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Effects of the dimensions of nonsexual multiple role relationships on the former clients' perception of the counselor and the counseling situation

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Signatures have been redacted for privacy

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CHAPTER 1. INTRODUCTION

Importance of the Study

The issue of *nonsexual multiple role relationships** (NMRR) is one of the most controversial current ethical problems in counseling and psychotherapy. NMRR occur when a psychologist and a client are involved in concurrent or sequential relationships that involve both counseling and another relationship, such as social, professional, or business interactions. One of the salient issues in this area is whether multiple roles are harmful for a client and therapeutic process. The American Psychological Association (APA) as well as other professional organizations, such as National Association of Social Workers, do not provide their members with explicit guidance on this matter. However, the most recent APA Ethics Code (American Psychological Association, 2002) contains three standards relevant to NMRR. They are Ethical Standards 3.05, 3.06, 3.08. However, the only explicit guidance is presented in Ethical Standard 3.05. The following are the excerpts from this standard.

3.05 Multiple Relationships.

(a) ...A psychologist refrains from entering into 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...

Multiple relationships that would not reasonably be expected to cause impairment

* multiple relationships, dual relationships, multiple role relationships, dual role relationships are synonyms; they are used interchangeably in the text

> or risk exploitation or harm are not unethical (American Psychological Association, 2002, p. 1065).

As we see from the citation, this ethical standard has rather vague formulations that may not be helpful for practitioners trying to make a decision concerning particular client.

Moreover, scholars have expressed varied opinions concerning these complex issues. Some believe that these relationships have great potential for harm and therefore have to be avoided whenever possible (Gabbard, 1994; Gottlieb, 1994; Pope and Vasquez, 1991). Other scholars think that although there is some potential for harm rooted in these relationships, multiple roles may benefit clients and enrich therapy (Lazarus, 1994; Ebert, 1997; Zur, 2001).

Past research in this area focused primarily on psychologists and their beliefs (Pope, Tabachnick, Keith-Spiegel, 1987; Borys, Pope, 1989; Anderson & Kitchener, 1996; Gottlieb, Sell, Schoenfeld, 1988; Sharkin, Birky, 1992). However, what clients and former clients think about nonsexual multiple roles, and how they view these relationships is unknown. We think that exploration of clients' perspectives, thoughts, and attitudes towards multiple role relationships is important. Such an exploration could potentially help address the question of whether and when multiple roles are harmful. Thus, the proposed research will be one of the first studies focusing on former clients' perspectives on NMRR.

Rationale for the Study

There are very few studies that have assessed clients' or former clients' perspectives on NMRR. One of the most salient ethical and therapeutic considerations is whether these relationships are beneficial or harmful for clients. From our perspective, this question cannot be answered without knowing clients' views and feelings related to NMRR. We suggest that

it is important to know: (a) whether views of former clients and clients on these relationships are homogeneous; (b) the factors that may influence these views and feelings.

Analyses of clinicians' writings about NMRR and cases presented in literature suggest that there exist at least two different dimensions of NMRR:

1. The *objective dimension* concerns behaviors of a psychologist and/or a client. The examples of these behaviors are: socializing together, going out for lunch, and conducting joint business. The discussion of acceptable and non-acceptable behaviors focuses on objective dimension of NMRR. Often when scholars write about boundary crossings and violations, they refer to objective dimension.
2. The *subjective dimension* refers to clients' and psychologists' reactions to the behaviors constituting multiple role relationships. These reactions may involve their feelings, thoughts and other inner experiences. Feminist therapy writers often refer to this dimension when they talk about dual relationships. However, many other authors who write about NMRR ignore this dimension.

From our perspective, when exploring the question of harmfulness of NMRR, it is important to focus not only on the objective dimensions of these relationships, but on the subjective dimensions as well. We think that one client may feel violated when psychologist acknowledges his/her presence at the social event, while another client may feel safe and secure socializing with psychologist. Given these possibilities, decisions concerning ethicality and/or harmfulness of NMRR, based on only objective appraisal of behavior, may be misleading. However, we do not know which dimension the clients take into account more (or rely solely upon) when deciding whether a psychologist's actions constitutes boundary violation, making decisions to involve themselves in NMRR, or analyzing the consequences

of these relationships. We think that exploration of these dimensions and their influences on clients' attitudes toward multiple role relationships is salient.

Purpose of Investigation

The purpose of our research project is to explore the relationships between the dimensions of NMRR and former clients' reactions to the counseling situation, their perceptions of the counselor, and perception of NMRR.

Research Questions

The following research questions are of interest to us.

1. Do former student clients have more positive reactions to the counseling situation, perceptions of the counselor, and attitude towards NMRR when subjective dimension of the NMRR is positive than when it is negative?
2. Do clients have different reactions to the counseling situation, attitudes towards NMRR and perceptions of a counselor when boundaries are crossed and multiple roles exist (objective dimension) in comparison to the absence of multiple roles?
3. Which dimension of NMRR, objective or subjective, most influences client's perceptions of the counselor, reactions to the counseling situation and attitudes towards NMRR?

Definition of Terms

It is important to note the definitions of the concepts we are preparing to study.

Boundaries or *therapeutic boundaries* refer to the limits in relationship between a client and a counselor (psychologist, psychotherapist, mental health services provider) and reactions to, as well as experiences of the limits by both participants. The limits may vary.

For the purposes of our study, we define these limits as they described by Gutheil & Gabbard (1993). They are role, time, place and space, money, gifts, clothing, self-disclosure, and physical contact. Reactions of participants to these limits may vary as well, ranging from acceptance and respect to offense and failure to understand them.

Nonsexual multiple role relationship (NMRR) refers to psychologist's and client's involvement in the relationship of non-erotic and nonromantic nature concurrent with or sequential to the counseling relationship. The former relationship is often called secondary. It may have social, professional, or business nature. There are two dimensions of NMRR: an objective dimension and a subjective dimension.

The *objective dimension of NMRR* refers to the behaviors exhibited by a psychologist and a client, such as going out for lunch or dinner, spending time with each other outside the scheduled sessions, working together, etc.

The *subjective dimension of NMRR* refers to client's and psychologist's reactions towards these behaviors such as feelings, thoughts, attitudes, etc.

Role boundaries refer to the boundaries that separate roles of a psychologist and a client from any other possible roles. When role boundaries are crossed NMRR develops. Role boundaries have objective and subjective dimensions as well.

We proposed that the dimensions of role boundaries (or NMRR) interact with each other to produce *four different types of role boundaries.*

1. *Blurred* boundaries have positive objective dimension (multiple roles present) and negative subjective dimension (negative client's reaction);
2. *Rigid* boundaries have negative objective dimension (multiple roles absent) and negative subjective dimension (negative client's reaction);

3. *Firm* boundaries have negative objective dimension (multiple roles are absent) and positive subjective dimension (positive client's reaction);
4. *Flexible* boundaries have positive objective dimension (multiple roles are present) and positive subjective dimension (positive client's reaction).

Attitude to NMRR refers to perception of multiple roles in the counseling relationships. It is positive when clients think that multiple roles are appropriate and feel comfortable and positive in situations involving these roles. When clients think of multiple roles as an obstacle and feel uncomfortable or negative towards counseling situations involving multiple roles, then their attitude is negative.

Hypotheses

Reactions to the counseling situation

1. We hypothesize that there will be no significant differences in participants', former counseling clients, reactions to the counseling situation depending on presence or absence of multiple roles.
2. We hypothesize that participants will have significantly different emotional reactions to the counseling situation when the client's reactions to objective dimension of NMRR (present or absent) is positive than when it is negative.

Perceptions of the counselor

3. We hypothesize that participants' perceptions of the counselor will not differ significantly depending on absence or presence of multiple roles in the counseling situation.

4. We hypothesize that participants' perceptions of the counselor will be significantly more positive when client's reactions to the objective dimension of NMRR (presence or absence of multiple roles) are positive than when they are negative.

Attitude towards NMRR

5. We hypothesize that participants will not have significantly different attitudes towards NMRR when multiple roles in the experimental condition are present compared to when they are absent.
6. We hypothesize that participants will have significantly more positive attitudes towards NMRR when multiple roles are present and when clients' reactions are positive, than when multiple roles are present and clients' reactions are negative. Additionally, we think that differences in former clients' attitudes towards NMRR won't be significant when multiple roles are absent.

CHAPTER 2. LITERATURE REVIEW

The Concept of Therapeutic Boundaries

The issue of multiple role relationships (MRR) may be examined from a boundary perspective. In this case, MRR represents a boundary violation or crossing. Multiple authors have presented different views on what are appropriate boundaries in psychotherapeutic relationships, and on how firm they should be (Bennet, Bricklin, VandeCreek,1994; Bridges, 1999; Brown, 1994b; Gutheil & Gabbard, 1993; Lazarus, 1994a, 1998). Authors frequently disagree and debate about the behaviors that constitute a boundary violation and about the firmness of the boundaries.

There exist multiple definitions of therapeutic boundaries (Gutheil & Gabbard, 1993; Smith & Fitzpatrick, 1995). Thus, Smith & Fitzpatrick (1995) describe therapeutic boundaries as "a therapeutic frame which defines a set of roles for the participants in the therapeutic process" (p. 499). According to Gutheil & Gabbard (1993), where the boundary lies depends on the limits that are introduced in the relationship by a psychologist and his/her client. But the responsibility of defining the limits rests with professional. Authors describe some common domains for counseling practice limits. They are: role; time; place and space; money; gifts; clothing; self-disclosure and related matters; physical contact. One has to keep in mind that authors look at the boundaries from psychodynamic perspective. It is important to examine the limits presented by Gutheil & Gabbard (1993) in more detail.

The first limit is role of the psychologist as therapist. It appears that role emerges in the process of discriminating between the psychologist and patient's parents or significant others. Also, it's said that clients may have different needs that contribute in definition of

psychologist's role. They advise, "...it is useful to differentiate between "libidinal demands", which cannot be gratified without entering into ethical transgressions and damaging enactments, and "growth needs", which prevent growth if not gratified to some extent" (p. 191).

The second type of boundary is time. It defines the limits of the session and provides structure for many patients. The beginning and ending of sessions at the agreed upon defined time are important. Starting or stopping late or early both disturb the boundary.

The third limit is place and space. The therapist's office or a room on a hospital unit is obviously the locale for almost all therapy. Common forms of these boundary violations are: sessions during lunch, or sessions in the car. In spite of this strictness, Gutheil & Gabbard (1993) recognize that in some therapeutic approaches they would not be considered as boundary violations. For example, behaviorists often accompany a client in a car, plane, elevator or even public restroom when the focus of treatment is reduction of phobic avoidance.

The fourth type of boundary is money. It defines the business nature of the therapeutic relationship. According to the authors, "some would argue that the fee received by the therapist is the only appropriate and allowable material gratification to be derived from clinical work" (p. 192).

Gifts and services are the other boundaries in therapeutic relationships. If psychologists are supposed to receive money for their work with the clients as the only material gratification, then a gift can be either a boundary crossing or a boundary violation. A related boundary violation is the use of favors or services from the patient for the benefits of the therapist.

Clothing represents a social boundary the transgression of which is usually inappropriate to the therapeutic situation. "Excessively revealing or frankly seductive clothing worn by the therapist may represent a boundary violation with potentially harmful effects to patients" (p. 193).

Self-disclosure is the seventh limit. It represents a complex issue. Occasionally, a therapist may use a neutral example from his/her own life to illustrate the point. Sharing the impact of patient's behavior can also be useful for some patients. However, it's unacceptable for a psychologist to share painful experiences that are too recent or traumatic or are not completely resolved. It is also inadvisable to reveal personal dreams or fantasies, social, sexual or financial details of one's life.

Finally, physical contact is a boundary as well. Gutheil & Gabbard (1993) state, "From the viewpoint of current risk-management principles, a handshake is about the limit of social physical contact" today. (p. 195). The list of boundaries presented by the authors is not exhaustive. One can add to this, for example, not accepting friends and relatives as clients.

These clear-cut limits however, were criticized by different authors (Bridges, 1999; Lazarus, 1994a; Ebert, 1997) for being too rigid and not inclusive of multiple factors that may influence development of boundaries. There exist several difficulties concerning the attempts to define objectively set of limits (therapeutic boundaries) as appropriate for every clinical case. They are:

- diversity of mental health professionals' theoretical orientations and approaches to therapy (Lazarus, 1998; Smith & Fitzpatrick, 1995);
- multicultural factors, such as client's gender, race, SES (Brown, 1994a);
- individual differences among the clients (Lazarus, 1998);

- historical ambiguity about boundaries; for example, mixed messages that were conveyed by some outstanding pioneer therapists (for more details see Gutheil & Gabbard, 1993, p. 189).

In spite of aforementioned difficulties, there exists a need for establishing and maintaining therapeutic boundaries in psychologist-client relationships. Many authors write about importance of boundaries' maintenance (Borys, 1994; Brown, 1994b; Gutheil & Gabbard, 1993; Smith & Fitzpatrick, 1995). Why is maintaining therapeutic boundaries so important? As Borys (1994) states, (1) therapeutic boundaries are an arena "in which critical emotional issues are manifested and worked through" for most clients and problems (p. 267); (2) clear and consistent boundaries are curative factor because they provide structure and safety; (3) "Patients' reactions to the alterations in usual boundaries are often unpredictable ahead of time (even if requested by the patient) and typically complex, ambivalent, and heavily colored by transferrential meaning" (p. 267). Gabbard (1994) adds that guidelines pertinent to maintenance of boundaries were designed "to minimize the opportunity for therapists to use their patients for their own gratification" (p. 283).

In connection with boundaries there is ongoing discussion of boundary crossings and boundary violations. When we speak about the breach of boundaries, it is important to discriminate between a boundary crossing and a boundary violation (Gutheil & Gabbard, 1993). Boundary crossing is a descriptive term, neither laudatory nor pejorative. Violation of boundary represents harmful crossing, a transgression of boundary.

Boundary crossings may be benign or harmful. There exist different groups of clients, however, with whom it is never advisable to cross the boundary. Lazarus (1994) named clients with severe psychopathology such as borderline personality features, passive-

aggressive, histrionic or manipulative behaviors, manifestations of suspiciousness or undue hostility. Borys (1994) added to this list: trauma survivors (child abuse and any other type of violence), clients with issues around self-esteem and separation-individuation, mourning clients suffered from deprivation or early loss.

At times it's difficult to distinguish between boundary crossing and boundary violation. Brown (1994b) describes three characteristics of boundary violation. They are,

- an objectification of the client for the use of the therapist, meaning that therapist uses a client as a resource for satisfying his/her human needs;
- a decision to cross the boundaries that is made impulsively rather than after consideration of multiple factors and consequences;
- a crossing of the boundaries that leads to even more power-imbalance placing the needs of the more powerful person (therapist) above needs of the less powerful person (client).

Brown (1994a) describes three myths about therapeutic boundaries that can be found in many writings about this topic. They are as following:

1. There exists one universal frame for psychotherapy, with definite universal boundaries.
2. Any professional can know a boundary violation when he/she sees one.
3. It is possible to never cross the boundaries if one follows the "mythological universal rules" (p. 33).

What is interesting in this field is that some ongoing discussions present the issues of boundaries as very heated and rather dramatic. However, there is the study conducted in this area which presents boundaries' maintenance as a relatively non-controversial area (Johnston & Farber, 1996). In their study of 213 psychologists, members of American Psychological Association Division 29 (Psychotherapy), the authors found that clients challenged

established boundaries relatively infrequently, and psychotherapists accommodated their requests in most cases. As Johnston & Farber (1996) state, "This finding stands in opposition to the generally accepted image of the psychotherapist standing firm in the face of persistent attempts by the patient to challenge existing boundaries" (p. 397).

In conclusion, most scholars writing about the issues of therapeutic boundaries recognize that there should be definite boundaries in therapeutic relationship. What the scholars disagree about is (1) what are these boundaries; (2) how flexible these boundaries should be; (2) how universal are these boundaries.

The concept of therapeutic boundaries is tightly connected with that of multiple role relationships. As Barnett (1996) states, "all dual relationships with patients in some way reflect a crossing of certain pre-established boundaries" (p. 138).

Ethics of Nonsexual Multiple Role Relationships

There exist different definitions of multiple role (or dual role) relationships, however, most of them are similar. This is how multiple role relationships are defined in the 2002 APA Ethics Code:

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

Pope & Vasquez (1991) gave more simple definition: "A dual relationship in psychotherapy occurs when the therapist is in another, significantly different relationship with one of his or her patients. Most commonly, the second role is social, financial, or professional". The other relationship is usually called "secondary relationship".

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

Different multiple role relationships are not equal to each other in the ethical sense. Today all professionals acknowledge that sexual relationships with current and former clients, as well as with their relatives and significant others, as well as acceptance of former sexual partners as clients, are unethical and harmful for the clients. This notion is supported by the current Ethics Code of APA (American Psychological Association, 2002; ethical principles 10.05 - 10.06). But there is little agreement about the wide range of other than sexual multiple role relationships. These relationships were named nonsexual multiple role relationships (NMRR).

During the past two decades the interest of professionals toward the issue of nonsexual multiple role relationships, as well as awareness of its importance and complexity was rising. Different authors wrote about this issue. Among them are D. Borys, L. Brown, B. Ebert, M. Gottlieb, T. Gutheil, A. Lazarus, K. Pope, and O. Zur just to name few. The category of nonsexual dual relationship was singled out of the more broad category of dual relationship in the reports of APA Ethics Committee. The issue of nonsexual dual relationship raises many different questions, most of which have not received definite answers so far. The salient questions are the following:

- What is the balance between harm and benefits in NMRR?
- How should mental health professionals handle NMRR?

