Pilot Studies

The major purpose of the pilot studies was to assess the four clinical case vignettes (Appendix B) to be used in the primary study for clarity, realism, and potential impact on the participants (see detailed description of the vignettes in chapter 3). Additionally, the researcher wanted to ascertain the variability of responses for the attachment measure. Two pilot studies were conducted. Two most realistic and impactful vignettes were selected for the primary study. They were also modified in accordance with participants' suggestions. For the detailed description of the pilot studies, including participants and results, see Appendix N.

Primary Study

Variables - descriptive statistics

Independent variables and a covariate.

There were two independent quantitative variables, Attachment Anxiety (ECRS, Anxiety) and Attachment Avoidance (ECRS, Avoidance), and one quantitative covariate, Impression Management (IM subscale of BIDR), in this study. All three variables had substantial variability, were normally distributed, and had high internal consistency. Please, refer to the Table 4 for more details.

Dependent variables.

Variable transformation. Initially, there were six paired variables: Index of Positive Feelings for vignette 1 (IPF1) and Index of Positive Feelings for vignette 2 (IPF2), Index of Negative Feelings for vignette 1 (INF1) and Index of Negative Feelings for vignette 2 (INF2), Cognitive Evaluation for vignette 1 (CE1) and Cognitive Evaluation for vignette 2 (CE2).

They were created to explore whether there were any differences between the types of multiple roles (social, vignette 1, versus professional, vignette 2) on any of the predictors. Even though no differences were expected, this possibility could not be excluded without checking. Descriptive statistics for the aforementioned six variables are presented in Table 5 (Appendix L).

To test the exploratory hypothesis that participants would react differently to the vignettes depending on the type of multiple roles (social versus professional) a series of paired samples t-tests was conducted. The results are summarized in the Table 6. As can be seen from the table, the t-tests on IPF1 with IPF2 and INF1 with INF2 were not significant, so these pairs of variables were combined into two separate indices to strengthen subsequent analysis. The resulting two variables were labeled as Index of Positive Feelings (IPF) and Index of Negative Feelings (INF).

Table 4. Descriptive statistics for the independent variables and a covariate

| Variables | N | Mean | SD | Min | Max | Skewness | alpha |
|-----------------------|-----|------|------|------|-------|----------|-------|
| Impression Management | 114 | 4.90 | 3.21 | 0.00 | 14.00 | .69 | .72 |
| Attachment Anxiety | 111 | 4.01 | 1.09 | 1.39 | 6.00 | -.34 | .91 |
| Attachment Avoidance | 111 | 3.07 | 1.08 | 1.00 | 5.89 | .06 | .94 |

Table 6. Results of Paired Samples T-tests

| Paired Variables | Paired differences | | t | df | p |
|------------------|--------------------|--------------------|------|-----|------|
| | Mean | Standard deviation | | | |
| IPF1 with IPF2 | .19 | 1.04 | 1.90 | 112 | .060 |
| INF1 with INF2 | -.05 | .72 | -.74 | 113 | .462 |
| CE1 with CE2 | 1.00 | 3.02 | 3.52 | 112 | .001 |

However, the t-test for the Cognitive Evaluation was significant. Therefore, CE1 and CE2 were not combined in the subsequent analysis and an ANCOVA with one between-subject factor and one within-subject factor was used on this variable.

All Indices of Negative Feelings, INF1, INF2, and INF, were slightly skewed (1.05 to 1.13). A square root transformation of INF was applied for the subsequent analyses (ANCOVA). However, results of the two subsequent ANCOVA tests (for INF and square root of INF) were not different. So, the author decided to use the non-transformed INF for the ease of results' interpretation.

Descriptive statistics. Descriptive statistics for the six dependent variables used in the primary analyses: Index of Negative Feelings (INF), Index of Positive Feelings (IPF), Cognitive Evaluation 1 (CE1), Cognitive Evaluation 2 (CE2), Counselor Rating (CRF), and General Attitude towards Multiple Roles (MRQ) including means, standard deviations, minimum and maximum values, skewness, and Cronbach's alphas are presented in the Table 7. As can be seen from the table, all variables, except INF, were relatively normally distributed. However, the aforementioned variable was slightly positively skewed. As was described above, the author computed a square root transformation of INF, which was more normally distributed (skewness=.74). However, since there were no differences in the results of the subsequent ANCOVA tests, the investigator reverted back to the use of original INF variable to make results more interpretable.

Relationships among dependent variables. Correlations for the variables are presented in Table 8. As can be seen from the table, MRQ is significantly correlated with only one dependent variable, CE2. This pattern was expected, as MRQ was completed by participants before they were exposed to the vignettes. Most of the other dependent variables were

Table 7. Descriptive statistics for dependent variables

| Variables | N | Mean | SD | Min | Max | Skewd | alpha |
|-----------|-----|-------|-------|-------|--------|-------|----------------------|
| INF | 114 | 1.74 | .55 | 1.00 | 3.44 | 1.05 | .87 |
| IPF | 113 | 3.00 | .80 | 1.00 | 4.78 | -.46 | .92 |
| CE1 | 113 | 1.66 | 2.27 | -4.50 | 6.00 | -.62 | .81;.87 ^a |
| CE2 | 114 | .61 | 2.24 | -5.75 | 5.75 | -.02 | .82;.85 ^a |
| CRF | 113 | 68.70 | 10.14 | 41.00 | 84.00 | -.62 | .91 |
| MRQ | 112 | 72.88 | 18.05 | 26.00 | 116.00 | -.28 | .88 |

Note. ^a Two estimates of alpha are provided for CE1 and CE2 because two subscales were used in each index computation.

Table 8. Correlations among dependent variables

| Variables | 1 | 2 | 3 | 4 | 5 |
|--|--------|-------|-------|-------|-----|
| 1. Index of Negative Feelings (INF) | | | | | |
| 2. Index of Positive Feelings (IPF) | -.19* | | | | |
| 3. Cognitive Evaluation 1 (CE1) | -.43** | .52** | | | |
| 4. Cognitive Evaluation 2 (CE2) | -.11 | .19* | .10 | | |
| 5. General Attitude towards Multiple Roles (MRQ) | .05 | -.03 | .11 | .26** | |
| 6. Counselor Rating (CRF) | -.34** | .36** | .43** | .28** | .13 |

* $p < 0.05$

** $p < 0.01$

significantly correlated with each other. Correlation values ranged from small to moderate, and the pattern of the relationships was conceptually consistent. The only exclusions were the relationships between INF and CE2 and relationships between CE1 and CE2. These variables were not significantly related.

Given normal distributions and patterns of relationships among dependent variables in our study, we chose to proceed with five separate ANCOVAs to test for the four study hypotheses.

Preliminary analysis

Randomization check.

Randomization checks were conducted to ascertain effectiveness of multiple roles (accepted vs. declined) manipulation. Differences between the two groups on the following variables: perception of outcome (of the past counseling), perceived quality of the (past) counseling relationship, attachment avoidance, and attachment anxiety were explored through the series of independent-samples t-tests. None of the results were significant. Please, see Table 9 in Appendix L for details.

Additionally, the author checked differences on the following variables: participants' gender, age, ethnicity, family status, SES, age of the most recent counseling experience, and number of sessions attended during the longest counseling experience. Non-parametric Mann-Whitney U test was used for these purposes. None of the results were significant. These results are presented in Table 10 (Appendix L). Given that none of the tests were significant, the author concluded that randomization of the subjects was completed successfully.

Analysis of interaction effects.

Even though only one interaction effect (between attachment avoidance and attachment anxiety) was hypothesized, the author wanted to check for all possible two-way and three-way interactions. Therefore, four separate Univariate 2 (gender: male, female) x 2 (multiple roles: present, absent) Analyses of Covariance (ANCOVAs) were conducted on the Index of Positive Feelings, Index of Negative Feelings, Counselor Rating, and General Attitude towards NMRR. Seven covariates were included in the analysis: Impression Management, Attachment Anxiety, Attachment Avoidance, interaction between Attachment Anxiety and

Attachment Avoidance, interaction between Multiple Roles and Attachment Anxiety, interaction between Multiple Roles and Attachment Avoidance, and three-way interaction among Attachment Anxiety, Attachment Avoidance, and Multiple Roles. None of the interaction effects for any of the analyses were significant. So, the interaction terms were excluded from the primary analysis. Additionally, main effect of gender was not significant for IPF, INF, or MRQ. So, this variable was excluded from the subsequent analyses on these dependent variables. The author proceeded to the primary analysis to test for the study hypotheses.

Primary analysis

Emotional reactions to the counseling situation.

Index of Positive Feelings. A one-way ANCOVA testing for the hypothesized main effects of multiple roles and attachment dimensions, anxiety and avoidance, on IPF was conducted. In this analysis, multiple roles were included as a factor. Attachment Anxiety, Attachment Avoidance, and Impression Management were included as quantitative independent variables. Impression Management was retained in this analysis to control for the possible desirability bias in participants' responses. However, relationship between it and Index of Positive Feelings was not significant ($F(1,105)=.19, p=.67$), which was a positive sign of participants' responses not being affected by social desirability bias.

Levene's test for the equality of variances was significant, $F(1,108)=4.88, p<.05$. However, significance of this test indicates only that variances are not identical. The author proceeded with further examination of the sample variances. The ratio of the variances was 1: 2, which, according to Keppel (1991), is an acceptable difference that does not violate

equality of the means assumption. Therefore, the further analysis of the main effects was conducted.

For the ANCOVA on IPF, the main effect of Multiple Roles was significant, $F(1, 106)=13.324$, $p<.001$, $\eta^2=.113$. The 95% confidence interval for the differences between means ranged from .26 to .83. Therefore, researchers can be 95% confident that the population mean for IPF score would be .26 to .83 points higher when multiple roles are accepted than when multiple roles are declined.

The main effect of Attachment Anxiety was not significant, $F(1,106)=1.24$, $p=.269$. The main effect of Attachment Avoidance was not significant as well, $F(1,106)=.018$, $p=.895$. Please, see Table 11 in Appendix L for the summary of all ANCOVA results.

Index of Negative Feelings. A one-way ANCOVA was conducted on INF. Multiple Roles were included in this analysis as a factor, while Attachment Anxiety and Attachment Avoidance were entered as quantitative independent variables, and Impression Management was entered as a covariate. Results for this test are summarized in Table 12.

As can be seen from the table, the main effect for Multiple Roles was significant, as was predicted. The 95% confidence interval for the differences between means ranged from -.52 to -.15. Therefore, researchers can be 95% confident that population mean for INF score will be between .15 and .52 points lower when multiple roles are accepted than when they are declined.

Table 12. Summary of ANCOVA results for INF

| Independent Variables/ Covariates | df | F | p | η^2 |
|--------------------------------------|--------|-------|-----|----------|
| Impression Management | 1, 106 | .22 | .64 | .00 |
| Attachment Avoidance | 1, 106 | .01 | .91 | .00 |
| Attachment Anxiety | 1, 106 | 4.66 | .03 | .04 |
| Multiple Roles | 1, 106 | 13.08 | .00 | .11 |

Additionally, the main effect for Attachment Anxiety was found ($\eta^2=.042$). The author computed 95% confidence interval for beta which ranged from .008 to .181. Therefore researchers can be 95% confident that with each one point increase in the Attachment Anxiety mean score, population mean for INF will increase between .008 and .181 points.

Cognitive evaluation of the counseling situation.

Contrary to the author's expectations, differences between Cognitive Evaluation paired dependent variables (CE1=cognitive evaluation of the counseling situation involving social interaction and CE2= cognitive evaluation of the counseling situation involving professional interaction) were significant. For detailed description of the paired-samples t-test see Table 6. Given these differences, a mixed 2 (multiple roles: accepted, declined) x 2 (multiple role type: social, professional) ANCOVA was conducted for the test of the third hypothesis.

In this analysis Multiple Role Type (social, professional) was entered as a within-subject factor. Multiple Roles and Gender were entered as between-subject factors. Attachment Anxiety and Attachment Avoidance were included as quantitative independent variables, and Impression Management was entered as a covariate. The author decided to not include interactions between attachment dimensions and multiple roles in this analysis to strengthen the power of the test.

Two significant within-subject effects were found. The main effect for Multiple Role Type was significant, $F(1,104)=8.66$, $p<.01$. However, interaction between Multiple Role Type and Multiple Roles was significant, $F(1,104)=13.93$, $p<.001$, as well. Therefore, the author proceeded with the analysis of the simple main effects.

For the social type situation, the mean score on Cognitive Evaluation was significantly higher ($p<.01$), when multiple roles were accepted ($M=2.38$) than when they were declined

($M=.99$). Researchers can be 95% confident that the population mean for the Cognitive Evaluation would be between .46 and 2.11 points higher when multiple roles are accepted than when they are declined in the social interaction condition.

Although for professional interaction situation test for the differences between Cognitive Evaluation means was not statistically significant, it was approaching significance ($p=.065$). The pattern of differences, however, was the opposite to the one described above. When multiple roles were accepted, the mean score on Cognitive Evaluation ($M=.38$) was lower than when they were declined ($M=1.04$). These differences are illustrated in figure 1. Overall, these results indicate that participants evaluate counseling situation differently depending on the type of secondary relationship and presence or absence of multiple roles.

