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Between a Rock and a Hard Place: Managing Dual Relationships

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Because LDS people often seek psychological help from LDS counselors, the potential for ethical dilemmas around dual relationships is high. This article reviews current professional literature concerning ethical responses to dual relationships in the context of LDS culture and practices. Recommendations are made for ethical decision making. Steps in the decision-making process are outlined.

Because LDS people often want to see LDS counselors, the potential for dual relationships is high, particularly in small communities or areas where there are few LDS counselors and a fairly large LDS population. If the client's concerns involve spiritual issues or concerns that are intertwined with LDS beliefs, practices, and values it is important that the counselor have correct understanding of those beliefs, practices, and values. Few non-LDS counselors have training or competency in such cross-cultural counseling with LDS clients. This can make appropriate referrals to non-LDS counselors hard to find in some locations.

Dual or multiple relationships can occur when professionals assume two or more roles simultaneously or sequentially with a person seeking their help. This may involve taking on more than one professional role, such as counselor and teacher, or combining professional and non-professional roles, such as counselor and friend (Herlihy & Corey, 1992).

Many LDS counselors find themselves grappling with ethical dilemmas around dual relationships; for example:

You have been seeing a client who is in your stake but not in your ward. You serve on the high council of that stake. The client is very distressed about his unhappy marriage;

his wife is cruelly insensitive toward him and he is depressed and lonely. At high council meeting it is announced that at the next high council meeting, there will be a church court held for your client as a result of an affair your client is allegedly having with his secretary. As a member of the high council, you are expected to sit on that church court.

Professional organizations for counselors and therapists all have ethical standards related to dual relationships. These standards prohibit dual relationships that may cause harm to clients. However, there is little consensus among professionals regarding what specific behaviors are unethical (see Tyler & Tyler, 1994; Plaut, 1997; Borys &

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Pope, 1989). The one exception is sexual intimacy with clients; there is nearly universal consensus among professionals that sexual intimacy is always harmful to the client and therefore unethical. Additionally, it is a felony in many states for a mental health professional to have sex with a client (Boylan, Malley & Reilly 2001). Most therapists and counselors would consider providing therapy to a friend unethical (Geyer, 1994), but there is less consensus on issues such as sending holiday greeting cards, inviting clients to an open house reception, or serving together in community or church activities (Oordt, 1990).

The complexity of issues and concerns in making ethical decisions makes absolute rules and answers difficult to determine. The problem is not just in the duality of roles and expectations; it is in (1) the human tendency to have incomplete and imperfect self-awareness, and (2) the potential this creates for exploiting others for personal advantage.

Understanding underlying dynamics of both the client and the counselor, the cultural backgrounds of both, and the nature and duration of services, are all important in making ethical decisions.

Not all dual relationships are harmful. That is, boundary crossing may not always be the same as boundary violation. For example, accepting a small gift such as flowers picked from the client's garden may be therapeutically useful, especially if the client's culture attaches important significance to giving such gifts. Rejection of the flowers may be seen as rejection by the client. On the other hand, accepting a new car from a client or a gift of stock from the client's company may change the nature of the relationship in therapy or the dynamics of power, and lead to exploitation of the client and/or ineffective therapy.

A long list of rules and absolute answers may not be as effective in understanding ethical behavior as would be understanding the principles that underlie ethical behavior. One of the chief attributes of effective ethical decision making is the ability to recognize the existence of an ethical dilemma (Rest, 1982). Dual relationships may be unavoidable at times. But the key is to find ways of minimizing the risk of harm to the client. Being aware of situations that may cause harm is the first line of defense against unethical behavior. Dual relationships can be problematic when:

- + they compromise the effectiveness of therapy,
- + they create client concerns about being harmed by the dual nature of the relationship,

- + observers of the relationship feel therapeutic effectiveness is compromised,
- + the therapist is vulnerable to false allegations and misperceptions by the client.

Kitchener & Harding (1990) have defined three important factors as harmful: (1) *Incompatibility of Expectations*, (2) *Divergence of Responsibility*, and (3) *Power Differential*.

INCOMPATIBILITY OF EXPECTATIONS

A basic assumption of the therapy relationship is that the welfare and best interest of the client comes first. Confidentiality is an important part of assuring safety for the client's personal disclosure. Dual relationships can strain the limits of confidentiality or the trust that confidentiality will be honored. Even though the therapist may honor the "letter of the law" regarding confidentiality, the client may fear that subtle or accidental "slips" could occur. In addition, the therapist may feel pressure to disclose confidential information in order to perform church assignments more effectively.

Also, the client may inaccurately expect that the therapist's church position may lead to greater access to services, welfare, and/or position for the client. The client may then feel betrayed when this does not occur. For example, if the therapist serves as the Relief Society President in the client's ward, the client may believe that the therapist can influence whether or not the Bishop will provide welfare or financial assistance if the client discloses financial concerns in therapy. If that assistance is not as forthcoming as the client hoped, this could have a negative impact on the therapeutic relationship.