Among authors writing about multiple relationships there exists disagreement about the harmfulness and/or beneficence, and as a result appropriateness of multiple relationships in therapy and counseling, and the ways of resolving them. Despite this apparent disagreement all the authors recognize existence of multiple role relationships and potential for harm that is inherent in them. In general, and without oversimplification these authors can be divided in three groups.

The first group includes B. Ebert, A. Lazarus, S. Rubin, M. Williams, O. Zur. These authors are concerned with prohibitions that exist in the area of multiple role relationships. They think that as a result of ethical standards (and legal practices as well) psychologists and other mental health providers are becoming more rigid in maintaining their boundaries with the clients. And this tendency is harmful, first of all, for the clients: "... practitioners who hide behind rigid boundaries, whose sense of ethics is uncompromising, will, in my opinion, fail to really help many of the clients who are unfortunate enough to consult them." (Lazarus, 1994a, p. 260) They also believe that many professionals at present try to avoid multiple role relationships or occasional involvements with the clients from which their clients can benefit. Ebert (1997) claims that "...the forgotten aspect of these prohibitions is that only those multiple role relationships that are harmful to or against the interests of the client are prohibited" (p. 137).

Rubin (2000) states that we have to move the focus of our attention from the term "multiple relationships" to the term "multiple levels of involvement". He argues that all the therapists have multiple levels of involvement with their clients and that this is neither

avoidable nor has to be avoided. He suggests that "the harmful aspects of multiple involvements and relationships do not stem from their mere existence. More than anything else, the dangers to multiple features of our involvement with each other are also rooted in the failure to perceive and properly balance the complex motivations, feelings, and behaviors that characterize human interactions - professional or otherwise"(p. 316).

Zur (2001) states that nonsexual multiple role relationships "are part of communal life where people are connected and interdependent in a healthy way... they enhanced therapeutic alliance, trust, and effectiveness". Williams (1997) thinks that standards of strict boundary maintenance and avoiding multiple relationships stem from psychodynamic perspective. These standards fail to encompass practices of humanistic and cognitive-behavioral therapies.

In general, Ebert (1997), Lazarus (1994, 1998), Rubin (2000), Williams (1997), and Zur (2001) consider nonsexual dual relationships to be healthy and beneficial for the clients in many cases. They tend to focus on the positive sides of these relationships, and they do not consider these relationships to be unethical as a class. However, they acknowledge that nonsexual multiple role relationships may be harmful in some cases and situations and that psychologists have to be sensitive to the potential consequences of their actions. "Without doubt, a wide range of multiple relationships exists that have potential to cause some degree of harm or to at least compromise the freedom of the less powerful party" (Rubin, 2000, p. 315).

The second group that views NMRR as potentially harmful includes such clinicians as: G. Corey, B. Herlihy, G. Gabbard, M. Gottlieb, T. Gutheil, M. Vasquez, K. Pope, and others. These authors focus on the problems that are connected with nonsexual multiple role

relationships and on their potential for harm. Although this group acknowledges that not all nonsexual multiple role relationships are harmful, they think that risk of exploiting a client and abusing the therapist's power is attended by those relationships. "It is crucial to clarify our relationship to each patient and to avoid sexual and nonsexual dual relationships which prevent that clarity and place the patient at great risk for harm"(Pope & Vasquez, 1991, p. 129).

Herlihy and Corey (1992) assert that dual relationships can be problematic along a number of dimensions: (1) they are pervasive, (2) they can be difficult to recognize, (3) they are sometimes unavoidable, (4) they can be very harmful but are not always harmful, (5) they are the subject of the conflicting advice from expert sources.

Kitchener (1988) identified three potential factors in a dual role relationship that may result in a professional's causing harm to a consumer. They are, (1) incompatibility of expectations between roles; (2) divergence of the obligations associated with the roles; (3) power and prestige of professional. Gottlieb (1993) supports Kitchener's notion on incompatibility of expectations between roles. He thinks that a conflict between role expectations is the main issue concerning NMRR.

When speaking about the harm that dual relationships can cause, Pope and Vasquez (1991) also note that these relationships:

- erode and distort the professional nature of therapeutic relationship;
- create conflicts of interest and thus compromise the disinterest (not lack of interest) necessary for professional judgment;
- cannot be equal because of the existing power imbalance in therapeutic relationship.

Gabbard (1994) expresses concern that the clients may not feel free to express their negative emotions such as anger to their therapist who is their friend as well or with whom they have other than therapeutic relationships.

In general, Gabbard (1994), Gottlieb (1993), Herlihy & Corey (1992), Kitchener (1988), Pope & Vasquez (1991) pay much more attention to potential of harm inherent in NMRR and suggest avoiding them whenever possible.

There is an emerging third voice in this discussion that belongs to the feminist therapists (Brown, 1994a; Lerman & Rigby, 1990; Walker, 2002). They stress both the benign nature of NMRR and their potential for harm. These therapists often refer to NMRR as overlapping relationships. Lerman & Rigby (1990) state that overlapping relationships have always been a fact of life, "even within the therapeutic context" (p. 54). The same authors recommend to avoid these relationships whenever possible at the same time acknowledging that it's not always possible. Feminist therapists write extensively about power differential and their attempt to equalize power in therapeutic relationships. Given this stand, overlapping relationships may serve interests of the clients equalizing power in the relationships (Saks-Berman, 1985).

Walker (2002) warns against development of such NMRR that can lead to therapist's loss of objectivity and infliction of harm to his/her clients. However, Walker calls for flexibility and discussion of clients' requests with clients. In her paper the author gives an example when she refused to shelter one of her clients because she thought it would slow down her progress in therapy, at the same time she described her attendance of one of her clients' wedding because it was not contraindicated therapeutically. Saks-Berman (1985) thinks that feminist therapists must guard against misusing NMRR.

The discussion described above evolves around the ethical principles of beneficence, do good, and nonmaleficence, do no harm. One group of practitioners insists that benefits of NMRR outweigh risks, other group thinks that risks are greater than benefits, yet another group stresses both and calls for flexibility. What is interesting is that this discussion is based mostly on the clinical evidence. There is clear lack of research supporting either of the opinions.

Research on Multiple Role Relationships

In spite of the controversy surrounding nonsexual multiple role relationships there were few studies done in this area. Moreover, almost all investigations focused on psychologists' perspectives on this issue.

Several studies on mental health professionals' perspectives on NMRR were done in a similar manner using similar therapist self-report instrument developed by Borys & Pope (1989) who utilized and adopted items from Pope, Tabachnick, & Keith-Spiegel (1987) study, then modified by Baer & Murdock (1995).

Pope, Tabachnick, and Keith-Spiegel (1987) explored ethical beliefs and behaviors of psychologists using a self-report attitude survey with a large national sample. Questions about multiple role relationships were a part of this survey. There were several interesting findings concerning NMRR. First, many behaviors constituting NMRR or leading to their development were assessed as ethical by substantial part of professionals. Thus, from the perspective of some psychotherapists the following behaviors were ethical under many circumstances or always: providing therapy to one of the friends (8.1 %) , accepting client's gift (11.9 %), accepting goods rather than money as payment (27.8 %), providing therapy to one's student or supervisee (13%), accepting a client's invitation to a party (17.5 %), asking

favors from clients (15.5 %), inviting clients to a party or social event (7.6 %), becoming social friend with a former client (28.7 %). However, a substantial proportion of respondents were unsure of the ethicality of some behaviors: accepting goods rather than money as a payment (21.6 %), accepting a client's gift worth at least $50 (15.8 %), going into business with a former client (17.5 %), asking favors from the clients (12.3 %), becoming social friends with a former client (13.4 %), etc. These results suggest that there is substantial variation among professionals' views concerning NMRR.

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

In addition, DeJulio & Berkman (2003) study of attitudes and behaviors of social workers supported the results of previous studies (Borys & Pope, 1989). They used Ethical Assessment Survey (EAS) developed by Borys & Pope (1989) and modified by Baer & Murdock (1995). The results showed that there was variability and ambiguity among clinicians' views on NMRR. For example, 18.9 % of participants thought that disclosing details of current personal stresses to clients was ethical under some conditions while 42.9 %

thought that it was never ethical. Concerning provision of therapy to current student or supervisee, 59.9 % of respondents thought that it was unethical; 23.2 % thought it was ethical under rare conditions; 9.9 % of respondents thought that it was ethical under some conditions; and 4.5 % of survey participants thought that it was ethical under most conditions or always.

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

Additional data pertinent to NMRR was provided by Anderson & Kitchener (1996) in their exploratory study of nonsexual posttherapy relationships between psychologists and clients. They found that there was little consensus among psychologists who participated in a study regarding whether or not nonsexual posttherapy relationships were ethical. Psychologists, participants in this study, were asked to identify reasons for viewing NMRR with former clients as either ethically problematic or not problematic. Among the reasons contributing to perception of relationships as problematic were the following: (a) dual role relationships exist; (b) impact of special knowledge about former client; (c) former client could not return to therapy with therapist (d) power differential still exists; (e) exploitation

occurred or could occur resulting in harm (f) impact on former client's internalized image of a therapist.

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

In general, the prior noted studies reflect clinicians' ambiguity about NMRR. Professionals have more agreement about some types of NMRR and situations potentially leading to them. However these points of agreement vary from study to study. Moreover, there is another general trend that can be discerned. More clinicians rate different situations representing NMRR or boundary crossings as being unethical or ethical under rare conditions than being always ethical or ethical under most conditions.

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

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

CHAPTER 3. MATERIALS AND METHODS

Participants

Power analysis to determine sample size

This study used a 2 (objective dimension: multiple roles present or absent) x 2 (subjective dimension: client's reactions positive or negative) factorial design (see p. 30 for details). Thus, sample size per group (number of participants per each condition) was computed using sample size formula for confidence intervals in factorial designs: $n=4\tilde{\sigma}^2\Sigma C^2(z/w)^2+1$

For the calculations we used the largest standard deviation estimate, $\tilde{\sigma}=16.87$, for an instrument, the Multiple Roles Questionnaire(MRQ) developed in a prior study (Diyankova & Scott, 2003) and used in the present investigation. A $z=2.5$ was set and adjusted for simultaneous confidence intervals; A width, $w=42$ (maximal possible width of the confidence interval that will allow meaningful comparison). Thus, we calculated the minimal per group sample size as $n=17$ with a total study sample of $N=68$.

Characteristics of sample/population

We were interested in the population of the former counseling clients. Although it is important to understand perspectives of general population as well as current clients on this important issue, we decided to focus our study on former counseling clients' perspectives. The rationale for this choice was that former clients' experience with counseling relationships that may enhance their ability to identify with the client in the counseling vignette and maximize the salience of the vignette to the study participants.

For the purposes of this study, we sampled volunteer research participants from the psychology department pool. Participants were selected on the basis of their previous

counseling experience. We restricted our sample to those who indicated past or current participation in counseling.

Instruments

Materials: Case vignettes

Twenty four counseling vignettes (see Appendix A) were developed. Given that vignettes for the pilot and primary study were very similar, only a set that was used in the primary study is presented in the Appendix A. The vignettes represented the two independent variables, objective and subjective dimensions of NMRR, and four experimental conditions (four possible combinations of the levels of two independent variables, see p. 32).

Each experimental condition was represented by two sets of three case vignettes. The first part of each vignette briefly described the counselor, the client, and the counseling situation. The second portion of the vignette described counseling relationship and counselor's behavior in terms of presence or absence of multiple roles and, thus, presented one of the two levels of the objective dimension of NMRR independent variable. The third part of each vignette depicted client's reactions to the behavior of a psychologist and the presence or absence of multiple roles and presented one of the two levels of the subjective dimension of NMRR independent variable. Thus, combination of the second and third parts of the vignettes presented an experimental condition. There were four experimental conditions in this study (see p. 31 for their description).

Each experimental condition was represented by three vignettes. We decided to use three vignettes instead of one because we wanted to strengthen the potential impact of the experimental conditions. In addition, nonsexual multiple role relationships is a heterogeneous category and we wanted to sample different types of NMRR.

Dependent Measures

The Reaction Questionnaire (RQ)

The Reaction Questionnaire (RQ) was developed for the purposes of investigating former and current clients' reactions to the case vignettes. In order to improve and modify this questionnaire a pilot study was conducted. Both the original and final versions of the questionnaire are presented in Appendix B. The final version of the RQ consists of 48 self-report items intended to assess intellectual and emotional domains of participants' reactions to the clinical case vignetttes. Given that our investigation was focused only on emotional reactions of participants, subjects' responses to the first portion of the questionnaire, those 18 questions focusing on individuals' feelings related to the case vignettes, were used. Each of the 18 items had three parts corresponding to three case vignettes. Participants were asked to indicate to what extent they experienced each of the feelings reflected in 18 items after reading each of the three vignettes. Each of the three parts of each of the eighteen items was assessed on the Likert-type scale ranging from (1) not at all to (5) to a great extent. These evaluations gave us 54 different ratings, half of which were positive and another half was negative. Twenty seven negative ratings were averaged across the vignettes and feelings for computation of the index of negative feelings. The same operation was performed for computation of the index of positive feelings.

The Adjective Check List (ACL)

The 1983 edition of the Adjective Check List (refer to Appendix C) developed by Gough & Heilbrun (1983) was used in this study. It is comprised of 300 items, adjectives and adjectival phrases commonly used to describe a person's attributes. We modified directions to the ACL to reflect our focus on participants' perception of the counselor described in the

vignettes (for original and modified directions see Appendix C). The ACL has 37 scales. Given that we were interested in general positive and negative participants' perceptions of the counselor, scales 2, number of favorable adjectives checked, and 3, number of unfavorable adjectives checked, were chosen to measure these dimensions. Additionally, scales 29, Critical Parent, and 30, Nurturing Parent, were selected. The reason for the choice of the aforementioned scales was that they measure potential important aspects of counselor's image, such as nurturance and self-absorption. We believe that these aspects of the image will be affected by NMRR.

Raw scores for each scale were computed by summing up the adjectives checked by a participant. Then scores were converted into the standard scores using conversion tables provided in the ACL manual (Gough & Heilbrun, 1983).

The ACL manual reports the following psychometrics. Internal consistencies of the scales ranged from .56 to .95 for males (with median of .76) and from .53 to .94 for females (with median of .75). Test-retest reliability of the scales (six months and a year after first testing) ranged from .34 to.77 for males and from .45 to .86 for females. The ACL was validated using Q-sort. It was standardized on the sample of more than 9,000 adolescents and adults. Some descriptive statistics, based on the standardization sample, related to the four scales used in our study are provided in the Table 1.

Table 1. Descriptive statistics for the four scales of ACL (Gough & Heilbrun,1983)

Statistics / Scales	number of items	range of standard scores	Males		Females	
			Mean	SD	Mean	SD
Number of favorable adjectives checked	75	1 - 99	49.29	9.00	48.66	9.92
Number of unfavorable adjectives checked	75	33 -212	51.21	9.35	51.39	9.08
Nurturing Parent	44	0 - 91	49.45	9.18	48.20	9.32
Critical Parent	44	6 -151	48.67	9.51	48.87	10.10

Multiple Roles Questionnaire (MRQ)

This 26-item self-report measure was developed by Diyankova & Scott in 2003 (see Appendix D). Each item on MRQ is assessed on 7 point Likert-type scale ranging from strongly disagree (1) to strongly agree (7). Score for each factor (description of the factors see below) is derived by summing up the item responses on this factor. The total score is derived by summing up the scores on the first factor with the recoded scores on the second factor. Scoring is reversed on the second factor so that total scores convey a consistent meaning, degree of acceptance. The total score represents the degree of acceptance of NMRR (larger score describes higher degree of acceptance).

Twenty six items of the scale were factor-analyzed on the sample of 899 undergraduate students. As a result of exploratory factor analysis, three factors were extracted that account for 42 % of the variance. These factors were: (1) Positive attitude towards NMRR (11 items); (2) Negative attitude towards NMRR (9 items); (3) Power differential (6 items). Total score

was calculated by summing up responses on first two factors. For the purposes of this study only questions from factor 1 and 2 were included because we were primarily interested in participants' attitudes towards NMRR not their perception of power differential.

Scale internal consistency estimates for the respective two factors, based upon a sample of undergraduate students (N=872) were: α_1=0.861 (positive attitude to NMRR), α_2=0.814 (negative attitude to NMRR). Validation study of this scale has not yet been conducted. The MRQ items and instructions for scoring are presented in Appendix D.

Other measures

Counseling Experience Scale. This scale was developed for the purposes of the study. It contains 10 questions (see Appendix J) pertaining to the participants' previous counseling experience, such as type of counseling, duration, perceived success, and nature of relationships with the counselor.

Demographic Questionnaire. This questionnaire developed by the author contains 6 questions gathering demographic information about participants' demographics (see Appendix K), such as age, gender, ethnicity, family status, and socio-economic status.

Questions concerning the case vignettes. The twelve questions were developed for the pilot study (Appendix F). Responses to these questions were used to modify vignettes.

Questions about Reaction Questionnnaire (Appendix G). Five questions were created for the pilot study. The purpose of these questions was to obtain participants' feedback concerning clarity and impact of the Reaction Questionnaire.

Variables

Independent variables (IVs)

There were two independent variables in the primary study. The first independent variable was the Objective Dimension of NMRR. It was presented in clinical case vignettes. It had two levels: (1) multiple roles present; (2) multiple roles absent. Thus, each vignette described a counseling situation in which multiple roles were either present or absent (refer to table 2 on p. 33 for the overview of all varaibles).

The second independent variable in this study was the Subjective Dimension of NMRR. It was reflected in the clinical case vignettes as well. This variable had two levels: (1) client's positive reaction to the counseling situation; (2) client's negative reaction to the counseling situation. Thus, each vignette contained either positive or negative reaction of a client to the described situation.

