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Factors Contributing to the Recognition of a Potential Nonsexual Multiple Relationship

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Factors Contributing to the Recognition of a Potential Nonsexual Multiple Relationship

by

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Each person whose signature appears below certifies that this doctoral project in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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ABSTRACT OF THE DOCTORAL PROJECT

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Clinical psychologists encounter situations for which no prescriptive professional standards exist, necessitating therapists' judgment to determine an appropriate course of action. This study examines the first step of therapists' decision-making process—recognition of the potential for a nonsexual multiple relationship. Based on the existing literature and previous empirical findings, our hypotheses are that (1) therapist sex (female), higher scores on the PAQ Expressivity (femininity) scale, higher scores on the VIA-IS-V3 Self-control scale, and participants' ranking Nonmaleficence as the most important ethical principle would be significantly (positively) predictive of Recognition scores, (2) higher scores on the PAQ Instrumentality (masculinity) scale, higher scores on the VIA-IS-V3 Inquisitiveness scale, and male (sex) participants who are presented with a vignette describing a potential nonsexual multiple relationship with a female client would be significantly (negatively) predictive of Recognition scores, and (3) PAQ Expressivity and Instrumentality scale scores would explain more unique variance in Recognition scores than therapist sex. An ordinal logistic regression analysis was used to investigate variance in therapists' first step in the decision-making process. Findings indicated that our overall model did not fit the data and there was no significant

difference between the baseline model and the final model. However, examination of individual predictor variables revealed that the female therapist and female client vignette combination was a significant positive predictor of Recognition score. Furthermore, exploratory analyses found that therapists who had the least clinical experience had less than expected Recognition scores of 0 (no recognition of an ethical issue) and therapists who had the most clinical experience had more than expected Recognition scores of 0. Overall, the findings of this study suggest that the influence of therapist and client factors on the decision-making process may be more salient to in later steps of the ethical decision-making process. The process at the immediate, reactive level (recognition) may be distinctly different from those at the levels of moral reasoning, establishment of moral intent, and/or engaging in moral behavior (Rest, 1979). With this, future studies should examine later steps of the therapist ethical decision-making process when confronted with a potential nonsexual multiple relationship with a client.

CHAPTER ONE

INTRODUCTION

Clinical psychologists are frequently confronted and challenged by situations in their professional practice for which there are no clear-cut ethical or legal standards. Familiar examples include situations involving potential involvement in nonsexual multiple relationships between therapists and clients. While the current APA Ethics Code is clear on its stance on sexual multiple relationships, stating "psychologists do not engage in exploitative multiple relationships, such as sexual intimacies with current clients" (Standard 10.05; APA, 2017, p. 15), the Code is far from proscriptive regarding nonsexual multiple relationships (Gottlieb, 1993). Standard 3.05 in the current APA Ethics Code states that nonsexual "multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (Standard 3.05; APA, 2017, p. 6).

Despite the earlier admonition of some that engagement in nonsexual multiple relationships damage the counseling relationship because the "practitioner's influence and the client's vulnerability carry over to the second relationship," which in turn may be exploitive to the patient (Kagle & Giebelhausen; 1994; p. 215), the current code is consistent with more recent opinions offered in the literature. Some clinicians have opined that it is nearly impossible for therapists to completely avoid engagement in nonsexual multiple relationships with patients (Adelman & Barrett, 1990; Barnett & Yutrzenka, 1993; Clipson, 2005; Haas & Malouf, 1989; Keith-Spiegel & Koocher, 1985).

Some argue that professionals can cross boundaries with patients and engage in nonsexual relationships without harm to a patient, and often to the benefit of the patient (e.g., Lazarus, 1998; Smith & Fitzpatrick, 1995; Williams 1997; Zur, 2001). Unfortunately, given the number of client complaints to licensing boards and professional organizations, there is evidence that nonsexual multiple relationships can cause harm to patients (Gross, 2005; Jochai, 2010).

With the ambiguity in the current APA Ethics Code, therapists are left to invoke their own clinical judgment to determine the possible risks of harm to their patients and decide whether to engage in a potential nonsexual multiple relationship. There have been several guidelines offered to clinicians to aid them in that judgment (e.g., Gottileb, 1993; Sonne, 2006; Younggren & Gottileb, 2004). Surprisingly, however, with few exceptions (e.g., Jochai, 2010), there is limited research to date regarding the decision-making process and what factors influence it. Based on the Synthesis Model of Ethical Decision-Making presented by Sonne and Weniger (2018), this study will examine the first step of the process by testing therapists' ability to recognize the potential of entering into a nonsexual multiple relationship with a current client and the therapist factors that influence that recognition.

To provide foundation for the research, this introduction has four objectives. First, this review provides a general description of ethics, and then, more specifically, ethics in psychology. Second, the positions of the various versions of the APA Ethics Code regarding nonsexual multiple relationships with current clients are described. Third, several general ethical decision-making models in psychology are presented, and then

models specific to engagement in nonsexual multiple relationships with current therapy clients are examined. And fourth, the empirical literature regarding four therapist factors and one client factor that may influence the clinician's recognition of a potential nonsexual multiple relationship with a current client is reviewed. The therapist factors include sex[1], instrumental and expressive gender characteristics (i.e. masculinity and femininity), relative allegiance to general ethical principles, and character virtues (i.e., caring, inquisitiveness, and self-control). The one client factor is the patient's sex.

Ethics

Ethics is a branch of philosophy that attempts to critically examine human conduct focusing on what is right and wrong, and the good or harm of human actions (Beauchamp, 1994). Basically, ethics is the philosophical study of morality (Englehards, 1996). "The term morality refers to social conventions about right and wrong human conduct that are so widely shared that they form a stable (sometimes incomplete) communal consensus" (Beauchamp & Childress, 1994, p. 4). The literature reveals different approaches to ethics, including nonnormative ethics and normative ethics.

Nonnormative ethics involves establishing what factually or conceptually is the case, versus what ought to be the case (Beauchamp & Childress, 2001). Two types of nonnormative ethics include descriptive ethics and metaethics. Descriptive ethics is the scientific study of morality, and examines moral action, ideals, and attributes from an

[1] When referencing past studies and literature, the language used by the author to refer to male and female (gender) will remain unchanged, but the contemporary term sex will be used to refer to male and female in this study.

empirical standpoint to discern how individuals and communities act or do not act (Horner, 2003). And metaethics is the study of the nature of moral judgments and the methods for justifying moral judgments; it does not include taking moral positions (Carter, 1996).

On the other hand, normative ethics (general normative ethics and practical ethics) involves taking a moral position by asking what is morally right and wrong regarding human action, and what should be done and why (Beauchamp, 1994; Beauchamp & Childress; 2001). General normative ethics addresses the question "which general moral norms for the guidance and evaluation of conduct should we accept, and why" (Beauchamp & Childress, 2013, p. 1). Practical ethics "uses general concepts and norms in the deliberation of real problems, practices, and policies in profession, institutions, and public policy" (Beauchamp & Childress, 2013, p. 2).

Normative ethics consists of three major approaches: virtue ethics, duty-based ethics (deontology), and consequential ethics (consequentialism). Virtue ethics emphasizes an individual's character as the key component of ethical thinking and considers important moral values rather than rules regarding the acts themselves (deontology) or their consequences (consequentialism). These theories are not novel; they stem from great philosophers such as Aristotle and were later examined and expanded by individuals such as Immanuel Kant and Sir William David Ross. Aristotle is the founder of what is now known as virtue and character ethics and Immanuel Kant is considered the founder of duty-based ethics. Ross (1930) emphasized seven *prima facie* duties: fidelity, reparation, gratitude, justice, beneficence, nonmaleficence, and self-improvement. Ross

(1930) recognized that some of these duties are more important than others, and that sometimes these duties may even contradict each other.

Principle-based ethics evolved from these theories; originally including four clusters of moral principles—respect for autonomy, nonmaleficence, beneficence, and justice. These four principle clusters are general in nature (Beauchamps & Childress, 2013), and from them emerged specific standards for professional conduct in various fields, including psychology. Shortly after WWII, psychologists in the American Psychological Association developed an Ethics Code based on a foundation of these aspirational moral principles and this Ethics Code also included enforceable standards for practice.

APA Ethics Code

The perception of American psychology rapidly changed through its application during World War II. At that time, psychologists not only provided mental health services to soldiers returning home from war who suffered from psychiatric disorders such as post-traumatic stress disorder (PTSD; Pols & Oak, 2007), but they also assisted in creating criteria to determine draft eligibility and assessing individuals for suitability for service. While previously regarded as mainly an academic pursuit, psychology began to be seen as a professional practice, especially as the general public's awareness of psychology increased (Fisher, 2003). As American psychology rapidly developed additional applications, the American Psychological Association's (APA) Committee on Ethical Standards for Psychology sought to develop an ethical framework for the profession, and techniques to identify and resolve moral issues. APA leadership selected

the Critical Incident Method as the first process in creating ethical standards, which were intended to be enforceable obligations for practitioners (Fisher, 2003).

Using the Critical Incident Method, the Committee asked APA members to indicate and describe professional circumstances that involved making decisions with ethical implications. With more than 1,000 incidents reported and reviewed, the APA Committee was able to identify major themes of ethical incidents that involved therapists' relationships with and responsibilities to others. After several drafts, critiques, and revisions, a final draft was published by APA in 1953 (Joyce and Rankin, 2010). Since the initial iteration of the APA's Ethical Code, there have been eleven published revisions with the most recent revision effective as of January 1, 2017 (APA, 2017). Each revision came about because of changes and fluctuations in sociocultural, legal, economic, and political landscapes (Fisher, 2003).

The 1953 Ethics Code was over 170 pages in length and encompassed actual case examples that illustrated each ethical standard. These standards were broadly written, aspirational in nature, and did not consider legal aspects. Revisions that came after the 1953 Ethics Code eliminated case examples and moved towards more specific language (Fisher, 2016). The 1963 Ethics Code included 19 Principles that encompassed a broad range of themes that included but were not limited to: responsibility, competence, client welfare, test security, publication credit, and research precautions. The Principles in the 1967, 1968, and 1972 Ethics Code remained the same. In the 1979 Code the Principles were expanded to include: responsibility, competence, moral and legal standards, public statements, confidentiality, welfare of the consumer, professional relationships,

utilization of assessment techniques, and the pursuit of research activities. The 1981 and 1989 Ethics Codes appeared similar to the 1979 Ethics Code, but two research related principles were added: research with human participants and care and use of animals.

A monumental change occurred in the 1992 revision of the APA Ethics Code. For the first time, there was a distinction made in the document between ethical principles and ethical standards. The overarching ethical principles were intended to be aspirational, inspiring the psychologist to the highest levels of professional practice. The ethical standards were intended to be sanctionable behavioral obligations. The general principles in the 1992 APA Ethics Code included: Competence, Integrity, Professional and Scientific Responsibility, Respect for People's Rights and Dignity, Concern for Other's Welfare, and Social Responsibility. These general principles were not only influenced by Beauchamp & Childress' four moral principles (respect for autonomy, nonmaleficence, beneficence, and justice), but also appeared to be influenced by general moral character traits as well. Examples of moral character traits include: nonmalevolence, honesty, integrity, conscientiousness, trustworthiness, fidelity, gratitude, and truthfulness (Beauchamps & Childress, 2013).

The list of aspirational principles has varied some from revision to revision of the Code over the years since 1992; but they continued to primarily mirror Beauchamps & Childress' four moral principles of bioethics. The 2002 and 2010 ethics codes include all four of Beauchamps & Childress' moral principles, along with other moral character traits. The current APA Ethics Code (APA 2017) lists five general ethical principles, one of which actually combines beneficence and nonmaleficence. Each is described below.

Principle A, Beneficence and Nonmaleficence, posits that therapists must avoid harming others and attempt to protect the wellbeing and rights of those with whom they interact (APA, 2017; Nagy, 2011). Principle B, Fidelity and Responsibility, holds that psychologists should establish trusting relationships with those with whom they work. Principle C, Integrity, states that psychologists encourage accuracy, honesty, and truthfulness in all professional activities. Principle D, Justice, posits that psychologists recognize that fairness and justice is applicable to all individuals who are involved with the processes, procedures, and services conducted by psychologists. And last, Principle E, Respect for People's Rights, affirms that psychologists respect the dignity and worth of all people, as well as respecting individuals' rights to privacy, confidentiality, and self-determination (APA, 2017).

These principles are intended to guide psychologists toward the highest ideals of psychology practice to protect clients, students, supervisees, researcher subjects, and others in the public with whom psychologists work. As such, these principles are integral to the psychologist's ethical decision making process. With this said, there are some variations in thought regarding what principles are most crucial and central to ethical-decision making, reflecting the complexities in the field, the individual differences among psychologists, and situational variance (Page, 2012). One study used the Analytic Hierarchy Process to examine the individual ranking of importance by first year psychology students in a university of four medical ethical principles (autonomy, nonmaleficence beneficence, and justice). The results suggested that in general individuals ranked nonmaleficence as significantly more important than the other

principles. However, this preference did not extend to their ethical judgements in specific ethical dilemmas (Page, 2012). There may be many situational and contextual factors along with methodological reasons (including the lack of experience in clinical practice of the participants and the fact that the dilemmas involved decisions regarding medical ethical dilemmas) for this discrepancy. It is clear, however, that further study is required to better understand the relationships between relative allegiance to the ethical principles and the decision-making process in situations posing potential ethical concerns.

Multiple Relationships between Psychologists and Consumers

Multiple relationships between psychologists and consumers were first referred to as dual relationships in the 1953/1958 Ethical Standards of Psychologists: A Summary of Ethical Principles (APA, 1953; 1958). The standard states that, "Psychologists do not normally enter into a clinical relationship with members of their own family, intimate friends, close associates, student, or others whose welfare might be jeopardized by such a dual relationship (Principle 8, APA, 1958, p. 270)."

Leading up to the 1977 revision of the APA Ethics Code, a significant number of complaints were received by the national and state ethics committees and state licensing boards alleging therapists' involvement in sexual dual relationships (later referred to as multiple relationships) with patients (Gottlieb, Sell, & Schoenfeld, 1988; Sell, Gottlieb, & Schoenfeld, 1986). Psychologists soon produced research evidence that sexual multiple relationships between therapists and their clients typically caused significant harm to the

clients and the therapeutic relationship (Gottlieb, 1994; Holroyd & Brodsky, 1980; Pope, 1988). As a result, APA formulated a revised Code that included a standard of conduct explicitly prohibiting sexual relationships with clients (APA, 1977). As subsequent versions of the Ethics Codes continued to reflect the unanimous agreement that sexual multiple relationships are unethical, the revisions evidenced gradual recognition of the potential harm of other types multiple relationships (namely nonsexual multiple relationships). For example, the Committee on Ethics of the APA revealed that approximately 40% to 50% of all complaints made to the national committee between 1990 and 1992 involved nonsexual multiple relationships (Afolabi, 2015).

Reflecting the concerns of the profession regarding the potential harm of nonsexual multiple relationships for consumers, the 1992 revision of the APA Ethics Code elaborated the definition of nonsexual multiple relationships, more fully discussed the potential for harm, and provided more specific guidance for the psychologist on how to manage that risk. The 1992 Ethics Code states:

> "Standard 1.17: Multiple relationships (a) In many communities and situations, it may not be feasible or reasonable for psychologists to avoid social or other nonprofessional contacts with persons such as patients, clients, students, supervisees, or research participants. Psychologists must always be sensitive to the potential harmful effects of other contacts on their work and on those persons with whom they deal. A psychologist refrains from entering or promising another personal, scientific, professional, financial, or other relationship with such persons if it appears likely that such a relationship reasonably might impair the

> psychologist's objectivity or otherwise interfere with the psychologist's effectively performing his or her functions as a psychologist, or might harm or exploit the other party. (b) Likewise, whenever feasible, a psychologist refrains from taking on professional or scientific obligations when pre-existing relationships would create a risk of such harm. (c) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist attempts to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code (APA, 1992, p. 5)."

The 1992 standard explicitly defines multiple relationships as "social or other nonprofessional contacts" (including "scientific, professional, [or] financial" with persons such as patients, clients, students, supervisees, or research participants" (p. 5). The standard then states that although it may not be possible to avoid all nonsexual multiple relationships, the psychologist should remain vigilant for risk of harm to the consumer through interference with the practitioner's objectivity and/or competence, and/or exploitation of the consumer. and refrain from engaging in that risk (Fisher & Younggren, 1997). Although the 1992 Code elaborated various aspects of nonsexual multiple relationships, some professionals argued that these regulatory guidelines were vaguely written (Pope & Vetter, 1992; Sonne, 1994). Terms and concepts in the 1992 APA Ethics Code such as "potential harmful effects" and "when feasible" left therapists reliant on their own interpretations.

The definition of nonsexual multiple relationships and standards for conduct were again revised in the 2002 Code. All subsequent revisions (2010 and 2017) kept the same definition and standards. The 2017 APA Ethics Code currently states,

> "Standard 3.05: Multiple relationships (a) 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 a relationship with a person closely associated with or related to the person with whom the psychologist has 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. A psychologist refrains from entering a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists. Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical. (b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code. (c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they

clarify role expectations and the extent of confidentiality and thereafter as changes occur (APA 2017, p. 6)."

The standards in the 2002, 2012, and 2017 APA Ethics Code much more clearly defined the concept of nonsexual multiple relationships. In addition, Standard 3.05 explicitly states that not every nonsexual multiple relationship is de facto unethical. The standard reads: "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (APA, 2017, p. 6; Knapp & VandeCreek, 2002). This statement reflects the reality of modern day psychology practice. As noted in the 1992 Code, in some circumstances nonsexual multiple relationships are inevitable and can be harmless, or even, arguably, beneficial for the client. Zur (2004) states that when executed with the clients' welfare in mind, it may enhance therapeutic alliance, the best predictor of therapeutic outcome states that there are types of nonsexual multiple relationships that are undoubtedly just a normal part of healthy, interconnected, and interdependent communities. Lazarus and Zur (2002) further argue that nonsexual multiple relationships are often falsely perceived by professionals as having great potential for harm and exploitation of the client just as sexual boundary violations are seen. They suggest that boundary crossings (including nonsexual multiple relationships) are often integrated in well-constructed treatment plans and that they can even increase therapeutic effectiveness (Lazarus & Zur, 2002).

A critical issue remains, even after the many revisions of the APA Ethics Code. There is little explicit guidance in the Code regarding what constitutes a harmful vs. harmless, or even beneficial, nonsexual multiple relationship, and therapists are often left

to use their best judgment regarding whether or not to engage in such a relationship. And, with the wide-spread diversity among therapists, judgments regarding that decision-making process often vary. The standard on Multiple Relationships in the American Association for Marriage and Family Therapy (AAMFT) Code of Ethical Principles is also vaguely defined (Ryder, 1990). Although it is likely impossible to anticipate every nuance, complexity, and detail of potential or actual nonsexual multiple relationships with current clients, it is vital that psychologists are able to access formal principles and decision-making models that provide useful and practical guidance as an aid to professional judgment (Pope & Vetter, 1992).

Ethical Decision-making Models and Guidelines

As suggested above, there is no gold standard for psychologists who find themselves in potential nonsexual multiple relationships with current clients (Clipson, 2005). The current APA Ethics Code reposes significant responsibility with the practitioner to use clinical judgment regarding the determination of potential risk of harm to the patient should the two enter a nonsexual multiple relationship. Since therapists' engagement in nonsexual multiple relationships can sometimes be inevitable (Barnett & Yutrzenka, 1993; Clipson, 2005; Haas & Malouf, 1989; Keith-Spiegal & Koocher, 1985), and arguably may at times be beneficial for the client, it is important that psychologists have credible models and guidelines to assist them in managing their relationships with patients sensitively, effectively, and ethically. Several models and guidelines have been proposed. Some are general, intended to inform decision-making across domains of

ethical dilemmas, and some are specific to the problem of nonsexual multiple relationships with current clients.

General Ethical Decision-making Models in Psychology

Rest (1983) proposed a Four-Component Model of moral behavior that encompasses the entire moral action process. These four components are referred to as "the major determinants of moral behavior" (p. 22), and include: moral sensitivity, moral judgment, moral motivation, and moral character. According to Rest (1994), the first component, moral sensitivity, refers to an individual's ability to recognize that a situation contains a moral issue. The second component, moral judgment, requires reasoning regarding the problem. The third component, moral motivation, involves choosing a moral course of action in the face of competing values. And the fourth component, moral character, entails carrying out the action. After Rest (1983) proposed his Four-Component Model, numerous other general models were proposed for psychologists and other mental health professionals (Haas & Malouf, 1989; Handelsman 1991; Kitchener, 1984; Knapp, Gottlieb, & Handelsman, 2015; Pope & Vasquez, 2016; Sonne & Weniger, 2018).

Along with general models, researchers have also proposed models that specifically include consideration of multiculturalism and feminist beliefs (Frame & Williams, 2005; Hill, Glaser, & Harden, 1998). The Multicultural Ethical Decision-making Model includes identifying the ethical issue while accounting for racial identity, acculturation, and power (Frame & Williams, 2005). Feminist models of ethical decision-

making models consider emotional-intuitive responses of the therapist as well as the location of the therapist and client in the social context (Hill, et al., 1998).