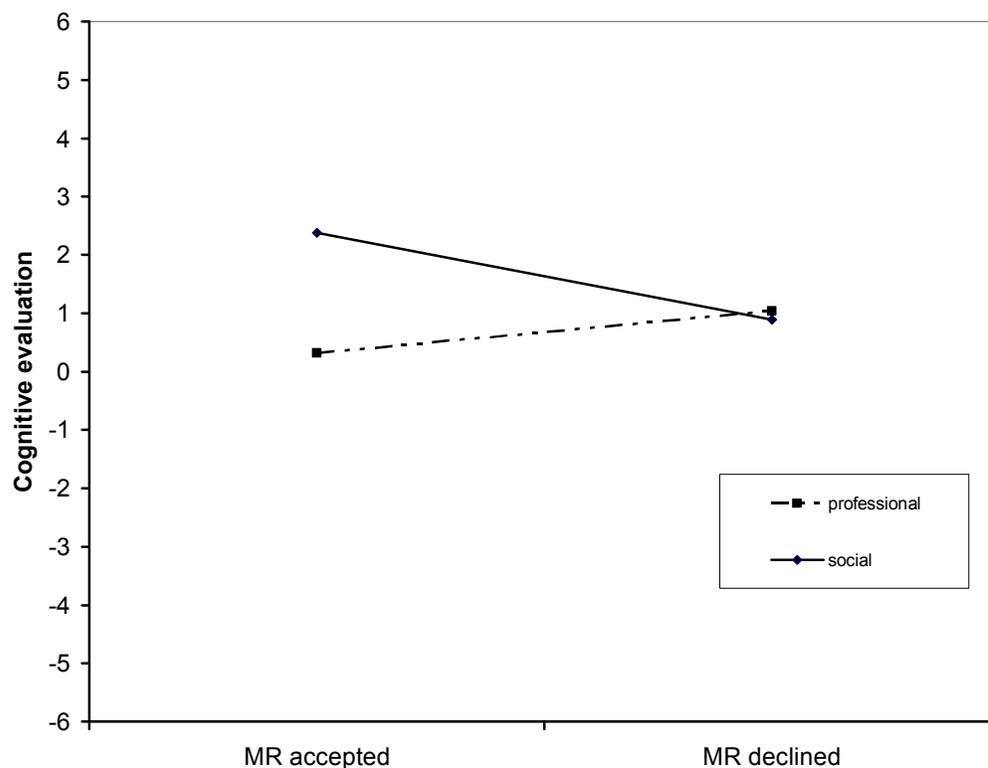


Figure 1. Interaction effect for Cognitive Evaluation

None of the between-subject effects were significant for Cognitive Evaluation. Results indicate that presence or absence of multiple roles, scores on the attachment anxiety and attachment avoidance did not explain variability in participants' cognitive evaluation of the counseling situation.

Perception of the counselor.

A 2(gender: male, female) x 2 (multiple roles: present, absent) ANCOVA on CRF was conducted. Attachment Anxiety and Attachment Avoidance were included as quantitative independent variables, and Impression Management was entered as a covariate. The main effects for two out of three independent variables, Multiple Roles and Attachment Avoidance, were significant. Additionally, significant main effect of gender was found. Relationship between Impression Management and Counselor Rating was not significant. Please, see Table 13 for the summary of the results.

The author proceeded with computation of 95% confidence intervals. It was found that each one point increase in Attachment Avoidance score will correspond to .24 to 3.71 point decrease in Counselor Rating score for the population under study (95% confidence). Additionally, researchers can be 95% confident that the population mean for CRF will be between 1.04 and 8.43 points higher when multiple roles are accepted than when they are declined. Finally, males scored significantly lower on CRF than females ($p=.006$); 95% confidence interval for the differences in means ranged from -9.12 to -1.56.

Table 13. Between-subject main effects for CRF

| Independent Variables | df | F | p | η^2 |
|-----------------------|--------|------|------|----------|
| Impression Management | 1, 103 | 1.18 | .279 | .01 |
| Attachment Avoidance | 1, 103 | 5.09 | .026 | .05 |
| Attachment Anxiety | 1, 103 | .179 | .673 | .00 |
| Multiple Roles | 1, 103 | 4.48 | .037 | .04 |
| Gender | 1, 103 | 6.30 | .014 | .06 |

General attitude towards multiple roles.

To test for the differences in participants' attitudes towards multiple roles a one-way Analysis of Covariance (ANCOVA) on MRQ was performed with gender entered as a factor, Attachment Anxiety, Attachment Avoidance, and interaction between Attachment Anxiety and Avoidance entered as quantitative independent variables, and Impression Management included as a covariate. None of the tests were significant with p-values ranging from .260 to .815.

Additional exploratory analysis

A set of additional exploratory analyses was conducted as some interesting patterns in the data were noticed by the author. The data for participants' counseling experience was collected (see Appendix I for the Counseling Experience Scale). The author decided to explore relationships between some aspects of the past counseling experience and dependent variables. First, correlations among Perception of the Outcome, Perceived Quality of Counseling Relationship, Attachment Anxiety, Attachment Avoidance and dependent variables were computed (see Table 14 in Appendix L). From the correlations, it was noted that Attitude towards Multiple Roles (MRQ) and Counselor Rating (CRF) were significantly positively correlated with participants' Perceptions of the Outcome (of their previous counseling; CES5) and the Perceived Quality of (their past) Counseling Relationship (CES6). Perception of Outcome was also significantly negatively correlated with Attachment Avoidance whereas Perceived Quality of the Counseling Relationship was significantly negatively correlated with attachment anxiety. These relationships seemed theoretically very interesting and warranted further exploration. Therefore, two separate regression analyses on Counselor Rating (CRF) and Attitude towards Multiple Roles (MRQ) were conducted.

General Attitude towards Multiple Roles.

Perception of Outcome, Perceived Quality of the Counseling Relationship, and Attachment Anxiety were entered as predictors into multiple regression on MRQ. It was found that the aforementioned model explained significant portion of variance in MRQ, $F(3,105)=4.34$, $p<.01$, $R^2=.11$, adjusted $R^2=.09$. Perceived Quality of Counseling Relationship was the most significant predictor, $B=8.99$, $t=2.94$, $p<.01$, CI: 2.93-15.05. Researchers can be 95% confident that for each one unit increase on the Perceived Quality of Counseling Relationship there will be corresponding increase between 2.93 and 15.05 points on MRQ.

Counselor perception.

The Perception of Outcome, Perceived Quality of Counseling Relationship, Attachment Anxiety, and Attachment Avoidance were entered as predictors into multiple regression on CRF. It was found that the aforementioned model accounted for the significant portion of the variance in CRF, $F(4,105)=4.72$, $p<.01$, $R^2=.15$, adjusted $R^2=.12$. Perceived Quality of Counseling Relationship was the only significant predictor, $t=2.59$, $B=4.34$, $p<.05$, CI: 1.01-7.66. Researchers can be 95% confident that for each 1 unit increase on the Perceived Quality of Counseling Relationship there will be corresponding increase between 1.01 and 7.66 points on CRF.

CHAPTER 5. DISCUSSION

The primary purpose of this research was to explore former clients' reactions to the counseling situations that involve multiple role relationships, as well as to assess their perception of the counselor involved in these situations. Additionally, participants' general attitudes towards multiple role relationships were studied. To assist with development of the materials for this research and the choice of measures, two pilot studies were conducted. First, the results of the pilot studies will be discussed briefly. Then, the author will focus on interpretation of the results from the primary study. The discussion will be organized around the proposed hypotheses. Finally, research limitations, clinical implications, and future directions will be reviewed.

Two small pilot studies were conducted. In pilot study one, participants, former counseling clients and counselors, provided feedback on the four types of the vignettes developed by the author. Two types of vignettes, one focusing on the social interaction outside of counseling and one focusing on the student-professor interaction (labeled as professional), were rated as highly realistic, easy to understand from both counselor and client perspectives, and well-balanced in relation to completeness versus brevity. Both former clients and counselors agreed in their ratings. As a result, two aforementioned vignettes were chosen for the purposes of the current study. Additionally, these vignettes have been slightly modified on the basis of the feedback received from the participants.

In pilot study two, participants, former counseling clients, were randomly assigned to receive four vignettes each. These vignettes either involved counselor accepting multiple role relationship or counselor declining multiple roles. Their reactions to these vignettes and their responses to the attachment style measure were explored. It was found that there was

substantial variability in participants' responses to the attachment scales. This was encouraging, and the decision to include these scales in the primary study was made. Additionally, even though the sample was very small, the differences in participants' reactions towards vignettes depending on acceptance or decline of multiple roles by the counselor were noticeable. This finding coupled with the vignette feedback from the previous pilot study showed that vignettes had desired effect on the subjects and could be used for the primary research.

The major questions posed in the primary study focused on the differences in participants' emotional reactions to and cognitive evaluation of the counseling situation involving multiple roles, as well as their perception of the counselor depicted in the vignette. Some of the predictors suggested by the researcher were acceptance/decline of multiple roles, attachment anxiety, and attachment avoidance. An analogue experimental design was conducted. The results for each of the study's four hypotheses will be discussed in details as follows.

Emotional Reactions to the Counseling Situation

It was hypothesized that participants will have more positive and less negative emotional reactions to the counseling situation when counselor and client are involved in multiple roles (interact outside of the counseling office) than when they are abstaining from a secondary relationship. This hypothesis was supported by the study findings. However, it is important to note that differences were rather small, so the described tendency is modest. Nevertheless the findings support propositions of some clinicians that multiple roles are not necessarily harmful for the clients and may even in some cases be beneficial for the counseling relationship (Lazarus, 1994; Zur, 2001). Additionally, these findings agree with the research done by Pulakos (1994) on the accidental encounters between therapists and clients. As was

previously discussed, clients almost always wanted more involvement from their therapist in these out-of-office situations.

On first glance however, current findings disagree with the previous findings by Diyankova and Scott (2006), who used the same measure to assess participants' emotional reactions to the counseling situation. These authors reported interaction between multiple roles and emotional reactions of clients described in the vignettes for the negative emotional reactions to the counseling situation. Additionally, they found no main effect of multiple roles for the positive emotional reactions. Differences between the findings of the two studies may be explained by the differences in counseling situations described in the vignettes. It is possible that individuals would ignore acceptance or decline of multiple roles when emotional cues from the clients in the vignettes are present.

The second part of this hypothesis focused on the differences in emotional reactions associated with individual variability in attachment anxiety and attachment avoidance. This was an exploratory hypothesis, and the direction of differences was not predicted. This hypothesis was only partially supported by the findings. More specifically, it was found that higher attachment anxiety was associated with more negative emotional reactions to the counseling situation. This effect was independent of the presence or absence of multiple roles.

Relationships between attachment anxiety and negative emotional reaction to the counseling situation may be understood in the larger context of the attachment theory. Thus, Bowlby (1988) suggested that the therapist's role is similar to that of a parent, and that the therapeutic situation activates clients' attachment systems. Malinckrodt (1991) argued that clients' affective responses are in part determined by their attachment styles. Therefore, the same counseling event may cause contrasting reactions from individuals with different styles.

These arguments help us understand different emotional reactions of individuals depending on their attachment anxiety. More specifically, Lopez (2001) found that attachment anxiety was significantly positively correlated with emotional reactivity. Additionally, Slade (1999) reported that individuals high on attachment anxiety may have higher expectations and demands and may be more expressive of their needs. Therefore, it is possible that individuals whose attachment styles are characterized by high anxiety expected more of the counseling situation presented in the vignettes and were more disappointed by its development.

What is surprising, positive emotional reactions to the counseling situation were not explained by either attachment avoidance or attachment anxiety. It is possible that high attachment anxiety leads to heightened negative emotional reactions but it does not affect positive aspects of emotional perception. Alford and colleagues (2006) have found that differences in general positive and negative affect in the college student population were explained by the interaction between attachment anxiety and attachment avoidance. However, a general tendency to experience positive or negative feelings may not generalize to the specific emotional reactions to the counseling situations described in the vignettes.

Cognitive Evaluation of the Counseling Situation

The author hypothesized that participants will assess the counseling situation as having more benefits, when multiple roles are accepted than when they are declined. It was also predicted that participants' differences in cognitive evaluation of the situation will be predicted by attachment anxiety, attachment avoidance, or the interaction between the two.

The first part of this hypothesis was only partially supported. Results showed that differences in cognitive evaluation were partially explained by the interaction between multiple roles and the type of the secondary relationship. Thus, when the secondary

relationship was a social interaction (client invited counselor to attend the former's art exhibit), participants saw more benefits when multiple roles were accepted than when they were declined. However, when the secondary relationship was professional (counselor was an instructor in the client's class), participants saw less benefits when multiple roles were accepted than when they were declined by the counselor. It is difficult to say whether variability in responses was due to the differences between social and professional nature of the secondary relationship or to the perceived differences in duration (one-time exhibit attendance versus a semester long instructor-student relationship).

These findings disagree with some previous results. Thus, Ramsdell and Ramsdell (1993) reported former clients' attitudes towards different types of multiple roles. Their participants thought that both attendance of a social event and engagement in a business relationship with the counselor were somewhat detrimental to therapy. The situations suggested by the researchers differed both in type and length of a secondary relationship. National surveys of ethical practices among mental health professionals (Borys & Pope, 1989; Pope, Tabachnick, & Keith-Spiegel, 1987) showed that approximately the same number of respondents endorsed attendance of client's social event (18%) and providing therapy to a student (13%) as ethical. More research is needed to understand these disagreements.

Surprisingly, the second part of the hypothesis was not supported. Multiple studies by Mikulincer and colleagues (1997, 1998, 1999) suggest that interaction between attachment anxiety and avoidance explains differences in several aspects of cognitive processing, such as cognitive flexibility and openness. However, this study did not find any associations between attachment avoidance, attachment anxiety, or the combination of the two and participants' cognitive evaluation of the counseling situation. This discrepancy may be explained by the

lack of the direct link between individuals' openness or cognitive flexibility and their assessment of benefits versus negative consequences of the specific counseling situation.

Perception of the Counselor

It was predicted that participants would have more positive perceptions of the counselor when he accepts multiple roles as opposed to declining. Additionally, it was hypothesized that counselor perception may be predicted by attachment anxiety, attachment avoidance, or both.

The results of the study completely supported the first part of this hypothesis. More specifically, it was found that participants viewed the counselor in the vignettes more positively when multiple roles were accepted than when they were declined by him. This is an interesting finding, when considered in the context of the debate related to the harmfulness versus beneficence of multiple role relationships. It seems to support the pro-multiple roles side of the debate. The aforementioned findings indirectly support Zur's (2001) proposition that nonsexual multiple role relationships with the clients may enhance therapeutic alliance and trust in the counseling relationship. This increase in trust and connection may be related to the overall perception of the counselor open to multiple roles as more friendly, trustworthy, sociable, and warm. Schefflin (2002) suggested that multiple roles may enhance overall rapport and positive expectation from the counseling through positive perception of the counselor involved in the secondary relationship.

In addition, the second part of the hypothesis, related to attachment style, was partially supported. It was found that attachment avoidance explained a small but significant portion of variance in counselor perception. More specifically, the lower was participants' attachment avoidance, the more positive was their rating of the counselor. This finding

supports Slade's (1999) proposition that insecurely attached individuals (high attachment avoidance is a part of it) may perceive emotionally available, responsive and empathic therapist as incapable of providing safety in the relationship. She also claimed that client's attachment organization has a profound effect on feelings about and expectations of the therapist.