Experimental conditions

The four combinations of the independent variables produced the following four experimental conditions in the 2 (multiple roles present/ absent) x 2 (clients' reactions positive/ clients' reactions negative) factorial design used in the study:

(1) multiple roles present, client's reactions positive

(2) multiple roles present, client's reactions negative

(3) multiple roles absent, client's reactions positive

(4) multiple roles absent, client's reactions negative

Dependent variables (DVs)

There were seven dependent variables in the study. The first and second dependent variables reflected participant's reaction to the counseling situation with multiple role

relationships presented in the clinical case vignettes as measured by the Reaction Questionnaire. The first dependent variable, index of negative feelings (INF) measured cumulative negative affect of the participants associated with the situation presented in the vignette (for the description of calculation see p. 26). The second DV, index of positive feelings (IPF) measured cumulative positive affect aroused by the counseling situations presented in the vignettes.

The third through sixth DVs measured participants' perceptions of the counselor depicted in the vignettes as measured by the Adjective Check List (ACL). The third variable, general favorable perception (GFP) of the counselor was measured by the number of favorable adjectives checked scale of the ACL. The fourth variable, general unfavorable perception of the counselor (GUP) was measured by the number of unfavorable adjectives checked scale of the ACL. Perception of Counselor's Nurturance (PCN), the fifth variable, reflected such specific aspects of the counselor image as loyalty, helpfulness, and responsibility. It was measured by the Nurturing Parent scale of the ACL. Perception of Counselor's Self-absorption (PCSA), the sixth variable, reflected such aspects of the counselor image as egoism, negative emotionality, independence, and lack of care about others. It was measured by the Critical Parent scale of the ACL.

Finally, the seventh variable, attitude towards nonsexual multiple role relationships (AMRR), was measured by the Multiple Roles Questionnaire (MRQ) with larger total score representing more positive attitude towards NMRR. Brief summary of the variables and measures is presented in Table 2.

Table 2. Brief summary of variables and measures.

Independent Variables	**Instruments**
1. Objective Dimension of NMRR with two levels: (1) multiple roles present; (2) multiple roles absent	clinical case vignettes
2. Subjective Dimension of NMRR with two levels: (1) client's positive reaction to the counseling situation; (2) client's negative reaction to the counseling situation.	clinical case vignettes
Dependent Variables	**Instruments**
1. Index of negative feelings (INF)	Reaction Questionnaire, index of negative feelings
2. Index of positive feelings (IPF)	Reaction Questionnaire, index of positive feelings
3. General favorable perception of the counselor (GFP)	the ACL, the number of favorable adjectives checked scale
4. General unfavorable perception of the counselor (GUP)	the ACL, the number of unfavorable adjectives checked scale
5. Perception of Counselor's Nurturance (PCN)	the ACL, the Nurturing Parent scale
6. Perception of Counselor's Self-absorption (PCSA)	the ACL, the Critical Parent scale
7. Attitude towards NMRR (AMRR)	Multiple Roles Questionnaire (MRQ)

Research Design

The research design used in the study is an experimental between groups 2 (multiple roles present/multiple roles absent) x 2 (clients' reactions positive/clients' reactions negative) factorial design. There were two manipulated factors each with 2 levels. This design produced four possible experimental conditions as previously described.

Operational Hypotheses

Reactions to the counseling situation

1. We hypothesize that there will be no significant differences in the participants' mean scores on the index of negative feelings (INF) or on the index of positive feelings (IPF) depending on presence or absence of multiple roles in the situation described in the vignette.
2. We hypothesize that participants' mean scores on the INF and IPF will differ significantly depending on whether clients' reactions in the vignette were positive or negative. More specifically, mean INF scores will be significantly lower when clients' reactions (described in the vignettes) to the situation involving multiple relationships are positive than when they are negative. For IPF, mean scores will be significantly higher when clients' reactions to the situation involving multiple relationships are positive than when they are negative.

Perception of the counselor

3. We hypothesize that there will be no significant differences in mean scores on the general favorable perception of the counselor (GFP) or on the perception of counselor self-

absorption (PCSA) depending on presence or absence of multiple roles in the situation described in the vignettes.

4. We hypothesize that participants who were exposed to positive clients' reactions (in the vignettes) will score significantly higher on GFP and significantly lower on PCSA than participants who were exposed to the negative clients' reactions.

Attitude towards NMRR

5. We hypothesize that mean scores on the Multiple Roles Questionnaire (MRQ) will not be significantly different for participants exposed to the presence of multiple roles in the vignettes and those exposed to the absence of multiple roles.
6. We hypothesize that participants exposed to the positive clients' reactions in the vignettes will have significantly higher mean scores on MRQ than those who were exposed to the negative reactions.

Procedures

Two studies were conducted: a pilot study and a primary investigation.

Pilot study

There were three purposes of the pilot study, (1) to test the case vignettes for their impact on the participants; (2) to obtain feedback related to case vignettes in order to improve them; (3) to further develop and modify the Reaction Questionnaire.

Approximately one hundred fifty potential participants were selected from the Psychology Department's subject pool at Iowa State University on the basis of their affirmative responses to the question "Have you ever been in counseling?" They were contacted via e-mail and

invited to participate in the study. Fifty one participants volunteered for the participation in the pilot study. They were presented with the written informed consent form (see Appendix E) and were given time to read the document, ask questions, and decide whether they wanted to participate in the study.

Data was collected from them during the six testing sessions with 4-10 subjects in each session. Sessions were conducted by a trained undergraduate research assistant. Each participant received an individual packet with the three vignettes, the Reaction Questionnaire, and two sets of feedback questions related to participants' impressions of the Case vignettes and the RQ (see Appendixes F and G). In the pilot study each participant received vignettes corresponding to only one experimental condition.

Participants' responses to the questionnaires were analyzed for the presence of the general trends and used:

(1) to analyze differences in participants' reactions to the counseling situation depending on the experimental condition;

(2) to assess the perceived realism of the vignettes;

(3) to modify and improve the vignettes;

(4) to modify and improve the RQ.

Primary study

Seventy three student volunteers participated in the primary study. Data was collected in university classrooms through the series of the experimental sessions conducted by one of the three undergraduate research assistants trained by the author and supervised both by the author and the faculty supervisor.

All participants were randomly assigned to one of the four experimental conditions. Thus, there were four groups, one for each experimental condition. After assignment to the experimental condition each participant received an individual packet that consisted of:

(1) the Informed Consent Form (Appendix H)

(2) General Instructions with Introduction (Appendix I)

(3) Vignettes (three vignettes corresponding to the experimental condition of the particular participant)

(4) Reaction Questionnaire (RQ)

(5) The Adjective Checklist (the ACL)

(7) Multiple Roles Questionnaire (MRQ)

(8) Counseling Experience Scale (Appendix J)

(9) Demographic Questionnaire (Appendix K)

Then, the experimenter introduced herself and read an introduction to the study (on the participants' instructions sheet). After this, participants were asked to read the informed consent form and encouraged to ask questions. Then persons willing to participate were asked to sign the informed consent form and return it to the experimenter. After this, participants were allowed to start working on their packets. All instructions were self-explanatory. After a participant was done with the packet he or she returned the packet to the experimenter. The experimenter gave the person either an extra-credit card or the drawing ticket (for participation in the drawing) and the debriefing statement (Appendix L). In addition, experimenter responded to the questions from the participants.

Analysis of Data

Pilot study

Data was analyzed qualitatively and quantitatively. General trends in participants' responses to the questions about the vignettes and Reaction Questionnaire were explored. The results were used to modify the vignettes and questionnaire. Additionally, descriptive statistics for the questions of the Reaction Questionnaire and two indices were calculated. And, two separate 2 (multiple roles present/multiple roles absent) x 2 (clients' reactions positive/clients' reactions negative) ANOVAs were conducted separately on the index of positive feelings and on the index of negative feelings.

Primary study

Although we expected dependent variables to be moderately to highly correlated (for matrix of intercorrelations refer to table 5 on p. 46), we judged them sufficiently distinct to be treated as separate constructs for the purposes of this investigation. Thus, to test hypotheses five separate 2 (multiple roles present/multiple roles absent) x2 (clients' reactions positive/clients' reactions negative) ANOVAs were performed. Confidence intervals for main or simple main effects were calculated when applicable.

CHAPTER 4. RESULTS

Pilot Study

The pilot study was conducted to refine the case vignettes and to test and modify the RQ.

Participants

The pilot sample consisted of 51 participants recruited from the Psychology Department research subject pool. All of the participants were enrolled in undergraduate psychology classes.

Potential participants were selected through the mass testing sessions on the basis of their responses to the five questions of the Counseling Experiences Scale - mass testing version (Appendix M). Ninety nine people, who answered "yes" to question 1, "Have you ever received counseling or psychotherapeutic services (been a client in counseling)?", said that they were older than 10 when counseling occurred and responded to the question 4, "How many times have you met with the counselor or psychologist during your longest counseling experience?" by indicating 2-3 times or more, were contacted via e-mail and invited to participate in the study. Fifty one persons expressed their willingness to participate and signed up. Participation in the study was anonymous and we did not collect any demographic data about participants.

Participants were non-randomly assigned to the one of the four experimental conditions with the following distribution among conditions:

(1) multiple roles present, client reaction positive - 14 participants

(2) multiple roles present, client reaction negative – 13 participants

(3) multiple roles absent, client reaction positive - 12 participants

(4) multiple roles absent, client reaction negative - 12 participants

Case vignettes

Responses to the questions concerning the case vignettes

We analyzed participants' responses to the questions about case vignettes. We were particularly interested in: (1) what was their general impression of situation described in a vignette; (2) how did they view counselor; (3) how realistic was situation from their perspective; (4) changes proposed by the participants.

Participants' general impression of the counseling situation was evaluated on the basis of their responses to the questions # 1, 5 and 9 of the 'questions concerning clinical case vignettes' questionnaire (see Appendix F) that asked: "What is your general impression of this situation (including your thoughts and feelings)? " in relation to each vignette. Each response was coded by the author on the 4-point scale: (1) positive, (2) negative, (3) neutral, (4) ambiguous.

Examination of the frequency of participants' responses (see table in Appendix N) to the questions about their general impressions of the case vignettes showed the following trends:

1. More participants presented with case vignettes, describing negative client's reactions, had negative impressions of the vignette, than participants who were presented with vignettes, describing positive client's reactions. This was true for vignettes 1 and 2. For vignette 3, the frequency distribution was approximately the same.
2. For positive impressions of the vignette relationships was reversed, meaning that more participants presented with case vignettes, describing positive client's reactions, viewed vignette in a positive way than participants presented with the vignettes describing negative client's reactions.

3. There were no clear tendencies in differences observed for whether positive or negative impressions depending on objective condition, presence or absence of multiple roles in the vignettes.

Participants' views of the counselor were evaluated on the basis of their responses to the questions # 2, 6 and 10 of the 'questions concerning clinical case vignettes' questionnaire (see Appendix F) that asked: "How do you view the counselor in this vignette?". Each response was coded by the author on the 4-point scale: (1) positive, (2) negative, (3) neutral, (4) ambiguous.

Exploration of the frequencies of participants' responses related to the view of the counselor in the vignette highlighted two general trends that were somewhat different from the aforementioned patterns of general impressions (see table in Appendix O):

1. Both for positive and negative views of the counselor, differences were detected for objective condition, namely presence or absence of multiple roles. This pattern was true for vignettes 1 and 2 but not for vignette 3.
2. However, for vignettes 2 and 3 participants' responses differed depending on subjective condition, positive or negative reactions of the clients in the vignette. More participants from the positive level of subjective condition than negative level of the subjective condition viewed the counselor in the positive terms. More participants from the negative level of the subjective condition than positive level of the subjective condition had negative perception of the counselor.

Table 3. Frequency of the spontaneous comments related to the realism of the vignettes

	Realistic	No comment	Not realistic
Vignette 1	19	31	1
Vignette 2	17	33	1
Vignette 3	15	31	5

In addition, we were interested in how realistic, feasible, or probable were situations described in the vignettes from the participants' points of view. Subjects' spontaneous written comments were used to gauge realism of the vignettes. Most participants either viewed situations described in the vignettes as realistic or did not comment on this issue. The frequency of participants' spontaneous comments is displayed in the table (p. 42, bottom).

Finally, we asked participants to give us feedback on what needed to be changed for vignettes to have more impact on the reader. Students gave us valuable suggestions concerning this matter. Some of the suggestions that we took in the account when modifying the vignettes were the following: (1) be more explicit concerning the timeframe of the events; (2) explain why clients in vignettes 2 and 3 still need therapy; (3) clarify if clients in all three vignettes are still in therapy; (4) correct misprints, redundancies, mistakes, and omissions.

There was one additional useful comment that was not taken in the account when modifying vignettes. Several persons noted that all three vignettes were too similar to each other. We welcomed this comment because this was exactly the effect that we were attempting to achieve.

Table 4. Descriptive statistics for the INF and IPF

Descriptives	INF	IPF
Mean	1.67	2.14
Standard Deviation	.64	.93
Skewness	1.22	.82
Std. Error of skewness	.33	.33
Minimum	1	1
Maximum	3.46	4.75

Responses to the Reaction Questionnaire

Descriptives. Two indices were calculated: index of negative feelings (INF) and index of positive feelings (IPF). Each index represented an average of the nine ratings of feelings across three vignettes. Descriptive statistics for the indices are summarized in the table . Even though the INF distribution was moderately skewed (1.22), we decided to proceed with ANOVAs because we evaluated the distribution as still meeting the assumption of normality.

Analyses of Variance. We conducted two separate 2x2 ANOVAs on respectively the INF and IPF to test for the differences in the scores depending on experimental condition. For INF, tests for the objective by subjective conditions interaction and main effect for objective condition were not significant. The test for main effect of subjective condition was significant ($F(1,50)=20.47$, $p<0.001$). Additionally, effect size was calculated: $\eta^2=0.3$.

For IPF, tests for the objective by subjective conditions interaction and main effect for objective condition were not significant as well. Test for main effect for subjective condition was significant ($F(1,50)=18.57$, $p<0.001$) with effect size, η^2, equal 0.28. We did not proceed with computation of the confidence intervals because it was a pilot study with only moderate sample and non-random assignment.

Reaction Questionnaire

Feedback from the participants concerning the Reaction Questionnaire was obtained through the separate questionnaire (see Appendix G). Most participants reported that items on the questionnaire were clear and reflected their reactions to the clinical case vignettes. We made several changes on the basis of our subjects' feedback. First, we added the following two feelings, disappointed and grateful to the part I, the ratings of feelings, because they were mentioned by several participants. Also, we used 'frustrated' instead of 'tense' because many participants mentioned that they were frustrated. Moreover, we thought that our future research subjects will be more able to identify with frustration than with tension.

Secondly, we reworded several statements related to participants' thoughts in the part two, the ratings of thoughts. Additionally, we took several statements out and added several new instead. For example, two statements describing psychologist as either a jerk or as cool were deleted. Instead, statements describing psychologist as either not professional or professional were added. Also, two more specific statements were introduced commenting on psychologist's rigidity or flexibility. For comparison of two forms of the questionnaire we refer the reader to Appendix B where both versions are presented.

Finally, a third part, open-ended questions, was added to the questionnaire. Nine items from the 'questions concerning the case vignettes' (see Appendix F) were included as it was anticipated that that these open-ended questions would provide valuable qualitative information about participants' reactions to the case vignettes.

Primary Study

Participants

The primary study sample consisted of 73 participants. They were recruited by two different ways and subsequently comprised two groups (groups' descriptions are below).

Groups' description

The sixty three individuals comprising group one came from the Psychology Department research subject pool. All of them were enrolled in undergraduate psychology classes and participated in this research for extra-credit points. The ten individuals that comprised group two were recruited through the printed ads disseminated on campus. They were either students or employees of Iowa State University. In addition, they were given a ticket for the drawing as a compensation for their participation. The drawing was held on May 1, 2004 and one of the participants won a $25 gift certificate to Target. Given that participants from the both groups were randomly assigned to the experimental conditions, we did not expect any pre-existing differences to influence our results. However, as a means to assess for possible differences on the dependent variables, related to the group membership, a MANOVA for the seven dependent variables was conducted with membership in the group as a fixed factor ($F(1,72)=0.537$, $p=0.803$). Follow-up ANOVAs were performed (see table in Appendix P). We did not find any significant differences between the two groups on any variables of interest.

Sample description

The sample consisted of 73 volunteer participants all of whom had received counseling services prior to their participation in the study. In this sample (n=31) 43 % were males, (n=39) 53 % were females, and (n=3) 4 % did not report their gender. Concerning ethnicity,

(n=57) 78 % were Caucasian, (n=4) 5.5 % - African American, (n=1) 1.4 % - Asian American, (n=2) 2.7 % - Latino/Latina, (n=1) 1.4 % - multiracial, (n=3) 4 % - international, (n=2) 2.7 % - other, and (n=3) 4 % did not indicate their ethnicity. Participants' age was distributed in the following manner: (n=30) 41.1 % were18-19 year old; (n=33) 45.2 % - 20-24 year old; (n=2) 2.7 % - 25-30 year old; (n=3) 4.1 % were 31 – 40 year old; (n=1) 1.4 % were 41-55 year old; (n=1) 1.4 % were56 or older; and (n=3) 4.1 % did not report their age.

Concerning counseling experience of the participants, (n=39) 53.4 % received counseling at the age of 18 or after, (n=34) 46.6 % received counseling at the age of 17 or before. Sixty two participants, 85 % indicated that they were not currently in counseling, whereas (n=11) 15 % were receiving services at the time of the study. Characterizing their longest counseling experience, (n=17) 23.3 % said that they had 4-6 sessions; (n=13) 17.8 % - 11-20 sessions; (n=9) 12.3 % - more than 20 sessions; (n=7) 9.6 % - 8-10sessions; (n=7) 9.6 % had 2-3 sessions; (n=4) 5.5 % - one session; (n=16) 22 % did not indicate number of sessions. Describing success of the counseling experience, (n=35) 48 % said that it was moderately successful to successful; (n=11) 15 % characterized it as neither successful nor unsuccessful; (n=11) 15 % estimated it in the range of not very successful to moderately unsuccessful; and (n=16) 22% did not respond to the question.