A recent general model, the Synthesis Model of Ethical Decision-making presented by Sonne and Weniger (2018), synthesizes numerous theoretical, philosophical, and empirical perspectives of ethical professional mental health practice. First, this model incorporates the foundational bases of principle, virtue, and relational ethics, while also recognizing intuitive and non-rational factors that are involved in the ethical decision-making process. Second, this model considers external factors that contribute to the decision-making process (e.g., contextual factors such as location and patient characteristics). Third, similar to several other general decision-making models, Sonne and Weniger's Synthesis Model incorporates a "cost-benefit analysis" of all the potential generated decisions. And last, similar to multicultural and feminist models of decision-making, the Synthesis Model takes into account diversity sensitivity, and individual and contextual diversity factors that contribute to the ethical decision-making process. This model includes two components. The first component considers a therapist's "Professional Ethical Identity," involving a constant and ever-evolving process through which practitioners build a core ethical identity. The second component includes a 10 step decision-making model, starting with the therapist first recognizing, identifying, and defining the ethical issue in plain language (Sonne & Weniger, 2018). This first step in the decision-making process is the focus of this study.

Models and Guidelines Specific to Nonsexual Multiple Relationships between Therapists and Current Clients

Gottileb (1993) created an early decision-making model specific to the ethical issues involved in nonsexual multiple relationships between therapists and their current patients. This model is based upon three important dimensions: the power differential between the therapist and client, the duration of the therapeutic relationship, and the clarity of any termination of the therapy.

Other experts have suggested guidelines outlining factors for therapists to consider as they step through the decision-making process regarding whether or not to engage in a nonsexual multiple relationship with a current client (Sonne, 2006; Younggren & Gottileb, 2004). Younggren and Gottileb (2004) outlined relevant questions for therapists to work through as they find themselves facing a potential nonsexual multiple relationship. These questions are divided into two domains: treatment-oriented questions and risk-management questions. The treatment-oriented questions include: asking oneself if entering a multiple relationship is necessary, if one should avoid a multiple relationship, if the multiple relationship could cause harm to the patient, if the multiple relationship would be beneficial to the clients, if there is a possibility that the multiple relationship could disrupt the therapeutic relationship, and if one can evaluate this matter objectively. The risk-management questions prompt the therapist to ask themselves about procedures: if they adequately documented the decision-making process, if they obtained proper informed consent regarding the multiple relationship, if there is evidence of professional consultations, if the sources of

consultation are credible, if the decision-making process was patient-oriented, if the patient's diagnostic issues were considered, if the therapist recognizes that the patient supports the establishment of a multiple relationship, and whether the therapist's theoretical orientation matters when considering the multiple relationship? Sonne (2006) addressed ethical decision-making by combining existing theoretical models, research findings, and clinical guidelines regarding nonsexual multiple relationships. Sonne's model serves as a practical checklist for therapists to consider as they engage in the process of recognizing and deciding whether or not to engage in nonsexual relationships with their client. Additionally, Sonne's guidelines consider therapist factors (e.g., gender, theoretical orientation, years of experience, culture, character traits), client factors (e.g., gender, culture, psychosocial strengths and vulnerabilities, and history of prior boundary violations) and secondary relationship factors (e.g., clarity of primary relationship roles vs. secondary relationship roles, compatibility of therapist/client roles with roles in secondary relationship, setting and locale of the secondary relationship) that may contribute to the recognition of an ethical problem.

Gottileb's (1993) model and Younggren's and Gottlieb's (2004) guidelines assume that therapists already recognize the potential for, or actual involvement in, a nonsexual multiple relationship with a current client. Omitting recognition from an ethical-decision making model implies that all therapists are equally likely to recognize situations raising the issue of a potential nonsexual multiple relationship; recent research suggests that that is not true (Jochai, 2010). Jochai (2010) found that there was indeed variance in therapists' recognition of a potential nonsexual multiple relationship. Further,

factors such as the therapist's positive affect, type of ethics training, and the interaction of client gender with therapist gender significantly accounted for some of that variance.

Research on Therapists' Actual Ethical Decision-Making Process Regarding Nonsexual Multiple Relationships with Current Clients

As noted above, several ethical decision-making models and guidelines have been presented in the literature designed to assist therapists confronted with potential or actual engagement in nonsexual multiple relationships with current clients. However, to date there is very limited research regarding therapists' actual engagement in that process. One notable exception cited briefly above is Jochai's (2010) study. She used the Cognitive Elaboration (CE) Model of Ethical Decision-making to explore the role of therapist factors (therapist gender, need for cognition, empathy, positive affect, anxiety, and type of ethics training), client factors (gender), and secondary relationship factors (moral intensity of the ethical dilemma) in a study of participants' (therapists') engagement of the first step of ethical decision-making—first, the degree to which they spent cognitive energy in deliberating a scenario depicting a potential nonsexual multiple relationship with a current client, and second, the recognition of the potential ethical problem. The results of her study found that, overall, the best predictors of the recognition of a potential nonsexual multiple relationship were the therapist's positive affect when confronted with the scenario and the type of ethics training the therapist had received (i.e., including didactic vs. experiential elements), as well as the interaction of client gender with therapist gender.

In this study, we will examine four therapist factors and one client factor that we predict will affect the recognition of a potential nonsexual multiple relationships between therapist and current patient. One therapist factor and one patient factor have been identified by Jochai (therapist and client sex). The remaining three therapist factors have been implied in the theoretical literature to be of importance but, to date, are unexamined in the empirical literature (instrumental and expressive gender characteristics [i.e. masculinity and femininity], relative allegiance to general ethical principles, and character virtues (caring, inquisitiveness, and self-control). The focus of this study will be solely on the first step in the decision-making process; we will ask participant therapists to "identify and define the ethical issue in plain language." This requires that therapists are able to recognize, identify, and label a potential ethical nonsexual multiple relationship between a therapist and a client.

Rationale for the Therapist and Client Factors Hypothesized to Affect Recognition of a Potential Nonsexual Multiple Relationship with a Current Client

According to Ferrell and Gresham (1985), it is crucial for researchers and professionals to understand the social, cultural, and environmental factors that contribute to the recognition of an ethical dilemma. Smith and Carroll (1984) argue that human socialization processes and environmental influences may impede moral behavior. But on the other hand, individual factors such as: knowledge, values, attitudes, and intentions may also enhance ethical behavior (Ferrell and Gresham, 1985). Specifically, as indicated above, this study will examine the influence of four therapist factors (the therapist's sex,

instrumental and expressive gender characteristics [i.e., masculine and feminine characteristics], relative importance of general ethical principles, and character virtue (i.e., caring, inquisitiveness, and self-control)], and one client factor (the client's sex) on that recognition. We discuss our rationale for including each of these factors below.

Gender (Sex) Factors

Before considering the role of gender (sex) and instrumental and expressive gender characteristics in the recognition of a potential nonsexual multiple relationship, it is important to understand historical perspectives and understanding of gender (sex) concepts. In psychology there are two commonly understood definitions of gender (sex). The first is consistent with sex assigned at birth (i.e., male and female), and the second views gender as a psychological construct (i.e., masculine vs. feminine gender roles; Bem, 1981). In psychology research, the influence of therapist gender on ethical decision-making has been primarily restricted to the concept of gender (sex) as biological assignment of male or female, and on the therapist's actual behavior (i.e., engage or not engage in a nonsexual multiple relationship). Limited empirical research to date does suggest that a therapist's sex may influence their recognition of an ethical dilemma and the result of decision-making process regarding a nonsexual multiple relationship with a client (Jochai, 2010).

Gender (Sex) Differences in General Decision-making. Many of the earlier studies focused on gender (sex) when examining and studying the relationship between gender (sex) and the nuances associated with decision-making in general. For example,

Hoffman (1972) concluded that compared to women, men are motivated by achievement needs. It's been said that men value objective and logical traits (Rosenkrantz, Vogel, Bee, Broverman, & Broverman, 1968) and have been socialized to value having an impact, resulting in engaging in more task-oriented and instrumental behavior (Sargent, 1981). Additionally, earlier studies have concluded that men tend to be more driven by objective and individualistic tasks compared to women (Gill, Stockard, Johnson, & Williams, 1987; and Stein & Bailey, 1973), and that they are more likely to adopt strategies that focus on bottom-line results rather than the methods used to achieve those results (Hennig & Jardim, 1977).

In contrast, earlier studies show that compared to men, women are more aware of others' feelings (Rosenkrantz et al., 1968) and are more strongly motivated by affiliation needs (Hoffman, 1972). Past studies have suggested that because of socialization pressures, the female personality is framed by communion with others (Chodorow, 1974); therefore women place a higher importance on relationships compared to men (Erikson, 1968). Based on a review of research, Minton and Schneider (1980) concluded men are more self-confident and independent, and women are more people-oriented. Gill et al. (1987) claim that women are more oriented toward relational goals and achievement in interpersonal relationships. Additionally, Skitka and Maslach (1996) found that female participants used "communion" constructs more often than men in the process of describing others. In this particular study, "communion" constructs referred to the concern for harmonious functioning of the group, interdependence, and relationships.

Empirical literature regarding investment decision-making found that gender (sex) was the most important explanatory factor affecting confidence in investment choices. Females were less confident about their decisions after controlling for multiple external factors (Estes & Hosseini, 1988). Along with confidence, past literature also supports gender (sex) differences in the nature and outcomes of management decisions involving risk-taking (Johnson & Powell 1994). These past studies suggest that women are more cautious, less confident and aggressive, easier to influence, and have inferior leadership and problem-solving abilities when making decisions regarding risk compared to men. With this said, past studies also show that there are no significant gender (sex) differences found in studies which examine management decision-making values or styles (Chaganti, 1986; Powell, 1990). Interestingly, after re-examining early business decision-making literature, Johnson and Powell (1994) concluded that the evidence on gender (sex) differences is no longer clear-cut.

Past studies also examined foundational gender (sex) differences between women and men in compliance and influenceability (Becker, 1986; Eagly & Carli, 1981). Past studies suggest that women are more likely to comply with orders, whereas men are more likely to rebel (e.g., Stockard, Van-de-Kragt, & Dodge, 1988). And Roberts (1991) suggests that women are more responsive to the information and feedback received from others, while men adopt a competitive attitude and thus, a self-confident and maybe even an overconfident approach (Lundeberg, Fox, & Puncochar, 1994). Lastly, Barnett and Karson (1989) concluded that women are likely to select actions in terms that are likely

to be approved by others as opposed to following rules or principles that are separate from relationships.

Gender (Sex) Differences in General Ethical Decision-making. Past studies have found gender (sex) differences in moral sensitivity. According to Rest (1982), moral sensitivity is an individual's awareness of how their actions affect others. A morally sensitive individual has the ability to understand a situation in terms of potential courses of action, determined by who may be affected by the action, and understand how the affected individual may think and feel about the action. You, Maeda, and Bebeau (2011) conducted a meta-analysis of 19 studies that were theoretically grounded in Rest's definition of moral or ethical sensitivity. Based on the analysis, the results indicated that women on average tend to score higher on moral sensitivity measures than men. It is important to note that this meta-analysis included men and women from all fields and backgrounds (e.g., counseling, graduate students, business, psychiatry, etc.).

Gilligan (1982) argues that men and women differ in their bases of moral reasoning, such that men focus more on justice, while women focus more on relationship issues. Gilligan's perspective suggests that women are more likely than men to base their moral decisions around consequences for the people involved, along with the responsibility to care for and avoid hurting others. On the other hand, men are more likely than women to view moral struggles as abstract, logical problems that concern rights and rules. Gilligan (1982) also notes that women display greater idealism and have an ethic of caring, while men are expected to be more relativistic.

Therapist Gender (Sex) Differences in Their Perceptions of the Ethicality and Engagement in Nonsexual Multiple Relationships with Current Clients. Borys and Pope (1989) examined sex differences in ratings of the ethicality of various nonsexual multiple relationships between a therapist and a client. Their findings indicated that male therapists tend to rate nonsexual multiple relationships with current clients involving social (e.g., disclosing details of one's current personal stresses to a client, inviting clients to an office/clinic open house, and inviting clients for a personal party or social event), financial (e.g., buying goods or services from a client), and professional (e.g., allowing a client to enroll in one's class for a grade) roles as more ethical than female therapists. Additionally, regarding ethical judgments, Hass, Malouf, and Mayerson (1988) found that although male and female therapists' both indicated that they would refuse trading therapy for accounting services, the effect was more pronounced for the female therapists. Haas, Malouf, & Mayerson (1988) suggest that female therapists may be more cautious of relational issues that could result from trading services with a current client. This thought aligns with the idea that females are more aware of potential negative effects on the relationship, and thus less risk-favorable in the therapeutic context compared to males.

Research findings to date also suggest that, consistent for the most part with their perceptions of the ethicality of nonsexual multiple relationships, male therapists actually engage in more nonsexual multiple relationships with current clients compared to female therapists. In one of the earliest studies on nonsexual multiple relationships, Tallman (1981) found that about one-third of the total sample of 38 psychotherapist participants

formed some sort of social relationship with some of their current clients. Of significance, with a sample that was equally divided by male and female therapists, it was only the male therapists who developed social relationships with any of their clients. Additionally, Borys and Pope (1989) found a significant gender (sex) difference suggesting that male therapists tend to engage in nonsexual multiple relationships with current clients more often than female therapists[2]. More specifically, male therapists reported a higher frequency of engaging in extra therapeutic social engagements with their clients (e.g., disclosing details of one's current personal stresses to a client, inviting clients to an office/clinic open house, employing a client, going out to eat with a client after a session) compared to their female colleagues. Additionally, male therapists reported more frequent involvements in dual professional roles with their clients (e.g., allowing a client to enroll in one's class for a grade).

Therapist Gender (Sex) Differences in Their Recognition of a Potential Nonsexual Multiple Relationship with a Current Client. As indicated above, to our knowledge, Jochai's (2010) study is likely the only one that has examined therapist factors associated with the recognition of a potential nonsexual multiple relationship with a current client. She found that male participant therapists were significantly less likely to recognize the potential for a nonsexual multiple relationship with a current client as presented in vignettes than female participant therapists, even after reporting greater cognitive expenditure (not statistically significant, but still important to note).

[2] Although Borys and Pope's study examined therapist engagement in nonsexual multiple relationships with both current and former clients, only their findings regarding involvement with current clients are reported here.

Interestingly, that result appeared to be mediated by the sex of the patient depicted in the vignette. Male participant therapists reading scenarios about male clients were most likely to recognize the potential ethical concern, while male participant therapists reviewing vignettes describing female clients were the least likely to recognize the dilemma.

Client Gender (Sex) Differences Affecting Therapist Ethical Decision-making. Along with therapist gender (sex), client gender (sex) has been shown to affect decision-making and, more specifically, recognition regarding potential nonsexual multiple relationships with clients. In the classic Borys and Pope (1989) study mentioned above, the data suggest that male therapists tend to engage in nonsexual multiple relationships more with female clients than with male clients. And although the results only approached significance, male therapists with primarily female clients rated social/financial involvements (e.g., disclosing details of one's current personal stresses to a client, inviting clients to an office/clinic open house, inviting clients for a personal party or social event, and buying goods or services from a client) and dual professional roles (e.g., allowing a client to enroll in one's class for a grade) as more ethical than did respondents in any other therapist-client gender (sex) pairing. Similarly, actual engagements in financial involvements and dual professional roles were more frequent among male therapists with mainly female clients than with any other gender (sex) pairing. Therefore, even though therapists' gender (sex) can stand alone as a factor in the perceived ethicality and involvement in a potential nonsexual multiple relationship, the interaction between the therapist's gender (sex) and client gender (sex) have shown to

contribute to the ratings of ethicality and behavior of engagement in a nonsexual multiple relationship.

In addition to the rating of ethicality and involvement in nonsexual multiple relationships, Jochai (2010) found a significant relationship between the interaction of therapist and client gender (sex) and the recognition of the nonsexual multiple relationship. Specifically, male participants reading scenarios with male clients were more likely to recognize the presented ethical dilemma depicting a potential nonsexual multiple relationship, while male participants rating the female vignettes were less likely to recognize the ethical dilemma.

Instrumental and Expressive Gender Characteristics: Masculinity and Femininity

In her classic work, Bem (1981) proposed that gender may be conceptualized as a psychological construct—a continuum of masculine to feminine instrumental and expressive characteristics. Any individual may fall along the continuum depending on the balance of these characteristics, including a position along the midline that she labeled androgynous. Bem explained that stereotyped masculine traits and characteristics include things like being a leader, aggressive, ambitious, analytical, assertive, athletic, competitive, dominant, independent, and self-reliant. And on the other hand, stereotyped feminine traits and characteristics include things such as being tender, affectionate, cheerful, compassionate, nurturing, soft-spoken, sympathetic, warm, and understanding (Bem, 1974).

Gender Characteristic Differences in General Ethical Decision-making. After Bem's (1981) conceptualization of gender as a psychological construct, interestingly much of the subsequent research in ethical decision-making continued to study gender as only a biological construct. An exception is Hofstede's (1991, 2001) work investigating cultural differences in ethical decision-making in marketing. Hofstede included the factors of masculinity and femininity in his research. According to Hofstede (1984), masculinity is defined as "a preference for achievement, heroism, assertiveness, and material success" (Hofstede, 1985, p. 348), and masculine individuals are considered assertive, aggressive, ambitious, and competitive. Feminine individuals on the other hand are described as modest, humble, nurturing, and accountable. Additionally, Hofstede described feminine individuals as more interpersonally-oriented, kind, and more likely to express achievement in terms of close human relationships.

Research investigating the influence of culture (particularly as defined by masculine and feminine characteristics) suggests that individuals from highly masculine cultures (e.g., United States and Japan) are less likely to be influenced by formal codes of ethics (i.e., deontological norms), especially when personal and outside interests conflict (Vitell, Nwachukwu, & Barnes, 1993). Also, because individuals from highly masculine cultures are seen to be driven by personal achievement and material success, they may be more likely to place their own self-interests above the interests of others. On the other hand, feminine cultures (e.g., Sweden) tend to have a stronger sense of social responsibility (Vitell et al., 1993).

Gender Characteristic Differences in Therapists' Ethical Decision-making Regarding Potential Nonsexual Multiple Relationships with Current Clients. There have been numerous changes and overlap in gender roles across decades and there seems to be more overlap in gender stereotype roles (Diekman & Eagly, 2000; Wilde & Diekman, 2005). To date, we are not aware of any empirical research examining the relationship between masculine and feminine characteristics and ethical decision-making in clinical psychology. In this study, we plan to address this void, particularly given the social/cultural changes over the last several decades and the resulting blending of gender characteristics and gender roles beyond sex designation.

Conclusion. All in all, the empirical evidence of gender (defined as binary categories) differences in general ethical-decision making is mixed. One possible explanation for the mixed findings is that assessment of the gender (sex) factor only by binary categories (male v. female) does not account for characteristics inherent in socially constructed gender roles that may influence ethical decision-making. In past decades men were traditionally assigned certain gender values (masculine traits) and women were assigned separate gender values (feminine traits), but with the changing times, push for gender equality, and gender diversity in various occupations, it seems that gender characteristics and values may in fact not be fully captured by sex. Therefore, in this study we will include both sex, gender (with a more contemporary definition than a simple binary conceptualization) and gender instrumental and expressive characteristics (i.e., along the masculinity-femininity dimension).

Relative Allegiance to General Ethical Principles

Corey, Corey, and Callanan (1998) state that because ethical codes cannot be applied in a rote manner, practitioners are more likely to respond to a dilemma based on their underlying ethical values. Therefore, it is reasonable to assume that the therapist's recognition of a potential ethical issue in the process ethical decision-making may be influenced by one's allegiance to general ethical principles. The literature regarding ethical decision-making undeniably highlights the importance of ethical principles in one's decision-making process. Decades ago, Stadler (1986) presented an ethical-decision making models that embraces moral principles as the basis for action. Stadler opined that therapists' moral beliefs influence their actions in response to an ethical dilemma. Additionally, Sileo and Kopala (1993) developed a worksheet to simplify the therapist's consideration of ethical issues with a primary goal of promoting beneficence. This worksheet includes assessment (A), benefit (B), consequences and consultation (C), duty (D), and education (E), while also incorporating the moral standards of autonomy, beneficence, nonmaleficence, fidelity, and justice to ensure sound decision-making in the face of an ethical dilemma. Further, Forester-Miller and Davis (1996), referred to the moral principles of autonomy, justice, beneficence, nonmaleficence, and fidelity as the touchstones of their ethical decision-making model. Therapy itself mirrors similar ethical principles in ethical decision-making. Gladding & Batra (2007) additionally identified veracity as a component of ethics in therapy. From these principles flow the ethical standards of practice of professional mental health associations. Regarding nonsexual multiple relationships, it is established that moral principles are crucial for the decision-

making process (Moleski & Kiselica, 2005), but the research regarding therapist's allegiance to these principles and ethical decision-making is less researched. And research regarding the ranking of these principles and the recognition of a potential nonsexual multiple relationship is non-existent.