There were some additional, not anticipated, findings related to the perception of the counselor. First, gender had a slight impact on participants' ratings of the counselor with males giving slightly lower ratings than females. Second, participants' perceptions of their past counseling relationship quality predicted their ratings of the counselor in the study vignette. Additionally, attachment avoidance was negatively related to the perceived quality of the past counseling relationship. These findings seem to be consistent with the previous research. Thus, some of the past findings suggest that individuals with high attachment avoidance tended to keep greater distance from their therapists (Dozier & Tyrell, 1998) and reported more negative therapeutic alliances (Mallinckrodt et al., 1995; Eames & Roth, 2000). Additionally, their therapists rated therapeutic alliances with these clients lower (Eames & Roth, 2000). In the light of these findings, it is not surprising that participants' attachment avoidance was negatively related to their perception of the quality of past counseling relationship. It is interesting, however, that the latter explained current ratings of the counselor in the vignette. It is possible that clients tend to project their experiences with the previous counselor to the new counseling situation. Their attachment style may facilitate this projection.

General Attitude towards Multiple Roles

The author hypothesized that general attitude towards multiple roles will be explained by gender, attachment avoidance, and attachment anxiety. This hypothesis was not supported by the findings. Findings related to gender are in direct contradiction to the findings from the previous study (Diyankova & Scott, 2003). It is possible that gender effect is so small, that the analysis did not have enough power to detect it. It was rather surprising that general attitude towards multiple roles was not predicted by any of the attachment dimensions, given that some of the more situational reactions to multiple roles were. On the other hand, general attitudes measured by the Multiple Role Questionnaire seem to assess both participants' cognitive evaluations of multiple roles and their emotional reactions to them. As was discussed above, individuals' cognitive evaluations of the counseling situations were not influenced by attachment style either. It is possible that individual's attachment style influences emotional reactions the relationship situation much more than cognitive evaluation of it.

However, in additional exploratory analysis it was found that general attitudes towards NMRR were predicted by the perceived quality of the previous counseling relationship. Participants who reported more positive counseling relationship had more positive attitudes towards multiple roles. Even though the author is not aware of past research findings that may support or disconfirm aforementioned conclusion, this finding seems reasonable. It is understandable that individuals who had more negative or neutral experiences with their previous counselors will be on guard in relation to future counseling interactions, and, more specifically, will be more cautious in respect to boundaries. On contrary, clients who had

positive relationship with their previous counselor may be more open to the idea of multiple roles and more flexible with the boundaries.

Summary of the Results

Overall, former clients in this study had more positive emotional and cognitive reactions to the counseling situation and perceived the counselor more positively when multiple roles were present than when they were absent. These results seem to support more liberal attitudes towards multiple roles in counseling endorsed in the writings of some professionals (Lazarus, 1994, 1998; Scheflin, 2002; Zur, 2001, 2005). Given that multiple roles are unavoidable in so many different contexts (Helbok et al., 2006; Kertesz, 2002; Kessler, 2005; Schank & Skovholt, 1997), it makes sense to start shifting the focus of attention from the question of whether they are harmful or beneficial to the question of how they can be managed most effectively to benefit and not harm the clients. Scheflin (2002) suggests teaching trainees to deal with the multiple roles to client's benefit rather than insisting that counselors should avoid out-of-counseling involvements.

Some relationship between dimensions of attachment style and reactions to the counseling situation and counselor were found. More specifically, high attachment anxiety was associated with more negative emotional reactions to the counseling situation. High attachment avoidance predicted lower ratings of the counselor in the vignette. These findings were consistent with the previous research on attachment and counseling (Malinckrodt, 1991; Lopez, 2001; Dozier & Tyrell, 1998; Mallinckrodt et al., 1995; Eames & Roth, 2000). However, aforementioned relationships were much weaker than was expected. Additionally, only some aspects of participants' reactions were explained by attachment.

Strengths

One of the major strengths of this study was the use of the experimental design that allowed controlled manipulation of the multiple role and type of multiple role factors. As a consequence of the chosen experimental design, the author can confidently conclude that presence or absence of multiple roles caused the differences in participants' reactions to the counseling situation and in their perceptions of the counselor.

Even though the use of the self-report measures will be discussed as the study's limitation, control for social desirability was a strength that partially compensated for this deficiency. No significant associations between social desirability and participants' responses on dependent measures were found. This is a very encouraging result that enhances findings from the study.

Another strength of this study was the focus on the former clients population. Even though a number of studies on mental health professionals' attitudes towards multiple roles have been published, very few studies to date have addressed clients' or former clients' perspectives on the issue. It seems reasonable to assume that those who have experienced counseling may convey informed and realistic perspectives on the potential and plausible counseling relationships portrayed in this study.

Finally, the use of the pilot studies for assessment and further development of the vignettes was a significant asset. Pilot studies participants, both counselors and clients, found vignettes selected for the primary study to be realistic and clear descriptions of the possible counseling scenarios.

Limitations

One of the major limitations of this study was its analogue nature. Readers have to exercise caution when generalizing these results to the actual counseling situation.

Unfortunately, this limitation is unavoidable, as it would be unethical to assign subjects to presence or absence of multiple roles in the real counseling situation, especially before we have a more clear understanding of their potential for harm.

Another important limitation was the use of self-report measures. As was noted above, control for social desirability partially addressed this issue. Related to this, some measures used in this study, such as Reaction Questionnaire, have been developed by the researcher for the purposes of this study. Thus, validity data for these questionnaires is lacking. This limitation is difficult to avoid when research in a new area is being conducted.

In addition, the study's sample was predominantly Caucasian. This limitation stems from the relative lack of diversity on the Iowa State campus. Additionally, it may be associated with the potential underutilization of the counseling services by ethnic minority individuals. It is unknown, whether the study's findings are generalizable to the other ethnic groups.

Implications

Although this study has some limitations and additional research is suggested before generalizations are made, it is important to start contemplating about the clinical implications of the findings. One of the major implications pertains to former clients' seeming openness towards multiple roles and generally positive reactions to them. This finding, combined with the past findings of multiple roles unavoidability in some contexts (Helbok et al., 2006; Kertesz, 2002; Kessler, 2005), leads one to question stringent ethical standards and defensive practices. It seems that at times mental health professionals, in their zest to protect clients

from harm, forget to ask their patients whether they were harmed or foresee being harmed or even whether they need protection. It is possible that, if counselors relinquish some of their power in the counseling relationship, then the client-counselor power differential will not be as high, and need to protect the clients would be significantly reduced. Thus, it is recommended that mental health professionals consult with their clients when multiple role dilemmas arise and work together to find the best solution possible. The words of one of the pilot studies participants: "it's not psychologist's decision to tell Ben drop the class; letting him know of potential consequences was the best Dr. Moss could do" remind us that counseling clients are often competent people capable of evaluating the situations and making their own choices.

The study's findings also have implications for counselor training. It is suggested that recommendations to avoid multiple roles whenever possible (Doverspike, 1999; Meyer, J., n.d.; Pope & Vasquez, 1991) should be substituted by teaching trainees how to manage dual relationships effectively, how to recognize potential for harm, how to take preventative measures, and how to openly discuss pros and cons with the clients. The author agrees with Schefflin (2002) that young therapists should be taught how to manage multiple roles for the ultimate benefit of the client.

In current psychological practice nonsexual multiple roles are becoming a serious ethical and legal issue which is reflected in increasing number of patient complaints (Fleer, 2002; Meyer, n.d.). It is possible that one of the ways to reduce these complains is to have an open and continuous dialogue with clients about dual relationships.

Another important implication refers to the findings associated with attachment style. The author suggests that practicing professionals pay attention to their client's attachment style

and anticipate possible reactions to the multiple role situations in accordance with it. Thus, it can be expected that anxiously attached client may experience negative feelings in the situation involving multiple roles, whether they are actually present or absent. Therefore, it is important to take additional steps and put an extra-effort into discussion of multiple role situations with such a client.

The finding pointing to the lower counselor ratings by highly avoidant clients suggests that it may be especially difficult to establish working therapeutic alliance with these types of clients. It is possible that no matter what a counselor does, he or she will be perceived as not available. Therefore, mental health professionals should be prepared to spend more time and effort developing trusting relationship with these clients.

Future Research Directions

There are multiple directions for the future research. First of all, replication of the current results for other populations seems important. Special emphasis should be put on exploration of reactions to multiple roles among different ethnic minority groups. Also, exploring differences between clients from the rural and urban areas may be interesting. In addition, studying attitudes of individuals from GLBT, ethnic minority, international and other cultural groups seems very important as they may have very different perspectives on multiple roles.

Second, further exploration of clients' and former clients' thoughts and attitudes towards multiple role relationships seems important. What considerations do they have when making a decision about beneficence or harmfulness of a specific multiple role situation? Also, will they think differently about situations depending on the type of multiple role or duration of the relationship? Exploring clients and former clients attitudes towards different multiple role scenarios seems important. There is a great variability of possible non-sexual secondary

relationships. Some examples include attending a client's wedding, counselor and client's children being friends, counselor buying groceries from a store owned by a client, counselor and client serving on a school board together, and counselor and client being social acquaintances. This list can go on. But the question remains, will clients perceive these situations differently?

Another interesting line of research has to do with attachment style and reactions to multiple roles. Even though current findings have been modest, the author thinks that it is important to continue exploration in this direction. Exploratory analysis done by the author suggests that there may be interesting mediators in relationships between attachment dimensions and reactions to multiple roles and counselor, such as perception of the past counseling experience and perceived quality of the past counseling relationship. These and other characteristics of the individual's counseling experience should be included in the future studies.

Also, inconsistent findings related to attachment in this study may be due to the inability of the vignettes to trigger participants' attachment system. The author suggests that in the future researchers use vignettes that are centered around participants themselves. For example, subjects may be asked to imagine that they are involved in multiple roles with their current or former counselor and then asked about their thoughts and feelings related to this situation. Another possibility will be studying incidence of multiple roles existing in the current relationships between psychologists and their clients qualitatively.

Conclusion

The current research is unique as it examined the widely discussed, but rarely empirically investigated, phenomenon of clients' attitudes towards nonsexual multiple role relationships.

It was found that presence of multiple role relationships often led to more favorable former clients' reactions to the counseling situation and the counselor. This finding supports more liberal perspectives on multiple roles in counseling (Lazarus, 1994, 1998; Zur, 2001, 2005). Additionally, the results have very important clinical implications, as they suggest that clients should be continuously and actively involved in the decision-making process related to dual roles.

Furthermore, some associations between former clients' attachment styles and their reactions to the counseling situation and the counselor were detected. These findings need further investigation. They also may have very interesting clinical implications, such as an importance of taking client's attachment style into account when dealing with dual roles.

APPENDIX A. SAMPLE SIZE COMPUTATION

$N=(Z_{\alpha/2} + Z_{\beta})^2 / \rho^{*2} + 3$, where

$z_{\alpha/2}=1.96$ at $\alpha=.05$

$z_{\beta}=1.65$ at $\beta=.95$

$z_{\beta}=.84$ at $\beta=.80$

Minimal meaningful correlation that the author wanted to detect was $p=.3$

$\rho^*=1/2[\ln(1+p) - \ln(1-p)]=1/2[\ln(1.3) - \ln(.7)]=.31$

Calculations of the sample size:

$N_1=(1.96 + .84)^2 / .096 + 3=85$ for the power of .80

$N_2=(1.96 + 1.65)^2 / .096 + 3=139$ for the power of .95

APPENDIX B. VIGNETTES

A. VIGNETTES (CASE DESCRIPTIONS) FOR THE PILOT STUDY

1. Multiple roles accepted

Instructions: The stories below describe situations that sometimes happen in counseling and psychotherapy. Please, read these stories carefully. Try to imagine yourself in the client's shoes. How would you feel and act if this happened to you? What would you think about this situation? Keep these questions in mind while reading the clients' stories.

STORIES

Dr. Halley Moss is a licensed counseling psychologist working at the mental health clinic. He is a successful professional respected by his clients and colleagues. He has been working in this field for 10 years. The following excerpts describe several situations that occurred in Dr. Moss's recent work with the clients.

Vignette 1

(239 words; Client is employed by therapist)

Alex O. (18 y.o.) started psychotherapy with Dr. Moss a year ago in connection with depression and suicidal thoughts after the death of his mother. Alex was saying that he felt alone and isolated and that his mother was the only person that he felt close to. He did not see a point in living anymore. Throughout his time in therapy he improved significantly. Alex was able to develop new social connections and even one close friendship. Although he still felt sad about his mother's death, he saw his future in a more positive and hopeful light.

After eleven months in therapy, Alex was no longer clinically depressed. It was still important for Alex to remain in counseling to continue working on his feelings of loss and extreme sadness. At the same time, it became difficult for Alex to continue therapy due to the serious financial difficulties. Although Alex was not able to pay for the weekly sessions he did not qualify for fee reduction according to the existing billing criteria.

Alex suggested he would do something for Dr. Moss in exchange for psychotherapy, for instance, mow the lawn, or help with the housework. Dr. Moss said that it seemed like a good idea. He said that his house needed to be repainted. Dr. Moss suggested to hire Alex to repaint the house. Alex happily agreed. They decided that Alex would paint psychologist's house in exchange for ten sessions.

Vignette 2

(222 words; Therapist accepts client's social invitation)

Megan Y. (46 years old) was in therapy with Dr. Moss for a year. She worked on the issues in romantic relationships with males. Megan had a history of intense and sometimes violent relationships with males. In one instance she was repeatedly physically abused by her male partner. As a child, Megan was physically and emotionally abused by both of her parents. When she was 10 her parents divorced and she never saw her mother again. This client was extremely sensitive to the feedback and criticism from others. She often felt angry and offended by other people actions. She also was afraid of others abandoning her. During

one year in therapy Megan made significant progress. Four months ago she left her abusive partner. Since then she has been living alone and feeling much better about herself.

In the last session Megan asked Dr. Moss if he would be willing to come to the opening of Megan's art exhibit. The client said that although it was not her first exhibit, she felt that this one was very good and hoped that it would help her to advance further in her artistic career. Dr. Moss thanked Megan for invitation and accepted it. He said that he would be delighted to look at her art work and to support her during such an important event.

Vignette 3 (218 words; Therapist agrees to be client's tennis partner)

Leann B. (35 y.o.) started counseling with Dr. Moss six months ago because of the terrible stress related headaches. The woman has been suffering these headaches for three years since starting her current job which was very demanding and competitive. She said that until approximately six months ago she was able to control her headaches with medication. However, lately nothing seemed to help. And pain has been interfering with her job performance and personal life.

Three months after beginning counseling Leann's health started to improve. As therapy progressed, the headaches became less frequent and more bearable. However, Leann remained in therapy and continued to work on development of her self-care skills. Four months into therapy, Dr. Moss and Leann ran into each other at the tennis courts. Leann was glad to see Dr. Moss there and suggested that they play a game together. Dr. Moss agreed. They seemed to be equal in their skills and enjoyed playing with each other.