Dependent variables

Overall, there were seven dependent variables in the study. Most of them were moderately to highly correlated (see table 5 on p. 46). One specific variable, perception of the counselor nurturance (PCN), was highly correlated with two other variables, GFP and GUP (r_1=0.89 and r_2=-0.81 correspondingly). Given that correlations were so high and that PCN was very similar to GFP but more specific, we decided to exclude PCN from the subsequent analyses

of variance. Thus, six dependent variables: index of negative feelings, index of positive feelings, general favorable perception of the counselor, general unfavorable perception of the counselor, perception of counselor's self-absorption, and attitude towards NMRR were judged to be separate interesting constructs. While we recognized the moderate correlations among them (see table 5), we chose to perform six separate ANOVAs with appropriate Bonferoni adjustment to protect against Type I error because we thought that each of these constructs was meaningful and interesting enough on its own to warrant the separate analysis. Moreover, the pattern of correlations was conceptually consistent. The INF was significantly negatively related to the IPF. The PCSA was significantly and positively correlated with GUP and significantly and negatively related to GFP and PCN.

Table 5. Correlations among seven dependent variables

Variables	1	2	3	4	5	6
1. Index of negative feelings (INF)						
2. Index of positive feelings (IPF)	-0.54**					
3. General favorable perception of the counselor (GFP)	-0.55**	0.47**				
4. General unfavorable perception of the counselor (GUP)	0.66**	-0.39**	-0.69**			
5. Perception of Counselor's Nurturance (PCN)	-0.59**	0.50**	0.89**	-0.81**		
6. Perception of Counselor's Self-absorption (PCSA)	0.61**	-0.47**	-0.46**	0.64**	-0.60**	
7. Attitude towards NMRR (AMRR)	-0.27*	0.25*	0.28*	-0.43**	0.40**	-0.35**

* Correlation is significant at the 0.05 level
** Correlation is significant at the 0.01 level

Descriptive Statistics

Several descriptive statistics indicators were calculated for each of the seven dependent variables. Means, standard deviations, an index of skewness, minimum and maximum values for each variable are presented in table . Distributions for six dependent variables were close to normal. However, the distribution of the scores for GUP was highly skewed (1.446). We took a square root transformation of GUP (see table for descriptive statistics) to address this issue. However, the index of skewness for this distribution was still above 1. So, we excluded this variable from the analyses of variance.

Table 6. Descriptive statistics for seven dependent variables

Variables / Statistics	INF	IPF	GFP	GUP	√GUP	PCN	PSCA	AMRR
N	72	72	73	73	73	73	73	72
Mean (M)	2.1	2.56	43.68	56.48	7.42	50.01	50.25	64.63
Standard Deviation	0.84	1.01	12.75	19.87	1.22	10.95	11.23	19.64
Minimum	1.00	1.00	13	39	6.24	14	30	21
Maximum	3.86	4.60	71	119	10.91	68	75	108
Skewness	0.544	0.311	-0.270	1.446	1.177	-0.751	0.366	-0.096
Standard error of skewness	0.283	0.283	0.281	0.281	0.281	0.281	0.281	0.283

ANOVAs

We performed five separate 2(presence/absence of multiple roles) x2 (positive/negative clients' reactions) ANOVAs and followed them up with computation of appropriate confidence intervals. To protect from Type I error we used Bonferoni adjustment for the computation of significance level. Thus, adjusted significance level was 0.02 (α=0.1/5=0.02). We will describe ANOVAs and follow-up tests for each variable separately. Results are presented in table 7 on the following page.

Table 7. ANOVAs for 5 DVs

DVs	Objective x subjective interaction			Main effect for objective condition		Main effect for subjective condition				
	F	p	η^2	F	p	F	p	η^2	.95 CI for main effect B	
									UL	LL
1. index of negative feelings	8.99	.004	.118	.665	.418	27.364	.00	.29		
2. index of positive feelings	3.917	.052	.055	.598	.442	22.644	.00	.25	.58	1.38
3. general favorable perception of the counselor	5.956	.017	.082	2.636	.109	3.934	.051	.05		
4. perception of the counselor's self-absorption	3.912	.052	.055	3.189	.079	8.290	.005	.11	-2.07	-11.69
5. Attitude towards NMRR	1.674	.20	.024	.288	.593	1.562	.216	.02		

Index of negative feelings. The ANOVA for the INF indicated that main effect for the objective condition was not significant, $F(1,72)=0.665$, $p>.05$. Main effect for the subjective condition was significant, $F(1,72)=27.36$, $p<.001$. The objective x subjective condition interaction was significant ($F(1,72)=8.99$, $p=0.004$). Given that interaction effect was statistically significant, we proceeded with the computation of the confidence intervals for the simple main effects. We were interested in the main effects for the subjective condition at both levels of objective condition, more specifically when multiple roles were present and when they were absent in the case descriptions.

The simple main effect for the subjective condition when multiple roles are present was highly significant, $t(1,32)=-6.29$, $p<0.01$. However, the simple main effect for the subjective condition when multiple roles absent was not significant, $t(1,32)=-1.51$, $p>.05$). Results for the two simple main effects are presented in the table 8.

We are 95 % confident that mean score on the INF is between 0.75 and 1.96 lower when client's reaction is positive than when client's reaction is negative when multiple roles are present for all population of former clients who are currently enrolled in Introductory psychology classes at Iowa State University. Additionally, there is no significant difference in the mean scores on the INF between client's reaction positive and client's reaction negative conditions when multiple roles are absent.

Table 8. Simple main effects for the subjective condition at two levels of the objective condition for the INF

	Contrast	t	df	p	Mean difference	.95 CI LL	UL
INF: Positive – negative reaction							
multiple roles present	-1.36	-6.29	31.9	0.000	-1.36	-1.96	-0.75
multiple roles absent	-0.36	-1.51	32.2	0.14	-0.36		

Index of positive feelings. A 2x2 ANOVA showed no significant main effect for the objective condition, $F(1,72)=0.598$, $p>.05$. Results for the main effect for subjective condition were significant, $F(1,72)=22.644$, $p<0.001$; $\eta^2=0.25$. The objective x subjective condition interaction was not significant, $F(1,72)=3.917$, $p>.05$. We followed up with computation of the 95% confidence interval for the main effect for subjective condition (LL=0.58; UL=1.38). Thus, we are 95 % confident that mean score on IPF is between 0.58 and 1.38 higher when client's reaction, depicted in the vignette, is positive than when client's reaction is negative for all population of the former clients who are currently enrolled in Introductory psychology classes at Iowa State University.

General Favorable Perception of the Counselor. Analysis of Variance for GFP indicated that both main effects were not statistically significant, both $F(1,72)<4$and both $ps>.05$. However the objective x subjective conditions interaction was significant, $F(1,72)=5.956$, $p<0.02$, $\eta^2=0.082$. Given that interaction effect was statistically significant, we proceeded with the analysis of the simple main effects. We looked at two simple main effects: (1) differences in GFP mean scores for subjective condition when multiple roles are present; (2) differences in GFP mean scores for subjective condition when multiple roles are absent. Results of the tests for simple main effects are summarized in table 9.

Table 9. Simple main effects for the subjective condition at two levels of the objective condition for the GFP

	Contrast	t	df	p	Mean difference	.95 CI LL	UL
GFP: Positive – negative reaction							
1. multiple roles present	13.00	3.296	32.6	0.02	13.00	1.95	24.05
2. multiple roles absent	-1.30	-0.340	32.9	0.74			

We are 95% confident that mean score on GFP is between 1.95 and 24.05 larger when client's reaction in the vignette is positive than when client's reaction is negative when multiple roles are present for population of the former clients who are currently enrolled in Introductory psychology classes at Iowa State University. However, there were no significant differences in mean GFP scores detected for subjective condition when multiple roles are absent.

Perception of Counselor's Self-Absorption. Tests for objective x subjective condition interaction ($F(1,72)=3.912$, $p>.05$) and main effect for the objective condition ($F(1,72)=3.189$, $p>.05$) were not significant. Test for the main effect for subjective condition was significant, $F(1,72)= 8.29$, $p<0.01$, $\eta^2=0.11$. We computed 95% confidence interval for the main effect for subjective condition (LL=-11.69; UL=-2.07). We are 95 % confident that mean score on PCSA is between 2.07 and 11.69 lower when client's reaction in the vignette is positive than when it is negative for the entire population of the former counseling clients who are currently enrolled in Introductory psychology classes at Iowa State University.

Attitudes towards NMRR. There were no significant results for main effect for objective condition, main effect for subjective condition or interaction on 2x2 ANOVA for MRQ. We

failed to reject the null hypothesis that there were no differences between experimental groups on MRQ. For the summary of the results see table 7 on p. 49.

Patterns of correlations among DVs'

Analysis of correlational matrix showed two interesting results that we would like to describe. First, the index of negative feelings was moderately to highly correlated with four variables measuring different aspects of the participants' perception of the counselor, GFP, GUP, PCN, and PCSA (absolute value of coefficients ranged from 0.55 to 0.66). All correlations were highly significant ($p \leq 0.01$). Also, the index of positive feelings was significantly and moderately correlated with the above described variables.

Secondly, attitude towards NMRR (AMRR) was significantly and moderately correlated with three of four variables measuring the participants' perception of the counselor with absolute values of coefficients ranging from 0.35 to 0.43 (correlational matrix is presented in table 5 on p. 46).

Summary of the results of primary study

Five separate 2 (multiple roles present/absent) x 2 (clients' reaction positive/negative) ANOVAs were conducted to test for the differences in the mean scores depending on experimental condition. There were no significant main effects for the objective condition found for any of the five dependent variables. Significant main effects for subjective condition were detected for the index of positive feelings and perception of counselor's self-absorption. Significant subjective by objective conditions interaction effect was found for the index of negative feelings and general favorable impression of the counselor. There were no significant interaction or main effects found for the attitude towards nonsexual multiple role

relationships. Additionally, potentially interesting patterns of correlations among seven dependent variables was found.

CHAPTER 5. DISCUSSION

Pilot Study

This study pursued three related goals. In conducting this study we were interested in (1) testing the impact of the case vignettes; (2) obtaining feedback related to the case vignettes and their impact and modifying them in accordance with it; (3) obtaining feedback about the Reaction Questionnaire (RQ) for the purposes of its improvement.

Impact of the case vignettes

We tested the impact of the vignettes through analysis of distribution of participants' general impressions of situation and their views on the counselor obtained from the questions concerning the case vignettes. Analyses of these distributions showed that the students were providing different responses depending on the condition they were in. For example, participants' views of the counselor in the vignette 2 were more positive when client's reaction described in the vignette was positive than when it was negative. For vignette 1, participants had more negative view of the counselor when multiple roles were present than when they were absent. These findings were not statistically significant. However, they showed general trends consistent with the design of the vignettes and the study.

Another way to explore the differences in participants' perceptions of the vignettes, was to test for the differences in participants' emotional reactions to the counseling situation depending on the experimental condition. We found that participants reacted significantly more negatively to the described counseling situation when the clients described in the vignette had negative reactions and experiences regardless of whether multiple roles were present or absent, than when clients had positive reactions to the same dimensions of the

objective condition. In other words, it did not matter to our participants whether multiple roles were present or absent in the counseling situation. Additionally, we found that participants reacted significantly more positively to the counseling situation when clients' reactions to the role dimension of the counseling relationship described in the vignettes were positive than when they were negative despite the presence or absence of multiple roles.

Modification of the case vignettes

Case vignettes were slightly modified in accordance with the participants' feedback. We carefully changed the time frame for all three vignettes to be more realistic and explicit. Explanation was given of the fact that clients in vignettes 2 and 3 were still in therapy in spite of significant improvement. We explicitly stated that all described clients were currently in therapy. Finally, we corrected all identified errors, omissions, and redundancies.

Overall, participants' responses and reactions indicated that vignettes had desired impact, were clear in contents, and had a good balance between the amount of details and possible confounding conditions.

Modification of the Reaction Questionnaire

The Reaction questionnaire was modified substantially from its original version. First, a third part, consisting of nine open-ended questions, was added. The reasoning behind this modification was that responses of the pilot study participants to these questions provided us with valuable information about their reactions to the clinical case vignettes. Although we did not intend to use this information in our primary study, we thought that it would be useful for our future research in this area.

Secondly, part two of the RQ was modified substantially with some statements reworded, others deleted, and several new ones were added. Thirdly, we modified instructions to the

first part of the RQ making them more explicit. Finally, we introduced minor changes to the part one of the RQ, ratings of feelings, that were our reactions to the participants' comments, feedback, and their choices of the strongest feelings.

Overall, we significantly modified the Reaction Questionnaire incorporating participants' feedback and their responses to the RQ. We believe that we made this questionnaire more sensitive to the participants' reactions by providing them with the three different modes of response, namely ratings of feelings, ratings of thoughts, and the opportunity to express their reactions in the mini-essay format.

Limitations of the study

The major limitation of the pilot study was non-random assignment of the participants to the experimental conditions. Given this solution, we cannot draw any conclusions related to the causality of the relationships and should be very cautious when interpreting the relationship between clients' reactions to the presence or absence of multiple roles and the participants' emotional reactions.

Primary Study

The primary purpose of this study was to explore the relationships between objective and subjective dimensions of NMRR and participants', former clients, reactions to the counseling situation, their perception of the counselor, and their attitudes towards NMRR. In particular, this study attempted to demonstrate the differential impact of the subjective dimension of NMRR (positive versus negative clients' reactions to NMRR) on the above described variables.

We proposed six hypotheses in the beginning of our study. Below each of these hypotheses is discussed.

Hypothesis 1

We hypothesized that there would be no significant differences in participants' reactions to the counseling situation depending on presence or absence of multiple roles. Our data supported this hypothesis. We did not find any significant differences in whether positive or negative emotional reactions of the participants to the counseling situation depending on the presence or absence of the multiple roles. This finding suggests that presence or absence of multiple roles in the counseling situation alone do not cause former client's emotional reactions to the counseling situation.

Hypothesis 2

We hypothesized that former clients would have significantly different emotional reactions to the counseling situation when client's reactions to the objective dimension of NMRR in this situation (presence or absence of multiple roles) is positive than when it is negative. Our findings partially supported this hypothesis. More specifically, we found that participants reacted significantly more positively to the counseling situation when clients in this situation reacted positively to either presence or absence of multiple roles, than when clients depicted in the vignettes reacted negatively to presence/absence of multiple roles. However, negative emotional reactions of our participants had a slightly different pattern. An interaction between presence/absence of multiple role and clients' emotional reactions occurred. Thus, we found that participants reacted significantly more negatively to the counseling situation when multiple roles were present and when clients, described in the vignette, had negative reactions than when multiple roles were present and clients had positive reactions. When the experimental situation did not involve multiple roles, then there was no difference in the

participants' negative affect related to counseling situation whether clients' reactions were positive or negative.

We think that findings related to hypotheses 1 and 2 have interesting implications. They suggest that the presence of multiple roles themselves do not cause participants to feel negatively about the counseling situation. Rather, the ways in which these multiple roles (whether present or absent) affect the client may color reactions to the counseling situation in general. These findings support to some extent views of all three groups of clinicians mentioned in chapter 2 because they show that NMRR may be perceived positively as well as negatively depending on the context. The closest to this is feminist perspective (Brown, 1994; Lerman & Rigby, 1990). Also, presence of multiple roles may sensitize participants to the negative emotional consequences even more.

Hypothesis 3

We hypothesized that the participants' perceptions of the counselor would not differ significantly depending on absence or presence of multiple roles in the counseling situation. This hypothesis was supported by our findings. We did not find any differences in the participants' perceptions of the counselor depending on presence or absence of multiple roles. Neither general favorability of perception nor perceived counselor's self-absorption (scales GFP and PCSA respectively) differed significantly. These findings suggest that presence or absence of multiple roles per se do not lead to participants' differential perceptions of the counselor involved in these relationships.

Hypothesis 4

We hypothesized that participants' perceptions of the counselor would be significantly more positive when client's reactions to the objective dimension of NMRR (presence or

absence of multiple roles) are positive than when they are negative. We measured two different aspects of the participants' perception of the counselor, general favorable perception and perception of the counselor's self-absorption. Our findings on these two variables were different.

Concerning general favorability, we found that participants perceived the counselor in the stories as significantly more social, adaptable, energetic, optimistic and generally more positive when multiple roles were present and clients in the stories reacted positively to this than when multiple roles were present and the vignette clients reacted negatively to their presence. But there were no differences in general favorability depending on the sign of clients' reactions when multiple roles were absent.

When examining the results of analysis associated with counselor's self-absorption (negative emotionality, independence, lack of care about others, and egoism), we see that participants perceived counselors as significantly more self-absorbed when clients in the stories reacted negatively to presence or absence of multiple roles, than when they reacted positively to these aspects of the counseling situation.

Thus, our findings partly support the fourth hypothesis and have important implications. More specifically, findings related to third and fourth hypotheses suggest that presence or absence of multiple roles per se do not influence former clients' perceptions of the counselor. However, clients' reactions to the multiple roles, whether absent or present, may significantly influence participants' perception of the counselor, and especially the general favorable attitude towards the helper. Also, participants may perceive counselor in the more negative light when both multiple roles and client's negative reaction to them are present.

Hypothesis 5

We hypothesized that participants would not have significantly different attitudes towards NMRR depending only on absence or presence of multiple roles in the experimental condition. And, we did not find any significant differences in attitudes towards NMRR depending on presence or absence of multiple roles.