There are a few existing studies that observe differences among ethical principles and decision-making worth noting. One study showed that among the ethical principles examined (i.e., autonomy, beneficence, and justice), only beneficence explained moral norm (Blondeau, Godin, Gagnea, & Martineau, 2004). Moral norm measures the personal obligation felt toward adopting a behavior. Specifically, in this study, the principle of beneficence was linked to the respondent's sense of moral obligation to sign the sticker on the health insurance card for being an organ donor. This study gives insight into the fact that various moral principles do seem to play different roles in ethical decision-making. In another study examining the relative importance of four ethical principles (autonomy, nonmaleficence, beneficence and justice) for the decision-maker, Page (2012) used Analytic Hierarchy Process to assess the participants' relative allegiance to the four moral principles. On average, individuals in this study (who were first-year psychology students at university) rated nonmaleficence as significantly more important that the other principles. These results are consistent with those of Landau and Osmo (2003). In their study "protection of life" (which is conceptually similar to the principle of nonmaleficence) was rated by their respondents as the most important principle. In Page's study, however, individuals' preference for nonmaleficence did not clearly relate to applied ethical judgements in specific scenarios involving medical ethical dilemmas.

For example, even though individuals stated that they value medical ethical principles, they did not actually seem to use them directly in their decision-making process. As indicated above, there were possible methodological problems with Page's study (i.e., their respondents were not experienced in psychological practice, the scenarios involved medical [rather than clinical psychology] dilemmas). Given the central role that general principles have been assigned by professionals in the conduct of ethical practice, it appears vital to continue researching the nuances of just how they may affect the practitioner in decision-making, particularly with regard to negotiating potential nonsexual multiple relationships. Further, our understanding of how therapists rank the importance of general ethical principles is crucial because, as mentioned earlier, sometimes these principles can come into conflict in a given ethical dilemma. For example, a therapist who ranks autonomy as the most important ethical principle underlying her practice may differ in opinion about engaging in nonsexual multiple relationships compared with a therapist who ranks nonmaleficence as the most important ethical principle. The former therapist may tend to most value their client's right to make her own decision about how best to fulfill her wants and needs, rather than be "protected" by the therapist from possible harm or confusion. The latter may tend to adopt the stance that any risk of potential harm or confusion for the client or the therapeutic relationship must be avoided.

In this study, we will examine the effect of the participant therapists' relative allegiance to the seven general ethical principles identified in Sonne and Weniger's (2018) model (beneficence, nonmaleficence, respecting patient rights (including

autonomy) and dignity, justice, integrity, individual responsibility, and professional and scientific responsibility to society) on their recognition of a potential nonsexual multiple relationship with a current client. These ethical principles are an extension of Beauchamp & Childress' four moral principles (respect for autonomy, nonmaleficence, beneficence, and justice) and are also similar to that of the current APA's Principles **(Beneficence and Nonmaleficence, Fidelity and Responsibility, Integrity, Justice, and Respect for People's Rights and Dignity).**

Character Virtues

Similar to the lack of research regarding therapists' relative allegiance to the general ethical principles, there is also a lack of research regarding how the therapists' character virtues affect recognition of an ethical dilemma regarding nonsexual multiple relationship with a current client. As explained previously, virtue ethics is an approach to ethics that emphasizes an individual's character as the main element of ethical judgment and behavior. As such, virtue ethics (and character virtues) are arguably quite relevant to the work of a clinical therapist.

Virtue ethics suggests that right or wrong does not only lie in its intrinsic value, but that morally right actions are fluid or dependent on the situation. Further, virtue ethics holds that the outcomes of these actions are more universal, meaning that the wellbeing of everyone involved is considered the final goal (Hursthouse, Rosalind, Pettigrove, & Glen, 2016). This approach to moral judgment highlights the mindful effort that is made by the individual to be and act as a good person (Jeong & Hyemin, 2013). Virtue ethics

enforces a certain level of responsibility on the therapist to be thoughtful and aware of the implications of their professional actions, but in a profoundly personal way. Virtue ethics may be viewed as the starting point from which clinical therapy came about in the effort to cultivate the wellbeing of all of humanity (Jeong & Hyemin, 2013). Some classic examples of traditional and professional character virtues include: fidelity, prudence, discretion, perseverance, courage, integrity, public spiritedness, benevolence, humility, and hope (May, 1984). May (1984) argued that these virtues are not simple correlates of related ethical principles and standards, but instead they represent characteristics of professionals that go beyond the boundaries of principles or rules.

Although there are no studies of which we are aware that have examined the relationship between a therapist's virtue characteristics and the recognition of a potential nonsexual multiple relationship with a current client, the topic has been discussed in the context of professional practice. Jordan and Meara (1990) describe how character virtues influence professional practice in the use of informed consent in the counseling relationship and in the role of professional relationships factors such as therapist "genuineness." In more recent literature, virtue ethics has become increasingly used as an alternative framework for professional ethics (Banks & Gallagher, 2008; Sinnicks, 2014). In this content, professional ethics refers to the ethics of professionals who are members of a particular profession such as medicine, law, teaching, or social work (Spielthenner, 2017). In addition, some studies have emphasized the importance of a value-based model in relation to ethical decision-making (Crossan, Mazutis, & Seijts, 2013). Crossan et al. highlight the pitfalls for omitting virtue ethical perspectives from ethical frameworks, and

argue that by taking a virtue ethical perspective, we elevate the assessment of personal character (being) to the same status given to the assessment of ethical or unethical acts (doing).

Rationale of Current Research

The empirical literature has suggested that various therapist and client factors affect therapists' decision-making when confronted with an ethical dilemma, specifically that of a potential nonsexual multiple relationship with a current client (Borys & Pope, 1989; Jochai, 2010). Unfortunately, there is very little research that specifically focuses on the first step of that process- the therapist's recognition of the potential for an ethical problem. This is a crucial piece of the decision-making process because without recognition and identification of a potential ethical concern, the decision-making process cannot begin, and therapists may then be at risk of confusing or harming clients and/or impairing the therapeutic relationship. Further, the literature defines some therapist factors and implicates others that are likely to affect therapist recognition of this particular ethical problem that we plan to examine: therapist and client sex, therapist gender characteristics (i.e., masculinity and femininity), therapist relative allegiance to general ethical principles, and therapist character virtues.

CHAPTER TWO

METHODS

Participants

Participants were recruited for this study using three methods. First, hosts of various professional psychotherapist social media groups were contacted by Facebook messenger and Reddit private messages with a request to advertise the recruitment post on their social media groups (See Appendix B). Second, APA's Committee on Rural Health, various APA Divisions, and state-specific psychological associations were emailed with a request to post an email to these listservs (See Appendix A). The following state-specific psychological associations shared that they themselves would forward the email to their members: Kansas, Louisiana, New Hampshire, and Wyoming Psychological Association. After obtaining permission to distribute the study via social media groups, and various listservs that required permission to recruit participants, social media posts were made and emails were sent out to therapists asking for their participation in this study. And third, doctoral-level clinical psychologists affiliated with Loma Linda University were contacted by email and in-person with a request to forward an email to their clinical psychologist colleagues currently working as therapists with adult clients (i.e., snowball recruitment). The social media post and email informed prospective participants of the nature of the study, the approximate time required to complete the survey materials, instructions for completing the survey, and a request for their consent to participate (see Appendices A and B). The social media post and email

then guided potential participants to an online site designed by the investigator. The site directed participants in alternating order to one of two surveys created for this study. In one of the surveys, participants viewed a vignette involving a male as a client (Group A); the other survey involved the same scenario but with a female client (Group B).

To increase the sample size, a second round of social media posts were made, and a second round of emails were sent to the listservs. On the second requests for participation, an IRB-approved statement regarding snowballing was added to the social media post and email. This statement asked participants to share the research survey with their colleagues who fit the inclusion criteria (i.e., doctoral-level clinical psychologists [with a Ph.D. or Psy.D. degree], or masters-level or doctoral-level marriage and family therapists [MFT or DMFT], who currently hold a license in good standing to practice in at least one state in the United States [U.S.] and who currently provide clinical psychotherapy services to adult patients). A third and fourth request for participation was emailed to four state-based professional associations: California Psychological Association, California Psychological Association Early Career Psychologists, Texas Psychological Association, and Texas Psychological Association Early Career Psychologists. Four months of recruitment resulted in an adequate number of respondents (a total of 380).

Overall, the recruitment post was made on 111 social media groups, emails were sent to APA's Rural Health Network, five different APA Divisions, and 20 state-specific psychological associations, and 14 clinical psychologists affiliated with Loma Linda University were contacted with a request to forward an email to their colleagues.

Administrators of six state-based psychological associations denied the request to post the email due to policies prohibiting the distribution of graduate student research. The exact number of individuals who received the request to participate is not known due to the lack of access to the overall number of individuals who were contacted via each listserv, viewed the social media post, or viewed the email via the snowballing method. Therefore, an overall response rate cannot be calculated.

Overall, 380 participants responded to the survey. Individuals who submitted responses that appeared invalid (e.g., random responding) and who failed to complete the vignette question and at least 85% of the Demographics Questionnaire were excluded from the respondent group (20 were excluded). Further, individuals who did not state their degree or were not practicing therapists holding a Ph.D., Psy.D., LMFT, or DMFT were eliminated from the respondent group (63 were eliminated). Additionally, individuals who were not currently seeing adult clients or licensed in the United States were eliminated from the study (21 were eliminated). The final total sample consisted of 276 participants, 146 in Group A (those who read a vignette regarding a male client) and 130 in Group B (those who read the same vignette but depicting a female client). Demographic data for each group of participants is presented in Table 1.

Table 1. Demographic data for Group A and Group B.

	Group A (N = 146) [a]		Group B (N = 130) [a]	
Demographic Characteristics	*M*	*SD*	*M*	*SD*
Age (years)	46.00	13.39	46.00	14.25
	N	%	N	%

Gender				
Male	25	17.1	33	25.4
Female	119	81.5	93	71.5
Non-binary	0	0	3	2.3
Transgender Female to Male	2	1.4	0	0
Transgender Male to Female	0	0	1	0.8
Clinical Experience Hours				
1 to 4999	59	45.7	42	36.5
5000 to 9999	22	17.1	27	23.5
10000 to 14999	18	14.0	9	7.8
15000 to 19999	2	1.6	9	7.8
20000 or more	28	21.7	28	24.3
Ethnicity				
American Indian or Alaskan Native	2	1.4	0	0
Asian Indian Subcontinent	6	4.1	5	3.8
Asian/Southeast Asia or Far East	9	6.2	4	3.1
Black or African American	4	2.7	5	3.8
Hispanic/Latino	8	5.5	4	3.1
Middle Eastern	2	1.4	1	0.8
Mixed	8	5.5	6	4.6
White or Caucasian	107	73.3	104	80.0
Other	0	0	1	0.8
Religious Affiliation				
Agnosticism	22	15.1	25	19.2
Atheism	22	15.1	19	14.6
Buddhism	7	4.8	3	2.3
Catholicism	9	6.2	5	3.8
Christianity	51	34.9	30	23.1
Hinduism	1	0.7	4	3.1
Humanism	4	2.7	0	0
Islam	1	0.7	1	0.8

Judaism	11	7.5	24	18.5
Sikhism	0	0	1	0.8
Other	18	12.3	18	13.8
Theoretical Orientation				
CBT and DBT	56	39.7	44	35.5
Emotion-focused	6	4.3	4	3.2
Gestalt	2	1.4	1	0.8
Humanistic	12	8.5	16	12.9
Psychoanalytic	5	3.5	4	3.2
Psychodynamic	25	17.7	30	24.2
Religious-based	2	1.4	0	0
Other	33	23.4	25	20.2
Degree				
Ph.D.	82	56.2	67	51.5
Psy.D.	46	31.5	35	26.9
LMFT	17	11.6	26	20.0
DMFT	1	0.7	2	1.5
Geographical Context				
Urban	57	39.3	55	42.3
Suburban	52	35.9	52	40.0
Rural	20	13.8	13	10.0
Military Base	4	2.8	4	3.1
Other	12	8.3	6	4.6
State of Licensure				
Multiple	20	14.4	13	10.2
AL	1	0.7	1	0.8
AR	0	0	2	1.6
AZ	2	1.4	3	2.3
CA	32	23.0	42	32.8
CO	1	0.7	2	1.8
FL	3	2.2	1	0.8
GA	2	1.4	0	0
HI	3	2.2	5	3.9
IL	4	2.9	1	0.8
IN	2	1.4	1	0.8

KS	5	3.6	1	0.8
KY	3	2.2	2	1.6
LA	2	1.4	2	1.6
MA	2	1.4	0	0
MD	2	1.4	5	3.9
ME	2	1.4	0	0
MI	1	0.7	1	0.8
MN	4	2.9	3	2.3
MO	1	0.7	0	0
MS	1	0.7	0	0
NC	2	1.4	1	0.8
NE	0	0	1	0.8
NH	2	1.4	0	0
NJ	4	2.9	2	1.6
NY	7	5.0	10	7.8
OH	2	1.4	2	1.6
OR	2	1.4	2	1.6
PA	8	5.8	9	7.0
RI	1	0.7	0	0
SC	1	0.7	0	0
SD	0	0	1	0.8
TN	1	0.7	0	0
TX	15	10.8	11	8.6
UT	0	0	2	1.6
VA	0	0	1	0.8
WA	0	0	1	0.8
WI	0	0	2	1.6
WY	1	0.7	0	0

[a] As noted in the document text, frequencies in each category may not add up to the total N in each group due to missing data in each category.

Measures

Demographics Questionnaire. The demographics questionnaire (see Appendix D) included items requesting the participant's gender, age, ethnic background, religious affiliation, and most advanced degree in psychology, as well as the location (i.e., state) and geographical context of the participant's clinical practice, if they were currently practicing as a clinical psychologist, and years of post-graduate clinical practice. The demographics questionnaire also requested information regarding the participant's current license status, theoretical orientation used to conceptualize adult therapy patients, and years of post-graduate clinical practice.

Recognition of the Ethical Dilemma (Recognition Score). Recognition of the Ethical Dilemma was measured by adopting the same method used in Jochai's (2010) dissertation study. The participants were asked to read one vignette, imagining that they were the therapists in the situation with a current client. The vignette incorporated a potential nonsexual multiple relationship that may or may not be recognized by the participant. Vignette A depicted the dilemma with a male client (See Appendix E); Vignette B described the same dilemma but with a female client (See Appendix F). We chose this vignette of three available from Jochai's study because it was determined to be of moderate difficulty in terms of recognition (i.e., generating some variance among the respondents). On a scale of 0 – 4, (0 meaning the participant failed to recognize potential for a multiple relationship in even the most general terms, and 4 meaning the participant explicitly recognizes the potential for a multiple relationship), Jochai's mean Recognition score for the group responding to the male client vignette was 1.90 (*SD* = 1.57) and for

the group responding to a female client the mean Recognition score was 1.60 (*SD* = 1.48).

In this study, recognition was measured by the participant's response to the question immediately following their reading of the clinical vignette: "As you reflect on this session with your client and prepare to make a note in his chart, what issues (if any) were raised for you in your interaction with the client? Please number each issue: #1, #2, #3, #4, etc.". Three judges were provided with the same set of coding rules with which to score participants' responses (see Appendix J). First, two judges (the student investigator and one independent graduate student judge) scored the degree to which the participant recognized that the vignette included an ethical dilemma involving a potential nonsexual multiple relationship. Specifically, the two judges identified whether the participant explicitly recognized the potential for a nonsexual multiple relationship (score of 4), recognized a general boundary crossing in the therapeutic relationship (score of 3), recognized a general ethical dilemma in the therapeutic relationship (score of 2), only described the action by the client or therapist that appeared to cross a boundary (score of 1), or failed to state that there was any issue related to either boundary crossings or nonsexual multiple relationships (score of 0). For Recognition scores that differed between the two judges, a third judge (a faculty member in the Loma Linda University Department of Psychology) rated the responses, and the score given by two of the three judges was used as the participant's Recognition score. In cases where all three judges' scores differed, the score rendered by the third judge was assigned.

Overall, the first two judges demonstrated 84% agreement in their initial Recognition scores assigned to a total of 276 vignettes; 16% (44 vignettes) of the ratings from the two judges differed and thus required the rating from the third judge. Of the cases requiring rating from the third judge, 9% (4 vignettes) resulted in different scores from all three judges. In addition, for one particularly complex participant response, the two initial judges yielded the same score, but both judges registered a lack of certainty about the score and requested input from the third judge. The third judge assigned a different score. As indicated above, in these five cases, the final Recognition score for each case was the value given by the third judge. Possible scores ranged from 0 to 4; higher scores indicated greater recognition of the potential nonsexual multiple relationship. Table 2 shows the inter-rater reliability between the two initial judges and Table 3 shows the overall mean Recognition scores and standard deviations for Groups A and B.

Table 2. Vignette inter-rater reliability between the initial two judges.

Vignette	% agreement
Vignette 1	84.0

Table 3. Recognition scores for Group A, Group B, and overall sample.

Average Recognition Score					
Group A		Group B		Both Groups	
M	*SD*	*M*	*SD*	*M*	*SD*
2.36	1.28	2.40	1.40	2.38	1.34

Gender Social Values Scale. The Personal Attribute Questionnaire (PAQ; Spence, Helmreich, & Stapp, 1974; See Appendix G) includes two scales, Instrumentality and Expressivity, which measure the degree to which a person can be classified according to masculine or feminine adjectives, respectively. The PAQ consists of a total of 24 characteristics that measure three different sets of gender traits on a dimensional scale. The M (Masculinity) subscale reflects instrumental and self-assertive characteristics (e.g., independence, self-confidence), and the F (Femininity) subscale reflects interpersonally-oriented expressive characteristics (e.g., kind, aware of feelings of others). A third subscale, the MF (Masculinity-Femininity) subscale, measures androgyny; this third subscale was not included in this study. Subjects rated themselves on a five-point scale (A-E with A indicating "Not at all.." and E indicating "very..") indicating the extent to which each of 24 attributes described them. A is then converted into a score of 0, B is converted into a score of 1, C is converted into a score of 2, D is converted into a score of 3, and E is converted into a score of 4. M, F and MF scores are then generated, based on the sum of the eight relevant items in each subscale.

Helmreich, Spence, and Wilhelm (1981) examined the psychometric properties of the PAQ and found satisfactory reliabilities (Cronbach alpha's) for the unit weighted scales in multiple samples (college students and parents). In the college student population, the male Cronbach's alpha for the M and F subscales both equaled 0.76. In the college student population, female Cronbach's alpha for the M and F subscales both equaled 0.73. In a parent population the male Cronbach's alpha for the M subscale equaled 0.78, and 0.80 for the F subscale. In the parent population females Cronbach's

alpha for the M subscale equaled 0.77 and 0.79 for the F subscale. Table 4 shows the overall mean PAQ scores and standard deviations for Group A and Group B.

Table 4. Personal Attributes Questionnaire scores in Group A and Group B.

Personal Attributes Questionnaire (PAQ) Score by Group							
PAQ-Instrumentality				PAQ-Expressivity			
Group A		Group B		Group A		Group B	
M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
22.39	3.88	21.55	3.66	24.38	3.56	24.34	3.20

Character Virtues. Values in Action Inventory of Strengths-V3 (VIA-IS-V3; McGrath, 2017; Appendix H) is a face-valid questionnaire designed to measure three character virtues: caring, inquisitiveness, and self-control. There are 8 declarative sentences (24 total) that assess each of the three virtues to which the respondent responds on a 5-point Likert scale (1=Very Much Unlike Me; 5=Very Much Like Me). For example, the character strength of Caring is measured with items that include: ‘‘I always treat people fairly whether I like them or not.” The character strength of Inquisitiveness is measured with items such as: ‘‘I am always coming up with new ways to do things.” And the character strength of Self-control is measured with items that include: “I always think about the consequences before I act.” Possible scores for each character virtue ranged between 8 and 40; with higher scores indicating higher levels of that character virtue. This whole measure showed good internal consistency, with an overall Cronbach’s alpha of 0.82. Cronbach’s alpha equaled 0.75 for the Caring subscale, 0.85 for the Inquisitiveness subscale, and 0.87 for the Self-control subscale (McGrath, 2017). Table 5

shows the overall mean VIA-IS-V3 scores and standard deviations for Group A and Group B.

Table 5. Values in Action Inventory of Strengths-V3 scores in Group A and Group B.