Leann suggested they meet once a week to play tennis together. Dr. Moss said that his tennis partner of 3 years moved away a month ago and that he has been looking for a new partner since then so this arrangement would work great. Also, Dr. Moss stated that their tennis partnership may strengthen their therapeutic relationship.

Vignette 4

(281 words; Therapist accepts the role of the client's course instructor)

Ben S., a 20 year-old college student, has been in therapy with Dr. Moss for 6 months. He worked on low self-esteem and performance anxiety that affected his relationships and academic performance. In the course of therapy Ben improved significantly. Lately, he and Dr. Moss were talking about finishing their work together. They agreed to have three more sessions. Meanwhile, Ben signed up for Abnormal Psychology class at his university. When he came to the first class, he found Dr. Moss as an instructor. He was really surprised because schedule said a different name. Dr. Moss explained that the class instructor got seriously sick last minute and Dr. Moss was asked to teach the class this semester. After the first class Dr. Moss asked Ben to talk to him in his office. He asked Ben to think about his feelings and thoughts related to the overlap in their relationship.

In a couple of days Ben and Dr. Moss discussed their thoughts and feelings about the situation in individual meeting. Ben said that after thinking about this situation he feels excited that Dr. Moss will be his teacher and is very comfortable with it. Dr. Moss said that although he was glad to see Ben, he had some concerns associated with how Ben may feel along the road if Dr. Moss's evaluation of his performance differs from what Ben expects. Additionally, Dr. Moss shared his concerns related to the effect their teacher-student relationship may have on the counseling relationship. After talking about different benefits

and risks, they both felt more comfortable about the situation. They decided that Ben will stay in the class because their therapy was coming to an end anyway.

2. Multiple roles declined

Instructions: The stories below describe situations that sometimes happen in counseling and psychotherapy. Please, read these stories carefully. Try to imagine yourself in the client's shoes. How would you feel and act if this happened to you? What would you think about this situation? Keep these questions in mind while reading the clients' stories.

STORIES

Dr. Halley Moss is a licensed counseling psychologist working at the mental health clinic. He is a successful professional respected by his clients and colleagues. He has been working in this field for 10 years. The following excerpts describe several situations that occurred in Dr. Moss's recent work with the clients.

Vignette 1

(233 words; Therapist refuses to employ client)

Alex O. (18 y.o.) started psychotherapy with Dr. Moss a year ago in connection with depression and suicidal thoughts after the death of his mother. Alex was saying that he felt alone and isolated and that his mother was the only person that he felt close to. He did not see a point in living anymore. Throughout his time in therapy he improved significantly. Alex was able to develop new social connections and even one close friendship. Although he still felt sad about his mother's death, he saw his future in a positive and hopeful light.

After eleven months in therapy, Alex was no longer clinically depressed. It was still important for Alex to remain in counseling to continue working on his feelings of loss and extreme sadness. At the same time, it became difficult for Alex to continue therapy due to the serious financial difficulties. Although Alex was not able to pay for the weekly sessions he did not qualify for fee reduction according to the existing billing criteria.

Alex suggested he would do something for Dr. Moss in exchange for psychotherapy, for instance, mow the lawn, or help with the housework. Dr. Moss said that although it seemed like a good idea, he feels reluctant to do that. He explained to Alex that their business relationship may potentially negatively affect their counseling relationship if any conflict of interest or disagreement arises.

Vignette 2 (218 words; Therapist rejects client's social invitation)

Megan Y. (46 years old) was in therapy with Dr. Moss for a year. She worked on the issues in romantic relationships with males. Megan had a history of intense and sometimes violent relationships with males. In one instance she was repeatedly physically abused by her male partner. As a child, Megan was physically and emotionally abused by both of her parents. When she was 10 her parents divorced and she never saw her mother again. This client was extremely sensitive to the feedback and criticism from others. She often felt angry and offended by other people's actions. She also was afraid of others abandoning her. During one year in therapy Megan made significant progress. Four months ago she left her abusive partner. Since then she has been living alone and feeling much better about herself.

In the last session Megan asked Dr. Moss if he would be willing to come to the opening of Megan's art exhibit. The client said that although it was not her first exhibit, she felt that this one was very good and hoped that it would help her to advance further in her artistic career. Dr. Moss thanked Megan for invitation and rejected it. He explained that their out-of-therapy interactions may complicate counseling process and possibly negatively affect Megan's progress in counseling.

Vignette 3

(218 words; Therapist refuses to be client's tennis partner)

Leann B.(35 y.o.) started counseling with Dr. Moss six months ago because of the terrible stress related headaches. The woman has been suffering these headaches for three years since starting her current job which was very demanding and competitive. She said that until approximately six months ago she was able to control her headaches with medication. However, lately nothing seemed to help. And pain has been interfering with her job performance and personal life.

Three months after beginning counseling Leann's health started to improve. As therapy progressed, the headaches became less frequent and more bearable. However, Leann remained in therapy and continued to work on development of her self-care skills. Four months into therapy, Dr. Moss and Leann ran into each other at the tennis courts. Leann was glad to see Dr. Moss there and suggested that they play a game together. Dr. Moss agreed. They seemed to be equal in their skills and enjoyed playing with each other.

Leann suggested they meet once a week to play tennis together. Dr. Moss said that although he enjoyed playing tennis with Leann, he did not want to make this a regular arrangement. Psychologist explained to Leann that their tennis partnership may interfere with the counseling relationship if one of them becomes too competitive or upset about the partner's actions.

Vignette 4

(285 words; Therapist is uncomfortable with the role of the client's course instructor)

Ben S., a 20 year-old college student, has been in therapy with Dr. Moss for 6 months. He worked on low self-esteem and performance anxiety that affected his relationships and academic performance. In the course of therapy Ben improved significantly. Lately, he and Dr. Moss were talking about finishing their work together. They agreed to have three more sessions. Meanwhile, Ben signed up for Abnormal Psychology class at his university. When he came to the first class, he found Dr. Moss as an instructor. He was really surprised because schedule said a different name. Dr. Moss explained that the class instructor got seriously sick last minute and Dr. Moss was asked to teach the class this semester. After the first class Dr. Moss asked Ben to talk to him in his office. He asked Ben to think about his feelings and thoughts related to the overlap in their relationship.

In a couple of days Ben and Dr. Moss discussed their thoughts and feelings about the situation in individual meeting. Ben said that after thinking about this situation he feels excited that Dr. Moss will be his teacher and is very comfortable with it. Dr. Moss said that although he was glad to see Ben, he had some concerns associated with how Ben may feel along the road if Dr. Moss's evaluation of his performance differs from what Ben expects. Additionally, Dr. Moss shared his concerns related to the effect their teacher-student

relationship may have on the counseling relationship. After talking about different benefits and risks, they both felt uncomfortable about being in both relationships at the same time. They decided that Ben will drop the class and take it next semester with a different instructor.

B. VIGNETTES FOR THE PRIMARY STUDY (changes from the pilot vignettes are indicated in cursive)

STORIES

Instructions: Two stories below describe situations that sometimes happen in counseling and psychotherapy. Please, read these stories carefully. Try to imagine yourself in the client's shoes. How would you feel and act if this happened to you? What would you think about this situation? Keep these questions in mind while reading the clients' stories. After each story you will have to fill out a questionnaire pertaining to this story.

Introduction: Dr. Halley Moss is a *37 year-old married male*. Dr. Moss is a licensed counseling psychologist working at a mental health clinic. He is a successful professional respected by both his clients and colleagues. Dr. Moss has been working as a psychologist for 10 years. *His clients describe him as knowledgeable, caring, and helpful*. The following excerpts describe several situations that occurred in Dr. Moss's recent work with his clients.

Story MRAC-1

Megan Y. (46 years old) has been in therapy with Dr. Moss for a year. She worked on issues in romantic relationships with males. Megan has had a history of intense and sometimes violent relationships with males. In one instance she was repeatedly physically abused by her male partner. Megan was physically and emotionally abused by both of her parents throughout her childhood. When she was 10, her parents divorced and she never saw her mother again. Megan is extremely sensitive to feedback and criticism from others. She often feels angry and offended by others' actions. She is also fearful of others abandoning her. During her year in therapy, Megan has made significant progress. Four months ago she left her abusive partner. Since then she has been living alone and feeling much better about herself. *In spite of this progress, both Megan and Dr. Moss feel that it is important for Megan to continue therapy. Megan feels that her traumatic past is still affecting her current views of herself and her relationships in a negative way. She believes that she needs support of Dr. Moss to continue working on her struggles.*

In their last session Megan asked Dr. Moss if he would be willing to come to the opening of her art exhibit. Megan said that although it was not her first exhibit, she felt that this one was very good and hoped that it would help her to advance further in her artistic career. Dr. Moss thanked Megan for invitation and accepted it. He said that he would be delighted to look at her art work and to support her during such an important event.

Story MRAC-2

Ben S., a 20 year-old college student, has been in therapy with Dr. Moss for 6 months. He has worked on low self-esteem and performance anxiety that have affected his relationships and academic performance. In the course of therapy, Ben improved significantly. Lately, he and Dr. Moss have been talking about finishing their work together. They agreed to have three *final* sessions. Meanwhile, Ben signed up for an Abnormal Psychology class at his university. When he came to the first class, he found that Dr. Moss was the instructor. This surprised Ben because his schedule listed a different instructor. Dr. Moss explained that the class instructor became seriously ill and at the last minute Dr. Moss was asked to teach the class this semester. After the first class Dr. Moss asked Ben to talk to him in his office. He asked Ben to think about his feelings and thoughts related to the overlap in their relationship.

In a couple of days Ben and Dr. Moss discussed their thoughts and feelings about the situation in an individual meeting. Ben said that after thinking about the situation he felt excited that Dr. Moss would be his teacher *because he respected and trusted him. Ben assured Dr. Moss that he would be very comfortable with this arrangement.* Dr. Moss said that although he was glad to see Ben, he had some concerns associated with how Ben may feel in the future if Dr. Moss's evaluation of his performance differs from what Ben expects. Additionally, Dr. Moss shared his concerns related to the effect their teacher-student relationship may have on the counseling relationship. After talking about different benefits and risks, they both felt more comfortable about the situation. They decided that Ben would stay in the class because their therapy was coming to an end.

Story MRD-1

Megan Y. (46 years old) has been in therapy with Dr. Moss for a year. She worked on issues in romantic relationships with males. Megan has had a history of intense and sometimes violent relationships with males. In one instance she was repeatedly physically abused by her male partner. Megan was physically and emotionally abused by both of her parents throughout her childhood. When she was 10, her parents divorced and she never saw her mother again. Megan is extremely sensitive to feedback and criticism from others. She often feels angry and offended by others' actions. She is also fearful of others abandoning her. During her year in therapy, Megan has made significant progress. Four months ago she left her abusive partner. Since then she has been living alone and feeling much better about herself. *In spite of this progress, both Megan and Dr. Moss feel that it is important for Megan to continue therapy. Megan feels that her traumatic past is still affecting her current views of herself and her relationships in a negative way. She believes that she needs support of Dr. Moss to continue working on her struggles.*

In their last session Megan asked Dr. Moss if he would be willing to come to the opening of her art exhibit. Megan said that although it was not her first exhibit, she felt that this one was very good and hoped that it would help her to advance further in her artistic career. Dr. Moss thanked Megan for invitation and *declined* it. He explained that their out-of-therapy interactions may complicate counseling process and possibly negatively affect Megan's progress in counseling.

Story MRD-2

Ben S., a 20 year-old college student, has been in therapy with Dr. Moss for 6 months. He has worked on low self-esteem and performance anxiety that have affected his relationships and academic performance. In the course of therapy, Ben improved significantly. Lately, he and Dr. Moss have been talking about finishing their work together. They agreed to have three final sessions. Meanwhile, Ben signed up for an Abnormal Psychology class at his university. When he came to the first class, he found that Dr. Moss was the instructor. This surprised Ben because his schedule listed a different instructor. Dr. Moss explained that the class instructor became seriously ill and at the last minute Dr. Moss was asked to teach the class this semester. After the first class Dr. Moss asked Ben to talk to him in his office. He asked Ben to think about his feelings and thoughts related to the overlap in their relationship.

In a couple of days Ben and Dr. Moss discussed their thoughts and feelings about the situation in an individual meeting. Ben said that after thinking about the situation he felt excited that Dr. Moss would be his teacher *because he respected and trusted him*. Ben assured Dr. Moss that he would be very comfortable with this arrangement. Dr. Moss said that although he was glad to see Ben, he had some concerns associated with how Ben may feel *in the future* if Dr. Moss's evaluation of his performance differs from what Ben expects. Additionally, Dr. Moss shared his concerns related to the effect their teacher-student relationship may have on the counseling relationship. After talking about different benefits and risks, they both felt uncomfortable about being in both relationships at the same time. They decided that Ben will drop the class and take it next semester with a different instructor.

APPENDIX C. VIGNETTE FEEDBACK QUESTIONNAIRE

I. INSTRUCTIONS

1. How clear were instructions for the vignettes? (Circle one alternative below)

Not clear at all Somewhat not clear Somewhat clear Very clear

2. If instructions were NOT sufficiently clear, please, suggest your modifications

II. DESCRIPTION OF PSYCHOLOGIST

3. Was there enough information provided about Dr. Moss? (Circle one alternative below)
 Not enough Somewhat not enough Somewhat enough Enough

4. If there was NOT enough information, what else do you need to know about Dr. Moss?

III. VIGNETTE 1**A. While reading this vignette,**

5. What were you thinking?
 6. What were you feeling?

B. After reading this vignette,

7. What are you thinking?
 8. How are you feeling?

C. Please, rate your agreement with the statements below on the scale from 0 to 10:

-----5 ----- 10
 completely neither agree completely
 disagree nor disagree agree

Please, explain your choice for each rating in the space provided below each item

9. I believe that situation described in the vignette could have happened in reality ____
 10. There is a good balance between completeness and brevity of description ____
 11. I understand client's experiences ____
 12. I understand client's motivations ____
 13. I understand psychologist's experiences ____
 14. I understand psychologist's motivations ____
 15. I can see how psychologist and client came to the described decision ____

D. If your ratings for any of the above items are 9 or 10, proceed to **part E.**

- 16.** If your ratings for any of the above items are 8 or less, suggest changes that will increase your rating.