Hypothesis 6

We hypothesized that participants would have significantly more positive attitude towards NMRR when multiple roles were present and when vignette clients' reactions were positive than when multiple roles were present and vignette clients' reactions to them were negative. Additionally, we thought that differences in former clients' attitudes towards NMRR would not be significant when multiple roles were absent. Our findings did not support this hypothesis. In fact we did not find any significant differences in attitudes towards NMRR depending on any experimental condition or their interaction.

Findings related to hypotheses 5 and 6 may have important implications. They suggest that participants general attitude towards NMRR is not influenced by the concrete counseling situations and their outcomes. Moreover, analysis of the participants' response patterns suggests that the majority of participants, former counseling clients, are rather conservative in their attitude towards NMRR. The general tendency appears to be a slight disapproval of NMRR. These findings agree with the previous research (Diyankova & Scott, 2003). Also, based on the results of this study, it appears that in general terms former clients' views are similar to those of mental health professionals (Borys & Pope, 1989). Generalizing further, our overall findings suggest that former clients may have preconceived notions about

acceptability of NMRR that may be in contradiction with their reactions and attitudes towards specific situations involving multiple role relationships and their consequences.

Limitations of the study

The primary study had several limitations that should be considered when interpreting its results. First of all, the sample size was smaller than we had hoped for and that led to the wide confidence intervals. We believe that increase in the sample size may lead to narrower and more precise confidence intervals. Secondly, we did not randomly sample from the population of the former clients who are students or employees of the Iowa State University. Thus, caution should be used when generalizing these results to the described and similar populations. Also, one of the measures used for this study, the RQ, was specifically developed for this investigation. We do not yet have enough information to support its reliability and validity. However, given the nature of the field and lack of specific instruments that can be used for research in this area, this is a limitation that currently exists.

Additionally, we acknowledge that using three vignettes, instead of one, for each experimental condition may have led some participants to form more relatively positive or negative impressions of the counselor, who also may have been perceived as consistently behaving in the described manner. Finally, we measured participants' perspectives at only one point in time. Thus, data present a current, static summary of their views, which may change with the passage of time.

Implications for the clinical practice

Although our study has serious limitations and additional research is suggested before generalizations are made, we would like to begin contemplating about clinical implications of our findings. The results suggest that mental health professionals do not need to

categorically and rigidly avoid all nonsexual multiple role relationships with their clients. Position of cautious openness suggested by feminist clinicians may be most appropriate for making decisions in the situations involving NMRR (Lerman & Rigby, 1990; Saks-Berman, 1985; Walker, 2002). Whereas very conservative position that advises against maintenance of NMRR in most situations (Gabbard, 1994; Gotlieb, 1993) may be too strict. However, writings of these and other authors attract clinicians' attention to the potential for harm inherent in NMRR (Gabbard, 1994; Gotlieb, 1993; Herlihy & Corey, 1992; Kitchener, 1988). It is important to be aware of this potential when presenting issue of NMRR to the clients and discussing possible solutions with them.

We found that it was not the presence or absence of multiple roles per se that led to the negative consequences, such as negative view of the counselor or negative feelings associated with counseling, but clients' emotional interpretations of NMRR and/or interactions between presence of multiple roles and these interpretations. Thus, we believe that counselors should be sensitive to their clients' unique perceptions of the multiple role relationships and openly explore these views and attitudes in session when appropriate. Additionally, it may be important to involve the clients in the decision-making processes by explicitly discussing counselor-client nonsexual multiple role relationships.

CHAPTER 6. CONCLUSIONS

Summary

We were interested in exploration of the former clients' perspective on nonsexual multiple roles relationships. We proposed that pure presence or absence of multiple role relationships was not the only factor contributing to former clients' reactions to the counseling, counselor and their attitudes towards NMRR in the situations associated with multiple role relationships. Our original idea was that clients' subjective perceptions and reactions to the situations involving multiple role relationships should be considered and evaluated as one of the possible factors.

Two studies were conducted. A pilot study tested two original instruments, case vignettes and the Reaction Questionnaire, developed to respectively introduce treatments and measure participants' reactions. On the basis of the feedback obtained from the participants both instruments were modified. Additionally, analysis of the former clients' reactions to the counseling situation preliminary supported our first two hypotheses. However, given that our subjects were not randomly assigned to the experimental conditions, these results should not be interpreted or generalized beyond just pilot study.

The primary study was conducted with 73 participants, all former counseling clients, who studied or worked at the Iowa State University during the time of data collection. Participants were randomly assigned to one of the four experimental conditions reflected in the case vignettes. Former clients were asked to read three vignettes reflecting one experimental condition and then fill out several questionnaires. We focused on studying how objective and

subjective dimensions of NMRR influence former clients' reactions to the counseling situation, perception of the counselor, and attitude towards NMRR.

Six hypotheses were formulated. We hypothesized that differences in clients' emotional reactions to the NMRR described in the vignettes, but not absence or presence of NMRR per se, would lead to differences in participants' reactions to the counseling situation. Both hypotheses were mostly supported by data. One correction that came from data related to the negative aspect of reaction to the counseling situation. We found that former clients reacted significantly more negatively to the counseling situation when multiple roles were present and when clients involved in the described situation had negative reactions, than when multiple roles were present and vignette clients had positive reactions.

The remaining hypotheses were formulated in a similar fashion, but related to two other aspects of interest, namely perception of the counselor and attitude towards NMRR. Our findings concerning relationships between dimensions of NMRR and counselor perception were very similar to those described above. However, our findings on relationships between dimensions of NMRR and attitude towards NMRR were very different. More specifically, we did not find any effect of either objective or subjective dimensions of NMRR or interaction between them on former clients' attitudes towards NMRR.

In conclusion, our studies explored several important aspects of the former clients' perspectives related to NMRR. They showed that presence or absence of NMRR was not the critical factor in the former clients' reactions to the counseling situation or their perception of the counselor as was assumed in the literature discussing these issues (see for example Herlihy & Corey, 1992 or Lazarus, 1994). Former clients' reactions to the situation and perception of the counselor changed depending on whether absence or presence of multiple

role relationships had positive or negative impact on the client (in the vignette) in the form of the client's emotional reactions. We consider the findings of the presented studies as important and novel in the research on multiple role relationships. We think that theoretical formulations suggested in this work as well as findings may contribute to the development of the more complex model of NMRR that may be formulated from constructivist perspective.

Moreover, our findings have important implications for the clinical practice. They suggest that mental health professionals do not have to avoid multiple role relationships with their clients by any means. Rather they should be sensitive to their clients' unique perceptions of these relationships, explore them openly in session, and involve their clients in the decision-making process. However, given limitations of the primary study, presented findings should be replicated by other studies with similar and different populations before generalizations can be made.

Future Research Directions

This project is one of the first that explores former clients' perspectives on multiple role relationships. However, many potentially interesting factors were not included in this study. One research inquiry that has yet to be explored is whether gender contributes to the clients' and former clients' reactions to the multiple roles. Some studies suggest that mental health professionals perspectives may differ depending on sex (Baer & Murdock, 1995; Borys & Pope, 1989). Additionally, study by Diyankova and Scott (2003) showed that female college students had significantly lower degree of acceptance of NMRR than did male students. One possible hypothesis may be that females pay more attention to the subjective dimension of multiple roles, while males are more affected by the objective dimension.

Another possible factor may be ethnicity. Thus, we think that White Americans may be affected more by the objective dimension, whereas Asian Americans and Latino/Latina may pay more attention to the subjective dimension (see Kertesz, 2002).

Looking at some factors that can covary with clients' perceptions of the counselor and reactions to the counseling situation may be promising. For example, negative response bias may contribute to the clients' views on the counselor involved in multiple roles. Another possibility may be that clients who score high on the social desirability measures will give more traditional responses (e.g., multiple roles are bad and counselors who maintain them are bad as well). Yet another possible factor is clients' expectations about counseling. Every former or current client has a set of expectations about counseling including expectations about counseling relationships. It is possible that clients evaluate situations involving multiple roles or their potential emergence through the prism of these expectations. Thus, it may be important to include measures of negative response bias, social desirability, and counseling expectations in the future research studies.

Further exploration of different populations' perspectives on NMRR is recommended. Thus, it may be interesting to explore views of people who have never been in counseling before and compare them to clients' and former clients' perspectives.

Use of different methodology is also suggested for the future research. For example, developing vignettes with alternative endings, to be chosen in a rank order fashion by research participants, or presenting each client with more than one experimental conditions may help to avoid some confounds.

Given the limitations of the primary study described above, we would strongly recommend replication of these results with former and current clients in the different settings. We can be more confident in our results if they are supported by these studies.

APPENDIX A

CLINICAL CASE VIGNETTES

A –male therapist

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

STORIES

Dr. John Crown is a licensed counseling psychologist working in a mental health clinic. He has been working as a mental health professional in different settings for fifteen years. He is highly respected by his colleagues and has helped many of his clients. The following excerpts describe several situations that occurred in Dr. Crown's work with his clients.

Set 11

(multiple roles present, client's reaction positive, male therapist)

Vignette 1

Ben D. (45 y.o.) is one of Dr. Crown's clients undergoing psychotherapy for issues in relationships. They have been working together for six months and plan on continuing. Two months ago Ben invited Dr. Crown to a party to celebrate Ben's promotion at his workplace. Ben thought that therapy contributed greatly to his advancement, so he wanted Dr. Crown to be a part of this celebration. Dr. Crown accepted Ben's invitation, and the party was enjoyable for both of them.

Sometime after the party, Ben invited the psychologist to go out with him and his friends. Dr. Crown accepted this offer. Beginning from that time the psychologist and the client were socializing together with a group of Ben's friends. Approximately once every two weeks they went out for a dinner or coffee together, sometimes they watched a movie afterwards.

Soon Ben realized that he had become more open and more willing to talk about his issues during therapy sessions. He felt safe with Dr. Crown because of their friendship outside the counseling office. Ben was confident that if he revealed more of his issues in counseling he would not lose Dr. Crown's respect and friendship. Ben felt that Dr. Crown cared about him and accepted him as a person.

Vignette 2

Leann B.(35 y.o.) started counseling with Dr. Crown six months ago because of terrible stress related headaches. Two months after beginning counseling Leann's health started to improve. As therapy progressed, the headaches became less frequent and more bearable. However, Leann remained in therapy and continued to work on development of self-care skills. Four months into therapy, Dr. Crown and Leann ran into each other at the tennis courts. Leann was glad to see Dr. Crown there and suggested that they play a game together. Dr. Crown agreed. They seemed to be equal in their skills and enjoyed playing with each other. Leann suggested they meet once a week to play tennis together.

Dr. Crown said that it was a good idea. So, they started playing tennis together. After playing tennis with Dr. Crown for two months Leann realized that she enjoyed it. She thought that Dr. Crown was an excellent partner because he was noncompetitive, supportive, and not too focused on the result. Additionally, he had a good sense of humor. Leann felt proud when she won.

Leann wanted to tell Dr. Crown how much she appreciated their tennis partnership. Also, Leann started to trust psychologist more in their counseling relationship. She felt as if he cared about her and supported her even more in sessions. And she found herself more and more willing to work on her issues in therapy.

Vignette 3

Alex O. (25 y.o.) started psychotherapy a year ago in connection with depression and suicidal thoughts after the death of his mother. Throughout his time in therapy he improved significantly. After eleven months in therapy, Alex was not clinically depressed anymore. It was still important for Alex to remain in therapy to continue working on his feelings of loss and extreme sadness. At the same time, it became difficult for Alex to continue therapy due to serious financial difficulties. Although Alex was not able to pay for the weekly sessions he did not qualify for fee reduction according to the existing billing criteria. So, Alex suggested he would do something for Dr. Crown in exchange for psychotherapy, for instance, mow the lawn, or help with housework. Dr. Crown thought it was a good idea. They agreed that Alex would paint Dr. Crown's house in exchange for ten sessions.

A month later Alex was still painting Dr. Crown's house. He had to put a lot of time in painting because the house was so big. However, he was satisfied with this arrangement. Alex thought that Dr. Crown cared for him and showed his support by agreeing to barter. Alex thought that this arrangement was the only possible way for him to stay in therapy. So, he appreciated Dr. Crown's willingness to be flexible. Alex noticed that he started to trust Dr. Crown even more and was more motivated to work on his issues in therapy.

Set 21

(multiple roles present, client's reaction negative, male therapist)

Vignette 1

Ben D. (45 y.o.) is one of Dr. Crown's clients undergoing psychotherapy for issues in relationships. They have been working together for six months and plan on continuing. Two months ago Ben invited Dr. Crown to a party to celebrate Ben's promotion at his workplace. Ben thought that therapy contributed greatly to his advancement, so he wanted Dr. Crown to be a part of this celebration. Dr. Crown accepted Ben's invitation, and the party was enjoyable for both of them.

Sometime after the party, Ben invited the psychologist to go out with him and his friends. Dr. Crown accepted this offer. Beginning from that time the psychologist and the client were socializing together with a group of Ben's friends. Approximately once every two weeks they went out for a dinner or coffee together, sometimes they watched a movie afterwards.

Soon Ben realized that he did not feel safe with Dr. Crown anymore because of their friendship outside the counseling office. Ben was afraid that if he revealed more of his issues in counseling he would lose Dr. Crown's respect and friendship. He thought that Dr. Crown

would reject him and that he would stop caring about Ben. As a result, Ben became restrained and reluctant to talk about his issues during therapy sessions.

Vignette 2

Leann B.(35 y.o.) started counseling with Dr. Crown six months ago because of terrible stress related headaches. Two months after beginning counseling Leann's health started to improve. As therapy progressed, the headaches became less frequent and more bearable. However, Leann remained in therapy and continued to work on development of self-care skills. Four months into therapy, Dr. Crown and Leann ran into each other at the tennis courts. Leann was glad to see Dr. Crown there and suggested that they play a game together. Dr. Crown agreed. They seemed to be equal in their skills and enjoyed playing with each other. Leann suggested they meet once a week to play tennis together.

Dr. Crown said that it was a good idea. So, they started playing tennis together. After playing tennis with Dr. Crown for two months Leann realized that she did not like it. She thought that Dr. Crown was a bad partner because he was too competitive, insensitive, and too focused on the result. Additionally, the psychologist did not have a good sense of humor. Leann felt insulted when Dr. Crown won.

Leann wanted to tell Dr. Crown that she did not appreciate their tennis partnership. Also, Leann started to trust psychologist less in their counseling relationship. She felt as if Dr. Crown did not care about her and did not support her in sessions anymore. And she found herself more and more reluctant to work on her issues in therapy.

Vignette 3

Alex O. (25 y.o.) started psychotherapy a year ago in connection with depression and suicidal thoughts after the death of his mother. Throughout his time in therapy he improved significantly. After eleven months in therapy, Alex was not clinically depressed anymore. It was still important for Alex to remain in therapy to continue working on his feelings of loss and extreme sadness. At the same time, it became difficult for Alex to continue therapy due to serious financial difficulties. Although Alex was not able to pay for the weekly sessions he did not qualify for fee reduction according to the existing billing criteria. So, Alex suggested he would do something for Dr. Crown in exchange for psychotherapy, for instance, mow the lawn, or help with housework. Dr. Crown thought it was a good idea. They agreed that Alex would paint Dr. Crown's house in exchange for ten sessions.

A month later Alex was still painting Dr. Crown's house. He had to put a lot of time in painting because the house was so big. Alex felt that he was not satisfied with their arrangement anymore. Alex thought that Dr. Crown exploited him knowing that bartering was the only possible way for Alex to stay in therapy. So, he did not appreciate Dr. Crown's help. Alex noticed that he started to trust Dr. Crown less and was less motivated to work on his issues in therapy.

Set 31

(multiple roles absent, client's reactions positive, male therapist)

Vignette 1

Ben D. (45 y.o.) is one of Dr. Crown's clients undergoing psychotherapy for issues in relationships. They have been working together for six months and plan on continuing. Two months ago Ben invited Dr. Crown to a party to celebrate Ben's promotion at his workplace. Ben thought that therapy contributed greatly to his advancement, so he wanted Dr. Crown to be a part of this celebration. Dr. Crown accepted Ben's invitation, and the party was enjoyable for both of them.

Sometime after the party, Ben invited the psychologist to go out with him and his friends. Dr. Crown declined this offer. He explained to Ben that as his therapist he was primarily interested in Ben's progress in therapy. Dr. Crown stated that their socializing together and having a relationship outside the office might have a negative impact on their therapeutic relationship and, as a result, it might complicate therapy and slow down Ben's progress.

Soon Ben realized that he started to feel safer with Dr. Crown because of the sincerity and honesty that the psychologist showed during discussion of Ben's invitation. Ben felt that Dr. Crown cared about him and accepted him as a person. As a result, Ben became more open and more willing to talk about his issues during therapy sessions.

Vignette 2

Leann B.(35 y.o.) started counseling with Dr. Crown six months ago because of terrible stress related headaches. Two months after beginning counseling Leann's health started to improve. As therapy progressed, the headaches became less frequent and more bearable. However, Leann remained in therapy and continued to work on development of self-care skills. Four months into therapy, Dr. Crown and Leann ran into each other at the tennis courts. Leann was glad to see Dr. Crown there and suggested that they play a game together. Dr. Crown agreed. They seemed to be equal in their skills and enjoyed playing with each other. Leann suggested they meet once a week to play tennis together.

Dr. Crown said that he appreciated Leann's offer, however, he thought that their joint athletic activity might be problematic for their therapeutic relationship and for therapy. So, he declined Leann's offer. Leann repeated her offer on two more occasions in the course of the next two months. But Dr. Crown was firm in his decision to not engage in tennis partnership with Leann.

Soon Leann realized that she appreciated Dr. Crown's refusal to play tennis with her. Leann thought that by declining her offer Dr. Crown showed his interest in and commitment to Leann and her progress in therapy. Also, Leann started to trust the psychologist more in their counseling relationship. She felt as if Dr. Crown cared about her and supported her even more in sessions. As a result, she found herself more and more willing to work on her issues in therapy.