Values in Action Inventory of Strengths-V3 (VIA-IS-V3) Score by Group							
VIA-IS-Inquisitiveness				VIA-IS-Self-Control			
Group A		Group B		Group A		Group B	
M	SD	M	SD	M	SD	M	SD
32.43	4.83	32.29	3.83	30.80	5.56	28.90	6.03

Relative Allegiance to General Ethical Principles. As in Page's (2012) study, participants provided their own rankings from least important to most important for the seven ethical principles: beneficence, nonmaleficence, respecting patient rights (including autonomy) and dignity, justice, integrity, individual responsibility, and professional and scientific responsibility to society (See Appendix I). The principle of beneficence asserts that the mental health professional acts with mercy and kindness based on their compassionate response to others (desire to help) to promote other's welfare. Nonmaleficence refers to the practitioner's commitment to not inflict harm on others. Respect for patient rights (including autonomy) and dignity is an individual's duty to respect the freedom of others to do as they choose as long as they do not infringe on the rights of others. Justice is the duty to treat all individuals fairly. Integrity refers to the professional's honesty, accuracy, and consistent moral behavior. Individual responsibility refers to the practitioner's acceptance of personal accountability for their judgments and behavior. Public responsibility refers to an individual's duty to honor

responsibility to public at large (general beneficence). Each participant was then categorized into one of seven different groups according to what principle they ranked as the most important ethical principle. Table 6 shows the frequencies of participants who endorsed each ethical principle as the most important in Groups A and B.

Table 6. *Ethical Principle Ranked as the Most Important in Group A and Group B.*

	Most Important					
	Group A		Group B		Total	
Ethical Principle	(N = 146) [a]		(N = 130) [a]		(N = 276) [a]	
	N	%	N	%	N	%
Beneficence	25	17.9	19	15.7	44	15.9
Nonmaleficence	48	34.3	43	35.5	91	33.0
Respecting patient	22	15.7	14	11.6	36	13.0
Justice	2	1.4	1	0.8	3	1.1
Integrity	27	19.3	23	19.0	50	18.1
Individual	9	6.4	7	5.8	16	6.1
Professional and	7	5.0	14	11.6	21	8.0

[a] As noted in the document text, frequencies in each category may not add up to the total N in each group due to missing data in each category.

Procedures

As described above, participants were recruited by social media posts, emails via listservs, and requests of doctoral-level clinical psychologists affiliated with Loma Linda

University to forward an email to their clinical psychologist colleagues currently working as therapists with adult clients. Each participant was recruitment by one of these three methods. The social media post and email informed participants of the nature of the study, the approximate time required to complete the survey materials, instructions for completing the survey and a request for their participation (see Appendix A and Appendix B). The social media post and email also described the opportunity for anyone who was in receipt of the social media post or email to receive one of three $50 gift certificates to Amazon regardless of whether or not they completed the survey. Participants were instructed to email the researcher with "DRAWING" in the subject line if they desired to be put in the drawing for the study. Participants were assured that their email addresses were in no way linked to their survey responses.

The social media post and email then guided participants to an online site that directed participants to the informed consent form (See Appendix C). The informed consent form outlined all of the procedures and risks associated with participation in the study, as well as the completion instructions.

Participants were informed that proceeding from the informed consent form to the study survey constituted their consent. Those participants who proceeded were alternately assigned to read one of the two Qualtrics surveys created for this study. One of the surveys presented a vignette involving a male client (Vignette A), and the second survey presented a vignette involving a female client (Vignette B). Participants then were asked to complete four measures contained within the Qualtrics survey. The order of the measures in the online survey were as follows: Demographic Questionnaire, Vignette and

Recognition Question, Personal Attributes Questionnaire, VIA-IS-V3, and Relative Allegiance to the General Ethical Principles.

Operationalized Hypotheses

The following operationalized hypotheses were proposed and designed to be tested with one multiple regression analysis.

Hypothesis 1: It was hypothesized that therapist female sex, higher scores on the PAQ Expressivity (femininity) scale, higher scores on the VIA-IS-V3 Self-control scale, and participants' ranking Nonmaleficence as the most important ethical principle would be significantly (positively) predictive of Recognition scores.

Hypothesis 2: It was hypothesized that higher scores on the PAQ Instrumentality (masculinity) scale, higher scores on the VIA-IS-V3 Inquisitiveness scale, and male participants who are presented with a vignette describing a potential nonsexual multiple relationship with a female client would be significantly (negatively) predictive of Recognition scores.

Hypothesis 3: It was hypothesized that PAQ Expressivity and Instrumentality scale scores would explain more unique variance in Recognition scores than therapist sex.

CHAPTER THREE

RESULTS

Initial Analyses

The total sample of individuals who responded to the recruitment post was first analyzed for invalid data, which included those who met the exclusion criteria (failure to complete the vignette questions and 85% of the Qualtrics survey, and random responses), and those who failed to meet the inclusion criteria (i.e., doctoral-level clinical psychologists [with a Ph.D. or Psy.D. degree], or masters-level or doctoral-level marriage and family therapists [MFT or DMFT], who currently hold a license in good standing to practice in at least one state in the United States [U.S.] and who currently provide clinical psychotherapy services to adult patients). Next, missing data was identified across both groups of participants. Then, several of the demographic variable categories were redefined due to variable responses or low frequencies in the data. Demographic data using the transformed variables for the remaining respondents in each of the two groups (Group A who responded to the survey including a vignette with a male client and Group B who responded to the same survey with an identical scenario, but with a female client) are then presented. Finally, analyses were conducted between participant groups A and B on each of the demographic variables to determine whether the groups could be combined for further analyses to test the study hypotheses.

Invalid data analyses

A total of 380 individuals responded to the initial inquiry and engaged with the Qualtrics survey. Of that total sample, 16 participants discontinued the survey prior to the vignette question; therefore, they were not assigned to either Group A or Group B, leaving 183 participants in Group A and 181 participants in Group B. In addition, four participants in Group B appeared to engage in random responding and were eliminated from the study. Several in each group were eliminated from further analyses due to failure to meet additional inclusion criteria. Specifically, 22 in Group A and 38 in Group B were eliminated because they were not practicing therapists holding a Ph.D., Psy.D., LMFT, or DMFT; three in Group A were deleted because they did not state their degree; four in Group A and five in Group B were eliminated because they were not licensed as a Ph.D., Psy.D., LMFT, or DMFT; and eight in Group A and four in Group B were eliminated because they were not currently working with adult clients.

Missing data analyses

The final total sample consisted of 276 participants (146 participants in Group A and 130 participants in Group B). Overall, four participants did not disclose their age (three in Group A and one in Group B), eight participants did not disclose their state(s) of licensure to practice (six in Group A and two in Group B), one participant in Group A did not disclose their geographical context, 11 participants did not disclose their clinical theoretical orientation (five in Group A and six in Group B), and 32 participants did not disclose their clinical hours accumulated, or their answer could not be translated into a

certain number of hours. For example, their responses may have been “thousands,” “impossible to count,” or “I have been working for so long, I don’t know” (17 in Group A and 15 in Group B).

Demographic variable transformations

Several demographic variable categories were redefined because of variable responses or low frequencies of responses. Regarding years of post-graduate clinical practice, participants were asked approximately how many face-to-face adult psychotherapy hours they accumulated since completion of graduate school. Participant responses included actual numbers along with ranges; therefore, hours accumulated were recoded into five categorical ranges. These ranges were recoded such that “1” represented 1 to 4,999 hours accumulated; “2” represented 5,000 to 9,999 hours accumulated; “3” represented 10,000 to 14,999 hours accumulated; “4” represented 15,000 to 19,999 hours accumulated; “5” represented 20,000 hours accumulated or more.

Levels of several categorical variables on the Demographics Questionnaire were redefined as well. Variable categories that contained few responses were combined into an "Other" category. These variables included participants’ gender, ethnicity, current religious affiliation, geographical context of their clinical practice, and theoretical orientation used to conceptualize their adult therapy patients regardless of the actual interventions they delivered.

Gender identity was assessed by asking the participant how they identified in terms of gender. Because only a small minority of participants identified as “Non-

binary," "Transgender Female to Male," and "Other," these categories were combined into a Transgender and Nonconforming category (TGNC). However, only six participants identified as having TNGC gender identity (two in Group A and four in Group B); therefore this category was eliminated from the statistical data analyses conducted to test the study hypotheses.

Participant ethnicity was assessed by asking participants to select one option for their ethnic background. The "Other" category for this variable was redefined to include "American Indian or Alaska Native," "Jewish," "Middle Eastern," and "Mixed" due to low frequencies in each. In addition, "Asian/Indian Subcontinent," and "Asian/Southeast Asia or Far East," were combined into one category, "Asian." The categories "Black or African American," "Hispanic/Latino," and "White or Caucasian," remained unchanged in the final ethnicity variable. The final ethnicity categories included: "Asian," "Black or African American," "Hispanic/Latino," "White or Caucasian," and "Other."

Participants' responses regarding their current religious affiliation resulted in low numbers in multiple response choices. The "Other" category for this variable was redefined to include "Buddhism," "Hinduism," "Humanism," "Islam," "Other," and "Sikhism." In addition, "Catholicism" was combined with "Christianity." The final religious affiliations included, "Agnosticism," "Atheism," "Catholicism/Christianity," "Judaism," and "Other."

Participants' theoretical orientation was redefined into eight categories. Based on written-in responses by participants who designated "Other", two new categories were added: "Systems" and "Integrative/Eclectic." Some existing categories were combined:

"Psychodynamic" and "Psychoanalytic" were combined; "Acceptance and Commitment Therapy" was combined with "Emotion Focused", and "Existential" was combined with "Gestalt." "Religious-based" was added into the "Other" category There were no responses for "Jungian," therefore this category was removed. "Cognitive-Behavioral/Dialectical Behavioral Therapy" and "Humanistic" remained unchanged. The final theoretical orientation variable included the following categories: "ACT/Emotion Focused," "Cognitive-Behavioral/Dialectical Behavioral Therapy," "Gestalt/Existential," "Humanistic" "Integrative" "Psychoanalytic/Psychodynamic," "Systems," and "Other."

Participants reported the state/states in which they are currently licensed or certified to conduct psychotherapy. These states were combined into four U.S. census bureau regions including "Northeast," "Midwest," "South," and "West." Lastly, the "Multiple States" category included participants who endorsed licensure in multiple states.

And, last, participants' geographical context was redefined to include four levels. Due to the low frequency of responses, existing categories "Other" and "Military Base" were combined. The final levels included "Urban," "Suburban," "Rural," and "Other."

Demographic data for Groups A and B

Demographic data using the transformed demographic variables for the two participant groups (A and B) are presented in Table 7.

Table 7. Demographic data for Group A and Group B.

	Group A (N = 146) [a]		Group B (N = 130) [a]	
Demographic Characteristics	*M*	*SD*	*M*	*SD*
Age (years)	46.00	13.39	46.00	14.25
	N	%	N	%
Gender (Sex)				
Male	25	17.1	33	25.4
Female	119	81.5	93	71.5
Transgender and Nonconforming category (TGNC)	2	1.4	4	3.1
Clinical Experience Hours				
1 to 4999	59	45.7	42	36.5
5000 to 9999	22	17.1	27	23.5
10000 to 14999	18	14.0	9	7.8
15000 to 19999	2	1.6	9	7.8
20000 or more	28	21.7	28	24.3
Ethnicity				
Asian	15	10.3	9	6.9
Black or African American	4	2.7	5	3.8
Hispanic/Latino	8	5.5	4	3.1
White or Caucasian	107	73.3	104	80.0
Other	12	8.2	8	6.2
Religious Affiliation				
Agnosticism	22	15.1	25	19.2
Atheism	22	15.1	19	14.6
Catholicism/Christianity	60	41.1	35	26.9
Judaism	11	7.5	24	18.5
Other	31	21.2	27	20.8
Theoretical Orientation				
ACT/Emotion Focused	10	7.0	9	7.3
CBT/DBT	56	39.2	44	35.8
Gestalt/Existential	2	1.4	2	1.6

Humanistic	14	9.8	16	13.0
Integrative	14	9.8	5	4.1
Psychoanalytic/Psychodynamic	30	21.0	34	27.6
Systems	4	2.8	2	1.6
Other	13	9.1	11	8.9
U.S. census bureau/location				
Northeast	27	19.3	21	16.4
Midwest	19	13.6	13	10.2
South	34	24.3	24	18.8
West	41	29.3	57	44.5
Multiple States	27	13.6	13	10.2
Geographical Context				
Urban	57	39.3	55	42.3
Suburban	52	35.9	52	40.0
Rural	20	13.8	13	10.0
Other	16	11.0	10	7.7

[a] As noted in the document text, frequencies in each category may not add up to the total N in each group due to missing data in each category.

Analyses of difference between Groups A and B

Several analyses of the transformed demographics variables were conducted in order to determine whether the two vignette client gender groups (Groups A and B) could be combined for the tests of the study hypotheses. First, an independent t-test was completed between the two groups of participants to explore possible differences on participants' age variable (see Table 8). There was no significant effect for respondent age.

Table 8. Descriptive statistics for continuous demographic variables.

	Group A (N = 146)		Group B (N = 130)			
Continuous Variables	*M*	*SD*	*M*	*SD*	*t*	*p*
Age (years)	46.00	13.39	46.00	14.25	.00	1.00

Chi-square analyses were conducted for the remaining categorical demographic variables (see Table 9). There was one significant association between vignette client gender group and respondent's current religious affiliation , X^2 (4, N = 276) = 11.21, p = .024 such that those participants who responded to the vignette depicting a male client more often endorsed Catholicism/Christianity as their religious affiliation, and those participants who responded to the vignette depicting a female client more often endorsed Judaism as their religious affiliation. No other significant between-group differences were observed for the remaining categorical demographic variables. Given the comparability of the two vignette client gender groups of participants (Groups A and B), the two groups were combined for all further analyses.

Table 9. Descriptive statistics and chi-square values for categorial variables.

	Group A N = 146 [a]		Group B N = 130 [a]			
Demographic Characteristics	N	%	N	%	χ^2	*p*
Gender (Sex)					4.05	.132
Male	25	17.1	33	25.4		
Female	119	81.5	93	71.5		
Transgender and Nonconforming category (TGNC)	2	1.4	4	3.1		
Clinical Experience Hours					9.98	.076

1 to 4999	59	45.7	42	36.5		
5000 to 9999	22	17.1	27	23.5		
10000 to 14999	18	14.0	9	7.8		
15000 to 19999	2	1.6	9	7.8		
20000 or more	28	21.7	28	24.3		
Ethnicity					2.87	.580
Asian	15	10.3	9	6.9		
Black or African American	4	2.7	5	3.8		
Hispanic/Latino	8	5.5	4	3.1		
White or Caucasian	107	73.3	104	80.0		
Other	12	8.2	8	6.2		
Religious Affiliation					11.21	.024
Agnosticism	22	15.1	25	19.2		
Atheism	22	15.1	19	14.6		
Catholicism/Christianity	60	41.1	35	26.9		
Judaism	11	7.5	24	18.5		
Other	31	21.2	27	20.8		
Theoretical Orientation					6.01	.538
ACT/Emotion Focused	10	7.0	9	7.3		
CBT/DBT	56	39.2	44	35.8		
Gestalt/Existential	2	1.4	2	1.6		
Humanistic	14	9.8	16	13.0		
Integrative	14	9.8	5	4.1		
Psychoanalytic/Psychodynamic	30	21.0	34	27.6		
Systems	4	2.8	2	1.6		
Other	13	9.1	11	8.9		
U.S. census bureau/location					7.31	.199
Northeast	27	19.3	21	16.4		
Midwest	19	13.6	13	10.2		
South	34	24.3	24	18.8		
West	41	29.3	57	44.5		
Multiple States	27	13.6	13	10.2		
Geographical Context					2.90	.408
Urban	57	39.3	55	42.3		
Suburban	52	35.9	52	40.0		

	Rural	20	13.8	13	10.0		
	Other	16	11.0	10	7.7		
Degree						4.31	.230
	PhD	82	56.2	67	51.5		
	PsyD	46	31.5	35	26.9		
	LMFT	17	11.6	26	20.0		
	DMFT	1	0.7	2	1.5		

[a] As noted in the document text, frequencies in each category may not add up to the total N in each group due to missing data in each category.

Final Participant Sample. The final sample consisted of 276 participants. Demographic data using the transformed demographic variables are presented in Table 10.

Table 10. Descriptive statistics for categorical and continuous variables.

	Total N = 276 [a]	
Continuous Variables	*M*	*SD*
Age (years)	*46.00*	*13.78*
Categorical Variables	N	%
Gender		
Male	58	21.0
Female	212	76.8
Transgender and Nonconforming category (TGNC)	6	2.2
Clinical Experience Hours		
1 to 4999	101	36.6
5000 to 9999	49	17.8
10000 to 14999	27	9.8
15000 to 19999	11	4.0
20000 or more	57	20.7
Ethnicity		

Asian	24	8.7
Black or African American	9	3.3
Hispanic/Latino	12	4.3
White or Caucasian	211	76.4
Other	20	7.2
Religious Affiliation		
Agnosticism	47	17.0
Atheism	41	14.9
Catholicism/Christianity	95	34.4
Judaism	35	12.7
Other	58	21.0
Theoretical Orientation		
ACT/Emotion Focused	19	6.9
CBT/DBT	100	36.2
Gestalt/Existential	4	1.4
Humanistic	30	10.9
Integrative	19	6.9
Psychoanalytic/Psychodynamic	64	23.2
Systems	34	2.2
Other	34	12.3
U.S. census bureau/location		
Northeast	27	19.3
Midwest	19	13.6
South	34	24.3
West	41	29.3
Multiple States	27	13.6
Geographical Context		
Urban	112	40.6
Suburban	103	37.3
Rural	33	12.0
Other	28	10.1
Degree		
PhD	149	54.0
PsyD	81	29.3
LMFT	43	15.6

DMFT	3	1.1

[a] As noted in the document text, frequencies in each category may not add up to the total N in each group due to missing data in each category.

Data Analyses

The original operationalized hypotheses were planned to be tested with one multiple regression analysis, but due to the ordinal nature of the dependent variable (Recognition score), an ordinal logistic regression was conducted instead. The following sections include a discussion of the statistical assumptions required for ordinal logistic regressions, a notation of violations of the assumptions, the results of the overall test of the regression model, and a presentation of the results in the order of proposed hypotheses.

Statistical Assumptions for Ordinal Logistic Regression Analyses

Independence of Observations

When collecting data, each participant was independently counted as one observation. Therefore, the assumption of independence of observations was not violated.

Univariate and Multivariate Outliers

The data for the combined sample was screened for possible univariate outliers (i.e., plus or minus three standard deviations). Box plots and histograms were created for

each variable. One univariate outlier was found in the study variable PAQ measuring Instrumentality (in Group A) and one univariate outlier was found in the study variable VIA measuring Caring (in Group A). The two participants who submitted these outlier responses were removed from the study. The sample was also assessed for multivariate outliers by using Mahalanobis distance, $p < .001$. No multivariate outliers were identified.

The final sample then consisted of 268 participants (142 who viewed the vignette with a male client and 126 who viewed the vignette with a female client). Table 11 shows the means, standard deviations, and ranges of the continuous variables included in the model and Table 12 shows the frequencies and percentages of the categorical variables included in the model.

Table 11. Descriptive statistics for continuous variables in total sample.

	Total (N = 268) [a]		
Continuous Variables	*M*	*SD*	range
Age (years)	46.11	13.87	26-90
PAQ-Instrumentality	22.06	3.70	10-30
PAQ-Expressivity	24.39	3.40	16-32
VIA-IS-Inquisitiveness	32.35	4.38	19-40
VIA-IS-Self-Control	30.46	5.70	16-40

[a] The number of participants = 268 after the Transgender and Nonconforming category (TGNC) and two outliers were removed.

Table 12. Descriptive statistics for categorical variables in total sample.

	Total (N = 268) [a]	
Categorical Variables	*N*	%
Gender (Female)	211	78.7
Gender (Male)	57	21.3
Male Therapist and Male Client Interaction	24	9.0
Female Therapist and Male Client Interaction	118	44.0
Female Therapist and Female Client Interaction	93	34.7
Ethical Principle Nonmaleficence- Ranked the Highest	88	34.6

[a] The number of participants = 268 after the Transgender and Nonconforming category (TGNC) and two outliers were removed.

Multicollinearity

To ensure that multicollinearity was not an issue, a linear regression analysis using SPSS multicollinearity diagnostics was conducted. All VIFs (Variance Inflation Factors) were between 1 and 10 (VIFs = 1.050 – 2.690) indicating that the assumption of no multicollinearity was supported Field (2018).

Proportional Odds

Analyses indicated that the location parameters (slope coefficients) for the outcome variable (Recognition score) were not the same across the possible response categories ($p < .001$). As such, the proportional odds assumption was violated. To adjust for this violation, the outcome variable (Recognition score) was transformed to

conceptually make the Recognition scores more ordinal in nature. Specifically, we combined Recognition score 3 (recognized a general boundary crossing in the therapeutic relationship), Recognition score 2 (recognized a general ethical dilemma in the therapeutic relationship), and Recognition score 1 (described the action by the client or therapist that appeared to cross a boundary). This new Recognition score was labeled Recognition Score 1. Recognition score 0 (failed to state that there was an issue) was left the same. Recognition score 4 (participant explicitly recognized the potential for a nonsexual multiple relationship) was left the same definitionally but was renamed Recognition score 2.