E. Please, comment on the language of the vignette.

17. How clearly the thoughts are expressed?
 18. Please, suggest changes that will increase clarity.

19. Using a pen, please, correct the grammar of the vignette

IV. VIGNETTE 2

A. While reading this vignette,

20. What were you thinking?
21. What were you feeling?

B. After reading this vignette,

22. What are you thinking?
23. How are you feeling?

C. Please, rate your agreement with the statements below on the scale from 0 to 10:

-----5----- 10
completely neither agree completely
disagree nor disagree agree

Please, explain your choice for each rating in the space provided below each item

24. I believe that situation described in the vignette could have happened in reality ____
25. There is a good balance between completeness and brevity of description ____
26. I understand client's experiences ____
27. I understand client's motivations ____
28. I understand psychologist's experiences ____
29. I understand psychologist's motivations ____
30. I can see how psychologist and client came to the described decision ____

D. If your ratings for any of the above items are 9 or 10, proceed to part E.

31. If your ratings for any of the above items are 8 or less, suggest changes that will increase your rating.

E. Please, comment on the language of the vignette.

32. How clearly the thoughts are expressed?
33. Please, suggest changes that will increase clarity.
34. Using a pen, please, correct the grammar of the vignette

V. VIGNETTE 3

A. While reading this vignette,

35. What were you thinking?
36. What were you feeling?

B. After reading this vignette,

37. What are you thinking?
38. How are you feeling?

C. Please, rate your agreement with the statements below on the scale from 0 to 10:

-----5----- 10
completely neither agree completely
disagree nor disagree agree

Please, explain your choice for each rating in the space provided below each item

39. I believe that situation described in the vignette could have happened in reality ____
40. There is a good balance between completeness and brevity of description ____
41. I understand client's experiences ____
42. I understand client's motivations ____
43. I understand psychologist's experiences ____
44. I understand psychologist's motivations ____
45. I can see how psychologist and client came to the described decision ____

D. If your ratings for any of the above items are 9 or 10, proceed to **part E**.

46. **If your ratings for any of the above items are 8 or less**, suggest changes that will increase your rating.

E. Please, comment on the language of the vignette.

47. How clearly the thoughts are expressed?
48. Please, suggest changes that will increase clarity.
49. Using a pen, please, correct the grammar of the vignette.

VI. VIGNETTE 4

A. While reading this vignette,

50. What were you thinking?
51. What were you feeling?

B. After reading this vignette,

52. What are you thinking?
53. How are you feeling?

C. Please, rate your agreement with the statements below on the scale from 0 to 10:

-----5----- 10

| | | |
|------------------------|-------------------------------|---------------------|
| completely disagree | neither agree nor disagree | completely agree |
|------------------------|-------------------------------|---------------------|

Please, explain your choice for each rating in the space provided below each item

54. I believe that situation described in the vignette could have happened in reality ____
55. There is a good balance between completeness and brevity of description ____
56. I understand client's experiences ____
57. I understand client's motivations ____
58. I understand psychologist's experiences ____
59. I understand psychologist's motivations ____
60. I can see how psychologist and client came to the described decision ____

D. If your ratings for any of the above items are 9 or 10, proceed to part E.

61. **If your ratings for any of the above items are 8 or less**, suggest changes that will increase your rating.

E. Please, comment on the language of the vignette.

62. How clearly the thoughts are expressed?
63. Please, suggest changes that will increase clarity.
64. Using a pen, please, correct the grammar of the vignette.

APPENDIX D. ECRS

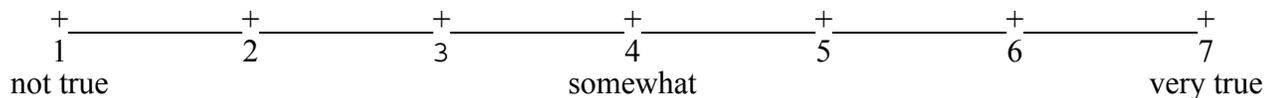
Directions: The following statements concern how you feel in romantic relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it.

| | | | | | | |
|-------------------|---|---|---------------|---|---|----------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Disagree Strongly | | | Neutral/Mixed | | | Agree Strongly |

1. I prefer not to show a partner how I feel deep down.
2. I worry about being abandoned.
3. I am very comfortable being close to romantic partners.
4. I worry a lot about my relationships.
5. Just when my partner starts to get close to me I find myself pulling away.
6. I worry that romantic partners won't care about me as much as I care about them.
7. I get uncomfortable when a romantic partner wants to be very close.
8. I worry a fair amount about losing my partner.
9. I don't feel comfortable opening up to romantic partners.
10. I often wish that my partner's feelings for me were as strong as my feelings for him/her.
11. I want to get close to my partner, but I keep pulling back.
12. I often want to merge completely with romantic partners, and this sometimes scares them away.
13. I am nervous when partners get too close to me.
14. I worry about being alone.
15. I feel comfortable sharing my private thoughts and feelings with my partner.
16. My desire to be very close sometimes scares people away.
17. I try to avoid getting too close to my partner.
18. I need a lot of reassurance that I am loved by my partner.
19. I find it relatively easy to get close to my partner.
20. Sometimes I feel that I force my partners to show more feeling, more commitment.
21. I find it difficult to allow myself to depend on romantic partners.
22. I do not often worry about being abandoned.
23. I prefer not to be too close to romantic partners.
24. If I can't get my partner to show interest in me, I get upset or angry.
25. I tell my partner just about everything.
26. I find that my partner(s) don't want to get as close as I would like.
27. I usually discuss my problems and concerns with my partner.
28. When I'm not involved in a relationship, I feel somewhat anxious and insecure.
29. I feel comfortable depending on romantic partners.
30. I get frustrated when my partner is not around as much as I would like.
31. I don't mind asking romantic partners for comfort, advice, or help.
32. I get frustrated if romantic partners are not available when I need them.
33. Please leave this question blank.
34. It helps to turn to my romantic partner in times of need.
35. When romantic partners disapprove of me, I feel really bad about myself.
36. I turn to my partner for many things, including comfort and reassurance.
37. I resent it when my partner spends time away from me.

APPENDIX E. BIDR Version 6 - Form 40A

Using the scale below as a guide, write a number beside each statement to indicate how true it is.



- ___ 1. My first impressions of people usually turn out to be right.
- ___ 2. It would be hard for me to break any of my bad habits.
- ___ 3. I don't care to know what other people really think of me.
- ___ 4. I have not always been honest with myself.
- ___ 5. I always know why I like things.
- ___ 6. When my emotions are aroused, it biases my thinking.
- ___ 7. Once I've made up my mind, other people can seldom change my opinion.
- ___ 8. I am not a safe driver when I exceed the speed limit.
- ___ 9. I am fully in control of my own fate.
- ___ 10. It's hard for me to shut off a disturbing thought.
- ___ 11. I never regret my decisions.
- ___ 12. I sometimes lose out on things because I can't make up my mind soon enough.
- ___ 13. The reason I vote is because my vote can make a difference.
- ___ 14. My parents were not always fair when they punished me.
- ___ 15. I am a completely rational person.
- ___ 16. I rarely appreciate criticism.
- ___ 17. I am very confident of my judgments
- ___ 18. I have sometimes doubted my ability as a lover.
- ___ 19. It's all right with me if some people happen to dislike me.

- ___ 20. I don't always know the reasons why I do the things I do.
- ___ 21. I sometimes tell lies if I have to.
- ___ 22. I never cover up my mistakes.
- ___ 23. There have been occasions when I have taken advantage of someone.
- ___ 24. I never swear.
- ___ 25. I sometimes try to get even rather than forgive and forget.
- ___ 26. I always obey laws, even if I'm unlikely to get caught.
- ___ 27. I have said something bad about a friend behind his/her back.
- ___ 28. When I hear people talking privately, I avoid listening.
- ___ 29. I have received too much change from a salesperson without telling him or her.
- ___ 30. I always declare everything at customs.
- ___ 31. When I was young I sometimes stole things.
- ___ 32. I have never dropped litter on the street.
- ___ 33. I sometimes drive faster than the speed limit.
- ___ 34. I never read sexy books or magazines.
- ___ 35. I have done things that I don't tell other people about.
- ___ 36. I never take things that don't belong to me.
- ___ 37. I have taken sick-leave from work or school even though I wasn't really sick.
- ___ 38. I have never damaged a library book or store merchandise without reporting it.
- ___ 39. I have some pretty awful habits.
- ___ 40. I don't gossip about other people's business.

APPENDIX F. REACTION QUESTIONNAIRES

REACTION QUESTIONNAIRE (pilot study)

You have finished the reading of the clinical case vignette (description of clients' experiences with their therapists). We asked you to imagine yourself in the client's shoes. Please, react to the vignette by responding to the questions below. Please, express your feelings (how you felt after reading a particular vignette) by completing the ratings below. Please, indicate to what extent YOU experienced each of the feelings from the table below after reading the vignettes. Fill in EACH CELL of the table using the following scale:

1 2 3 4 5

Not at all a little somewhat definitely to a great extent

| | <u>FEELING</u> | <u>RATING</u> |
|-----|-----------------|---------------|
| 1. | Hurt | |
| 2. | Helped | |
| 3. | Anxious | |
| 4. | Happy | |
| 5. | Angry | |
| 6. | Safe | |
| 7. | Sad | |
| 8. | Reassured | |
| 9. | Offended | |
| 10. | Cared for | |
| 11. | Misled | |
| 12. | Encouraged | |
| 13. | Frustrated | |
| 14. | Supported | |
| 15. | Exploited | |
| 16. | Relaxed | |
| 17. | Disappointed | |
| 18. | Grateful | |
| 19. | Other (Specify) | |

Please, provide your analysis of the situation described in the vignette. To respond to the questions 20 – 27 below use the following scale:

| | | | | | | |
|--------------------------|---|---|----------------------|---|---|-----------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Disagree Strongly | | | Neutral/Mixed | | | Agree Strongly |

20. ___ How beneficial is the described situation for the client?
21. ___ How harmful is the described situation for the client?
22. ___ How much this situation will negatively impact the relationship between the counselor and the client?
23. ___ How much this situation will positively impact the relationship between the counselor and the client?
24. ___ How much the described situation will positively impact the process of counseling?
25. ___ How much the described situation will negatively affect the process of counseling?
26. ___ How much the described situation will negatively impact the outcome of counseling?
27. ___ How much the described situation will positively impact the outcome of counseling?

Questions 28- 32 are open-ended. Please, provide your response in the space below each question. If you need additional space, please, use the back of the sheet. In the latter case, please, indicate question number to which you are responding.

28. How beneficial or harmful this situation is for the client? Why? Please, give a detailed response
29. How would described situation develop? What will happen afterwards?
30. If you were a client in this situation, how would you like it to develop?
31. What would you do if you were in the client's shoes?
80. Do you agree with the psychologist's actions in this situation? Why or why not?
32. What would you like psychologist in this situation to do?

REACTION QUESTIONNAIRE (RQ; used in the primary study)

You have finished the reading of the clinical case vignette (description of clients' experiences with their therapists). We asked you to imagine yourself in the client's shoes. Please, react to the vignette by responding to the questions below. Please, express your feelings (how you felt after reading a particular vignette) by completing the ratings below. Please, indicate to what extent YOU experienced each of the feelings from the table below after reading the vignettes. Fill in EACH CELL of the table using the following scale:

| | | | | |
|-------------------|-----------------|-----------------|-------------------|--------------------------|
| 1 | 2 | 3 | 4 | 5 |
| Not at all | a little | somewhat | definitely | to a great extent |

| | <u>FEELING</u> | <u>RATING</u> |
|-----|-----------------|---------------|
| 28. | Hurt | |
| 29. | Helped | |
| 30. | Anxious | |
| 31. | Happy | |
| 32. | Angry | |
| 33. | Safe | |
| 34. | Sad | |
| 35. | Reassured | |
| 36. | Offended | |
| 37. | Cared for | |
| 38. | Misled | |
| 39. | Encouraged | |
| 40. | Frustrated | |
| 41. | Supported | |
| 42. | Exploited | |
| 43. | Relaxed | |
| 44. | Disappointed | |
| 45. | Grateful | |
| 46. | Other (Specify) | |

Please, provide your analysis of the situation described in the vignette. To respond to the questions 20 – 27 below use the following scale:

| | | | | | | |
|-------------------|----------|----------|-----------------|----------|----------|------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Not at all | | | Somewhat | | | Very much |

20. ___ How beneficial is the described situation for the client?
21. ___ How harmful is the described situation for the client?
22. ___ How much this situation will negatively impact the relationship between the counselor and the client?
23. ___ How much this situation will positively impact the relationship between the counselor and the client?
24. ___ How much the described situation will positively impact the process of counseling?
25. ___ How much the described situation will negatively affect the process of counseling?
26. ___ How much the described situation will negatively impact the outcome of counseling?
27. ___ How much the described situation will positively impact the outcome of counseling?

APPENDIX G. MULTIPLE ROLES QUESTIONNAIRE (MRQ)

Statements of this questionnaire concern your relationships with a psychologist, counselor, psychotherapist, social worker, or any mental health professional that you have received counseling or psychotherapy from.

Answer the statements of this questionnaire using the scale below (write an appropriate number to the left of each statement):

| | | | | | | |
|------------------------------|-----------------|------------------------------|----------------|---------------------------|--------------|---------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly disagree | disagree | slightly disagree | neutral | slightly agree | agree | strongly agree |

1. I think it's normal to give presents worth \$10 or more to my psychologist.
2. I think that relationships between my psychologist and me should be limited by a session.
3. I feel cared for when my psychologist calls me at home or spends some time with me outside the office.
4. I think it's OK for my psychologist and me to sometimes hug or touch each other.
5. I'll feel completely comfortable if my psychologist invites me for coffee or lunch.
6. If my psychologist asks me for a favor (such as giving him/her a ride home), I'll feel comfortable doing this.
7. I think it may be harmful for me to have other than professional relationships (be friends or socialize together) with my psychologist.
8. I'll feel safe having my psychologist as my business partner.
9. I feel embarrassed when my psychologist recognizes me at the street or in the store.
10. I think it's not appropriate for my psychologist to call me at home or spend spare time with me.
11. I think it may be beneficial for me to have my psychologist as a business partner.
12. I'll feel abandoned and betrayed if my psychologist doesn't want to be my friend outside the counseling office.
13. If I have a friend or relative who is psychologist, I'll feel completely comfortable and safe receiving professional counseling from him/her.
14. I think it may be harmful for my progress in counseling and for myself to accept my psychologist's invitation for coffee or lunch.
15. I'll feel insecure and uncomfortable if hired by my psychologist's office.
16. I think it's completely appropriate for my psychologist to ask small favors from me and the other clients.
17. It feels intrusive and unpleasant when my psychologist touches or hugs me.
18. I'll feel secure and cared for entering counseling with my psychology class instructor.
19. I think it's not acceptable to invite my psychologist for a party or social event.
20. I'll feel imposed upon by accepting a gift worth \$10 or more from my psychologist.
21. I think that receiving counseling from my psychology class instructor may be harmful to me.