Discussing confidentiality and its limits with clients can be very helpful in reducing incompatibility of expectations. Because at times working with church leaders can be useful and in the best interest of the client, discussing informed consent and allowing the client to choose whether or not to sign a release of information can reduce misunderstandings. Of course, clients also must be informed of legal mandates to report abuse and "duty in warn" obligations.

DIVERGENCE OF RESPONSIBILITY

"No man can serve two masters" (Matt.6:24). In fact, a therapist who is involved in a dual relationship may

feel divided loyalties. This can result in a loss of objectivity. For example, if the client discloses personal concerns to a therapist who also serves in the ward Bishopric, how might these disclosures in therapy impact recommendations for assignments and callings? A particular church assignment might be desired and even useful for the client but may not be best when the needs of the entire ward are considered. This creates conflict for the therapist and the possibility of harm for the client or reduced effectiveness of therapy. The client may feel not cared for, or misunderstood – and the potential for real or perceived emotional abandonment increases significantly.

Dual roles involving multiple sources of power and authority can also create confusion for the client. Does working through issues related to sexual behavior imply forgiveness by the church for sexual offenses if the therapist is also the bishop or stake president? If the client's former therapist is later called as the bishop, the client may assume ecclesiastical forgiveness even though the offenses were never addressed with previous church authorities – but had been discussed in previous therapy. If the therapist formerly served as a bishop or is the bishop of another ward, the client may erroneously assume priesthood authority exists (and ecclesiastical forgiveness) where it does not.

Of course LDS therapists do not have authority to speak for the church when serving in the role of therapist. Richards & Potts (1995) surveyed 205 LDS counselors and therapists concerning spiritual practices in therapy. A major ethical concern mentioned by these counselors and therapists was the danger of usurping religious authority. Indeed, LDS therapists working with LDS clients need to be very alert regarding potential confusion about their own roles as opposed to the roles assigned to priesthood and church leaders (for example, ethical standards for psychological treatment prohibit imposing values on a client, whereas, "preaching the word" may be a required requisite for a particular church calling). Careful ongoing reflection regarding differences between these roles and assignments can reduce or eliminate confusion.

Another concern mentioned by Richards & Potts (1995) was the danger of engaging in *priestcraft* – by either being paid for spiritual services or seeking to create more business for oneself by providing spiritual services for a fee (see 2 Nephi 26:29, Alma 1:16, Acts 8:18-

21). Mixing spiritual services such as giving priesthood blessings with psychotherapy can not only confuse clients about therapeutic versus ecclesiastical roles and responsibilities, but could readily be construed as engaging in priestcraft. As well-meaning as such practices might be, it is much more in the client's best interest to avoid the potential harmful effects of such role confusion. Instead, the skillful use of spiritually-based interventions which address clients' spiritual concerns and needs, can be very effective in helping clients find peace and meaning regarding the painful events of their lives (Richards & Bergin, 1997).

POWER DIFFERENTIAL

Any time there is a difference in power there is a possible potential for exploitation. The greater the difference in power, the greater the potential for abuse of that power.

The therapist has access to personal knowledge about the client – personal history, psychological profile, strengths and weaknesses, hopes and fears, relationship patterns, sexual habits and personal secrets. Much of this information is not available about other church members who are not in therapy. Clients do not have similar access to such information about the therapist. This creates vulnerability for the client. When the therapist also has power in other roles (such as ecclesiastical, financial, or social), the danger for harm to the client increases. Clients may also fear being seen as less worthy or spiritually flawed if they discuss concerns with a therapist who also has a church role.

Personal self-disclosure may also play a role in the therapy relationship. A therapist's personal information that may appropriately be disclosed in church classes, meetings or talks is not usually available to clients. Although disclosing such information may at times be helpful, it may very well be potentially harmful; therefore the potential impact should always be carefully considered.

Being aware of boundaries that define counseling and therapy and differentiate it from other relationships can help in decision-making. Asking such questions as "what does a therapist do?" versus "what does a home teacher, Bishop, or Relief Society President do?" can help in maintaining roles and reducing dual role conflict. Keeping therapy confined to time, place, and location designated for therapy can also reduce dual role problems.

Under the right circumstances and with good judgment, social activities, accepting a gift, carefully considered personal disclosures, and linking therapy concerns to the client's real-life church experiences can be not only innocuous but even very beneficial. A certain level of intimacy, closeness, trust and caring is necessary for a productive therapeutic relationship. Rigid rules can never replace careful awareness of ethical issues, self-knowledge, good clinical judgment, and a deep personal commitment to the welfare of the client.