As such, the final outcome variable consisted of Recognition score 2, Recognition score 1, and Recognition score 0, such that Recognition score 2 indicated that the participant explicitly recognized the potential for a nonsexual multiple relationship, Recognition score 1 indicated that the participant recognized a general boundary crossing, a general ethical dilemma, or described an action by the client or therapist that appeared to cross a boundary, and Recognition score 0 indicated that the participant failed to state that there was any issue regarding boundary crossings. Conceptually, the Recognition scores were separated by participants who did not recognize any ethical issue regarding boundary crossings, participants who recognized or identified some ethical issue, and participants who recognized explicitly the potential for a nonsexual multiple relationship.

After transforming the outcome variable, analyses revealed no violation of the proportional odds assumption, $p > .05$. The location parameters (slope coefficients) of

the dependent variable are the same across response categories. With this, the ordinal logistic regression analysis was conducted to test the study hypotheses

Testing the Model

An ordinal logistic regression analysis was used to investigate various variables that may account for the variance in therapists' first step in the decision-making process—the ability to recognize the potential of a nonsexual multiple relationship with a current client. As reported above, inspection of correlations between the predictors did not indicate any potential issues with multicollinearity, and the assumption of parallel lines was not violated.

Ordinal regression analysis indicated that our overall model did not fit the data and there was no significant difference between the baseline model and the final model, $p > .05$. However, examination of individual predictor variables revealed that the female therapist and female client vignette combination was a significant positive predictor of Recognition score, $b = 0.89$, Wald $\chi^2(1) = 3.96$, $p = .047$. This slope represents the difference in log-odds between the female therapist and female client gender interaction group relative to the reference group, which is the male therapist and female client group. Female therapists presented with a female client in the vignette were more than twice as likely to have a higher Recognition score (exp [.89] = 2.44; 95% CI = [.013, 1.761]).

Exploratory Analyses

Given that the predictor variables did not contribute to participants' recognition of a potential nonsexual multiple relationship according to the model proposed in this study, two sets of exploratory analyses were conducted to further examine the data. First, the specific relationships between each of two individual predictor variables (Clinical Experience and Highest Ranked Ethical Principle) and the outcome variable (Recognition score) were investigated. Second, correlation analyses were conducted to explore the relationships among the original predictor variables.

Associations of Clinical Experience and Highest Ranked Ethical Principle with Recognition Score

A Chi-square analysis was conducted to examine the relationship between the variable Clinical Experience (i.e., face-to-face adult psychotherapy hours accumulated since the completion of graduate school) and the outcome variable, Recognition of a Potential Nonsexual Multiple Relationship. There was a significant association between therapists' clinical experience and their ability to recognize the potential for a nonsexual multiple relationship in the vignette, $\chi^2(8) = 17.53$, $p = .025$. Those therapists who had the least amount of clinical experience (1 to 4,999 hours) had far less than expected Recognition scores of 0, therapists who had the most amount of clinical experience (20,000 hours or more) had more than expected Recognition scores of 0. In addition, therapists who had the least amount of clinical experience (1 to 4,999 hours) had far more than expected Recognition scores of 1.

In addition to the results of the chi-square analysis, some Recognition scores and Clinical Experience frequencies are worth noting. Of therapists who had a Recognition score of 0, 24.4% had the least amount of clinical experience (1 to 4999 hours) and 34.1% had the most amount of clinical experience (20,000 hours or more). In addition, of those therapists who had a Recognition score of 2, 34.1% had the least amount of clinical experience (1 to 4,999 hours) and 18.2% had the most amount of clinical experience (20,000 hours or more). Percentages of Recognition scores and Clinical Experience are presented in Table 13.

Table 13. Percentages of clinical experience for each Recognition score.

	Recognition score [a]		
	Score 0	Score 1	Score 2
Clinical Experience	%	%	%
1 to 4999	24.4	47.8	34.1
5000 to 9999	26.8	15.7	29.5
10000 to 14999	4.9	11.3	15.9
15000 to 19999	9.8	3.8	2.3
20000 or more	34.1	21.4	18.2

[a] Percentages in each column represents the frequencies of each clinical experience subcategory of hours for that specific Recognition score.

A Chi-square analysis did not indicate any significant associations between Recognition scores and ethical principles ranked as the most important, but again some frequencies are worth noting. Among therapists who had a Recognition score of 2 (explicitly recognized the potential for a nonsexual multiple relationship), 26.7% ranked

Beneficence as the most important ethical principle, 22.2% ranked Respecting patient rights (Autonomy) as the most important ethical principle, and 22.2% ranked Nonmaleficence as the most important ethical principle. In contrast, among therapists who had a Recognition sore of 0 (failed to state that there was any ethical issue), 34.9% ranked Nonmaleficence as the most important ethical principle. Percentages of ethical principles ranked as the most important and Recognition scores are presented in Table 14.

Table 14. Percentages of ethical principles ranked as the most important for each Recognition score.

	Recognition Scores [a]		
	Score 0	Score 1	Score 2
Ethical Principle	%	%	%
Beneficence	20.9	13.3	26.7
Nonmaleficence	34.9	38.2	22.2
Respecting patient rights	11.6	12.1	22.2
Justice	0	1.7	0
Integrity	16.3	20.8	15.6
Individual Responsibility	4.7	4.5	11.1
Professional and Scientific	11.6	8.7	2.2

[a] Percentages in each column represents the frequencies of the highest ranked ethical principle for that specific Recognition score.

Correlation Analyses Among Predictor Variables

Bivariate (Pearson) correlation analyses among the predictor variables revealed several significant relationships worth noting (see Table 15). Specifically, Instrumentality (PAQ-M) and Expressivity (PAQ-F) scores were each significantly positively related with VIA-IS-Inquisitiveness; only Instrumentality (PAQ-M) was significantly positively related to VIA-IS-Self-control. Additionally, VIA-IS-Self-control scores were significantly inversely related to ranking the ethical principle Nonmaleficence as the most important ethical principle, such that individuals who rated Nonmaleficence as the most important ethical principle had lower VIA-IS-Self-control scores.

Table 15. Intercorrelations between predictor variables.

Subscale	1	2	3	4
1. PAQ-M				
2. PAQ-F	*.108*			
3. VIA-IS-Inquisitiveness	*.426***	*.183***		
4. VIA-IS-Self-control	*.269***	*.109*	*.049*	
5. Nonmaleficence Ranked the Highest	*-.045*	*.105*	*.093*	*-.161***

* $p < .05$; ** $p < .01$

CHAPTER FOUR

DISCUSSION

Empirical literature to date suggests that various therapist and client factors affect therapists' overall decision-making when confronted with an ethical dilemma, specifically that of a potential nonsexual multiple relationship with a current client (Borys & Pope, 1989; Haas, Malouf, & Mayerson, 1988; Ivey & Doenges, 2013; Jochai, 2010; Sonne, 2006; Williams 1997). However, there is very little research that explicitly focuses on the first step of that process—the therapist's recognition of the potential for an ethical problem. This study examined this crucial piece of the decision-making process because without recognition and identification of a potential ethical concern, the decision-making process cannot begin, and therapists may then risk confusing or harming clients and/or impairing the therapeutic relationship. Then, this study assessed the association of several therapist factors and one client factor with therapists' negotiation of this first step. Some of the factors (i.e., therapist sex; client sex; the interaction of therapist's sex and client's sex) have been previously identified in the decision-making literature. Some of the predictive therapist factors explored in this study, however, have been implied in the theoretical literature to be of importance but, to date, are unexamined empirically (i.e., instrumental and expressive gender characteristics [masculinity and femininity], relative allegiance to general ethical principles, and character virtues [inquisitiveness and self-control].

The primary goal of this study was to investigate the overall influence of various therapist and client factors on the therapist's recognition of a potential nonsexual multiple relationship with a current client, according to three specific hypotheses. Unfortunately, the results of this study did not provide overall support for the proposed hypotheses. However, exploratory analyses did reveal a more complex interrelationship among therapist sex, client sex, and the therapist's Recognition score; specifically, the interaction of therapist sex (female) and client sex (female) is significantly positively predictive of Recognition score.

Discussion of the results for each of the three specific hypotheses is presented first below. Then, the results of the exploratory analyses are discussed. Then, the limitations of the study are outlined. Finally, the Discussion concludes with the potential implications of this study for clinical training and for future research.

Discussion of the Results for the Hypotheses

Ordinal regression analysis did not provide support for the proposed overall model of therapist and clients factors predictive of therapists' recognition of a potential nonsexual multiple relationship with a current client. More specifically, first, it was hypothesized that therapist's sex (female), higher scores on the PAQ Expressivity (femininity) scale, higher scores on the VIA-IS-V3 Self-control scale, and participants' ranking Nonmaleficence as the most important ethical principle would be significantly positively predictive of Recognition scores. The findings indicated that none of these factors were significantly related to therapist's recognition of a potential nonsexual

multiple relationship. One possible explanation for this is that the individual characteristics of therapist sex and client sex are more salient in later steps of the therapist's decision-making process when confronted with a potential nonsexual multiple relationship with a client (Borys & Pope, 1989). The same argument may also be the case for the therapist's expressive (feminine) gender characteristics. Research suggests that highly masculine cultures (e.g., United States and Japan) are less likely to be influenced by formal codes of ethics and feminine cultures tend to have a stronger sense of social responsibility (Hofstede, 1999; Hofstede, 2000; Kale, 1996; Vitell, Nwachukwu, & Barnes, 1993). Hofstead (2003) suggested that gender characteristics also influence behaviors in business negotiations, such that masculinity leads to ego-boosting behaviors and extends sympathy for the strong and superiors, as well as masculine cultures tending to resolve conflicts by fighting rather than compromising. On the other hand, femininity leads to ego-effacing behaviors and extending sympathy for the weak. However, these findings associate masculinity and femininity with behavior, fundamentally the last step in the ethical decision-making process. In discussing how the factors above may affect decision-making at different steps of the decision-making process, it may be helpful to note that prominent models of moral or ethical decision-making (Jones, 1991; Rest, 1986; Street, 2001) share three elements: (1) perception of a moral problem (the moral domain), (2) processes of moral reasoning (judgment), and (3) behavior. Interestingly, even these models differ in the conceptualization of at what point in the overall decision-making process individual and situational factors moderate the decision-making process. As discussed in further detail below, however, exploratory analyses did reveal a more

complex interrelationship among therapist's sex, client's sex, clinical experience, and the therapist's Recognition score.

Further, the failure of the data to support the hypothesis that therapists' ranking of Nonmaleficence as the most important ethical principle would be significantly positively predictive of Recognition score may reflect the fact that a therapist's general preference for an ethical principle does not extend to a specific application of the ethical decision-making process. In fact, Page (2012) found that even though first-year university psychology students rated Nonmaleficence as significantly more important than other principles, this preference did not clearly relate to applied ethical judgements and behaviors in specific scenarios involving medical ethical dilemmas. Page (2012) concluded that even though people state they value specific ethical principles, they may not directly use them in the decision-making process, in that people do not base their decisions in ethical situations on abstract ethical principles, and instead, people focus more on unique situational information. Similar to Page's (2012) study, Nonmaleficence was also rated as the most important ethical principle in this study; however, the highest recognition scores were actually associated with the group that rated Beneficence as the most important ethical principle. Nonmaleficence and Respecting Patient Rights (Autonomy) were associated with the second (tied) highest Recognition scores.

Lastly, the finding that higher VIA-IS-V3 Self-control scale scores were not significantly positively predictive of Recognition scores as hypothesized may be due to the aspirational nature of virtue ethics. Therefore, a therapist's identification with a virtue or character strength may not affect the therapist's process of decision-making when

confronted with an actual ethical dilemma. For one, proponents of virtue ethics acknowledge that virtue ethics and principle ethics are complementary and not competing philosophical systems, and principle ethics asks, "What shall I do?" whereas virtue ethics asks, "What shall I be?" (Jordan & Meara, 1990, pp. 107-108). Bersoff (1998) argued that the answers to “What shall I do?" and "What shall I be?" are inextricably intertwined, such that “who I am is determined by what I do” (Bersoff, 1998, p. 88). The point here is that though we may value and identify with certain character virtues and character strengths, our ethical decision-making (and, perhaps, particularly, the first step of that process) may not directly reflect them in some specific situations. The concept of character in virtue ethics may apply to how we reason, whereas situationist social psychologists argue that information about people’s distinctive character traits is not useful for determining what they will do. Instead, situations rather than character actually are stronger determinants of our behavior (Kamtekar, 2004). As an example, the moral intensity of a dilemma has been defined is a situational characteristic that influences the decision-making process. Researchers have determined that the increased moral intensity of an issue implies greater probability for ethical behaviors (Jones, 1991; Street, et al., 2001). Moral intensity incorporates elements such as (1) the degree of harm or benefit to a client if the action is made, (2) immediacy of consequences, and (3) number of people affected by the intended action (Jones, 1991, p. 376; Street, et al., 2001).

Second, it was hypothesized that higher scores on the PAQ Instrumentality (masculinity) scale, higher scores on the VIA-IS-V3 Inquisitiveness scale, and male (sex) participants who are presented with a vignette describing a potential nonsexual multiple

relationship with a female client would be significantly negatively predictive of Recognition scores. The results indicate that none of these factors were significantly inversely related to therapist's recognition of a potential nonsexual multiple relationship. Similar to the discussion of the results for the first hypothesis above regarding expressive (feminine) gender characteristics and Recognition score, instrumental (masculine) gender characteristics may also be predictive only in later action steps of the decision-making process. And, specific to the prediction that higher VIA-IS-V3 Inquisitiveness scale scores would be significantly negatively predictive of Recognition scores, again, it is possible that identification with a specific virtue or character strength may be aspirational in nature, and not necessarily related to therapists' recognition of (or even judgment and action regarding) an ethical dilemma.

Lastly, the finding that male therapists presented with a vignette describing a potential nonsexual multiple relationship with a female client were not less likely than other dyads to recognize the ethical issue ran counter to Jochai's (2010) findings. Jochai's male participants who rated vignettes with female clients were the least likely to recognize the potential dilemma. There may be numerous explanations to this finding. First, compared to Pope, Tabachnick, and Keith-Spiegel's 1987 study, a recent study showed that among psychologists there has been a trend of increasing conservatism over the last three decades regarding both ethical ratings of and engagement in nonsexual multiple relationships with clients (Schwartz-Mette & Shen-Miller, 2018). In addition, between the years 2012 and 2013 the total psychology workforce increased by 8.8% for females and decreased by 10.2% for males (U.S. Census Bureau, 2005-2013). Thus, it

may be that the more seasoned and possibly less conservative (male) psychologists make-up less of the workforce today. Second, ethics training for clinical psychologists has changed drastically in the past thirty years. Ethics courses are now mandated (Ransohoff, 2010), and a recent survey of American Psychological Association accredited programs showed that the over 90% of ethics professors in psychology programs reported that their ethics courses included teaching on boundary issues, multiple relationships, principle ethics, and ethical issues in individual psychotherapy (Domenech Rodríguez, Erickson Cornish, Thomas, Forrest, Anderson, & Bow, 2014). In addition, this survey showed that ethics professors are using educational and teaching strategies that include group discussions, student presentations, and experimental exercises in addition to lectures. These types of educational strategies challenge students to think critically (Domenech Rodríguez et al., 2014). All in all, the retirement trends of older (particularly, male) psychologists, and the content and process of ethics training may contribute to increased conservatism and, in turn, decreased influence of therapist sex and client sex interactions on recognition of a potential nonsexual multiple relationship.

Third, it was hypothesized that therapists' PAQ Expressivity and Instrumentality scale scores (measuring feminine and masculine gender characteristics) would explain more unique variance in Recognition scores than therapist sex. The results of the study did not support this prediction. It may be that for the sample in this study, that participant sex and gender characteristics were interrelated, such that the variables shared significant variance. Interestingly, inspection of the mean Expressivity and Instrumentality scale scores within male and female therapist sex groups showed that scores on Expressivity

and Instrumentally for male participants and female participants were astonishingly similar (Expressivity: Male Mean Score = 23.86, Female Mean Score = 24.49; Instrumentally: Male Mean Score = 21.79, Female Mean Score =22.10). The similarity in these gender characteristic scores suggest that most female and male therapists self-report both feminine and masculine psychological characteristics. In addition, evidence from meta-analyses on gender differences supports that males and females are similar on most psychological variables (i.e., gender similarities hypothesis; Koestner & Aube 1995; Spence, 1993). Exceptions include motor behaviors and some aspects of sexuality (Hyde, 2005). Further, Eagly and Johnson (1990) found that even though women may foster more caring behaviors, these gender roles may only have an influence on discretionary behaviors that are not directly related to the role of the occupation, suggesting that gender roles may have only a minor influence in settings with clear-cut rules about the performance of particular tasks (e.g., a physician [or therapist] must gather patient's information regarding presenting concerns, provide a diagnosis, and design treatment plan).

Ultimately, and in response to all three hypotheses, the lack of support for the proposed overall model of therapist and clients factors predictive of therapists' recognition of a potential nonsexual multiple relationship may be due to the fact that process at the immediate reaction level (recognition) may be different from those at the levels of moral reasoning, establishing of moral intent, and/or engaging in moral behavior (Rest, 1979). With this, therapist and client factors examined in this study may be more salient and discriminating in later action steps of decision-making. In addition, the lack of

support for the proposed overall model may also be due to an indirect relationship between principle and virtue ethics, as well as behavior, rising conservatism in field of psychology, changes in ethics training, and the interrelationships of therapist sex and gender characteristics.

Discussion of the Results of the Exploratory Analyses

As reported above, exploratory analyses were conducted in this study. First, examination of individual predictor variables in the original ordinal regression analysis revealed a significant relationship between Therapist Sex / Client Sex Interaction and the outcome variable (Recognition score). Second, the specific relationships between each of two individual predictor variables (Therapist Clinical Experience and Highest Ranked Ethical Principle) and the outcome variable (Recognition score) were investigated. Third, correlation analyses were conducted to explore the interrelationships among the original predictor variables.

Therapist Sex and Client Sex Interaction with Recognition Score

First, in examining a part of the second hypothesis (male participants who are presented with a vignette describing a potential nonsexual multiple relationship with a female client would be significantly [negatively] predictive of Recognition scores), exploratory analyses revealed that the interaction of therapist sex and client sex was significantly positively predictive of therapists' recognition of a potential nonsexual multiple relationship compared to the reference group. The findings indicated that female

participants presented with a vignette describing a potential nonsexual multiple relationship with a female client was significantly more likely to have a higher Recognition score than the reference group. In contrast, using similar methodology but a different statistical analysis (two-way analysis of variance), Jochai (2010) found that male therapists reading scenarios about male clients were the most likely to recognize a potential nonsexual multiple relationship. Despite the different results, the higher Recognition scores associated with same sex dyads may reflect an enhanced sensitivity to potential relationship issues with matched sexes. For example, Bhati (2014) found that across all stages of therapy, female clients who were matched with female therapists reported higher therapeutic alliance ratings than any other sex dyad. Same sex therapists and clients may share a more nuanced type of relationship more quickly, allowing for greater recognition of potential problematic issues in that relationship.

Associations of Clinical Experience and Highest Ranked Ethical Principle with Recognition Score

Regarding clinical experience and therapists' ability to recognize the potential for a nonsexual multiple relationship with a current client, a chi-square analyses suggested that those therapists who had the least amount of clinical experience (1 to 4,999 hours) had far less than expected Recognition scores of 0 and therapists who had the most amount of clinical experience (20,000 hours or more) had more than expected Recognition scores of 0. These findings are especially interesting because they are not immediately intuitive; the expectation is that more experienced therapists would be more

likely to detect a potential ethical issue with a client. Interestingly, Jochai (2010) found that ethics training that incorporated an experiential component (e.g., role-playing and experimental exercises) was a positive predictor of recognition of a potential nonsexual multiple relationship. Jochai (2010) theorized that it is vital for therapist trainees to actually practice their ethical decision-making process to fully appreciate all of the steps, including, according to her data, the recognition of a potential ethical dilemma. And, according to the study cited above (Domenech Rodríguez et al., 2014), this type of training has increased in graduate psychology programs today, which is different than the previous (and, as some argued, dangerous) notion that ethics can best be taught through "osmosis" in the context of situation-based learning during practicum and internship training (Handelsman, 1986). In addition, regarding important teaching goals, educators frequently endorsed that advancement of critical thinking, providing information and resource on ethics, and preparing students to use ethical decision-making models (Domenech Rodríguez, et al., 2014). This recent trend in ethics training for psychologists may provide insight into why therapists with the least amount of clinical experience have fewer than expected Recognition scores of 0; they are the most recently trained with strategies that emphasize critical thinking and use hands-on and unique instructional strategies.

There is another potential explanation for these findings. Ronnestad and Skovholt (2003) theorized that even though more seasoned therapists have more experience and professional development experience, they may also have confidence in their ability to maintain professional relationships while bending clinical boundaries. And, Schwartz-

Mette and Shen-Miller (2018) suggested that more experienced therapists are further removed from supervision and may be more protective of their clinician autonomy regarding boundary negotiations with clients. In addition, these researchers found that compared to early career psychologists, more seasoned psychologists reported higher frequencies of various boundary crossings with clients (e.g., lending money or becoming friends).