APPENDIX H. COUNSELOR RATING FORM – SHORT VERSION (CRF-S)

Directions: On the following 2 pages, each characteristic is followed by a seven-point scale that ranges from “not very” to “very.” Please mark an “x” at the point on the scale that best represents how you viewed the counselor in the vignettes. For example:

Funny

not very x : : : : : : very

Well Dressed

not very : : : : : x : very

This rating might show that the therapist did not joke around, but was well dressed.

Experienced

not very : : : : : : very

Expert

not very : : : : : : very

Friendly

not very : : : : : : very

Honest

not very : : : : : : very

Likable

not very : : : : : : very

Prepared

not very : : : : : : very

Reliable

not very : : : : : : very

Sincere

not very _____ very

Skillful

not very _____ very

Sociable

not very _____ very

Trustworthy

not very _____ very

Warm

not very _____ very

APPENDIX I. COUNSELING EXPERIENCE SCALE

1. Have you ever received counseling or psychotherapeutic services (been a client in counseling)?
 - (1) Yes
 - (2) No

2. How old were you during your most recent counseling experience?
 - (1) 10 years old or younger
 - (2) 10- 14 years old
 - (3) 15 years or older

3. What type of counseling have you received?
 - (1) Individual counseling or psychotherapy
 - (2) Family counseling or psychotherapy (counseling either with your parents, or with your spouse (fiancée, partner, etc.), or with your brothers/sisters)
 - (3) Group counseling or psychotherapy (as an individual you participated in a group where members were not your family)
 - (4) Individual counseling and Family counseling
 - (5) Individual counseling and Group counseling
 - (6) Family counseling and Group counseling
 - (7) Individual, Family, and Group counseling
 - (8) Other

4. How many times have you met with the counselor or psychologist during your longest counseling experience?
 - (1) Once
 - (2) 2-3 times
 - (3) 4-6 times
 - (4) 8- 10 times
 - (5) 11- 20 times
 - (6) more than 20 times

5. How successful was your counseling experience?
 - (1) Not very successful
 - (2) Moderately unsuccessful
 - (3) Neither successful nor unsuccessful
 - (4) Moderately successful
 - (5) Successful

6. What kind of relationships did you have with your counselor or psychotherapist?
 - (1) Negative relationships: My counselor or psychotherapist was not supportive and/or showed minimal understanding. I have a lot to complain about.
 - (2) Neutral relationships: My counselor or psychotherapist and I did not have a strong bond, but we were able to work collaboratively on my issues.
 - (3) Positive relationships: My counselor or psychotherapist and I had a strong/good connection. I felt understood by him/her. I have a little to complain about.

APPENDIX J. DEMOGRAPHIC QUESTIONNAIRE

Please, answer the following questions by circling the appropriate alternative.

1. What is your gender?
 - (1) male
 - (2) female

2. How old are you?
 - (1) 18-19
 - (2) 20-24
 - (3) 25 – 30
 - (4) 31 – 40
 - (5) 41 – 55
 - (6) 56 or older

3. What is your ethnicity?
 - (1) Caucasian
 - (2) African American
 - (3) Asian American
 - (4) Latino/ Latina American
 - (5) Native American
 - (6) Pacific Islander
 - (7) Multiracial
 - (8) International student (specify country and ethnic group)_____
 - (9) Other (specify) _____

4. What is your school standing or year in school?
 - (1) freshmen
 - (2) sophomore
 - (3) junior
 - (4) senior
 - (5) graduate student
 - (6) other (specify) _____

5. What is your family status?
 - (1) Single
 - (2) Married, living together
 - (3) Divorced or separated
 - (4) Living with a partner
 - (5) Single with children
 - (6) Other (specify) _____

6. What is your socio-economic status?
 - (1) Low SES
 - (2) Middle SES
 - (3) High SES

APPENDIX K. INFORMED CONSENTS

INFORMED CONSENT DOCUMENT (Pilot study, student group)

Title of Study: Perception of multiple roles in counseling relationships – Pilot study

Primary Investigator: Irina V. Diyankova, M.S.

This is a research study. You must be 18 years or older in order to participate. Please take your time in deciding if you would like to participate. Please feel free to ask questions at any time. As noted on your course syllabus, participation in this experiment is one of the options for earning experimental credit in your psychology class.

Supervisor: Norman Scott, Ph.D.

INTRODUCTION

The purpose of this study is to validate the clinical case vignettes describing different types of counseling relationship between mental health professional and client. You are being invited to participate in this study because of your experience with counseling.

DESCRIPTION OF PROCEDURES

If you agree to participate in this study, your participation will last 50 minutes or less. During the study you may expect the following procedures to be followed. You will be presented with several clinical case vignettes (descriptions of client and therapist interactions) and asked to read them. Afterwards, you will be asked to fill out several questionnaires related to these vignettes. You may skip any question that you do not wish to answer or that make you feel uncomfortable.

RISKS AND LIMITATIONS

There are no risks associated with this study.

BENEFITS

If you decide to participate in this study there may be no direct benefit to you. It is hoped that the information gained in this study will benefit psychological science by providing it with new insights about and understanding of the client's perspective on counseling relationships.

COSTS AND COMPENSATION

You will not have any costs from participating in this study. You will be compensated for participating in this study with one extra credit point towards your grade in Psych 101, Psych 230, or Psych 280 classes.

PARTICIPANT RIGHTS

Your participation in this study is completely voluntary and you may refuse to participate or leave the study at any time. If you decide to not participate in the study or leave the study early, it will not result in any penalty or loss of benefits to which you are otherwise entitled. You can decline to answer any question that makes you feel uncomfortable.

CONFIDENTIALITY

Records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations and will not be made publicly available. However, federal government regulatory agencies and the Institutional Review Board (a committee that reviews and approves human subject research studies) may inspect and/or copy your records for quality assurance and data analysis. These records may contain private information. To ensure confidentiality to the extent permitted by law, the following measures will be taken (a) participants will be assigned a unique code that will be used on forms and in databases instead of their name; (b) signed informed consents will be collected and stored separately from questionnaire responses. If the results of this study are published, your identity will remain confidential.

QUESTIONS OR PROBLEMS

You are encouraged to ask questions at any time during this study. For further information about the study contact Irina Diyankova at 294-96-68 or ivdiyan@iastate.edu or Dr. Norman Scott at 294-15-09 or nascott@iastate.edu. If you have any questions about the rights of research subjects or research-related injury, please contact the IRB Administrator, (515) 294-4566, jcs1959@iastate.edu, or Diane Ament, Director, Office of Research Assurances (515) 294-3115, dament@iastate.edu.

PARTICIPANT SIGNATURE

Your signature indicates that you voluntarily agree to participate in this study, that the study has been explained to you, that you have been given the time to read the document and that your questions have been satisfactorily answered. You will receive a copy of the signed and dated written informed consent prior to your participation in the study.

Participant's Name (printed) _____

(Participant's Signature)

(Date)

INVESTIGATOR STATEMENT

I certify that the participant has been given adequate time to read and learn about the study and all of their questions have been answered. It is my opinion that the participant understands the purpose, risks, benefits and the procedures that will be followed in this study and has voluntarily agreed to participate.

(Signature of Person Obtaining
Informed Consent)

(Date)

INFORMED CONSENT DOCUMENT (Pilot study, counselor group)

Title of Study: Perception of multiple roles in counseling relationships – Pilot study

Primary Investigator: Irina V. Diyankova, M.S.

This is a research study. You must be 18 years or older in order to participate. Please take your time in deciding if you would like to participate. Please feel free to ask questions at any time.

Supervisor: Norman Scott, Ph.D.

INTRODUCTION

The purpose of this study is to validate the clinical case vignettes describing different types of counseling relationship between mental health professional and client. You are being invited to participate in this study because of your expertise in the counseling field.

DESCRIPTION OF PROCEDURES

If you agree to participate in this study, your participation will last 50 minutes or less. During the study you may expect the following procedures to be followed. You will be presented with several clinical case vignettes (descriptions of client and therapist interactions) and asked to read them. Afterwards, you will be asked to fill out a questionnaire related to these vignettes and a brief demographic questionnaire. You may skip any question that you do not wish to answer or that make you feel uncomfortable.

RISKS AND LIMITATIONS

There are no risks associated with this study.

BENEFITS

If you decide to participate in this study there may be no direct benefit to you. It is hoped that the information gained in this study will benefit psychological science by providing it with new insights about and understanding of the client's perspective on counseling relationships.

COSTS AND COMPENSATION

You will not have any costs from participating in this study. You will receive no compensation.

PARTICIPANT RIGHTS

Your participation in this study is completely voluntary and you may refuse to participate or leave the study at any time. If you decide to not participate in the study or leave the study early, it will not result in any penalty or loss of benefits to which you are otherwise entitled.

CONFIDENTIALITY

Records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations and will not be made publicly available. However, federal government regulatory agencies and the Institutional Review Board (a committee that

reviews and approves human subject research studies) may inspect and/or copy your records for quality assurance and data analysis. These records may contain private information. To ensure confidentiality to the extent permitted by law, the following measures will be taken (a) participants will be assigned a unique code that will be used on forms and in databases instead of their name; (b) signed informed consents will be collected and stored separately from questionnaire responses. If the results of this study are published, your identity will remain confidential.

QUESTIONS OR PROBLEMS

You are encouraged to ask questions at any time during this study. For further information about the study contact Irina Diyankova at 294-96-68 or ivdiyan@iastate.edu or Dr. Norman Scott at 294-15-09 or nascott@iastate.edu. If you have any questions about the rights of research subjects or research-related injury, please contact the IRB Administrator, (515) 294-4566, jcs1959@iastate.edu, or Diane Ament, Director, Office of Research Assurances (515) 294-3115, dament@iastate.edu.

PARTICIPANT SIGNATURE

Your signature indicates that you voluntarily agree to participate in this study, that the study has been explained to you, that you have been given the time to read the document and that your questions have been satisfactorily answered. You will receive a copy of the signed and dated written informed consent prior to your participation in the study.

Participant's Name (printed) _____

(Participant's Signature)

(Date)

INVESTIGATOR STATEMENT

I certify that the participant has been given adequate time to read and learn about the study and all of their questions have been answered. It is my opinion that the participant understands the purpose, risks, benefits and the procedures that will be followed in this study and has voluntarily agreed to participate.

(Signature of Person Obtaining
Informed Consent)

(Date)

INFORMED CONSENT DOCUMENT (Primary study)

Title of Study: Perception of counseling relationships

Primary Investigator: Irina V. Diyankova, M.S.

This is a research study. You must be 18 years or older in order to participate. Please take your time in deciding if you would like to participate. Please feel free to ask questions at any time. As noted on your course syllabus, participation in this experiment is one of the options for earning experimental credit in your psychology class.

Supervisor: Norman Scott, Ph.D.

INTRODUCTION

The purpose of this study is to explore former and current clients' views on and attitudes towards multiple role relationships between clients and mental health professionals. You are being invited to participate in this study because of your previous counseling experience in the client's role.

DESCRIPTION OF PROCEDURES

If you agree to participate in this study, your participation will last between 60 and 90 minutes. During the study you may expect the following study procedures to be followed. You'll be given a research packet, including a series of questionnaires and two case descriptions focused on counselor-client relationship. You will be asked to work through the materials in the packet in the presented order, filling out one instrument after another. You will not be asked to share about the nature of your issues or things discussed in counseling. You may skip any question that you do not wish to answer or that makes you feel uncomfortable.

RISKS AND LIMITATIONS

There are no risks associated with this study. However, there are some limitations. Thus, if you participated in the pilot study entitled "Perception of multiple roles in counseling (pilot study)" in the Fall 2006 (experiment # 37), you will not have an opportunity to participate in this study due to your previous exposure to the research materials.

BENEFITS

If you decide to participate in this study there may be no direct benefit to you. It is hoped that the information gained in this study will benefit psychological science by providing it with new insights about and understanding of the clients' perspectives on counseling relationships.

COSTS AND COMPENSATION

You will not have any costs from participating in this study. You will be compensated for participating in this study with two extra credit points towards your grade in Psychology or Sociology class.

PARTICIPANT RIGHTS

Your participation in this study is completely voluntary and you may refuse to participate or leave the study at any time. If you decide to not participate in the study or leave the study early, it will not result in any penalty or loss of benefits to which you are otherwise entitled.

CONFIDENTIALITY

Records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations and will not be made publicly available. However, federal government regulatory agencies and the Institutional Review Board (a committee that reviews and approves human subject research studies) may inspect and/or copy your records for quality assurance and data analysis. These records may contain private information. To ensure confidentiality to the extent permitted by law, the following measures will be taken (a) participants will be assigned a unique code that will be used on forms and in databases instead of their name; (b) all identifying information will be kept separately in the secure file in the supervisor's office. If the results of this study are published, your identity will remain confidential.

QUESTIONS OR PROBLEMS

You are encouraged to ask questions at any time during this study. For further information about the study contact Irina Diyankova at 294-96-68 or ivdiyan@iastate.edu or Dr. Norman Scott at 294-15-09 or nascott@iastate.edu. If you have any questions about the rights of research subjects or research-related injury, please contact the IRB Administrator, (515) 294-4566, jcs1959@iastate.edu, or Diane Ament, Director, Office of Research Assurances (515) 294-3115, dament@iastate.edu.

PARTICIPANT SIGNATURE

Your signature indicates that you voluntarily agree to participate in this study, that the study has been explained to you, that you have been given the time to read the document and that your questions have been satisfactorily answered. You will receive a copy of the signed and dated written informed consent prior to your participation in the study.

Participant's Name (printed) _____

(Participant's Signature)

(Date)

INVESTIGATOR STATEMENT

I certify that the participant has been given adequate time to read and learn about the study and all of their questions have been answered. It is my opinion that the participant understands the purpose, risks, benefits and the procedures that will be followed in this study and has voluntarily agreed to participate.