Vignette 3

Alex O. (25 y.o.) started psychotherapy a year ago in connection with depression and suicidal thoughts after the death of his mother. Throughout his time in therapy he improved significantly. After eleven months in therapy, Alex was not clinically depressed anymore. It was still important for Alex to remain in therapy to continue working on his feelings of loss and extreme sadness. At the same time, it became difficult for Alex to continue therapy due to serious financial difficulties. Although Alex was not able to pay for the weekly sessions he did not qualify for fee reduction according to the existing billing criteria. So, Alex suggested he would do something for Dr. Crown in exchange for psychotherapy, for instance, mow the lawn, or help with housework. Dr. Crown thought it was not a good idea. He told Alex that his work for Dr. Crown might interfere significantly with their therapeutic relationship. Dr. Crown suggested that Alex look for other sources of financial support. Following the psychologist's recommendation, Alex found a part-time evening maintenance job.

A month later Alex worked almost every weeknight in order to keep up with the therapy fees. He felt that he was satisfied with this arrangement. He thought that Dr. Crown cared for him and showed support by establishing the boundaries of their therapeutic relationship. Alex appreciated it. He noticed that he started to trust Dr. Crown more and was more willing to work on his issues in therapy.

Set 41

(multiple roles absent, client's reactions negative, male therapist)

Vignette 1

Ben D. (45 y.o.) is one of Dr. Crown's clients undergoing psychotherapy for issues in relationships. They have been working together for six months and plan on continuing. Two months ago Ben invited Dr. Crown to a party to celebrate Ben's promotion at his workplace. Ben thought that therapy contributed greatly to his advancement, so he wanted Dr. Crown to be a part of this celebration. Dr. Crown accepted Ben's invitation, and the party was enjoyable for both of them.

Sometime after the party, Ben invited the psychologist to go out with him and his friends. Dr. Crown declined this offer. He explained to Ben that as his therapist he was primarily interested in Ben's progress in therapy. Dr. Crown stated that their socializing together and having a relationship outside the office might have a negative impact on their therapeutic relationship and, as a result, it might complicate therapy and slow down Ben's progress.

Soon Ben realized that he did not feel safe with Dr. Crown anymore because of his refusal to socialize together. Ben thought that Dr. Crown rejected him and that he did not care too much about him. As a result, Ben became restrained and reluctant to talk about his issues during therapy sessions.

Vignette 2

Leann B.(35 y.o.) started counseling with Dr. Crown six months ago because of terrible stress related headaches. Two months after beginning counseling Leann's health started to improve. As therapy progressed, the headaches became less frequent and more bearable. However, Leann remained in therapy and continued to work on development of self-care skills. Four months into therapy, Dr. Crown and Leann ran into each other at the tennis

courts. Leann was glad to see Dr. Crown there and suggested that they play a game together. Dr. Crown agreed. They seemed to be equal in their skills and enjoyed playing with each other. Leann suggested they meet once a week to play tennis together.

Dr. Crown said that he appreciated Leann's offer, however, he thought that their joint athletic activity might be problematic for their therapeutic relationship and for therapy. So, he declined Leann's offer. Leann repeated her offer on two more occasions in the course of the next two months. But Dr. Crown was firm in his decision to not engage in tennis partnership with Leann.

Soon Leann realized that she felt offended by Dr. Crown's refusal to play tennis with her. Leann thought that by declining her offer Dr. Crown showed lack of interest in and commitment to Leann and her progress in therapy. Also, Leann started to trust psychologist less in their counseling relationship. She felt as if Dr. Crown did not care about her and did not support her anymore in sessions. As a result, Leann found herself less and less willing to work on her issues in therapy.

Vignette 3

Alex O. (25 y.o.) started psychotherapy a year ago in connection with depression and suicidal thoughts after the death of his mother. Throughout his time in therapy he improved significantly. After eleven months in therapy, Alex was not clinically depressed anymore. It was still important for Alex to remain in therapy to continue working on his feelings of loss and extreme sadness. At the same time, it became difficult for Alex to continue therapy due to serious financial difficulties. Although Alex was not able to pay for the weekly sessions he did not qualify for fee reduction according to the existing billing criteria. So, Alex suggested he would do something for Dr. Crown in exchange for psychotherapy, for instance, mow the lawn, or help with housework. Dr. Crown thought it was not a good idea. He told Alex that his work for Dr. Crown might interfere significantly with their therapeutic relationship. Dr. Crown suggested that Alex look for other sources of financial support. Following the psychologist's recommendation, Alex found a part-time evening maintenance job.

A month later Alex worked almost every weeknight in order to keep up with the therapy fees. He felt that he was not satisfied with this arrangement. Alex thought that it was not fair for him to work four to five nights a week in order to cover one hour of therapy. Also he thought that Dr. Crown showed a lack of care and sensitivity by refusing to help his client out. Alex noticed that he started to trust Dr. Crown less and was less motivated to work on his issues in therapy.

B –female therapist

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

STORIES

Dr. Erin Crown is a licensed counseling psychologist working in a mental health clinic. She has been working as a mental health professional in different settings for fifteen years. She is highly respected by her colleagues and has helped many of her clients. The following excerpts describe several situations that occurred in Dr. Crown's work with her clients.

Set 12

(multiple roles present, client's reactions positive, female therapist)

Vignette 1

Ben D. (45 y.o.) is one of Dr. Crown's clients undergoing psychotherapy for issues in relationships. They have been working together for six months and plan on continuing. Two months ago Ben invited Dr. Crown to a party to celebrate Ben's promotion at his workplace. Ben thought that therapy contributed greatly to his advancement, so he wanted Dr. Crown to be a part of this celebration. Dr. Crown accepted Ben's invitation, and the party was enjoyable for both of them.

Sometime after the party, Ben invited the psychologist to go out with him and his friends. Dr. Crown accepted this offer. Beginning from that time the psychologist and the client were socializing together with a group of Ben's friends. Approximately once every two weeks they went out for a dinner or coffee together, sometimes they watched a movie afterwards.

Soon Ben realized that he had become more open and more willing to talk about his issues during therapy sessions. He felt safe with Dr. Crown because of their friendship outside the counseling office. Ben was confident that if he revealed more of his issues in counseling he would not lose Dr. Crown's respect. Ben felt that Dr. Crown cared about him and accepted him as a person.

Vignette 2

Leann B.(35 y.o.) started counseling with Dr. Crown six months ago because of terrible stress related headaches. Two months after beginning counseling Leann's health started to improve. As therapy progressed, the headaches became less frequent and more bearable. However, Leann remained in therapy and continued to work on development of self-care skills. Four months into therapy, Dr. Crown and Leann ran into each other at the tennis courts. Leann was glad to see Dr. Crown there and suggested that they play a game together. Dr. Crown agreed. They seemed to be equal in their skills and enjoyed playing with each other. Leann suggested they meet once a week to play tennis together.

Dr. Crown said that it was a good idea. So, they started playing tennis together. After playing tennis with Dr. Crown for two months Leann realized that she enjoyed it. She thought that Dr. Crown was an excellent partner because she was noncompetitive,

supportive, and not too focused on the result. Additionally, the psychologist had a good sense of humor. Leann felt proud when she won.

Leann wanted to tell Dr. Crown how much she appreciated their tennis partnership. Also, Leann started to trust psychologist more in their counseling relationship. She felt as if Dr. Crown cared about her and supported her even more in sessions. And Leann found herself more and more willing to work on her issues in therapy.

Vignette 3

Alex O. (25 y.o.) started psychotherapy a year ago in connection with depression and suicidal thoughts after the death of his mother. Throughout his time in therapy he improved significantly. After eleven months in therapy, Alex was not clinically depressed anymore. It was still important for Alex to remain in therapy to continue working on his feelings of loss and extreme sadness. At the same time, it became difficult for Alex to continue therapy due to serious financial difficulties. Although Alex was not able to pay for the weekly sessions he did not qualify for fee reduction according to the existing billing criteria. So, Alex suggested he would do something for Dr. Crown in exchange for psychotherapy, for instance, mow the lawn, or help with housework. Dr. Crown thought it was a good idea. They agreed that Alex would paint Dr. Crown's house in exchange for ten sessions.

A month later Alex was still painting Dr. Crown's house. He had to put a lot of time in painting because the house was so big. However, he was satisfied with this arrangement. Alex thought that Dr. Crown cared for him and showed her support of the client by agreeing to barter. Alex thought that this arrangement was the only possible way for him to stay in therapy. So, he appreciated Dr. Crown's willingness to be flexible. Alex noticed that he started to trust Dr. Crown even more and was more motivated to work on his issues in therapy.

Set 22

(multiple roles present, client's reactions negative, female therapist)

Vignette 1

Ben D. (45 y.o.) is one of Dr. Crown's clients undergoing psychotherapy for issues in relationships. They have been working together for six months and plan on continuing. Two months ago Ben invited Dr. Crown to a party to celebrate Ben's promotion at his workplace. Ben thought that therapy contributed greatly to his advancement, so he wanted Dr. Crown to be a part of this celebration. Dr. Crown accepted Ben's invitation, and the party was enjoyable for both of them.

Sometime after the party, Ben invited the psychologist to go out with him and his friends. Dr. Crown accepted this offer. Beginning from that time the psychologist and the client were socializing together with a group of Ben's friends. Approximately once every two weeks they went out for a dinner or coffee together, sometimes they watched a movie afterwards.

Soon Ben realized that he did not feel safe with Dr. Crown anymore because of their friendship outside the counseling office. Ben was afraid that if he revealed more of his issues in counseling he would lose Dr. Crown's respect and friendship. He thought that Dr. Crown would reject him and that he would stop caring about Ben. As a result, Ben became restrained and reluctant to talk about his issues during therapy sessions.

Vignette 2

Leann B.(35 y.o.) started counseling with Dr. Crown six months ago because of terrible stress related headaches. Two months after beginning counseling Leann's health started to improve. As therapy progressed, the headaches became less frequent and more bearable. However, Leann remained in therapy and continued to work on development of self-care skills. Four months into therapy, Dr. Crown and Leann ran into each other at the tennis courts. Leann was glad to see Dr. Crown there and suggested that they play a game together. Dr. Crown agreed. They seemed to be equal in their skills and enjoyed playing with each other. Leann suggested they meet once a week to play tennis together.

Dr. Crown said that it was a good idea. So, they started playing tennis together. After playing tennis with Dr. Crown for two months Leann realized that she did not like it. She thought that Dr. Crown was a bad partner because she was too competitive, insensitive, and too focused on the result. Additionally, the psychologist did not have a good sense of humor. Leann felt insulted when Dr. Crown won.

Leann wanted to tell Dr. Crown that she did not appreciate their tennis partnership. Also, Leann started to trust psychologist less in their counseling relationship. She felt as if Dr. Crown did not care about her and did not support her in sessions anymore. And she found herself more and more reluctant to work on her issues in therapy.

Vignette 3

Alex O. (25 y.o.) started psychotherapy a year ago in connection with depression and suicidal thoughts after the death of his mother. Throughout his time in therapy he improved significantly. After eleven months in therapy, Alex was not clinically depressed anymore. It was still important for Alex to remain in therapy to continue working on his feelings of loss and extreme sadness. At the same time, it became difficult for Alex to continue therapy due to serious financial difficulties. Although Alex was not able to pay for the weekly sessions he did not qualify for fee reduction according to the existing billing criteria. So, Alex suggested he would do something for Dr. Crown in exchange for psychotherapy, for instance, mow the lawn, or help with housework. Dr. Crown thought it was a good idea. They agreed that Alex would paint Dr. Crown's house in exchange for ten sessions.

A month later Alex was still painting Dr. Crown's house. He had to put a lot of time in painting because the house was so big. Alex felt that he was not satisfied with their arrangement anymore. Alex thought that Dr. Crown exploited him knowing that bartering was the only possible way for Alex to stay in therapy. So, he did not appreciate Dr. Crown's help. Alex noticed that he started to trust Dr. Crown less and was less motivated to work on his issues in therapy.

Set 32

(multiple roles absent, client's reactions positive, female therapist)

Vignette 1

Ben D. (45 y.o.) is one of Dr. Crown's clients undergoing psychotherapy for issues in relationships. They have been working together for six months and plan on continuing. Two months ago Ben invited Dr. Crown to a party to celebrate Ben's promotion at his workplace. Ben thought that therapy contributed greatly to his advancement, so he wanted Dr. Crown to be a part of this celebration. Dr. Crown accepted Ben's invitation, and the party was enjoyable for both of them.

Sometime after the party, Ben invited the psychologist to go out with him and his friends. Dr. Crown declined this offer. She explained to Ben that as his therapist she was primarily interested in Ben's progress in therapy. Dr. Crown stated that their socializing together and having a relationship outside the office might have a negative impact on their therapeutic relationship and, as a result, it might complicate therapy and slow down Ben's progress.

Soon Ben realized that he started to feel safer with Dr. Crown because of the sincerity and honesty that the psychologist showed during discussion of Ben's invitation. Ben felt that Dr. Crown cared about him and accepted him as a person. As a result, Ben became more open and more willing to talk about his issues during therapy sessions.

Vignette 2

Leann B.(35 y.o.) started counseling with Dr. Crown six months ago because of terrible stress related headaches. Two months after beginning counseling Leann's health started to improve. As therapy progressed, the headaches became less frequent and more bearable. However, Leann remained in therapy and continued to work on development of self-care skills. Four months into therapy, Dr. Crown and Leann ran into each other at the tennis courts. Leann was glad to see Dr. Crown there and suggested that they play a game together. Dr. Crown agreed. They seemed to be equal in their skills and enjoyed playing with each other. Leann suggested they meet once a week to play tennis together.

Dr. Crown said that she appreciated Leann's offer, however, she thought that their joint athletic activity might be problematic for their therapeutic relationship and for therapy. So, she declined Leann's offer. Leann repeated her offer on two more occasions in the course of the next two months. But Dr. Crown was firm in her decision to not engage in tennis partnership with Leann.

Soon Leann realized that she appreciated Dr. Crown's refusal to play tennis with her. Leann thought that by declining her offer Dr. Crown showed her interest in and commitment to Leann and her progress in therapy. Also, Leann started to trust the psychologist more in their counseling relationship. She felt as if Dr. Crown cared about her and supported her even more in sessions. As a result, Leann found herself more and more willing to work on her issues in therapy.

Vignette 3

Alex O. (25 y.o.) started psychotherapy a year ago in connection with depression and suicidal thoughts after the death of his mother. Throughout his time in therapy he improved significantly. After eleven months in therapy, Alex was not clinically depressed anymore. It was still important for Alex to remain in therapy to continue working on his feelings of loss and extreme sadness. At the same time, it became difficult for Alex to continue therapy due to serious financial difficulties. Although Alex was not able to pay for the weekly sessions he did not qualify for fee reduction according to the existing billing criteria. So, Alex suggested he would do something for Dr. Crown in exchange for psychotherapy, for instance, mow the lawn, or help with housework. Dr. Crown thought it was not a good idea. She told Alex that his work for Dr. Crown might interfere significantly with their therapeutic relationship. Dr. Crown suggested that Alex look for other sources of financial support. Following the psychologist's recommendation, Alex found a part-time evening maintenance job.

A month later Alex worked almost every weeknight in order to keep up with the therapy fees. He felt that he was satisfied with this arrangement. He thought that Dr. Crown cared for him and showed support by establishing the boundaries of their therapeutic relationship. Alex appreciated it. He noticed that he started to trust Dr. Crown more and was more willing to work on his issues in therapy.

Set 42

(multiple roles absent, client's reactions negative, female therapist)

Vignette 1

Ben D. (45 y.o.) is one of Dr. Crown's clients undergoing psychotherapy for issues in relationships. They have been working together for six months and plan on continuing. Two months ago Ben invited Dr. Crown to a party to celebrate Ben's promotion at his workplace. Ben thought that therapy contributed greatly to his advancement, so he wanted Dr. Crown to be a part of this celebration. Dr. Crown accepted Ben's invitation, and the party was enjoyable for both of them.

Sometime after the party, Ben invited the psychologist to go out with him and his friends. Dr. Crown declined this offer. She explained to Ben that as his therapist she was primarily interested in Ben's progress in therapy. Dr. Crown stated that their socializing together and having a relationship outside the office might have a negative impact on their therapeutic relationship and, as a result, it might complicate therapy and slow down Ben's progress.

Soon Ben realized that he did not feel safe with Dr. Crown anymore because of her refusal to socialize together. Ben thought that Dr. Crown rejected him and that she did not care too much about him. As a result, Ben became restrained and reluctant to talk about his issues during therapy sessions.

Vignette 2

Leann B.(35 y.o.) started counseling with Dr. Crown six months ago because of terrible stress related headaches. Two months after beginning counseling Leann's health started to improve. As therapy progressed, the headaches became less frequent and more bearable. However, Leann remained in therapy and continued to work on development of self-care skills. Four months into therapy, Dr. Crown and Leann ran into each other at the tennis

courts. Leann was glad to see Dr. Crown there and suggested that they play a game together. Dr. Crown agreed. They seemed to be equal in their skills and enjoyed playing with each other. Leann suggested they meet once a week to play tennis together.

Dr. Crown said that she appreciated Leann's offer, however, she thought that their joint athletic activity might be problematic for their therapeutic relationship and for therapy. So, she declined Leann's offer. Leann repeated her offer on two more occasions in the course of the next two months. But Dr. Crown was firm in her decision to not engage in tennis partnership with Leann.