As mentioned above in the Results section, a Chi-square analysis did not indicate any significant associations between Recognition scores and ethical principles ranked as the most important, but some frequencies are worth noting. As stated above, across all participants Nonmaleficence (which asserts that an individual commits to not inflict harm on others) was most often ranked as the most important ethical principle (by 33%), Integrity (asserts that an individual practices with honesty, accuracy, and consistent moral behavior) had the second highest frequency as the most important ethical principle (by 18%), and Beneficence (asserts that an individual acts with mercy and kindness based on the compassionate response to others [desire to help] to promote the other's welfare) was the third (by 15.9%; see Table 6). However, the highest Recognition scores were actually associated with the group that rated Beneficence as the most important ethical principle, and Nonmaleficence and Respecting Patient Rights (Autonomy) were associated with the second (tied) highest Recognition scores. It was hypothesized that not wanting to inflict harm on others would be most associated with the highest Recognition scores, but as stated previously, there may be less of an association between allegiance to ethical principles and the decision-making process (Page, 2012). Burkemper's (2002) study

found that regarding the decision-making process, therapists weigh professional ethics differently in different ethical dilemmas (e.g., a child abuse scenario versus an HIV scenario). This falls in line with a previously stated point that people may not base their decisions in across ethical situations on a single, abstract ethical principle across ethical situations; instead people may attend more to unique situational information and align with various principles depending on that information (Page, 2012).

Correlation Analyses Among Predictor Variables

Several correlation analyses among the original predictor variables were conducted. PAQ Instrumentality and Expressivity scores were each significantly positively related with VIA-IS-Inquisitiveness. Therapists in our sample tended to endorse moderate levels of both Instrumentality and Expressivity. They also tended to score, as a group, in the high range of Inquisitiveness, which is not surprising in a group of therapists.

In addition, Instrumentality (PAQ-M) was significantly positively related to VIA-IS-Self-control. This finding contrasts with the literature that indicates that males report having less self-control than females over the lifespan (Chapple, Vaske, & Hope, 2010; Gottfredson & Hirschi, 1990; Turner & Piquero, 2002). However, recent studies regarding self-control and development found that gender differences in self-control are quite complex and gender-based processes that impact the development of self-control should further be explored taking into consideration social and environmental factors (Blackwell & Piquero, 2005; Jo & Bouffard, 2014). This finding may also be a function

of the specific operationalizations of the measure constructs. The PAQ-M Instrumentality construct is defined by instrumental and self-assertive characteristics (e.g., can easily make decisions, does well under pressure, feelings of superiority, independent, competitive, and high self-confidence). These characteristics suggest high self-efficacy, which according to Ajzen (2002) has been associated with controllability (beliefs about the extent to which performing a behavior is up to the actor).

Lastly, VIA-IS-Self-control scores were significantly inversely related to ranking the ethical principle Nonmaleficence as the most important ethical principle, in that individuals who rated Nonmaleficence as the most important ethical principle had lower VIA-IS-Self-control scores. One may anticipate that allegiance to Nonmaleficence (asserts that an individual commit to not inflict harm on others) as the most important ethical principle would be positively related to self-control. One possible reason for this finding is that Nonmaleficence may be a value that far exceeds acquisition or intentionality. In considering the nativist approach, knowledge about issues of fairness, care, and harm are considered innate characteristics, suggesting that most people that grow up in a reasonable environment will naturally come to develop these moral ideas (Haidt & Joseph, 2004; Suhler & Churchland, 2011) According to Haidt and Joseph, (2004), many psychological factors (e.g., emotions, motivation, and ways of processing social information) are innate in our hardwiring, which allows us to solve recurrent problems. In conclusion, it may be possible that therapists who ranked Nonmaleficence as the most important ethical principle may not be overly concerned about or conscious of self-control behaviors.

Implications for Clinical Training

This study highlights the importance of ethics training and the complexities of recognition of a potential ethical dilemma. Specifically, findings indicated that earlier career psychologists with the least amount of clinical experience (1 to 4,999 hours) had much lower than expected Recognition scores of 0. In fact, they identified the potential for a nonsexual multiple relationship more frequently than any other clinical experience category. Second to this group with the highest percentage of recognition of a potential nonsexual multiple relationship was the group with the second lowest number of clinical experience hours (5,000 to 9,999 hours). It is reasonable to assume that these earlier career psychologists are closest to their graduate school training compared to the other clinical training groups. These findings suggest that the recent changes in ethics training, along with a culture shift in the psychology profession (toward greater conservatism) may contribute to therapists' ability to recognize the potential for a potential nonsexual multiple relationship. To add, Jochai's (2010) study found that ethics training was a positive predictor of recognition of a potential nonsexual multiple relationship. She theorized that it is vital for therapist trainees to learn to consider the role of all aspects involved in the therapist and client interaction (e.g., experimental exercises and role-playing) as it pertains to the decision-making process in order to facilitate recognition of an ethical dilemma. Fortunately, as previously discussed, there are reports of an increase in this type of emphasis and training in graduate school programs today (Domenech Rodríguez et al., 2014) as discussed in the Discussion section.

In addition, the findings in this study indicated that there may be a complex relationship among therapist's sex, client's sex, and recognition of a potential nonsexual multiple relationship. This study found that the interaction of therapist's sex (female) and client's sex (female) was a positive predictor of Recognition score. The findings in this study along with those in Jochai's (2010) study suggest that these sex interactions are complex and possibly changing with advances in ethics training, the current gender gap in the psychology workforce, and with the recent trend of conservatism in the field (APA, 2013; Domenech Rodríguez et al., 2014; Schwartz-Mette & Shen-Miller, 2018). This is even more reason for supervisors and instructors to incorporate discussions and exercises into their teachings that promote trainees' critical thinking in relation to therapist-client dyad (sex) interactions and the recognition of a potential nonsexual multiple relationship.

Limitations of the Study and Implications for Future Research

Limitations of the study materials include issues related to the Demographic Questionnaire, such as the placing of the Demographic Questionnaire in the sequence of documents in the survey and the ways in which therapists' clinical experience and theoretical orientation were assessed. Limitations related to recruitment include the problems and potential biases associated with participant recruitment via APA Listservs, social media, and the snowballing method. Other limitations related to recruitment include the relatively small male, minority, and non-cisgender sample sizes. Lastly, limitations related to the study design include the possibility of suboptimal operationalization of the dependent variable and/or predictors.

Limitations Related to the Demographic Questionnaire

Three issues were noted with the Demographic Questionnaire used in this study. The first of these was the probability that placing the Demographic Questionnaire that included questions regarding the participants' gender (sex) and ethnicity before the four measures could have hindered performance as a result of stereotype threat. Stereotype threat has been well-defined and studied in the literature, and it refers to the risk and fear of confirming a negative stereotype about one's social group, which in turn alters performance and behavior (Roberson & Kulik, 2007; Steele & Aronson, 1995). Researchers have identified groups affected by stereotype threat as "stigma conscious" and this group includes women, racial/ethnic minorities, members of lower socio-economic classes, elders, gay and bisexual men, and people with disabilities (Aronson, Lustina, Good, Keough, Steele, & Brown, 1999; Lustina & Aronson, 1998). Future researchers may circumvent any potential issues related to stereotype threat by placing the demographic questionnaires after experimental tasks.

Second, the way in which therapists' clinical experience (i.e., Over the course of your career to date since graduate school, approximately how many face-to-face hours have you accumulated with adult patients in psychotherapy in all contexts in which you have worked) was assessed in the Demographic Questionnaire led to substantial loss of data. As noted in the Results section, numerous participants did not disclose their clinical hours accumulated, or their answer could not be translated into hours, such that they provided non-numerical responses such as "impossible to count," or "I have been

working for so long, I don't know." Future researches can prevent this type of data loss by making this question multiple choice or by asking simpler questions. This question can be turned into a multiple choice question by asking participants to "select from the options (1 to 4,999 hours; 5,000 to 9,999 hours; 10,000 to 14,999 hours) that best approximates the total face-to-face hours you have accumulated in psychotherapy in all contexts in which you have worked." And to decrease the cognitive load for a write-in response, this question may be asked in a simple two part question, such as "how many years have you been proving face-to-face adult psychotherapy?" and "what's a general estimate of the amount of adult face-to-face hours you provide each month?"

Third, several participants noted that they did not identify with any of the theoretical orientation options, or they were unable to select one theoretical orientation because they used more than one theoretical orientation as a foundation for conceptualizing their adult therapy patients. With this feedback, it may be useful for future researchers to make this a write-in question which they can later code the answers.

Limitations Related to Recruitment

A peer recruiting doctoral-level psychologists via the use of APA listservs was told by an APA Division administrator that there's an important methodological limitation involving any research that employs APA listservs. This administrator noted that virtually half of APA members do not receive emails from any APA Division and the use of APA listservs for recruitment excludes a considerable portion of potential participants and possibly invites bias. The same methodological limitation can be

extended to any research that employs social media as a means of recruiting, for not all therapists are on social media platforms which also creates the potential to invite bias. Lastly, the snowballing method can also create bias in that specific respondents are targeted.

An additional recruitment limitation to this study was that there were significantly more females than males in this study (212 vs. 58). One possible reason for the low sample size of male participants is the gender gap in the field of psychology. In 2013, the U.S. Census Bureau identified that for every active male psychologist, there were 2.1 active female psychologists in the workforce. To add, there are also more males exiting the workforce (APA, 2013). Similar to sex, there were significantly more White and Caucasian participants than minority or Mixed participants (211 vs. 65). In this study, 76% of the total sample identified as White or Caucasian and this is consistent with data released by the U.S. Census Bureau in 2013, which states that Whites account for 83.6% of active psychologists (APA, 2013). Therefore, significant findings should not be generalized to male or ethnic minority psychologists.

Further, this study's demographic questionnaire was designed based on a contemporary characterization of gender. It's been noted that transgender and non-binary individuals have largely been excluded in psychological research, resulting in missed opportunities of understanding significant aspects of how gender is organized and functions within people's lives and society (Tate, Youssef, & Bettergarcia, 2014; Van Andres, 2015). In this study, only six participants identified with something other than male or female, and these participants were ultimately excluded from data analyses.

Future researchers can avoid this issue by networking with therapists and individuals who are well connected with transgender and non-binary therapists communities.

Limitations Related to Study Design

Limitations related to the study design include the possibility of suboptimal operationalization of the dependent variable (recognition of a potential nonsexual multiple relationship) and/or predictors (e.g., importance of ethical principles in clinical practice).

As described in the Results section, the original dependent variable (Recognition score) consisted of five separate scores, but in order to make the scores ordinal in nature for data analysis, the final dependent variable was transformed into only 3 separate scores. With this, the dependent variable used in this study may not be the most optimal way of measuring therapist recognition of a potential nonsexual multiple relationship with a client.

In addition, another limitation related to study design may include the examination of incorrect variables as predictors of the recognition of a potential nonsexual multiple relationship with a client. Two participants wrote in an e-mail that they objected to the measure that assessed the participants' ranking of the ethical principles, for it assumed that therapists do not consider all ethical principles when confronted with an ethical issue. In addition, the Personal Attributes Questionnaire (PAQ) and Virtue Characteristics Scale (VIA-IS-V3) may not have operationalization or defined constructs deemed of importance for this specific study of decision-making in the

context of a therapist-client interaction in therapy. For example, for VIA-IS-Self-control scale, the question "I think through the consequences every time before I act" is relevant in relation to the decision-making process of an ethical issue, but the question "I always finish what I start" may be less so related.

Implications for Future Research

Despite support in the empirical literature for our hypothesized therapist and client predictors of that variance, none of our hypotheses were supported by our data. And though study findings suggested that there is some variation in therapists' recognition of a potential nonsexual multiple relationship with a client, these findings suggest that the influence of therapist and client factors on the decision-making process may be more salient and appropriate to examine in later steps of the ethical decision-making process. The process at the immediate, reactive level (recognition) may be distinctly different from those at the levels of moral reasoning, establishment of moral intent, and/or engaging in moral behavior (Rest, 1979). According to Jones (1991), many issues that activate decision-making are complex and ambiguous and in most instances, the ethical aspects of a situation are not immediately obvious. With this, future studies should examine later steps of the therapist's ethical decision-making process when confronted with a potential nonsexual multiple relationship with a client.

In addition, implications for future research include making changes to the measure regarding the influence of ethical principles on the decision-making process. This study along with Page's (2012) study concluded that even though people state they value

specific ethical principles, they may not directly use them in the decision-making process regarding a specific situation. Therefore, the relationship between principle ethics and ethical decision-making should be examined differently. For example, instead of asking therapists' to designate the principle they believe is the most important ethical principle, researchers may instead present a scenario depicting a clear ethical issue and ask three questions, (1) What issues (if any) were raised for you in your interaction with the client? (2) What is the next step you would take in this situation? And, (3) What ethical principle do you think is the most relevant and applicable in this scenario? Researchers may then examine the relationship and influence (if any) between the action stated and the ethical principle chosen.

In addition, as stated in the Limitations section above, future research should operationalize the dependent variable in a manner that is most conducive to data analysis (e.g., irrefutably ordinal in nature from a data analyses perspective). In addition, to further evaluate the complexity between therapist sex and client sex interaction on the ethical decision-making process, it may be beneficial for future research to provide each participant with two vignettes (one with a male client and one with a female client) depicting similar ethical scenarios. Collecting data regarding both client sexes from a single participant may provide more insight into the complexities related to therapist sex and client sex examined in this study.

Finally, this study along with Jochai's (2010) study suggests that clinical experience and ethics training influence the decision-making process in relation to the recognition of a potential nonsexual multiple relationship. Whether researchers examine

the first step of recognition of a potential ethical issues or later steps of the decision-making process, it may be valuable to examine specific aspects of participants' ethics training as it relates to the ethical decision-making process, such as whether they engaged in role-playing or other experiential exercises. The results may then continue to inform clinical training practices.

REFERENCES

Abdolmohammadi, M. J., Read, W. J., & Scarbrough, D. P. (2003). Does selection socialization help to explain accountants' weak ethical reasoning?. *Journal of Business Ethics*, *42*(1), 71-81.

Adleman, J., & Barrett, S. E. (1990). *Overlapping relationships: Importance of the feminist ethical perspective*. Springer Publishing Co.

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

Ajzen, I. (2002). Perceived behavioral control, self-efficacy, locus of control, and the theory of planned behavior 1. *Journal of applied social psychology*, *32*(4), 665 683.

American Association for Marriage and Family Therapy (2015). *AAMFT code of ethics*. Alexandria, VA: AAMFT.

American Psychological Association. (1953). *Ethical standards of psychologists*. American Psychological Association.

American Psychological Association. (1958). Ethical standards of psychologists. *American Psychologist*, 13, 268–271.

American Psychological Association. (1963). Ethical standards of psychologists. Washington, D.C.: American Psychological Association.

American Psychological Association. (1977). Ethical standards of psychologists. Washington, DC: Author.

American Psychological Association. (1979). Ethical standards of psychologists. Washington, DC: Author.

American Psychological Association. (1981). Ethical principles of psychologists. American Psychologist, 36, 633-638.

American Psychological Association. (1989). Directory of the American Psychological Association. Washington, DC: Author. American Psychological Association. (1990). Ethical principles of psychologists (amended June 2, 1989). *American Psychologist*, 45, 390-395.

American Psychological Association. (1992). Ethical principles of psychologists and code ofconduct. *American Psychologist*, 47, 1597-1611.
American Psychological Association. (2002). Ethical principles of psychologists and code ofconduct. *American Psychologist*, 57, 1060–1073.

Ariail, D. L., Abdolmohammadi, M. J., & Smith, L. M. (2012). Ethical predisposition of certified public accountants: A study of gender differences. *Research on professional responsibility and ethics in accounting*. Emerald Group Publishing Limited.

Aronson, J., Lustina, M. J., Good, C., Keough, K., Steele, C. M., & Brown, J. (1999). When white men can't do math: Necessary and sufficient factors in stereotype threat. *Journal of experimental social psychology*, *35*(1), 29-46.

Banks, S., & Gallagher, A. (2008). *Ethics in professional life: Virtues for health and social.* Macmillan International Higher Education.

Barnett, J. E.,&Yutrzenka, B. A. (1993). Nonsexual dual relationships in professional practice, with special applications to rural and military communities. *The Independent Practitioner,* 243-248.

Barnett, J. H., & Karson, M. J. (1989). Managers, values, and executive decisions: An exploration of the role of gender, career stage, organizational level, function, and the importance of ethics, relationships and results in managerial decision making. *Journal of Business Ethics*, *8*(10), 747-771.

Batt-Rawden, S. A., Chisolm, M. S., Anton, B., & Flickinger, T. E. (2013). Teaching empathy to medical students: an updated, systematic review. *Academic Medicine*, *88*(8), 1171-1177.

Beauchamp, T. L., & Childress, J. F. (1994). *Principles of biomedical ethics*. Oxford University Press, USA.

Beauchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical ethics*. Oxford University Press, USA.

Beauchamp, T. L., & Childress, J. F. (2013). Principles of biomedical ethics (7th ed.). New York, NY: Oxford University Press, p. 124.

Becker, B. J. (1986). Influence again: An examination of reviews and studies of gender differences in social influence. *The psychology of gender: Advances through meta-analysis*, 178-209.

Bem, S. L. (1974). The measurement of psychological androgyny. *Journal of consulting and clinical psychology*, *42*(2), 155.

Bem, S. L. (1981). Gender schema theory: A cognitive account of sex typing. *Psychological review*, *88*(4), 354.

Bersoff, D. N. (1996). The virtue of principle ethics. *The Counseling Psychologist*, *24*(1), 86-91.

Bhati, K. S. (2014). Effect of client-therapist gender match on the therapeutic relationship: An exploratory analysis. *Psychological Reports*, *115*(2), 565-583.

Blackwell, B. S., & Piquero, A. R. (2005). On the relationships between gender, power control, self-control, and crime. *Journal of Criminal Justice*, *33*(1), 1-17.

Blondeau, D., Godin, G., Gagnéa, C., & Martineau, I. (2004). Do ethical principles explain moral norm? A test for consent to organ donation. *Journal of Applied Biobehavioral Research*, *9*(4), 230-243.

Borys, D. S., & Pope, K. S. (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. *Professional Psychology: Research and Practice*, 20(5), 283-29

Burkemper, E. M. (2002). Family therapists' ethical decision-making processes in two duty-to warn situations. *Journal of Marital and Family Therapy*, *28*(2), 203-211.

Burns, D. D., & Auerbach, A. (1996). *Therapeutic empathy in cognitive-behavioral therapy: Does it really make a difference? Frontiers of cognitive therapy*, 135 164.

Cancian, F. M., & Oliker, S. J. (2000). *Caring and gender*. Rowman & Littlefield.

Chaganti, R., 1986. Management in women-owned enterprises. *Journal of Small Business Management*, 24, 18.

Chapple, C. L., Vaske, J., & Hope, T. L. (2010). Sex differences in the causes of self control: An examination of mediation, moderation, and gendered etiologies. *Journal of Criminal Justice*, *38*(6), 1122-1131.

Chiarella, M., & Adrian, A. (2014). Boundary violations, gender and the nature of nursing work. *Nursing ethics*, *21*(3), 267-277.

Chodorow, N. (1974). Family structure and feminine perspective. *Women in culture and society*, 41-48.

Clipson, C. R. (2005). Misuse of psychologist influence: Multiple relationships. *Journal of aggression, maltreatment & trauma, 11*(1-2), 169-203.

Corey, C., & Corey, M. S. Callanan. (1998). *Issues and Ethics in the Helping Professions.* Brooks/Cole.

Cottone, R. R., & Claus, R. E. (2000). Ethical decision-making models: A review of the literature. *Journal of Counseling & Development, 78*(3), 275-283.

Crisham, P. (1992). *Resolving ethical and moral dilemmas of nursing interventions*. New York: Delmar Publishers.

Crossan, M., Mazutis, D., & Seijts, G. (2013). In search of virtue: The role of virtues, values and character strengths in ethical decision making. *Journal of Business Ethics*, *113*(4), 567-581.

Decker, W. H., & Calo, T. J. (2007). Observers' impressions of unethical persons and whistleblowers. *Journal of Business Ethics*, *76*(3), 309-318.

Diekman, A. B., & Eagly, A. H. (2000). Stereotypes as dynamic constructs: Women and men of the past, present, and future. *Personality and social psychology bulletin*, *26*(10), 1171 1188.

Domenech Rodríguez, M. M., Erickson Cornish, J. A., Thomas, J. T., Forrest, L., Anderson, A., & Bow, J. N. (2014). Ethics education in professional psychology: A survey of American Psychological Association accredited programs. *Training and Education in Professional Psychology*, *8*(4), 241.

Doty, E., Tomkiewicz, J., & Bass, K. (2005). Sex differences in motivational traits and ethical decision making among graduating accounting majors. *College Student Journal*, *39*(4).