(Signature of Person Obtaining
Informed Consent)

(Date)

APPENDIX L. SUPPLEMENTAL TABLES FOR THE PRIMARY STUDY

Table 5. Descriptive statistics for the paired dependent variables

| Variables | N | Mean | SD | Min | Max | Skewed | alpha |
|-----------|-----|------|------|-------|------|--------|-----------|
| IPF1 | 114 | 3.08 | 1.06 | 1.00 | 5.00 | -.34 | .94 |
| IPF2 | 113 | 2.90 | .83 | 1.00 | 4.89 | -.31 | .89 |
| INF1 | 114 | 1.72 | .67 | 1.00 | 3.56 | 1.06 | .86 |
| INF2 | 114 | 1.77 | .64 | 1.00 | 3.78 | 1.13 | .84 |
| CE1 | 113 | 1.66 | 2.27 | -4.50 | 6.00 | -.62 | .81 - .87 |
| CE2 | 114 | .61 | 2.24 | -5.75 | 5.75 | -.02 | .82 - .85 |

Table 9. Randomization check (Independent-samples t-tests for differences between MR accepted and MR declined conditions)

| Variables | t | df | p | M dif ^a |
|--|------|-----|-----|--------------------|
| Attachment Avoidance | -.99 | 109 | .32 | -.20 |
| Attachment Anxiety | -.66 | 109 | .51 | -.14 |
| Perception of outcome | 1.06 | 112 | .29 | .25 |
| Perceived quality of counseling relationship | .17 | 112 | .87 | .02 |

Note. ^a M dif= differences between means

Table 10. Randomization check (Mann-Whitney U test for differences in distributions between MR accepted and MR denied conditions)

| Variables | Z | p |
|-------------------------------------|-------|-----|
| Participants' gender | -1.83 | .07 |
| Participants' age | -1.36 | .18 |
| Participants' ethnicity | -.11 | .91 |
| Participants' family status | -1.57 | .12 |
| Participants' SES | -.38 | .70 |
| Participants' age during counseling | -1.82 | .07 |
| Number of sessions attended | -.65 | .52 |

Table 11. Summary of ANCOVA results for IPF

| Independent Variables | F | p | η^2 |
|-----------------------|-------|-----|----------|
| Impression Management | .19 | .67 | .00 |
| Attachment Avoidance | .04 | .84 | .00 |
| Attachment Anxiety | 1.38 | .24 | .01 |
| Multiple Roles | 13.31 | .00 | .11 |

Note. Degrees of freedom: 1, 105

Table 14. Correlations among quality of counseling experience, quality of counseling relationship, attachment dimensions, and dependent variables

| Variables | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|-------|-------|-------|-------|--------|-------|-------|-------|-------|
| 1. Quality of counseling experience (CES5) | | | | | | | | | |
| 2. Attachment avoidance | -.21* | | | | | | | | |
| 3. Attachment anxiety | -.13 | .19* | | | | | | | |
| 4. Index of positive feelings (IPF) | -.00 | -.06 | -.12 | | | | | | |
| 5. Index of negative feelings (INF) | -.04 | .08 | .22* | -.17 | | | | | |
| 6. Cognitive Evaluation 1 (CE1) | -.01 | -.09 | -.15 | .50** | -.39** | | | | |
| 7. Cognitive Evaluation 2 (CE2) | .13 | -.06 | .21* | .18 | -.11 | .08 | | | |
| 8. Counselor Rating (CRF) | .24* | -.21* | -.03 | .34** | -.30** | .40** | .25** | | |
| 9. Attitude towards multiple roles (MRQ) | .21* | -.02 | .04 | -.08 | .14 | .03 | .24* | .07 | |
| 10. Quality of counseling relationship (CES6) | .50** | -.12 | -.20* | -.01 | -.14 | .15 | .03 | .30** | .33** |

* Correlation is significant at the 0.05 level

** Correlation is significant at the 0.01 level

APPENDIX M. INSTITUTIONAL REVIEW BOARD APPROVAL

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Institutional Review Board
Office of Research Assurances
Vice Provost for Research
1138 Pearson Hall
Ames, Iowa 50011-2207
515 294-4566
FAX 515 294-4267

DATE: 28 November 2006
TO: Irina Diyankova
W112 Lagomarcino
CC: Dr. Norm Scott
W112 Lagomarcino
FROM: Jan Canny, IRB Administrator
Office of Research Assurances
SUBJECT: IRB ID 06-569

Approval Date: 27 November 2006
Date for Continuing Review: 26 November 2007

The Co-Chair of the Institutional Review Board of Iowa State University has reviewed and approved the protocol entitled: "Perception of Multiple Roles in Counseling." The protocol has been assigned the following ID Number: 06-569. Please refer to this number in all correspondence regarding the protocol.

Your study has been approved from 27 November 2006 to 27 November 2007. The **continuing review date** for this study is no later than 26 November 2007. Federal regulations require continuing review of ongoing projects. Please submit the form with sufficient time (i.e. three to four weeks) for the IRB to review and approve continuation of the study, prior to the continuing review date.

Failure to complete and submit the continuing review form will result in expiration of IRB approval on the continuing review date and the file will be administratively closed. All research related activities involving the participants **must stop** on the continuing review date, until approval can be re-established, except when necessary to eliminate immediate hazard to research participants. As a courtesy to you, we will send a reminder of the approaching review prior to this date.

Please remember that any **changes in the protocol or consent form** may not be implemented without prior IRB review and approval, using the "Continuing Review and/or Modification" form. Research investigators are expected to comply with the principles of the Belmont Report, and state and federal regulations regarding the involvement of humans in research. These documents are located on the Office of Research Assurances website or available by calling (515) 294-4566, www.compliance.iastate.edu.

You must promptly report any of the following to the IRB: (1) **all serious and/or unexpected adverse experiences** involving risks to subjects or others; and (2) **any other unanticipated problems involving risks** to subjects or others.

Upon completion of the project, please submit a Project Closure Form to the Office of Research Assurances, 1138 Pearson Hall, to officially close the project.

Two sets of materials should be submitted for each project – the original signed copy of the application form and one copy and two sets of accompanying materials. **Federal regulations require that one copy of the grant application or proposal be submitted for comparison with the application for approval.**

FOR IRB USE ONLY:

Initial action by the Institutional Review Board (IRB):

- Project approved. Date: 27 November 2006
- Pending further review. Date: _____
- Project not approved. Date: _____

Follow-up action by the IRB:

[Redacted Signature] _____ 27 November 2006
 IRB Approval Signature Date

SECTION III: ENVIRONMENTAL HEALTH AND SAFETY INFORMATION

- Yes No Does this project involve human cell or tissue cultures (primary OR immortalized), or human blood components, body fluids or tissues? If the answer is “no”, please proceed to SECTION III: APPLICATION FOR IRB APPROVAL. If the answer is “yes,” please proceed to Part A: Human Cell Lines.

PART A: HUMAN CELL LINES

- Yes No Does this project involve human cell or tissue cultures (primary OR immortalized cell lines/strains) that have been documented to be free of bloodborne pathogens? If the answer is “yes,” please attach copies of the documentation. If the answer is “no,” please answer question 1 below.

1) Please list the specific cell lines/strains to be used, their source and description of use.

| CELL LINE | SOURCE | DESCRIPTION OF USE |
|-----------|--------|--------------------|
| | | |
| | | |
| | | |

Add New Row

2) Please refer to the ISU “Bloodborne Pathogens Manual,” which contains the requirements of the OSHA Bloodborne Pathogens Standard. Please list the specific precautions to be followed for this project below (e.g., retractable needles used for blood draws):

N/A

Anyone working with human cell lines/strains that have not been documented to be free of bloodborne pathogens is required to have Bloodborne Pathogen Training annually. Current Bloodborne Pathogen Training dates must be listed in Section I for all Key Personnel. Please contact Environmental Health and Safety (294-5359) if you need to

APPENDIX N. PILOT STUDIES RESULTS

Pilot study 1

In study 1, direct feedback about the vignettes was solicited from participants, ten students and four counselors. Each participant was randomly assigned to one of the multiple role conditions (accepted vs. declined) and received a packet corresponding to the respective condition. Research packets contained informed consent form (Appendix K), Demographic Questionnaire (Appendix J), Counseling Experience Questionnaire (Appendix I), Experiences in Close Relationships Scale (Appendix D), four vignettes, all corresponding to their experimental conditions (Appendix B), and the Vignette Feedback Questionnaire (Appendix C).

Participants

Ten students, former counseling clients, and four counselors participated in this study. Demographic characteristics of the student sample were as follows. There were 5 males and 5 females. Nine individuals were Caucasian and one was Asian. There were 8 freshmen, one sophomore, and one junior. Eight persons reported that they were middle class, one indicated low SES, and one reported high SES. Participants' age ranged from 18 to 24. All ten students had been in counseling before. Five received counseling at the age of 15 or older, one - during the age range of 10-14 years old, and four - at the age younger than 10 years old. Six participants indicated that they had been in individual counseling, three had participated in both individual and family therapy, and one had been involved only in group counseling. Two individuals attended counseling once, one person completed 2-3 sessions, four participants experienced 4-6 sessions, two individuals attended 8-10 sessions, and one person completed 11-20 sessions. Of the 10 students, three reported their counseling to be

successful, two said it was moderately successful, two reported neither unsuccessful nor successful experience, and three reported not very successful experience. When asked about the nature of their relationship with the counselor, one described it as negative, six labeled it as neutral, and three said it was positive.

Four counselors, all employed at the Iowa State Student Counseling Services, also participated in this pilot study. All counselors were female. Three of them were Caucasian, and one was of Hispanic origin. Their mean age was 31.25 years (range: 29-36). Their counseling experience ranged from 6 to 8 years ($M=7$).

Results

Clarity of instruction.

Twelve participants responded to the question asking to rate the overall clarity of instructions associated with the vignettes. The mean was 3.67 (out of 4) and standard deviation was .49. Two participants, one counselor and one student, suggested improvements in the vignettes' grammar. No other relevant ideas related to increasing the clarity of instruction or specific clarity issues were reported. The vignette grammar was modified in response to the feedback.

Amount of information about psychologist.

Twelve participants responded to the question asking to rate how adequate was the amount of information provided about Dr. Moss, the psychologist in the vignettes. The mean rating was 3.33 (out of 4) and standard deviation was .65. Some of the suggestions made by the participants were the following: describe his personality, because one needs to understand both people involved in situation (student participant), and indicate his age, marital status, and how he is viewed by others (student participant). Several other student participants raised

questions about Dr. Moss's marital status when reacting to the vignettes. As response to this feedback, information about Dr. Moss's age and marital status was included in his description, as well as three descriptors of his personality ("His clients describe him as knowledgeable, caring, and helpful").

Vignette ratings.

Five ratings from the Vignette Feedback Questionnaire (Appendix C; questions 9, 10, 12, 14, & 15): realism, completeness/brevity, client's motivations, psychologist's motivation, and situation development were analyzed. Means and standard deviations for these ratings are summarized in Table 15. The response scale used for these ratings ranged from 1 to 10. As can be seen from this table, ratings for vignettes 2 and 4 were much higher on all of the dimensions, except psychologist's motivations, than ratings for vignettes 1 and 3. Additionally, counselors rated the realism of vignettes 2 and 4 very high, 9.25 and 10 respectively. On the basis of this data, vignettes 2 and 4 were chosen for the primary study.

Written comments.

Participants' written comments provided information about their perceptions of the vignettes and about the vignettes' impact on them. These comments are summarized in Table 16 (in the end of Appendix N). In general, vignettes were viewed as thought provoking as indicated by the questions asked by participants, such as "Why would it be harmful to look at art?" (Vignette 2, multiple roles absent condition).

Table 15. Means and Standard Deviations for the feedback questions depending on vignette, condition, and type of respondent (N= 14)

| Vig- nettes | Criteria (1-10 scale) | Means (Standard Deviations) | | | | Student |
|-------------------------------|-------------------------------|--------------------------------|----------------|----------------|----------------|-----------------|
| | | Entire sample | MR present | MR absent | Couns | |
| 1 | Realism | 7.86 (2.77) | 7.00 (3.32) | 8.71 (1.98) | 8.00 (2.16) | 7.80 (3.08) |
| | Completeness vs brevity | 7.92 (1.85) | 7.14 (2.12) | 8.83 (.98) | 8.50 (1.00) | 7.67 (2.12) |
| | Client's motivations | 7.86 (1.46) | 8.43 (1.81) | 7.29 (.76) | 7.25 (1.71) | 6.80 (3.59) |
| | Psychologist's motivations | 7.29 (2.43) | 6.57 (2.99) | 8.00 (1.63) | 6.50 (3.32) | 4.50 (3.40) |
| | Situation development | 7.50 (2.50) | 7.43 (2.23) | 7.57 (2.93) | 6.25 (2.50) | 8.00 (2.45) |
| | 2 | Realism | 9.43 (.65) | 9.43 (.79) | 9.43 (.54) | 9.25 (.96) |
| Completeness vs brevity | | 8.85 (1.34) | 8.71 (1.70) | 9.00 (.89) | 8.75 (.50) | 8.89 (1.62) |
| Client's motivations | | 8.86 (1.29) | 9.14 (.69) | 8.57 (1.72) | 9.25 (.50) | 8.70 (1.49) |
| Psychologist's motivations | | 7.29 (2.43) | 7.43 (2.07) | 7.14 (2.91) | 8.00 (2.16) | 7.00 (2.58) |
| Situation development | | 8.14 (2.82) | 8.86 (1.46) | 7.43 (3.73) | 9.00 (.81) | 7.80 (3.29) |
| 3 | | Realism | 7.46 (3.15) | 5.50 (3.72) | 9.14 (1.07) | 7.33 (3.78) |
| | Completeness vs brevity | 7.67 (2.06) | 6.00 (1.55) | 9.33 (.516) | 7.67 (2.31) | 7.67 (2.12) |
| | Client's motivations | 8.15 (1.99) | 7.50 (2.74) | 8.71 (.951) | 9.00 (0.00) | 7.90 (2.23) |
| | Psychologist's motivations | 7.15 (2.64) | 6.33 (2.81) | 7.86 (2.49) | 7.00 (3.46) | 7.20 (2.57) |
| | Situation development | 7.92 (2.66) | 6.67 (3.45) | 9.00 (1.16) | 6.00 (3.60) | 8.50 (2.22) |
| | 4 | Realism | 9.08 (1.50) | 8.83 (1.94) | 9.29 (1.11) | 10.00 (0.00) |
| Completeness vs brevity | | 8.50 (1.88) | 7.33 (2.06) | 9.67 (.52) | 9.00 (1.00) | 8.33 (2.12) |
| Client's motivations | | 8.00 (2.24) | 8.67 (1.86) | 7.43 (2.51) | 9.33 (.58) | 7.60 (2.41) |
| Psychologist's motivations | | 8.23 (2.35) | 7.83 (2.23) | 8.57 (2.57) | 9.33 (.58) | 7.90 (2.60) |
| Situation development | | 9.27 (1.79) | 8.60 (2.60) | 9.83 (.41) | 9.50 (.71) | 9.22 (1.99) |

Also, participants' responses/thoughts were rather heterogeneous in both conditions. They ranged from understanding and acceptance of situation to confusion or disagreement about it.