Soon Leann realized that she felt offended by Dr. Crown's refusal to play tennis with her. Leann thought that by declining her offer Dr. Crown showed lack of interest in and commitment to Leann and her progress in therapy. Also, Leann started to trust psychologist less in their counseling relationship. She felt as if Dr. Crown did not care about her and did not support her anymore in sessions. As a result, Leann found herself less and less willing to work on her issues in therapy.

Vignette 3

Alex O. (25 y.o.) started psychotherapy a year ago in connection with depression and suicidal thoughts after the death of his mother. Throughout his time in therapy he improved significantly. After eleven months in therapy, Alex was not clinically depressed anymore. It was still important for Alex to remain in therapy to continue working on his feelings of loss and extreme sadness. At the same time, it became difficult for Alex to continue therapy due to serious financial difficulties. Although Alex was not able to pay for the weekly sessions he did not qualify for fee reduction according to the existing billing criteria. So, Alex suggested he would do something for Dr. Crown in exchange for psychotherapy, for instance, mow the lawn, or help with housework. Dr. Crown thought it was not a good idea. She told Alex that his work for Dr. Crown might interfere significantly with their therapeutic relationship. Dr. Crown suggested that Alex look for other sources of financial support. Following the psychologist's recommendation, Alex found a part-time evening maintenance job.

A month later Alex worked almost every weeknight in order to keep up with the therapy fees. He felt that he was not satisfied with this arrangement. Alex thought that it was not fair for him to work four to five nights a week in order to cover one hour of therapy. Also, he thought that Dr. Crown showed a lack of care and sensitivity by refusing to help her client out. Alex noticed that he started to trust Dr. Crown less and was less motivated to work on his issues in therapy.

APPENDIX B

TWO VERSIONS OF THE REACTION QUESTIONNAIRE

1. The Reaction Questionnaire (Original Version)

We want you to give us your most complete and accurate reactions to **each** of these three separate vignettes. Please, take your time to carefully think about it.

Part I. After reading vignettes you may have some feelings. We want you to express these feelings by completing ratings for each of the three vignettes. Please, indicate to what extent you experienced each of the feelings from the table below after reading each of the vignettes. Fill in each cell of the table using the following scale:

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

		Vignette 1	Vignette 2	Vignette 3
1.	Hurt			
2.	Helped			
3.	Anxious			
4.	Happy			
5.	Angry			
6.	Safe			
7.	Sad			
8.	Reassured			
9.	Offended			
10.	Cared for			
11.	Misled			
12.	Encouraged			
13.	Tense			
14.	Supported			
15.	Exploited			
16.	Relaxed			

17.	Other (specify)			
18.	Other (specify)			
19.	Other (specify)			

From the table on the previous page choose the one strongest feeling associated with each vignette. Indicate what caused this feeling.

		Vignette 1	Vignette 2	Vignette 3
20.	Strongest feeling			
21.	What caused this feeling?			

Part II.

Using the scale below, indicate to what extent thoughts listed below were present in your mind as you recall your overall impressions from reading three vignettes.

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

22.I would like to be this client _____

23.This situation is too bad _____

24.I like this psychologist _____

25.If I were in this client's place I would behave in a different way _____

26.I perfectly understand client's feelings _____

27.I don't believe this could have happened _____

28.I don't want to be this client _____

29.This psychologist is a jerk _____

30.If I were this client I would do exactly the same _____

31.I don't understand why client feels so bad about this situation _____

32.One cannot accurately predict the consequences of other than counseling relationships for the client _____

33.This client's reactions are weird _____

34.I don't understand psychologist's actions _____

35.This psychologist is cool _____

36.I don't like this psychologist _____

37.Other thoughts (please, specify each thought):

2. The Reaction Questionnaire (Final Version)

You have finished reading the clinical case vignettes (descriptions of clients' experiences with their therapists). We asked you to imagine yourself in the client's shoes. Please, react to the vignettes by responding to the questions below.

Part I. Please, express your feelings (how you felt after reading a particular vignette) by completing the ratings below. Please, indicate **to what extent YOU experienced each of the feelings from the table below after reading each of the vignettes**. Fill in EACH CELL of the table using the following scale:

1 2 3 4 5

Not at all a little somewhat definitely to a great extent

		Vignette 1	Vignette 2	Vignette 3
1.	Hurt			
2.	Helped			
3.	Anxious			
4.	Happy			
5.	Angry			
6.	Safe			
7.	Sad			
8.	Reassured			
9.	Offended			
10.	Cared for			

11.	Misled			
12.	Encouraged			
13.	Frustrated			
14.	Supported			
15.	Exploited			
16.	Relaxed			
17.	Disappointed			
18.	Grateful			
19.	Other (Specify)			

Please, choose one strongest feeling associated with each vignette. Indicate what caused this feeling. Please write your answer in the appropriate cell below.

		Vignette 1	Vignette 2	Vignette 3
20.	Strongest feeling			
21.	What caused this feeling?			

Part II.

Using the scale below, indicate to what extent the thoughts listed below were present in your mind as you recall your overall impressions from reading three vignettes.

1 2 3 4 5

Not at all a little somewhat definitely to a great extent

22.I would like to be in this client's place _____

23.This situation is too bad _____

24.I like this psychologist _____

25. Clients need friends outside of counseling relationships _____

26.I understand client's feelings and reactions _____

27.I don't want to be in this client's place _____

28.This psychologist is not professional _____

29.If I were this client I would do exactly the same _____

30.I don't understand why client feels so bad about this situation _____

31. This psychologist is very rigid in his/her beliefs and or actions _____

32.This client's reactions are weird _____

33.I don't understand psychologist's actions _____

34.This psychologist is professional _____

35.I don't like this psychologist _____

36.Relationships between client and psychologist need to remain professional

37.This psychologist is flexible and open-minded

38.This psychologist is too involved with his/her clients

39.It is good that relationships between psychologist and client are not limited by counseling and psychologist's office

Part III Please answer each question thoroughly in your own words (separately for each vignette). You can use space on the back of each sheet if needed. Please, print your answer legibly.

Vignette 1

40.What is your general impression of this situation (including you thoughts and feelings)?

41.How do you view the counselor in this vignette?

42.How do you view the client in this vignette?

Vignette 2

43.What is your general impression of this situation (including you thoughts and feelings)?

44.How do you view the counselor in this vignette?

45.How do you view the client in this vignette?

Vignette 3

46. What is your general impression of this situation (including you thoughts and feelings)?

47. How do you view the counselor in this vignette?

48. How do you view the client in this vignette?

APPENDIX C
THE ADJECTIVE CHECK LIST WITH INSTRUCTIONS

The Adjective Check List's Original Instructions

This booklet contains a list of adjectives. Please read them quickly and put an **X** in the box beside each one you would consider to be self-descriptive. Do not worry about duplications, contradictions, and so forth. Work quickly and do not spend too much time on any one adjective. Try to be frank, and check those adjectives which describe you as you really are, not as you would like to be.

The Adjective Check List's Modified Instructions

This booklet contains a list of adjectives. Please read them quickly and put an **X** in the box beside each adjective you would consider to be descriptive of the psychologist depicted in the three vignettes you just read. Do not worry about duplications, contradictions, and so forth. Work quickly and do not spend too much time on any one adjective. Try to be frank, and check the adjectives you believe describe this psychologist as he/she really is, NOT as you would like him/her to be.

The Adjective Check List

By Harrison G. Gough, Ph.D.
University of California (Berkeley)

ACL

THE ADJECTIVE CHECK LIST

By Harrison G. Gough, Ph.D.

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TO THE CLIENT: Complete the following steps.

1. IMPORTANT MARK ONE

SEX
MALE ○
FEMALE ○

2. IDENTIFICATION NUMBER

3. NAME: Print your name, one letter per box, in the boxes below. Print your last name first, skip one box, and print as much of your first name as possible. Fill in the appropriate bubble below each box, including blank bubbles for skipped boxes.

TEST DIRECTIONS: This answer sheet contains a list of 300 adjectives. Please read them quickly and blacken in the circle beside each one you would consider to be self-descriptive. Do not worry about duplications, contradictions, and so forth. Work quickly and do not spend too much time on any one adjective. Try to be frank, and fill the circles for the adjectives which describe you as you really are, not as you would like to be. BE SURE TO TURN THE PAGE OVER and continue through adjective number 300 on the reverse side.

MARKING INSTRUCTIONS

- Use a soft (No. 2) black lead pencil.
- Make dark, heavy marks that fill the bubble.
- Mark ONLY the bubble areas.
- Make no stray marks.
- Erase completely any answer you wish to change.

EXAMPLES: Proper Mark: ○●○○ Improper Marks: ✓⊗○⊙

● PREPAID PROFILE

RO	#	CODE

1 ○ absent-minded	39 ○ complicated	77 ○ emotional	115 ○ humorous
2 ○ active	40 ○ conceited	78 ○ energetic	116 ○ hurried
3 ○ adaptable	41 ○ confident	79 ○ enterprising	117 ○ idealistic
4 ○ adventurous	42 ○ confused	80 ○ enthusiastic	118 ○ imaginative
5 ○ affected	43 ○ conscientious	81 ○ evasive	119 ○ immature
6 ○ affectionate	44 ○ conservative	82 ○ excitable	120 ○ impatient
7 ○ aggressive	45 ○ considerate	83 ○ fair-minded	121 ○ impulsive
8 ○ alert	46 ○ contented	84 ○ fault-finding	122 ○ independent
9 ○ aloof	47 ○ conventional	85 ○ fearful	123 ○ indifferent
10 ○ ambitious	48 ○ cool	86 ○ feminine	124 ○ individualistic
11 ○ anxious	49 ○ cooperative	87 ○ fickle	125 ○ industrious
12 ○ apathetic	50 ○ courageous	88 ○ flirtatious	126 ○ infantile
13 ○ appreciative	51 ○ cowardly	89 ○ foolish	127 ○ informal
14 ○ argumentative	52 ○ cruel	90 ○ forceful	128 ○ ingenious
15 ○ arrogant	53 ○ curious	91 ○ foresighted	129 ○ inhibited
16 ○ artistic	54 ○ cynical	92 ○ forgetful	130 ○ initiative
17 ○ assertive	55 ○ daring	93 ○ forgiving	131 ○ insightful
18 ○ attractive	56 ○ deceitful	94 ○ formal	132 ○ intelligent
19 ○ autocratic	57 ○ defensive	95 ○ frank	133 ○ interests narrow
20 ○ awkward	58 ○ deliberate	96 ○ friendly	134 ○ interests wide
21 ○ bitter	59 ○ demanding	97 ○ frivolous	135 ○ intolerant
22 ○ blustery	60 ○ dependable	98 ○ fussy	136 ○ inventive
23 ○ boastful	61 ○ dependent	99 ○ generous	137 ○ irresponsible
24 ○ bossy	62 ○ despondent	100 ○ gentle	138 ○ irritable
25 ○ calm	63 ○ determined	101 ○ gloomy	139 ○ jolly
26 ○ capable	64 ○ dignified	102 ○ good-looking	140 ○ kind
27 ○ careless	65 ○ discreet	103 ○ good-natured	141 ○ lazy
28 ○ cautious	66 ○ disorderly	104 ○ greedy	142 ○ leisurely
29 ○ changeable	67 ○ dissatisfied	105 ○ handsome	143 ○ logical
30 ○ charming	68 ○ distractible	106 ○ hard-headed	144 ○ loud
31 ○ cheerful	69 ○ distrustful	107 ○ hard-hearted	145 ○ loyal
32 ○ civilized	70 ○ dominant	108 ○ hasty	146 ○ mannerly
33 ○ clear-thinking	71 ○ dreamy	109 ○ headstrong	147 ○ masculine
34 ○ clever	72 ○ dull	110 ○ healthy	148 ○ mature
35 ○ coarse	73 ○ easygoing	111 ○ helpful	149 ○ meek
36 ○ cold	74 ○ effeminate	112 ○ high-strung	150 ○ methodical
37 ○ commonplace	75 ○ efficient	113 ○ honest	151 ○ mild
38 ○ complaining	76 ○ egotistical	114 ○ hostile	152 ○ mischievous

CONTINUE ON REVERSE SIDE

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Approved Date: January 30, 2004
Expiration Date: January 29, 2005

ACL THE ADJECTIVE CHECK

Consulting Psychologists Press
3803 East Bayshore Road, Palo Alto,

153 ◯ moderate	191 ◯ quiet	229 ◯ shrewd	267 ◯ thrifty
154 ◯ modest	192 ◯ quitting	230 ◯ shy	268 ◯ timid
155 ◯ moody	193 ◯ rational	231 ◯ silent	269 ◯ tolerant
156 ◯ nagging	194 ◯ rattlebrained	232 ◯ simple	270 ◯ touchy
157 ◯ natural	195 ◯ realistic	233 ◯ sincere	271 ◯ tough
158 ◯ nervous	196 ◯ reasonable	234 ◯ slipshod	272 ◯ trusting
159 ◯ noisy	197 ◯ rebellious	235 ◯ slow	273 ◯ unaffected
160 ◯ obliging	198 ◯ reckless	236 ◯ sly	274 ◯ unambitious
161 ◯ obnoxious	199 ◯ reflective	237 ◯ smug	275 ◯ unassuming
162 ◯ opinionated	200 ◯ relaxed	238 ◯ snobbish	276 ◯ unconventional
163 ◯ opportunistic	201 ◯ reliable	239 ◯ sociable	277 ◯ undependable
164 ◯ optimistic	202 ◯ resentful	240 ◯ soft-hearted	278 ◯ understanding
165 ◯ organized	203 ◯ reserved	241 ◯ sophisticated	279 ◯ unemotional
166 ◯ original	204 ◯ resourceful	242 ◯ spendthrift	280 ◯ unexcitable
167 ◯ outgoing	205 ◯ responsible	243 ◯ spineless	281 ◯ unfriendly
168 ◯ outspoken	206 ◯ restless	244 ◯ spontaneous	282 ◯ uninhibited
169 ◯ painstaking	207 ◯ retiring	245 ◯ spunky	283 ◯ unintelligent
170 ◯ patient	208 ◯ rigid	246 ◯ stable	284 ◯ unkind
171 ◯ peaceable	209 ◯ robust	247 ◯ steady	285 ◯ unrealistic
172 ◯ peculiar	210 ◯ rude	248 ◯ stern	286 ◯ unscrupulous
173 ◯ persevering	211 ◯ sarcastic	249 ◯ stingy	287 ◯ unselfish
174 ◯ persistent	212 ◯ self-centered	250 ◯ stolid	288 ◯ unstable
175 ◯ pessimistic	213 ◯ self-confident	251 ◯ strong	289 ◯ vindictive
176 ◯ planful	214 ◯ self-controlled	252 ◯ stubborn	290 ◯ versatile
177 ◯ pleasant	215 ◯ self-denying	253 ◯ submissive	291 ◯ warm
178 ◯ pleasure-seeking	216 ◯ self-pitying	254 ◯ suggestible	292 ◯ wary
179 ◯ poised	217 ◯ self-punishing	255 ◯ sulky	293 ◯ weak
180 ◯ polished	218 ◯ self-seeking	256 ◯ superstitious	294 ◯ whiny
181 ◯ practical	219 ◯ selfish	257 ◯ suspicious	295 ◯ wholesome
182 ◯ praising	220 ◯ sensitive	258 ◯ sympathetic	296 ◯ wise
183 ◯ precise	221 ◯ sentimental	259 ◯ tactful	297 ◯ withdrawn
184 ◯ prejudiced	222 ◯ serious	260 ◯ tactless	298 ◯ witty
185 ◯ preoccupied	223 ◯ severe	261 ◯ talkative	299 ◯ worrying
186 ◯ progressive	224 ◯ sexy	262 ◯ temperamental	300 ◯ zany
187 ◯ prudish	255 ◯ shallow	263 ◯ tense	
188 ◯ quarrelsome	226 ◯ sharp-witted	264 ◯ thankless	
189 ◯ queer	227 ◯ shiftless	265 ◯ thorough	
190 ◯ quick	228 ◯ show-off	266 ◯ thoughtful	

APPENDIX D

MULTIPLE ROLES QUESTIONNAIRE

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

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

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

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

APPENDIX E

INFORMED CONSENT FOR THE PILOT STUDY

INFORMED CONSENT DOCUMENT

Title of Study: Perception of nonsexual multiple role relationships (pilot study).
Investigators: Irina V. Diyankova, B.A.
This is a research study. Please take your time in deciding if you would like to participate. Please feel free to ask questions at any time.

INTRODUCTION

The purpose of this study is to develop several measures for studying relationships between the counselor and the client. You are being invited to participate in this study because of your previous counseling experience in the client's role.

DESCRIPTION OF PROCEDURES

If you agree to participate in this study, your participation will last for 50 minutes or less. During the study you may expect the following study procedures to be followed. You'll be given several clinical case vignettes and asked to read them. Afterwards, you will be asked to fill out several questionnaires related to these vignettes. You may skip any question that you do not wish to answer or that makes you feel uncomfortable.

RISKS AND LIMITATIONS

There are no risks associated with this study. However, there are some limitations. Thus, if you participate in this pilot study, you won't have an opportunity to participate in the primary study of this project due to your exposure to research materials.

BENEFITS

If you decide to participate in this study there may be no direct benefit to you. It is hoped that the information gained in this study will benefit psychological science by providing it with new research instruments appropriate for doing research in such important areas as ethics and counseling.

COSTS AND COMPENSATION

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

PARTICIPANT RIGHTS

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

CONFIDENTIALITY

Records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations and will not be made publicly available. However, federal government regulatory agencies and the Institutional Review Board (a committee that reviews and approves human subject research studies) may inspect and/or copy your records for quality assurance and data analysis. These records may contain private information. To ensure confidentiality to the extent permitted by law, the following measures will be taken (a) subjects will be assigned a unique code that will be used on forms instead of their name; (b) all identifying information will be kept separately in the secure file in the principal investigator's office (c) all identifying information will be erased after 04/01/04. If the results of this study are published, your identity will remain confidential.