Eagly, A. H., & Carli, L. L. (1981). Sex of researchers and sex-typed communications as determinants of sex differences in influenceability: a meta-analysis of social influence studies. *Psychological Bulletin*, *90*(1), 1.

Eagly, A.H. and Johnson, B.T. (1990) Gender and leadership style: A meta-analysis. Psychological Bulletin, 108, 233–256.

Eagly, A. H., Wood, W., & Diekman, A. B. (2000). Social role theory of sex differences and similarities: A current appraisal. *The developmental social psychology of gender*, *12*, 174.

Eagly, A. H., & Wood, W. (2016). Social role theory of sex differences. *The Wiley Blackwell encyclopedia of gender and sexuality studies*, 1-3.

Erikson, E. (1968). Youth: Identity and crisis. *New York, NY: WW*.

Estes, R., & Hosseini, J. (1988). The gender gap on Wall Street: an empirical analysis of confidence in investment decision making. *The Journal of Psychology*, *122*(6), 577-590.

Estrada, D., Frame, M. W., & Williams, C. B. (2004). Cross-cultural supervision: Guiding the conversation toward race and ethnicity. *Journal of Multicultural Counseling and Development*, *32*, 307.

Ferrell, O. C., & Gresham, L. G. (1985). A contingency framework for understanding ethical decision making in marketing. *The Journal of Marketing*, 87-96.

Fisher, C. B. (2003). Decoding the ethics code: A practical guide for psychologists. Thousand Oaks, CA: Sage.

Fisher, C. B. (2016). *Decoding the ethics code: A practical guide for psychologists*. Sage Publications.

Fisher, C. B., & Younggren, J. N. (1997). The value and utility of the 1992 ethics code. *Professional Psychology: Research and Practice*, *28*(6), 582.

Forester-Miller, H., & Davis, T. E. (1995). *A practitioner's guide to ethical decision making*. Alexandria, VA: American Counseling Association.

Fritzsche, D. J. (1991). A model of decision-making incorporating ethical values. *Journal of Business Ethics*, *10*(11), 841-852.

Gill, S., Stockard, J., Johnson, M., & Williams, S. (1987). Measuring gender differences: The expressive dimension and critique of androgyny scales. *Sex roles*, *17*(7-8), 375-400.

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

Gladding, S. T., & Batra, P. (2007). *Counseling: A comprehensive profession*. Pearson Education India.

Gottlieb, M. C. (1993). Avoiding exploitive dual relationships: A decision-making model. Psychotherapy, 30, 41–48.

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

Gottlieb, M. C. (1994). Ethical decision making, boundaries, and treatment effectiveness: A reprise. *Ethics & Behavior*, *4*(3), 287-293.

Gross, B. (2005). Double vision: An objective view of dual relationships. *Annals of the American Psychotherapy Association*, *8*(3), 36-39.

Grossman, M., & Wood, W. (1992). Sex differences in emotional intensity: A social role explanation. Journal of Personality and Social Psychology, 65, 1010-1022.

Haas, L. J., Malouf, J. L., & Mayerson, N. H. (1988). Personal and professional characteristics as factors in psychologists' ethical decision making. *Professional Psychology: Research and Practice*, *19*(1), 35.

Haas, L. J.,& Malouf, J. L. (1989). Keeping up the good work: A practitioner's guide to mental health ethics. Sarasota, FL: Professional Resource Exchange, Inc

Haidt, J., & Joseph, C. (2004). Intuitive ethics: How innately prepared intuitions generate culturally variable virtues. *Daedalus*, *133*(4), 55-66.

Handelsman, M. M. (1986). Problems with ethics training by" osmosis.". *Professional Psychology: Research and Practice*, *17*(4), 371.

Helmreich, R. L., Spence, J. T., & Wilhelm, J. A. (1981). A psychometric analysis of the Personal Attributes Questionnaire. *Sex Roles*, *7*(11), 1097-1108.

Hennig, M., & Jardim, A. (1977). *Managerial Woman*. Anchor Press/Doubleday.

Hill, M., Glaser, K., & Harden, J. (1998). A feminist model for ethical decision making. *Women & Therapy*, *21*(3), 101-121.

Hoffman, L. W. (1972). Early childhood experiences and women's achievement motives. Journalof Social Issues, 28, 129–155.

Hofstede, G. (1985). The interaction between national and organizational value systems. *Journal of management Studies*, *22*(4), 347-357.

Hofstede, G.: 1984, Culture's Consequences (Sage, Beverly Hills).

Hofstede G. Culture's consequences. 2nd ed. Thousand Oaks: Sage Publications; 2001.

Hofstede, G., & Usunier, J. C. (2003). Hofstede's dimensions of culture and their influence on international business negotiations. *International business negotiation*, 137-153.

Holroyd, J. C., & Brodsky, A. M. (1980). Does touching patients lead to sexual intercourse? *Professional Psychology*, *11*(5), 807.

Horner, J. (2003). Morality, ethics, and law: Introductory concepts. In *Seminars in Speech and Language* (Vol. 24, No. 04, pp. 263-274). Copyright© 2003 by Thieme Medical Publishers, Inc., 333 Seventh Avenue, New York, NY 10001, USA.

Hunt, S. D., & Vitell, S. (1986). A general theory of marketing ethics. *Journal of macromarketing*, *6*(1), 5-16.

Hursthouse, Rosalind and Pettigrove, Glen, "Virtue Ethics", *The Stanford Encyclopedia of Philosophy* (Winter 2016 Edition), Edward N. Zalta (ed.)

Ivey, L. C., & Doenges, T. (2013). Resolving the dilemma of multiple relationships for primary care behavioral health providers. *Professional Psychology: Research and Practice*, *44*(4), 218.

Jeong, C., Hyemin. (2013). Exploring the relationship between virtue ethics and moral identity. Ethics & Behavior, 23(1), 44-56.

Jo, Y., & Bouffard, L. (2014). Stability of self-control and gender. *Journal of Criminal Justice*, *42*(4), 356-365.

Jochai, D. (2010). Ethical decision-making regarding nonsexual multiple relationships. *Loma Linda University, ProQuest Dissertations Publishing.*

Johnson, J. E., & Powell, P. L. (1994). Decision making, risk and gender: Are managers different?. *British Journal of Management*, *5*(2), 123-138.

Johnson, R. N. (2003). Virtue and right. *Ethics*, *113*(4), 810-834.

Jones, T. M. (1991). Ethical decision making by individuals in organizations: An issue contingent model. *Academy of management review*, *16*(2), 366-395.

Jordan, A. E., & Meara, N. M. (1990). Ethics and the professional practice of psychologists: The role of virtues and principles. *Professional Psychology: Research and Practice*, *21*(2), 107.

Kaslow, N. J., Rubin, N. J., Bebeau, M. J., Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., & Smith, I. L. (2007). Guiding principles and recommendations for the assessment of competence. *Professional Psychology: Research and Practice*, *38*(5), 441.

Kagle, J. D., & Giebelhausen, P. N. (1994). Dual relationships and professional boundaries. Social Work, 39, 213–220.

Kalé, S. (1996). How national culture, organizational culture and personality impact buyer-seller interactions. *International business negotiations*, 21-37.

Kamtekar, R. (2004). Situationism and virtue ethics on the content of our character. *Ethics, 114(3), 458-491.*

Keith-Spiegel, P., & Koocher, G. P. (1985). Ethics in psychology: Professional standards and cases. New York: Random House.

Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical decisions in counseling psychology. *The Counseling Psychologist*, *12*(3), 43-55.

Landau, R., & Osmo, R. (2003). Professional and personal hierarchies of ethical principles. *International Journal of Social Welfare*, *12*(1), 42-49.

Lazarus, A. A. (1998). How do you like these boundaries? *The Clinical Psychologist, 51,* 22–25.

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

Lundeberg, M. A., Fox, P. W., & Punćcohaŕ, J. (1994). Highly confident but wrong: Genderdifferences and similarities in confidence judgments. *Journal of educational psychology*, *86*(1), 114.

Marques, P. A., & Azevedo-Pereira, J. (2009). Ethical ideology and ethical judgments in the Portuguese accounting profession. *Journal of Business Ethics*, *86*(2), 227-242.

May, W. F. (1984). The virtues in a professional setting. *Soundings, 67,* 245-266.

McGrath, R. E. (2017). The VIA assessment suite for adults: development and initial evaluation. *VIA Institute on Character.*

Mercer, S. W., & Reynolds, W. J. (2002). Empathy and quality of care. *British Journal of General Practice, 52*

Minton, H. L., Schneider, F. W., & Wrightsman, L. S. (1980). *Differential psychology, Brooks.* Cole Publishing Company.

Moleski, S. M., & Kiselica, M. S. (2005). Dual relationships: A continuum ranging from the destructive to the therapeutic. *Journal of Counseling & Development*, *83*(1), 3-11.

Nagy, Thomas F. (2011). Essential ethics for psychologists: A primer for understanding and mastering core issues, (pp. 127-144).

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). *Process and outcome in psychotherapy: Noch einmal.* In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (p. 270–376). John Wiley & Sons.

Page, K. (2012). The four principles: Can they be measured and do they predict ethical decision making?. *BMC medical ethics*, *13*(1), 10.

Pols, H., & Oak, S. (2007). War & military mental health: The US psychiatric response in the 20th century. *American Journal of Public Health*, *97*(12), 2132-2142.

Pope, K. S. (1988). Dual relationships: A source of ethical, legal and chemical problems. Independent Practitioner, 8, 17-25.

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

Pope, K. S., & Vasquez, M. J. (2016). *Ethics in psychotherapy and counseling: A practical guide*. John Wiley & Sons.

Powell, G., 1990. One more time: Do male and female managers differ? Academy of Management Executive 4 (3), 68 75.

Powell, M., & Ansic, D. (1997). Gender differences in risk behaviour in financial decision making: An experimental analysis. *Journal of economic psychology*, *18*(6), 605-628.

Rest, J. R. (1979). Development in judging moral issues. Minneapolis, MN: University.

Rest, J. R. (1983). Morality. *Handbook of child psychology*, *3*, 556-629.

Rest, J. R. (1986). Moral development: Advances in research and theory. *New York: Praeger.*

Ransohoff, P. M. (2010). Ethics education in psychoanalytic training: A survey. *Journal of the American Psychoanalytic Association*, *58*(1), 83-99.

Roberts, T. A. (1991). Gender and the influence of evaluations on self-assessments in achievement settings. *Psychological bulletin*, *109*(2), 297.

Roberson, L., & Kulik, C. T. (2007). Stereotype threat at work. *Academy of Management Perspectives*, *21*(2), 24-40.

Rønnestad, M. H., & Skovholt, T. M. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development*, *30*(1), 45-58.

Rosenkrantz, P., Vogel, S., Bee, H., Broverman, I., & Broverman, D. M. (1968). Sex-role stereotypes and self-concepts in college students. *Journal of consulting and clinicalpsychology*, *32*(3), 287.

Ross, W. D. (1988). The right and the good (1930). *Digital Text International*.

Ryder, R., & Hepworth, J. (1990). AAMFT ethical code: "Dual relationships". *Journal of Marital and Family Therapy*, *16*(2), 127-132.

Sargent, A. (1981). The androgynous manager. New York: AMACOM.

Schwartz-Mette, R. A., & Shen-Miller, D. S. (2018). Ships in the rising sea? Changes over time in psychologists' ethical beliefs and behaviors. *Ethics & Behavior*, *28*(3), 176-198.

Sell, J. M., Gottlieb, M. C, & Schoenfeld, L. (1986). Ethical considerations of social/romantic relationships with present and former clients. Professional Psychology: Research and Practice, 17, 504-508.

Sileo, F. J., & Kopala, M. (1993). An A-B-C-D-E Worksheet for Promoting Beneficence When Considering Ethical Issues. *Counseling and Values*, *37*(2), 89-95.

Skitka, L. J., & Maslach, C. (1996). Gender as schematic category: A role construct approach. *Social Behavior and Personality: an international journal*, *24*(1), 53 73.

Smith, D., & Fitzpatrick, M. (1995). Patient–therapist boundary issues: An integrative review of theory and research. Professional Psychology: Research and Practice, 26, 499–506.

Smith, H. R., & Carroll, A. B. (1984). Organizational ethics: A stacked deck. *Journal of Business Ethics*, *3*(2), 95-100.

Sonne, J. L. (1994). Multiple relationships: Does the new ethics code answer the right questions?. *Professional Psychology: Research and Practice*, 25(4), 336.

Sonne, J. L. (2006). Nonsexual multiple relationships: A practical decision-making model for clinicians. *The Independent Practitioner,* Fall 187-192

Sonne, J.L.& Weniger, J.L. (2018). Ethical clinical practice: Negotiating a whole lot of gray in a wise way. In Butcher, J.N., Hooley, J.M., & Kendall, P.C. (Eds.) *APA handbook of psychopathology* (pp. 729-749). Washington, DC: American Psychological Association.

Spence, J. T., Helmreich, R. L., & Stapp, J. (1974). *The Personal Attributes Questionnaire: A measure of sex role stereotypes and masculinity-femininity*. University of Texas. Spielthenner, G. (2017). Virtue-based approaches to professional ethics: A plea for more rigorous use of empirical science. *Ethic-An International Journal for Moral Philosophy*, *16*(1), 15-34.

Stadler, H. A. (1986). Making hard choices: Clarifying controversial ethical issues. *Counseling & Human Development,* 19, 1-10.

Steele, C. M., & Aronson, J. (1995). Stereotype threat and the intellectual test performance of African Americans. *Journal of personality and social psychology*, *69*(5), 797.

Stein, A. H., & Bailey, M. M. (1973). The socialization of achievement orientation in females. *Psychological Bulletin*, *80*(5), 345.

Stockard, J., Van De Kragt, A. J., & Dodge, P. J. (1988). Gender roles and behavior in social dilemmas: Are there sex differences in cooperation and in its justification?. *Social Psychology Quarterly*, 154-163.

Street, M. D., Douglas, S. C., Geiger, S. W., & Martinko, M. J. (2001). The impact of cognitive expenditure on the ethical decision-making process: The cognitive elaboration model. Organizational Behavior and Human Decision Processes, 86, 256-277.

Suhler, C. L., & Churchland, P. (2011). Can innate, modular "foundations" explain morality? Challenges for Haidt's moral foundations theory. *Journal of cognitive neuroscience*, *23*(9), 2103-2116.

Tallman, G. (1981). Therapist-client social relationships. Unpublished manuscript, California State University, Northridge.

Tate, C. C., Youssef, C. P., & Bettergarcia, J. N. (2014). Integrating the study of transgender spectrum and cisgender experiences of self-categorization from a personality perspective. *Review of General Psychology*, *18*(4), 302-312.

Trevino, L. K. (1986). Ethical decision making in organizations: A person-situation interactionist model. *Academy of management Review*, *11*(3), 601-617.

U.S. Census Bureau. (2005-2013). American Community Survey 1-Year PUMS file.

Van Anders, S. M. (2015). Beyond sexual orientation: Integrating gender/sex and diverse sexualities via sexual configurations theory. *Archives of Sexual Behavior, 44*(5), 1177 1213.

Van Hooft, S. (1996). Bioethics and caring. *Journal of Medical Ethics*, *22*(2), 83-89.

Venkatesh, V., Morris, M. G., & Ackerman, P. L. (2000). A longitudinal field investigation of gender differences in individual technology adoption decision-making processes. *Organizational behavior and human decision processes, 83*(1), 33-60.

Vitell, S. J., Nwachukwu, S. L., & Barnes, J. H. (1993). The effects of culture on ethical decision-making: An application of Hofstede's typology. *Journal of business ethics*, *12*(10), 753-760.

Wilde, A., & Diekman, A. B. (2005). Cross-cultural similarities and differences in dynamic stereotypes: A Comparison Between Germany and the United States. *Psychology of Women Quarterly*, *29*(2), 188-196.

Williams, M. H. (1997). Boundary violations: Do some contended standards of care fail to encompass commonplace procedures of humanistic, behavioral, and eclectic psychotherapies?. *Psychotherapy: Theory, Research, Practice, Training*, *34*(3), 238.

Wood, W., Christensen, P. N., Hebl, M. R., & Rothgerber, H. (1997). Conformity to sex typed norms, affect, and the self-concept. *Journal of personality and social psychology*, *73*(3), 523.

You, D., Maeda, Y., & Bebeau, M. J. (2011). Gender differences in moral sensitivity: A meta analysis. *Ethics & Behavior*, *21*(4), 263-282.

Younggren, J. N., & Gottlieb, M. C. (2004). Managing risk when contemplating multiple relationships. *Professional Psychology: Research and Practice*, *35*(3), 255.

Zur, O. (2001). Out-of-office experience: When crossing office boundaries and engaging in dual relationships are clinically beneficial and ethically sound. *The Independent Practitioner*, 21, 96–98.

Zur, O. (2004). To cross or not to cross: Do boundaries in therapy protect or harm. *PsychotherapyBulletin*, *39*(3), 27-32.

APPENDIX A

Email to Participants

My name is Nikki Patel and I am a Ph.D. clinical psychology graduate student in the Department of Psychology at Loma Linda University. Please consider helping me with my dissertation research study investigating therapist and client factors that affect decision-making in clinical practice.

- Participation is expected to take only about 15 - 25 minutes of your time.
- I am recruiting doctoral-level clinical psychologists (Ph.D. or Psy.D.), and masters-level or doctoral-level Marriage and Family Therapists (MFT or DMFT), who are U.S.-licensed therapists and see adult therapy patients to participate in my dissertation study, chaired by Dr. Janet Sonne.
- We are also offering the opportunity to win one of three $50 Amazon gift cards regardless of whether or not you choose to participate in my dissertation study!

Here is the link to the study: Qualtrics Link

Whether you are able to complete the survey or not, I also ask that you forward this recruitment post to as many of your colleagues who fit the inclusion criteria as you are comfortable with, in-state and out-of-state, and ask them to complete the survey and/or forward it to some of their colleagues (who fit the inclusion criteria).
To enter the drawing for one of three $50 Amazon gift cards, please email me before September 1, 2019 at nipatel@llu.edu with "DRAWING" in the subject line and state that you would like to enter. I will then email the Amazon gift card code to the three winners no later than September 15, 2019. This study has been approved by Loma Linda University's IRB.
Thank you so much for your time,
Nikki Patel, M.A.

APPENDIX B

Social Media Recruitment Post

I am a Ph.D. clinical psychology graduate student recruiting doctoral-level clinical psychologists (Ph.D. or Psy.D), and masters-level or doctoral-level Marriage and Family Therapists (MFT or DMFT), who are U.S.-licensed therapists and see adult therapy patients to participate in my dissertation survey study, chaired by Dr. Janet Sonne. Participation is expected to take only about 15 – 25 minutes of your time.
We are also offering the opportunity to win one of three $50 Amazon gift cards regardless of whether or not you choose to participate in my dissertation study!
Survey questions will examine therapist and client factors that affect decision-making in clinical practice.
Here is the link to the study: Qualtrics Link
To enter for one of three $50 Amazon gift cards, , please email me before September 1, 2019 at nipatel@llu.edu with "DRAWING" in the subject line and state that you would like to enter this drawing. I will then email the Amazon gift card code to the three winners no later than September 15, 2019.
This study has been approved by Loma Linda University's IRB.
Thank you for your time,
Nikki Patel, M.A

APPENDIX C

Informed Consent

INFORMED CONSENT
TITLE: Therapist and Client Factors Involved in Clinical Decision-Making
SPONSOR: LLU Department of Psychology
PRINCIPAL
INVESTIGATOR: Janet Sonne, Ph.D.

WHY IS THIS STUDY BEING DONE?
The purpose of the study is to examine how different therapist and client factors affect licensed clinical psychologists' and marriage and family therapists' clinical decision-making regarding a current adult client. You are invited to participate in this study if you hold a doctoral degree (Ph.D. or Psy.D.) in Clinical Psychology or a Master's or Doctoral degree in Marriage and Family Therapy (MFT or DMFT), have a current license or certification to practice in good standing in at least one U.S. state, and currently see adult clients in psychotherapy. We hope to recruit at least 263 participants.

HOW WILL I BE INVOLVED?
Once you have given informed consent, participation in this study involves your completion and submission of an online demographic questionnaire, review of a brief vignette, response to one follow-up question, and completion of three brief questionnaires. The total time expected for completion of all parts of the study is about 15 - 25 minutes. You may also elect to voluntarily enter a drawing for one of three $50 Amazon gift cards regardless whether or not you decide to participate in or complete the study, as described in our recruitment post.

WHAT ARE THE REASONABLY FORESEEABLE RISKS OR DISCOMFORTS I MIGHT HAVE?
Participating in this study exposes you to minimal risk. This study poses no greater risk to you than what you would routinely encounter in daily life. We will be asking some potentially sensitive questions about your personal characteristics, your experience as a therapist and your clinical decision-making with an adult psychotherapy client presented in a vignette in which you are asked to assume the role as the therapist. As such you may experience some discomfort as you consider and submit your responses.