Other suggested changes.

For vignette 2, the one that described Megan and her art exhibit, (multiple roles absent condition) it was suggested to substitute the word "rejected" with something softer, such as "declined", which was done. One of the participants asked to explain what kind of abuse the client suffered. However, the author decided that explanation of Megan's abuse contained enough details and that it was unnecessary to include more. One of the counselors requested more information about time left in therapy and the client's personality. As a response to this request, the author inserted three sentences describing Megan's progress in therapy and her current needs.

There were three comments associated with vignette 4, the one that described Ben and a student-client role conflict. All comments were requests for more information about Ben's emotions and thoughts. As a response to this request, the author slightly expanded on description of Ben's emotions and reactions (see Appendix B, part B; changes are indicated by italics).

Vignettes' impact on the participants.

The author analyzed participants' statements concerning their general perception of the counseling situation, as well as perception of the counselor and client in the vignette (see summary in table 17 in the end of Appendix N). First, it was obvious that study participants gave the situations a considerable thought and had good insight into pros and cons of multiple roles described in the vignettes. Second, differences in reactions depending on the experimental condition were noticeable. Thus, participants from the "multiple roles present"

condition brought up two major themes: possible interference between counseling and secondary relationship, and comfort/support. Subjects from “multiple roles absent” condition highlighted the following major themes: questioning whether harm can result from involvement into secondary relationship, and questioning psychologist as a person. Observed differences were a positive sign of vignettes from different experimental conditions having a differential impact.

Pilot study 2

There were two purposes for the second pilot study. First, it was important to assess the variability of participants’ responses to the vignettes. One concern was associated with the possible homogeneity of reactions. Second, it was important to evaluate responses to the Experiences in Close Relationships Scale (ECRS) to ascertain whether there was enough variability to use it in the primary study.

Participants

Seven students, all former counseling clients, participated in this study. There were six males and one female. Their age ranged from 18 to 24 years old. Five individuals were Caucasian and two persons were of Hispanic origin. Five participants reported middle SES and two people indicated high SES.

Results

Quantitative responses to the vignettes.

Participants’ responses to the questions associated with vignettes 2 and 4 were analyzed. Six dependent variables were computed, namely Index of Positive Feelings for vignette 2 (IPF2), Index of Negative Feelings for vignette 2 (INF2), Cognitive Evaluation for vignette 2 (CE2), Index of Positive Feelings for vignette 4 (IPF4), Index of Negative Feelings for

vignette 4 (INF4), and Cognitive Evaluation for vignette 4 (CE4). Descriptive statistics for these variables are presented in Table 17. As can be observed, only one of the variables, INF2, was slightly skewed.

The researcher conducted a series of independent samples t-tests to explore the differences in participants' reactions depending on the experimental condition (multiple roles present versus multiple roles absent). The results of the t-tests are summarized in Table 18.

As can be seen from the table, two t-tests, for IPF2 and CE2, reached statistical significance, two others, for INF2 and INF4, almost reached significance (p values of .063 and .088), and the tests for IPF4 and CE4 were not significant. Even though the last two tests were not significant, there was still interesting difference in the values of the means. Additionally, one has to keep in mind a very small size of the pilot study sample which may not have had enough power to detect the differences.

Table 17. Descriptive statistics for six dependent variables (Pilot study 2; N=7)

| Variables | Mean | SD | Min | Max | Skewd |
|-----------|-------|------|-------|------|-------|
| INF2 | 1.54 | .83 | 1.00 | 3.00 | 1.35 |
| IPF2 | 2.52 | .94 | 1.00 | 3.78 | -.47 |
| CE2 | 2.46 | 2.41 | -1.00 | 4.75 | -.59 |
| INF4 | 1.57 | .38 | 1.00 | 2.11 | -.07 |
| IPF4 | 1.95 | .83 | 1.00 | 3.33 | .78 |
| CE4 | -1.67 | 2.70 | -5.00 | 2.00 | .21 |

Table 18. Independent samples t-tests for differences in reactions to the counseling situation depending on experimental condition (multiple roles present vs absent)

| Variables | t | df | p | M dif ^a |
|-----------|-------|----|------|--------------------|
| INF2 | -2.39 | 5 | .063 | -1.13 |
| IPF2 | 4.46 | 5 | .007 | 1.56 |
| CE2 | 7.23 | 5 | .001 | 4.31 |
| INF4 | -2.11 | 5 | .088 | -.49 |
| IPF4 | .35 | 5 | .740 | .24 |
| CE4 | -.27 | 5 | .798 | -.61 |

Note. ^a M dif= differences between means.

Qualitative responses to the vignettes.

Participants' responses to the open-ended questions (28-33) of the Reaction Questionnaire, pilot study version (Appendix F), were analyzed. The results were summarized in Table 19 (in the end of Appendix N). It was noticed that situation described in vignette 2 was considered as slightly more beneficial when multiple roles were present than when they were absent. Two participants from the multiple roles present condition indicated that psychologist will have more insight into client's behavior due to the out-of-office interactions.

As displayed in Table 19 (in the end of Appendix N), the situation described in vignette 4 was considered as harmful/slightly harmful/interfering by most participants in both conditions. However, the type of harm, foreseen by the subjects, differed depending on the experimental condition. Thus, individuals in multiple roles present condition noted that the situation may be harmful if client gets a bad grade in class, whereas participants from multiple roles absent condition noted that client's self-esteem may suffer as a result of rejection from psychologist. Additionally, participants provided a range of responses to the questions of what they would do in client's place, whether they agree with psychologist, and what they would like a professional to do.

Responses to the attachment measure.

Experiences in Close Relationships Scale (ECRS) was administered to the participants from both pilot studies. Descriptive statistics for two attachment style indices, Attachment Avoidance and Attachment Anxiety, are summarized in table 20 (in the end of Appendix N). As can be noticed from the table, participants exhibited a wide range of responses to these subscales which was a very positive sign indicating sufficient variability of responses. These subscales were included in the primary study as covariates.

SUPPLEMENTAL TABLES FOR THE PILOT STUDIES

Table 16. Participants' feedback about the vignettes depending on condition

| Criteria | Multiple roles accepted | Multiple roles declined |
|----------------------|---|---|
| | Vignette 2: Megan & art show | |
| General perception | 1) would have handled it differently as a psychologist (C); 2) can see why Dr. Moss wanted to be supportive of his client's work (C); 3) was wondering if romantic relationships between Megan and Dr. Moss would occur (S); 4) Dr. Moss shouldn't have attended art show (S); 5) wondering if he should go to her show or if this makes relationship too personal (S) 6) outside relationships would interfere with therapy (S) 7) thinking about all the abuse; feel overwhelmed (S); | 1) understand client, sad for her (C) 2) would have handled it differently as a psychologist (C); 3) why would it be harmful to look at art? (S) 4) feel confused (S); 5) the patient-doctor relationship cannot be interfered with (S); 6) it makes me think that he does not like the client or has something to hide (S) |
| Realism of situation | 1) very likely that a patient would appreciate psychologist seeing their accomplishments (S) 2) this could have happened (S) | 1) have experienced this personally (C) 2) pretty real (S) 3) this happens a lot (S) |
| Psychologist | 1) there was not much about psychologist (S) | 1) understand that he doesn't want to compromise therapeutic relationship (C, S); 2) why he couldn't go to her art exhibit? (2S); 3) he is a jerk |
| client | 1) him going to her show would mean a lot to her (S); 2) why did she feel so close to him (S)? 3) feel proud of her (S); 4) feel compassion towards her (S); | 1) wants to share her accomplishment with psychologist (C, S); 2) would feel abandoned by Dr. Moss (S); 3) if he went it would mean a lot to her (S) |
| | Vignette 4: Ben & psychology class | |
| General perception | 1) I don't think teacher-student and counseling relationship can coincide (S); 2) feel surprised (S) 3) they both feel comfortable (S) 4) they came to a good decision (S) 5) feel confused (S) 6) why psychologist had a good connection with all of the other clients and not this one? (S) 7) the boy wanted to stay in the class and the sessions were ending anyway (S); 8) Why Ben would care if Dr. Moss was an instructor if they got along? (S) 9) it could get awkward but also how exciting it is to have someone you like as an instructor (S)! | 1) Why can't he teach and have Ben be a student (S)? 2) I think that psychologist is just a different person than he is to his clients (S) 3) It's cool that Dr. Moss was a teacher (S); 4) Ben has to find another class to add (S); 5) although doubtful, still possible (S); 6) there is no other option (S) 7) I really like this vignette: clear & concise (C); 8) it was a good choice for the client to take the class another semester (C) 9) therapeutic relationship can be problematic if the client was taught by the therapist (C) |
| Realism of situation | 1) could but not as likely (S) 2) my professor is a psychologist | 1) therapists can often teach as well as practice (C) |

Table 16. (continued)

| Criteria | Multiple roles accepted | Multiple roles declined |
|--------------|--|--|
| Psychologist | 1) he wanted to be fair; he wanted counseling relationships to last (S); 2) it would be hard on him professionally 3) it is clear why he did not want Ben in the class (S) | 1) he does not want relationships to conflict (S); |
| Client | 1) he felt that Dr. Moss was a good psychologist and most likely a good teacher (S); 2) I feel annoyed that Ben has to drop the class (S) | 1) I would still take the class (S) 2) Ben was OK with it but after talking to Dr. Moss decided to not take it (S); 3) I would drop the class due to out-of-office conflict (S); |

Note. C – counselor; S – student

Table 19. Reactions to the vignettes (Pilot study 2)

| | MULTIPLE ROLES ACCEPTED | MULTIPLE ROLES DECLINED |
|---|---|---|
| Question | Response | Response |
| VIGNETTE 2: Megan & Art show | | |
| Situation: beneficial or harmful. Why? | 2) not harmful at all; may boost her confidence when Dr. sees her art 3) beneficial b/c it shows cl can trust both herself and someone else 4) neither harmful nor beneficial; wouldn't have much effect on cl | 1) somewhat harmful; cl. may feel offended 2) harmful b/c if therapist went to exhibit cl may get too attached 3) slightly beneficial b/c she is working on understanding that she is strong and shouldn't worry too much about what others think |
| How would sit. develop? | 2) after seeing her art, Dr. may understand cl better and provide better care; their rel-p might strengthen and cl may feel better about opening up 3) Dr will come to the exhibit; it shows trusting rel-p 4) Dr might have more material for insight into his cl behavior | 1) Dr. won't go to the exhibit but cl will be happy 2) she will become too dependent on therapist 3) she might get slightly upset, but if she has made as much progress as stated, she would understand his position |
| What would you do in client's shoes? | 1) I would feel grateful for the help and art exhibit attendance 2) I would be delighted for my psychologist to come to my art exhibit 3) I would invite therapist to come but wouldn't bother him at the show 4) nothing differently | 1) understand Dr.'s position 2) accept therapist's decision 3) I would be a little hurt b/c I put myself out there and got rejected |
| Agree with psychologist? Why? | 2) agree; it's not a personal event 3) Yes. If Dr didn't show up the cl could take offense and feel as if all their sessions were a waste of time. 4) agree b/c it wouldn't affect dr-cl rel-p negatively | 1) yes, acts in cl's best interests 2) yes, b/c the progress won't be affected 3) Yes, I don't think it's right to have contact with patients outside of the therapy sessions |
| What would you like psychologist to do? | 2) attend the show and give positive encouragement to cl 3) go to the art exhibit and talk to the cl about her work and not anything else, especially what was said in sessions. 4) go to the art exhibit to show support for his cl & her work | 1) what he's already doing 2) what he did 3) what he did |

Table 19. (continued)

| | MULTIPLE ROLES ACCEPTED | MULTIPLE ROLES DECLINED |
|--|---|--|
| Question | Response | Response |
| VIGNETTE 4: Ben and psychology class | | |
| Situation: beneficial or harmful. Why? | 1) it could interfere with counseling if he gets a bad grade 2) may be quite harmful; doesn't seem right 3) beneficial b/c cl would do better in the class with the teacher they like; only harmful thing would be if the cl was to be singled out 4) will be harmful, especially if cl does badly in class; he will be hurt even more in his self-esteem | 1) beneficial: both are uncomfortable with arrangement, so it needs to be changed 2) harmful: it's not client's fault to choose the class; it would probably help his self-esteem to take the class with someone he knows 3) slightly harmful b/c he was already having low self-esteem problems and he may have felt rejected |
| How would sit. develop? | 1) they will continue and hopefully it will work out 2) if cl continues to attend class, it could have an adverse effect on all treatment 3) would develop normally, just a teacher-student rel-p 4) if student needs counseling again, it will be awkward | 1) counseling will continue; Ben will take class with different instructor 2) Ben's self-esteem might drop 3) Since they both agreed in the end, things would go on as normal |
| What would you do in client's shoes? | 1) continue both until I am uncomfortable with it 2) I would switch the classes; I might feel uncomfortable 3) I would take the class; don't see anything odd about the situation 4) switch to a different class/teacher | 1) the same as Ben did 2) I would not drop the class 3) I would be a little upset and feel a little rejected b/c I was excited to have him at first, but I would understand |
| Agree with psychologist? Why? | 1) yes, he is a professional and has to do his work 2) it's not psychologist's decision to tell Ben drop the class; letting him know of potential consequences was the best Dr could do 3) No b/c singled cl out 4) Agree with his concern but not his final decision. I feel it changes the integrity of their dr-cl rel-p | 1) yes, handled sit well enough 2) no, b/c I think Ben's self-esteem will be affected 3) Yes, he did what was best and talked to Ben about how he felt before any decisions were made. |

Table 19. (continued)

| Question | MULTIPLE ROLES ACCEPTED | MULTIPLE ROLES DECLINED |
|---|---|--|
| | Response | Response |
| What would you like psychologist to do? | 1) same 2) let the cl know of potential risks 3) teach the class as any other class; treat the client as any other student. I still don't see any conflicts of interest. 4) to suggest that student changes classes so that if he needs counseling in the future, he will not hesitate to get help from the dr again | 1) what he did 2) not make Ben drop the class; both teach and treat Ben 3) What he did, make sure and talk to the client before making any decisions that affect them directly |

Table 20. Descriptive statistics for attachment indices (N=17)

| Variables | Mean | SD | Min | Max | Skew |
|----------------------|------|------|------|------|------|
| Attachment Avoidance | 2.79 | 1.10 | 1.17 | 4.83 | .29 |
| Attachment Anxiety | 3.19 | 1.05 | 1.50 | 5.61 | .57 |

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