QUESTIONS OR PROBLEMS

You are encouraged to ask questions at any time during this study. For further information about the study contact Irina Diyankova at 294-87-94 or ivdiyan@iastate.edu or Dr. Norman Scott at 294-15-09 or nascott@iastate.edu . If you have any questions about the rights of research subjects or research-related injury, please contact the Human Subjects Research Office, 2810 Beardshear Hall, (515) 294-4566; austingr@iastate.edu or the Research Compliance Officer, Office of Research Compliance, 2810 Beardshear Hall, (515) 294-3115; dament@iastate.edu

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SUBJECT SIGNATURE

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

Subject's Name (printed) _____

_____ _____

(Subject's Signature) (Date)

INVESTIGATOR STATEMENT

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

_____ _____

(Signature of Person Obtaining Informed Consent) (Date)

APPENDIX F

QUESTIONS CONCERNING THE CASE VIGNETTES

We are interested in improving clinical vignettes that were presented to you earlier. Your sincere and honest feedback will help us to modify them. Please, answer the following questions thoughtfully and thoroughly. Take as much time as you need working on them. We appreciate your input!

Vignette 1

1. What is your general impression of this situation (including you thoughts and feelings)?
2. How do you view the counselor in this vignette?
3. How do you view the client in this vignette?
4. What would you change in this vignette for it to become more realistic and have greater impact on the reader?

Vignette 2

5. What is your general impression of this situation (including you thoughts and feelings)?
6. How do you view the counselor in this vignette?
7. How do you view the client in this vignette?
8. What would you change in this vignette for it to become more realistic and have greater impact on the reader?

Vignette 3

9. What is your general impression of this situation (including you thoughts and feelings)?
10. How do you view the counselor in this vignette?
11. How do you view the client in this vignette?
12. What would you change in this vignette for it to become more realistic and have greater impact on the reader?

APPENDIX G

QUESTIONS ABOUT THE REACTION QUESTIONNAIRE

We are working on modifying Reaction Questionnaire. The purpose of this questionnaire is to obtain information about individuals' reactions to the case vignettes. Instead of asking people to write an essay about their reactions we are asking them questions to help them sort things out and put them on paper. We want to have an impression of what individuals' reactions to the vignettes were after reading their responses to the questions of Reaction Questionnaire.

You were one of the first persons to fill out new Reaction Questionnaire. We need your feedback in order to make this questionnaire serve our purposes. Please, go back to Reaction Questionnaire and read its questions and your responses. Then answer the following questions as thoroughly and thoughtfully as you can.

1. How clear were the questions?
2. To what extent your answers to the questions reflected your reactions to the vignettes?
3. Which questions need clarification?
   Suggest your wording
4. Which of your reactions to the vignettes were not covered by the questions? (please, describe these reactions in details)
5. Please, share with us any other comments (whether positive or negative) you have concerning Reaction Questionnaire.

APPENDIX H

INFORMED CONSENT FOR THE PRIMARY STUDY

INFORMED CONSENT DOCUMENT

Title of Study: Perception of counseling relationships
Primary Investigator: Irina V. Diyankova, B.A.
This is a research study. You must be 18 years or older in order to participate. Please take your time in deciding if you would like to participate. Please feel free to ask questions at any time.
Supervisor: Norman Scott, Ph.D.

INTRODUCTION

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

DESCRIPTION OF PROCEDURES

If you agree to participate in this study, your participation will last between 60 and 90 minutes. During the study you may expect the following study procedures to be followed. You'll be given a questionnaire and asked to fill it out. Then you will be presented with several clinical case vignettes (descriptions of client and therapist interactions) and asked to read them. Afterwards, you will be asked to fill out several questionnaires related to these vignettes. In the end you will be asked to provide some demographic information about yourself and answer to the questions of the Counseling Experience scale. You will not be asked to share about the nature of your issues or things discussed in counseling. You may skip any question that you do not wish to answer or that makes you feel uncomfortable.

RISKS AND LIMITATIONS

There are no risks associated with this study. However, there are some limitations. Thus, if you participated in the pilot study entitled "Perception of nonsexual multiple role relationships (pilot study)" in the Fall 2003 (experiment # 45), you won't have an opportunity to participate in this study due to your previous exposure to the research materials.

BENEFITS

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

COSTS AND COMPENSATION

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

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

CONFIDENTIALITY
Records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations and will not be made publicly available. However, federal government regulatory agencies and the Institutional Review Board (a committee that reviews and approves human subject research studies) may inspect and/or copy your records for quality assurance and data analysis. These records may contain private information. To ensure confidentiality to the extent permitted by law, the following measures will be taken (a) participants will be assigned a unique code that will be used on forms and in databases instead of their name; (b) all identifying information will be kept separately in the secure file in the principal investigator's office (c) all identifying information will be erased after 07/01/04. If the results of this study are published, your identity will remain confidential.

QUESTIONS OR PROBLEMS
You are encouraged to ask questions at any time during this study. For further information about the study contact Irina Diyankova at 294-87-94 or ivdiyan@iastate.edu or Dr. Norman Scott at 294-15-09 or nascott@iastate.edu. If you have any questions about the rights of research subjects or research-related injury, please contact the Human Subjects Research Office, 2810 Beardshear Hall, (515) 294-4566; austingr@iastate.edu or the Research Compliance Officer, Office of Research Compliance, 2810 Beardshear Hall, (515) 294-3115; dament@iastate.edu

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

Participant's Name (printed) _____

_____ _____
(Participant's Signature) (Date)

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

_____ _____
(Signature of Person Obtaining Informed Consent) (Date)

APPENDIX I

GENERAL INSTRUCTIONS AND INTRODUCTION TO THE PRIMARY STUDY

Perception of counseling relationships study

Introduction

Welcome to the study "Perception of counseling relationships". The purpose of this study is to explore former and current clients' views on and attitudes towards relationships between clients and mental health professionals. It is important for researchers and mental health professionals to understand how clients see counseling relationships in order to find better and more efficient ways of helping.

You have expertise in the area of counseling relationships because you have been in counseling before. We need your input in order to understand clients' perspective better. Please, use your experience and good judgment when responding to the questions and writing comments. We will depend on you to provide us with honest and helpful feedback.

General instructions

1. Please fill out the Expectations About Counseling questionnaire (EAC-B)
2. Next, read three vignettes (case descriptions) enclosed in your packet.
3. Go to the Reaction Questionnaire and answer the questions.
4. Fill out the Adjective Checklist.
5. Respond to the Questions of Multiple Role Questionnaire (MRQ)
6. Fill out the Counseling Experience Scale and Demographic Questionnaire
7. Please, hand in the packet to the research assistant, and obtain an extra-credit card (it should be for 3 extra credits).
8. Obtain and read the debriefing statement. Feel free to ask questions (if any).
9. You are free to go. **Thank you for your participation!**

APPENDIX J

COUNSELING EXPERIENCE SCALE

1. What type of counseling have you received? You may choose as many alternatives as are applicable to your counseling experience.
   (1) Individual counseling or psychotherapy
   (2) Family counseling or psychotherapy (participation in counseling or psychotherapy either with your parents, your spouse, or your children)
   (3) Group counseling or psychotherapy
   (4) Other

2. How old were you during your most recent counseling experience?
   (1) 10 years old or younger
   (2) 10- 14 years old
   (3) 15- 17 years old
   (4) 18 or older

3. Are you currently in counseling?
   (1) Yes
   (2) No

THE REST OF THE QUESTIONS REFER TO THE LONGEST COUNSELING EXPERIENCE YOU HAD AT OR AFTER THE AGE OF 15. IF YOU HAVE ONLY BEEN IN COUNSELING BEFORE 15, THEN SKIP QUESTIONS # 4-10.

4. How many times did you meet with your counselor or psychologist?
   (1) Once
   (2) 2-3 times
   (3) 4-6 times
   (4) 8- 10 times
   (5) 11- 20 times
   (6) more than 20 times

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

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

(3) Positive relationships: My counselor or psychotherapist and I had a strong/good connection. I felt understood by him/her. I have a little to complain about.

7. Did you ever have any relationship with your counselor or psychotherapist and/or members of his/her family outside the office? For example, (1) you socialized together, (2) you were social acquaintances, (3) you were friends with his/her spouse and/or kids, (4) you were his/her student, colleague, or employee, etc.
   (1) Yes
   (2) No
   IF ANSWER IS **NO** SKIP QUESTIONS # 8 – 10

8. How successful were those "outside the office" relationships?
   (1) Not successful at all
   (2) Fairly successful
   (3) Very successful

9. How did these "outside the office" relationships influence counseling?
   (1) did not influence at all
   (2) minimally influenced
   (3) somewhat influenced
   (4) significantly influenced

10. Was this influence positive, negative or neutral?
    (1) negative
    (2) ambiguous
    (3) neutral
    (4) positive

APPENDIX K

DEMOGRAPHIC QUESTIONNAIRE

Please, answer the following questions by circling the appropriate alternative

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

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

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

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

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

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

APPENDIX L

DEBRIEFING

Title of Study: Perception of Counseling Relationships

Thank you for your participation. The study that you participated in was designed to explore current and former clients' views and attitudes towards nonsexual multiple role relationships. The issues of nonsexual multiple role relationships is controversial. This issue has been continually debated in the scientific and professional literature. At this point, there is no established opinion concerning ethicality, harmfulness, or beneficence of these relationships. We hope to gain more knowledge about the nature of nonsexual multiple role relationships and about clients' attitudes towards them as a result of this study.

All your responses will be kept confidential. All identifying information (names, e-mail addresses, phone numbers, etc.) will be separated from the rest of the data after today's session. Your data will be combined with that from the other participants and analyzed as one set so that no individuals' responses can be identified.

If you have any additional questions, you may contact the Principal Investigator, Irina Diyankova, at W283 Lagomarcino Hall, Department of Psychology, Iowa State University, Ames, IA 50011; 294-87-94; ivdiyan@iasate.edu or project supervisor, Dr. Norman Scott at 294-1509 or nascott@iastate.edu.

For your convenience we provided some community resources in case you are interested in counseling:

- Student Counseling Services: 3rd floor of the Student Services Building, Ames, IA; 294-5056 (counseling is free for students).
- Richmond Center: 125 South 3 rd street, Ames, IA; 232-5811

If you have any questions about the rights of research subjects or research-related injury, please contact the Human Subjects Research Office, 2810 Beardshear Hall, (515) 294-4566; austingr@iastate.edu or the Research Compliance Officer, Office of Research Compliance, 2810 Beardshear Hall, (515) 294-3115; dament@iastate.edu

APPENDIX M

COUNSELING EXPERIENCES SCALE – MASS TESTING VERSION

1. Have you ever received counseling or psychotherapeutic services (been a client in counseling)?
   (1) Yes
   (2) No
   If your answer is no, skip to question # 6

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

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

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

5. In your opinion, how helpful has been your counseling experience?
   (1) Not helpful
   (2) Somewhat not helpful
   (3) Neither helpful, nor unhelpful
   (4) Moderately helpful
   (5) Helpful

APPENDIX N

TABLE OF FREQUENCES OF PARTICIPANTS' RESPONSES TO THE GENERAL IMPRESSIONS OF THE COUNSELING SITUATION QUESTIONS DEPENDING ON THE EXPERIMENTAL CONDITION

Experimental condition	General impression			
	positive	negative	neutral	ambiguous
Vignette 1				
Present, positive	2	4	1	7
Present, negative	0	7	2	4
Absent, positive	1	0	6	5
Absent, negative	0	6	3	3
TOTAL	3	17	12	19
Vignette 2				
Present, positive	5	1	2	6
Present, negative	0	5	5	3
Absent, positive	3	1	6	2
Absent, negative	1	5	3	3
TOTAL	9	12	16	14
Vignette 3				
Present, positive	3	7	3	1
Present, negative	0	2	4	7
Absent, positive	2	3	3	4
Absent, negative	0	9	2	1
TOTAL	5	21	12	13

APPENDIX O

TABLE OF FREQUENCES OF PARTICIPANTS' RESPONSES TO THE VIEW OF THE COUNSELOR QUESTIONS DEPENDING ON THE EXPERIMENTAL CONDITION

Experimental condition	View of the counselor			
	positive	negative	neutral	ambiguous
Vignette 1				
Present, positive	4	6	0	4
Present, negative	2	8	0	3
Absent, positive	8	1	0	3
Absent, negative	6	1	0	5
TOTAL	20	16	0	15
Vignette 2				
Present, positive	7	4	0	3
Present, negative	2	8	0	3
Absent, positive	9	0	1	2
Absent, negative	5	3	1	3
TOTAL	23	15	2	11
Vignette 3				
Present, positive	6	2	0	6
Present, negative	5	4	1	3
Absent, positive	8	2	0	2
Absent, negative	2	5	0	5
TOTAL	21	13	1	16

APPENDIX P

TABLE OF THE RESULTS OF ANOVAS FOR 7 DEPENDENT VARIABLES WITH GROUP MEMBERSHIP AS A FACTOR

Dependent variable	F*	p
1. Index of negative feelings	0.151	0.699
2. Index of positive feelings	0.748	0.390
3. General favorable perception of the counselor	0.101	0.751
4. General unfavorable perception of the counselor	0.146	0.704
5. Perception of Counselor's Nurturance	0.354	0.554
6. Perception of Counselor's Self-absorption	0.232	0.631
7. Attitude towards multiple role relationships	0.422	0.518

* degrees of freedom were the following: 1 & 72

APPENDIX Q

HUMAN SUBJECTS IN RESEARCH APPROVAL LETTERS

Enclosed:

(1) Copy of the approval letter for the pilot study: "Perception of nonsexual multiple role relationships (pilot study)"

(2) Copy of the approval letter for the primary study: "Perception of counseling relationships"

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Institutional Review Board
Office of Research Compliance
Vice Provost for Research and
Advanced Studies
2810 Beardshear Hall
Ames, Iowa 50011-2036
515 294-4566
FAX 515 294-7288

TO: Irina Diyankova

FROM: Ginny Austin, IRB Coordinator

RE: IRB ID # 03-785

DATE REVIEWED: October 22, 2003

The project, "Perception of nonsexual multiple role relationships (pilot study)" has been declared exempt from Federal regulations as described in 45 CFR 46.101(b)(2).

(2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

To be in compliance with ISU's Federal Wide Assurance through the Office of Human Research Protections (OHRP) all projects involving human subjects, must be reviewed by the Institutional Review Board (IRB). Only the IRB may determine if the project must follow the requirements of 45 CFR 46 or is exempt from the requirements specified in this law. Therefore, all human subject projects must be submitted and reviewed by the IRB.

Because this project is exempt it does not require further IRB review and is exempt from the Department of Health and Human Service (DHHS) regulations for the protection of human subjects.

We do, however, urge you to protect the rights of your participants in the same ways that you would if IRB approval were required. This includes providing relevant information about the research to the participants. Although this project is exempt, you must carry out the research as proposed in the IRB application, including obtaining and documenting (signed) informed consent, if applicable to your project.

Any modification of this research should be submitted to the IRB on a Continuation and/or Modification form to determine if the project still meets the Federal criteria for exemption. If it is determined that exemption is no longer warranted, then an IRB proposal will need to be submitted and approved before proceeding with data collection.

cc: Psychology

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Institutional Review Board
Office of Research Compliance
Vice Provost for Research and
Advanced Studies
2810 Beardshear Hall
Ames, Iowa 50011-2036
515 294-4566
FAX 515 294-7288

TO: Irina Diyankova

FROM: Human Subjects Research Office

PROJECT TITLE: *"Perception of Counseling Relationships"*

RE: IRB ID No.: 04-040

APPROVAL DATE: January 30, 2004 **REVIEW DATE:** January 30, 2004

LENGTH OF APPROVAL: 1 Year **CONTINUING REVIEW DATE: January 29, 2005**

TYPE OF APPLICATION: ☒ **New Project** ☐ **Continuing Review**

Your human subjects research project application, as indicated above, has been approved by the Iowa State University IRB #1 for recruitment of subjects not to exceed the number indicated on the application form. All research for this study must be conducted according to the proposal that was approved by the IRB. If written informed consent is required, the IRB-stamped and dated Informed Consent Document(s), approved by the IRB for this project only, are attached. Please make copies from the attached "masters" for subjects to sign upon agreeing to participate. The original signed Informed Consent Document should be placed in your study files. A copy of the Informed Consent Document should be given to the subject.

If this study is sponsored by an external funding source, the original Assurance Certification/Identification form has been forwarded to the Office of Sponsored Programs Administration.

The IRB must conduct **continuing review** of research at intervals appropriate to the degree of risk, but not less than once per year. Renewal is the PI's responsibility, but as a reminder, you will receive notices at least 60 days and 30 days prior to the next review. **Please note the continuing review date for your study.**

Any **modification** of this research project must be submitted to the IRB for review and approval, prior to implementation. Modifications include but are not limited to: changing the protocol or study procedures, changing investigators or sponsors (funding sources), including additional key personnel, changing the Informed Consent Document, an increase in the total number of subjects anticipated, or adding new materials (e.g., letters, advertisements, questionnaires). Any future correspondence should include the IRB identification number provided and the study title.

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

Your research records may be audited at any time during or after the implementation of your study. Federal and University policy require that all research records be maintained for a period of three (3) years following the close of the research protocol. If the principal investigator terminates association with the University before that time, the signed informed consent documents should be given to the Departmental Executive Officer to be maintained.

Research investigators are expected to comply with the University's Federal Wide Assurance, the Belmont Report, 45 CFR 46 and other applicable regulations prior to conducting the research. These documents are on the Human Subjects Research Office website or are available by calling (515) 294-4566.

Upon completion of the project, a Project Closure Form will need to be submitted to the Human Subjects Research Office to officially close the project.

C: Psychology
Norman Scott

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