We have taken the following precautions to mitigate the possibility of your discomfort as you respond to the survey. First, you have the right to refuse to answer any question you choose not to answer. And, you may withdraw from the study at any time.

Second, we have engaged a number of safeguards to protect the confidentiality of your responses. Your online survey responses are not linked to any information regarding your identity (e.g., name, email address, etc.), and you are not asked to provide any specific

identifying information apart from the questions asked in the general demographic information (e.g., gender, location, degree, etc.). The survey platform (Qualtrics) is configured so as to automatically delete location data and IP addresses; this is accomplished via activating an "Anonymize Responses" option for this survey.

If you decide to enter the drawing for one of three $50 Amazon gift cards and voluntarily choose to submit your email address to the student investigator as described in the recruitment post, neither your email nor email address will be linked in any way to your survey responses should you participate in the study, nor used for any other purpose other than to notify you that you have won an Amazon gift card. Your survey responses and your email and email address will be securely and separately stored in electronic password-protected files stored on a Loma Linda University-based drive. No hard copies of survey results or email address entries will be made or distributed. All emails and email addresses will be deleted from the student investigator's computer files immediately following notification of the winners of the results of the drawing. All survey data will be kept for 3 years after the completion of the study.

In addition, the survey answers you provide will be analyzed only in combination with other participants' answers. As such, any publications or presentations that result from this research project will be based only on analyses of the group results.

WILL THERE BE ANY BENEFIT TO ME OR OTHERS?

Regardless of whether you participate in or complete the study, you may elect to voluntarily enter a drawing for one of three $50 Amazon gift cards. Entry in the drawing is completely voluntary. If you choose to enter the drawing, you may send an email to the student investigator Nikki Patel at nipatel@llu.edu, before September 1, 2019. If you are one of three gift card winners, you will be emailed the code for the Amazon gift card by the student investigator from nipatel@llu.edu by September 15, 2019. Your email address will not be used for any purpose other than notifying you that you have won a gift card. Your email and email address will be securely stored and not linked in any way to your responses on the online survey should you decide to participate. Further, your email to the student investigator and your email address will be deleted from the student investigator's files at the end of the drawing.

Other than that, you may not directly benefit from participation in this study. However, the findings of this study may benefit the field of clinical psychology and marriage and family therapy therapists and clients by informing decision-making among licensed clinical psychologists and marriage and family therapists who provide psychotherapy services to adult patients.

WHAT ARE MY RIGHTS AS A SUBJECT?

Your participation in this study and your entry into the drawing are separate, and each entirely voluntary. You may refuse to participate at the outset of this study. You may

refuse to answer any questions in the study that you do not wish to answer. And, you may withdraw from the study at any time once the study has started. Regardless of whether or not you participate in the study, you may choose to enter the drawing or you may choose not to. You may also print a copy of this Informed Consent Form.

WHAT COSTS ARE INVOLVED?
There is no cost to you for participating in this study.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?
You will not be paid to participate in this research study.

WHO DO I CALL IF I HAVE QUESTIONS?
If you have questions about this research study, please contact the graduate student investigator, Nikki Patel, at (951) 741-4188 or email at nipatel@llu.edu. You may also contact the Research Committee Chair, Dr. Janet Sonne, at (909) 214-4327 or at jsonne@llu.edu.

Last, if you would like to contact an impartial third party who is not associated or connected with this study regarding concerns you have about this study, please contact the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda CA 92354 by emailing patientrelations@llu.edu or calling (909) 558-4647.

PARTICIPANT'S STATEMENT OF INFORMED CONSENT
I have read the contents of this consent form, which is in English, a language that I read and understand. If I had any questions concerning this study, they have been answered to my satisfaction. I have also been provided the option to print a copy of this informed consent form.

I hereby give my voluntary consent to participate in this study. I understand that proceeding to the online questionnaires associated with the study acknowledges my passive consent to participate. This does not waive my rights, nor does it release the investigators or the institution from their responsibilities. I may call or email Dr. Janet Sonne (909-214-4327; jsonne@llu.edu) if I have additional questions or concerns.

APPENDIX D

Demographics Questionnaire

1. What is your gender?
    - Female
    - Male
    - Non-Binary
    - Transgender Male to Female
    - Transgender Female to Male
    - Genderfluid
    - Uncertain
    - Other
2. What is your age (in years)?
    - Please type in your age:
3. What is your ethnic background?
    - American Indian or Alaska Native
    - Asian/Southeast Asia or Far East
    - Asian/Indian Subcontinent
    - Middle Eastern
    - Black or African American
    - Hispanic or Latino
    - Native Hawaiian or Other Pacific Islander
    - White or Caucasian
    - Mixed
    - Other
4. What is your current religious affiliation?
    - Agnosticism
    - Atheism
    - Buddhism
    - Catholicism
    - Christianity
    - Humanism
    - Hinduism
    - Islam
    - Jainism
    - Judaism
    - Sikhism
    - Other
1. What is your most advanced degree in a mental health field (e.g., LMFT, DMFT, Ph.D., Psy.D.) Please type your answer below.

    _____
2. Are you currently licensed or certified to conduct psychotherapy in your state?
    - Yes

No

3. If you are currently licensed or certified to conduct psychotherapy, in what state/states are you licensed or certified? (Write "NA" if you are not currently licensed or certified).

   _____

4. Have you ever been sanctioned by a state licensing or certification board?
   Yes
   No
5. Has your license or certification ever been suspended (put on probation) by a state licensing or certification board?
   Yes
   No
6. Has your license or certification ever been revoked by a state licensing or certification board?
   Yes
   No
7. Are you currently engaged in a clinical practice in which you see adult patients in psychotherapy?
   Yes
   No
8. What is the geographical context of your clinical practice?
   Urban
   Suburban
   Rural
   Military Base
   Other
9. Over the course of your career to date since graduate school, approximately how many face-to-face hours have you accumulated with adult patients in psychotherapy in all contexts in which you have worked?

   _____

10. What theoretical orientation do you use as a foundation for conceptualizing your adult therapy patients regardless of the actual interventions you use?
    Cognitive-Behavioral (including CBT and DBT)
    Emotion-Focused
    Gestalt
    Humanistic
    Jungian
    Psychodynamic
    Psychoanalytic
    Religious-based
    Other

APPENDIX E

Vignette A and Related Question

Imagine that you are the therapist for the client described below. You are seeing the client in your private practice. Please read the following vignette and then respond to the question that follow.

Vignette 1:
M. is a 25-year-old man whom you have been seeing in individual psychotherapy for four months. M. is a first-year internal medicine resident at a local medical school. He entered therapy due to his difficulty coping with his older brother's sudden death. He has reported to you that his brother had a history of drug and alcohol abuse. He indicated that following his brother's death he has had recurring dreams of his brother choking him and has often felt faint after waking up from the dream. M. told you that he fears that his brother may have tried to hurt him when they were younger, but that he has repressed a clear memory of the event. He expressed concern that now that his brother is gone, he will never be able to confront him and confirm or disconfirm his fear. In the process of working with M. you have noticed that he often appears to have difficulty identifying his emotional responses and sharing with you his feelings. When he came in to see you yesterday, M. noticed that you were suffering from a severe nasal congestion and a cough. At the end of the session, M. expressed to you that as a physician he could prescribe an antibiotic to help relieve you of your symptoms. That discussion led to his disclosure that he recently prescribed himself a sedative for his insomnia.

1. As you reflect on this session with your client and prepare to make a note in her chart, what issues (if any) were raised for you in your interaction with the client? Please number each issue: #1, #2, #3, #4, etc.:

APPENDIX F

Vignette B and Related Question

Imagine that you are the therapist for the client described below. You are seeing the client in your private practice. Please read the following vignette and then respond to the question that follow.

Vignette 1:
M. is a 25-year-old woman whom you have been seeing in individual psychotherapy for four months. M. is a first-year internal medicine resident at a local medical school. She entered therapy due to his difficulty coping with his older brother's sudden death. She has reported to you that her brother had a history of drug and alcohol abuse. She indicated that following her brother's death she has had recurring dreams of her brother choking her and has often felt faint after waking up from the dream. M. told you that she fears that her brother may have tried to hurt her when they were younger, but that she has repressed a clear memory of the event. She expressed concern that now that her brother is gone, she will never be able to confront him and confirm or disconfirm her fear. In the process of working with M. you have noticed that she often appears to have difficulty identifying her emotional responses and sharing with you her feelings. When she came in to see you yesterday, M. noticed that you were suffering from a severe nasal congestion and a cough. At the end of the session, M. expressed to you that as a physician she could prescribe an antibiotic to help relieve you of your symptoms. That discussion led to her disclosure that she recently prescribed herself a sedative for her insomnia.

1. As you reflect on this session with your client and prepare to make a note in his chart, what issues (if any) were raised for you in your interaction with the client? Please number each issue: #1, #2, #3, #4, etc.:

APPENDIX G

Personal Attributes Questionnaire

(Spence, Helmreich & Stapp, 1973)

Instructions:

The items below inquire about what kind of person you think you are. Each item consists of a PAIR of characteristics, with the letters A-E in between. For example

Not at all artistic A.....B.....C.....D.....E Very artistic

Each pair describes contradictory characteristics - that is, you cannot be both at the same time, such as very artistic and not at all artistic.

The letters form a scale between the two extremes. You are to choose a letter that describes where you fall on the scale. For example, if you think that you have no artistic ability, you would choose A. If you think that you are pretty good, you might choose D. If you are only medium, you might choose C, and so forth.

1. Not at all aggressive	A.....B.....C.....D.....E	Very aggressive
2. Not at all independent	A.....B.....C.....D.....E	Very independent
3. Not at all emotional	A.....B.....C.....D.....E	Very emotional
4. Very submissive	A.....B.....C.....D.....E	Very dominant
5. Not at all excitable in a crisis	A.....B.....C.....D.....E	Very excitable in a major crisis
6. Very passive	A.....B.....C.....D.....E	Very active
7. Not at all able to devote self completely to others	A.....B.....C.....D.....E	Able to devote self completely to others
8. Very rough	A.....B.....C.....D.....E	Very gentle
9. Not at all helpful to others	A.....B.....C.....D.....E	Very helpful to others
10. Not at all competitive	A.....B.....C.....D.....E	Very competitive
11. Very home oriented	A.....B.....C.....D.....E	Very worldly
12. Not at all kind	A.....B.....C.....D.....E	Very kind
13. Indifferent to others approval	A.....B.....C.....D.....E	Highly needful of others approval
14. Feelings not easily hurt	A.....B.....C.....D.....E	Feelings easily hurt
15. Not at all aware of feelings of others	A.....B.....C.....D.....E	Very aware of feelings of others
16. Can make decisions easily	A.....B.....C.....D.....E	Has difficulty making decisions
17. Gives up very easily	A.....B.....C.....D.....E	Never gives up easily
18. Never cries	A.....B.....C.....D.....E	Cries very easily

19.	Not at all self-confident	A.....B.....C.....D.....E	Very self-confident
20.	Feels very inferior	A.....B.....C.....D.....E	Feels very superior
21.	Not at all understanding of others	A.....B.....C.....D.....E	Very understanding of others
22.	Very cold in relations with others	A.....B.....C.....D.....E	Very warm in relations with others
23.	Very little need for security	A.....B.....C.....D.....E	Very strong need for security
24.	Goes to pieces under pressure	A.....B.....C.....D.....E	Stands up well under pressure

APPENDIX H

VIA-IS-V3 Survey
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VIA-IS-V3 Directions:
Please choose one option in response to each statement. All of the questions reflect statements that many people would find desirable, but we want you to answer only in terms of whether the statement describes what you are like. Please be honest and accurate!

1. I am always coming up with new ways to do things.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

2. I always treat people fairly whether I like them or not.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

3. I have a hard time finishing what I start.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

4. It is easy for me to stay disciplined.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

5. I leave a lot of tasks incomplete.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me

5- Very Much Like Me

6. Without exception, I support my teammates or fellow group members.
   1- Very Much Unlike Me
   2- Unlike Me
   3- Neutral
   4- Like Me
   5- Very Much Like Me

7. I am not someone who comes up with new and different ideas.
   1- Very Much Unlike Me
   2- Unlike Me
   3- Neutral
   4- Like Me
   5- Very Much Like Me

8. I am a vengeful person.
   1- Very Much Unlike Me
   2- Unlike Me
   3- Neutral
   4- Like Me
   5- Very Much Like Me

9. I never miss the chance to learn something new.
   1- Very Much Unlike Me
   2- Unlike Me
   3- Neutral
   4- Like Me
   5- Very Much Like Me

10. I am good at expressing love to someone else.
   1- Very Much Unlike Me
   2- Unlike Me
   3- Neutral
   4- Like Me
   5- Very Much Like Me

11. My friends say that I have lots of new and different ideas.
   1- Very Much Unlike Me
   2- Unlike Me
   3- Neutral
   4- Like Me
   5- Very Much Like Me

12. It's hard to find things that interest me.

1- Very Much Unlike Me
2- Unlike Me
3- Neutral
4- Like Me
5- Very Much Like Me

13. I love to learn new things.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

14. I always think about the consequences before I act.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

15. I am good at finishing tasks even when I want to stop.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

16. Even if I do not like someone, I treat him or her fairly.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

17. I always try to help people in need.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

18. I lack self-discipline.
    1- Very Much Unlike Me
    2- Unlike Me

3- Neutral
4- Like Me
5- Very Much Like Me

19. I am always willing to give someone a chance to make amends.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

20. I always finish what I start.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

21. I think through the consequences every time before I act.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

22. I am always curious about the world.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

23. It is difficult for me to express my love to others.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral
    4- Like Me
    5- Very Much Like Me

24. I rarely explore new things.
    1- Very Much Unlike Me
    2- Unlike Me
    3- Neutral

4- Like Me
5- Very Much Like Me

APPENDIX I

Relative Allegiance to General Ethical Principles

Clinicians often guide their clinical practice decisions based on general ethical principles. While most clinicians would acknowledge that all of the principles are important in their decision-making, it is likely that clinicians have some sense of their relative importance in their everyday professional practice.

Please rank in order the relative importance of the general ethical principles listed below in your clinical work, with 1 being the most important, and 7 being the least important. Although many therapists may rank some or all of these moral values as equally important, please do your best to give each one only one ranking.

- **Beneficence:** asserts that an individual acts with mercy and kindness based on the compassionate response to others (desire to help) to promote the other's welfare
- **Nonmaleficence:** asserts that an individual commits to not inflict harm on others
- **Respecting patient rights (including autonomy) and dignity:** asserts that an individual has a duty to respect the freedom and dignity of others to do as they choose as long as they do not infringe on the rights of others
- **Justice:** asserts that an individual has a duty to treat all others fairly
- **Integrity:** asserts that an individual practices with honesty, accuracy, and consistent moral behavior
- **Individual responsibility:** asserts that an individual has personal accountability for their judgments and behavior
- **Professional and Scientific Responsibility to Society:** asserts that an individual has a duty to honor responsibility to public at large (general beneficence).

1 - most important	
2	
3	
4	
5	
6	
7 - least important	

APPENDIX J

Rules for Scoring Responses to the Vignettes
Jochia's (2011) Scoring Guide

Definition of Multiple Relationship:
(a) 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 a relationship with a person closely associated with or related to the person with whom the psychologist has 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. (Principle 3.05)

Rules for Scoring:

A score of **4** will be given if:

- The subject indicates explicitly the potential for a dual or multiple relationship between the therapist and the client.
- The subject indicates explicitly the potential for the therapist or the client to take on additional roles different from those in the therapeutic relationship (e.g., the client becomes a friend; the client runs an errand; the therapist becomes a landlord for the client).
- The subject indicates explicitly the potential for the blurring or confusion or exchange of roles between the therapist and the client (e.g., the client taking care of the therapist; the therapist getting his or her needs met by the client).

A score of **3** will be given if:

- The subject recognizes a boundary issue, but does not explicitly indicate the potential for a dual or multiple relationship.
- The subject recognizes a boundary issue, but does not explicitly indicate the potential for the addition of roles beyond those of therapist and client.
- The subject recognizes a boundary issue, but does not explicitly indicate the potential for the blurring, confusion, or exchange of therapist/client roles.

A score of **2** will be given if:

- The subject recognizes an ethical issue, but does not explicitly indicate the potential for a dual or multiple relationship.
- The subject recognizes an ethical issue, but does not explicitly indicate the potential for the addition of roles beyond those of therapist and client.
- The subject recognizes an ethical issue, but does not explicitly indicate the potential for the blurring, confusion, or exchange of therapist/client roles.

A score of **1** will be given if:

- The subject indicates an action by the client or therapist that appears to cross a boundary (e.g., giving a gift), but does not explicitly indicate the potential for a dual or multiple relationship.
- The subject indicates an action by the client or therapist that appears to cross a boundary, but does not explicitly indicate the potential for the addition of roles beyond those of therapist and client.
- The subject indicates an action by the client or therapist that appears to cross a boundary, but does not explicitly indicate the potential for the blurring, confusion, or exchange of therapist/client roles.

A score of **0** will be given if:

- The subject fails to recognize any of the above dual or multiple relationship, role addition, confusion, blurring or exchange, boundary issues, or ethical issues between the therapist and client, and fails to indicate any action by the client or therapist that appears to cross a boundary (e.g., the subject indicates relationship issues between the client and people other than the therapist, as in domestic violence or possible sexual abuse).

APPENDIX K

Social Media Groups

AATBS MFT and Counseling
ACT for ABA Practitioners
ACT Made Simple - Acceptance & Commitment Therapy for Practitioners
Addiction Therapists Group
APA ATI in Research Methods with Diverse Racial & Ethnic Groups Alumni
APA Division 45
APA Division 7 - Developmental Psychology
Asian American Psychology Student Association (AAPSA)
Ask a Therapist – Reddit
Association for the Psychoanalysis of Culture and Society
Attachment-Based Therapists
Austin Mental Health Professionals
AZ Mental Health Professionals
AZ Private Practice - LPC, LMFT & LCSW's
Bay Area MFT/PsyD & PhD Collective
Become a More Effective Therapist
California Licensed Psychologists
California Psychotherapists in Private Practice
CBT – Reddit
CBT Practitioner Network
Christian Counselors in Private Practice
Christian therapists
Clinicians of Color in Private Practice
Cognitive Behavior Therapy
Contextual Behavioral Science (CBS)
Counselling and Psychotherapy Networking
Counsellors & Psychotherapists Worldwide
CSULB Marriage and Family Therapy
DC Therapist Connect
Division on South Asian Americans (DoSAA)
Early Career Feminist Psychologists
East Texas Therapy Network
EMDR Therapist Resources
Emotion-Focused Family Therapy (EFFT)
Filipino American Mental Health Professionals
Florida Mental Health Professionals
Florida Therapist Network (Mental Health Counselors)
Florida Therapists in Private Practice and Referral Resources
Greater Houston Mental Health Professionals
IFS (Internal Family Systems) Community Group
IPA in Health. International psychoanalytical

LA Therapists (Psychotherapists, Psychologist, LCSW)
Latinx Counselors & Therapists
Latinx Doctoral Psychology Students and Early-Career Psychologists
Latinx Therapists
LGBQIA and Trans Affirming Therapists
LGBTQ-Affirming Mental Health Resources
LMFT Competency Group
LPC, LMFT, Psychology & Social Work Professionals
Marriage and Family Therapist Book Exchange
The Site for Contemporary Psychoanalysis
Therapists – Reddit
Therapy – Reddit
Marriage and Family Therapists of Washington State
Marriage and Family Therapists
Melanin & Mental Health Professionals
Mental health professionals
Mental Health Professionals of Fairfield County, CT
MFT & PCC: Dual licensure in California
MFT Guide
MFT Resource Group
Midsouth Therapist Network Page
MilSpouse Network for Mental Health Professionals
Mindfulness Practitioners of Color
Mississippi Mental and Behavioral Health Professionals
MN LGBTQ+ Therapists Network
Montana Mental Health Professionals
Muslim Mental Health Professionals and Students
My Private Practice Collective
DC Therapist Connect
Nevada Association of School Psychologists (NVASP)
North Texas Therapists Network
NYC Area therapists in private practice
Omaha Therapist Network (OTN)
Online Psychologist
Online Therapists of Texas
Orange County Shrinks Clinical Group
Play Therapy and EMDR Therapy Conversations
Professional Mental Health Counselors, Social Workers, & Psychologists
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Psychotherapist Training Resource Page
Psychotherapy: Cognitive Behavioral Therapy within an Integrative Approach
Real Therapists Of New York And New Jersey

Resilience Based Psychotherapists - Supporting Families in Tough Times
Respectful Relationships ~ Therapists & Counselors
SD Mental Health Professionals
Self Care for Therapists
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The Couples Therapist Couch
The Modern Therapists Group
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The Testing Psychologist Community
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Therapist and Educators Market Place Buy/Sell/ Trade
Therapists in Corvallis & Albany
Therapists in Private Practice (TIPP)
Therapists Support LGBTQ in OC
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- Louisiana Psychological Association
- Minnesota Psychological Association
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- New Hampshire Psychological Association
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- New York State Psychological Association
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- Texas Psychological Association
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