Attempting to understand the dialectical complexity of dual relationships may engender feelings like (the comic strip character) Charlie Brown's as he struggles with growing beyond "all-or-nothing" thinking and declares:

We have not succeeded in answering all of our problems. Indeed, we often feel we have not completely answered any of them. The answers we have found only serve to raise a whole set of new questions. In some ways we feel we are as confused as ever, but *we believe we are confused on a much higher level, and about more important things.* (Charles Schulz)

SEXUAL INTIMACY

The area of least confusion around ethical standards, of course, regards sexual intimacy with a client. Despite the fact that the prohibition against sexual involvement with clients has been the clearest and most publicized proscription of all ethical standards, sexual exploitation is the most frequent classification of ethical complaints (Pope, 1990). Training in making ethical decisions related to managing sexual attraction in therapy is critical in knowing how to ethically respond to clients. Although education, self-awareness, and skills training are vital – a strong sense of personal ethics and a dedicated regard for the welfare of others are even more compelling for maintaining professional boundaries. Unfortunately, only about 12% to 20% of respondents in training programs report having received in-depth training on managing sexual attractions in clinical practice (Glaser & Thorpe, 1986).

Apparently because of the sensitive nature of this issue many educators have been hesitant to address these concerns directly with trainees. Although no standard educational approach exists, open discussion and self-awareness appear to be strong factors in helping therapists maintain a buffer against the sexual exploitation of

clients (Pope, Sonne & Holroyd, 1993; Hamilton & Spruill, 1999).

The therapist's willingness to minimize the negative impact of client-therapist sexual involvement is often used as a rationale for condoning the behavior. Offending therapists often rationalize sexual misconduct as a "reconstructive sexual experience" for the client. Research suggests, however, that such intimacies have a devastating impact on clients. In a survey conducted by the Wisconsin Psychological Association (1985), every respondent who reported sexual involvement with a therapist endorsed all negative-effect statements on a questionnaire with "strongly agree." Women who reported sexual involvement with therapists initially appeared to feel protective of the therapists and to blame themselves for the sexual involvement, but the emotional outcome is described as being very similar to the emotional sequelae of parent-child incest (Bates & Brodsky, 1988; D'Addario, 1977; Kardener, 1974; Marmor, 1972; Pope & Bouhoutsos, 1986; White, 1986). Typical responses include ambivalence, guilt, emptiness and isolation, sexual confusion, identity and boundary disturbance, lability of mood, depression and anxiety, inability to trust, suppressed rage, suicidal risk, and cognitive dysfunction, especially in attention, concentration, flashbacks and intrusive thoughts (Pope, 1987). It is more common for the therapist to end the sexual relationship than for the client to do so (Chesler, 1972a).

Although offenses may occur under a variety of circumstances, research suggests a profile of the vulnerable therapist who is most likely to slip into an ethical violation. Ninety-two percent of reported violations involve male therapists with female clients. Violations also occur, however, between all gender combinations with female as well as male therapists and same-sex as well as heterosexual clients (Bouhoutsas, Holroyd, Lerman, Forer & Greenbery, 1983).

The most common personality style among offenders is the therapist who seeks to become a "guru" (Chesler, 1972b). Such therapists are exploitative, strong personalities who desire to create an empire of followers. Marmor (1976) reported that therapists who become sexually involved with clients often have a strong desire to be seen by others as loving and affectionate but harbor hostility toward women and have a subtle sadistic need to exploit, humiliate, or reject them. They often use reaction formation as a defense against feelings of masculine inadequacy

or fear of being seen as homosexual. They also exhibit some psychopathic tendencies and are less likely to believe it is necessary to follow conventional rules. Psychotherapy often takes on a "cult aspect." These therapists expect the client to become a "true believer" in the therapist's method. The "cult leader" therapist tends to have narcissistic, grandiose, and paranoid features and encourages others to idealize him as an authority. Clients are encouraged to become "true believers" and accept the therapist's theory as valid, true, and superior to all others. Alienation from other views is strongly encouraged. Clients may be told that other therapists or methods cannot be helpful and that the "cult leader" therapist holds special skills or abilities not known or used by other therapists. This therapist becomes the "teacher or master" with the client in a position of significantly less power as a "pupil." The group of "believers" is seen as an elite "family" who become hostile and suspicious of other forms of intervention. Devaluation, harassment, or denigration of those who defect, depart, or seek other solutions may be done in the name of "concern" or "caring" (Schoener & Milgram, 1984).

However, not all therapists who offend fit this profile. Situational and other personal variables that contribute to ethical violations include (Marmor 1976, Schoener & Conroe 1989):

- Being alone and isolated from others
- Eroticized transference
- Seductiveness or flirtatiousness of client
- Libidinal needs of the therapist not met (therapist's marital problems)
- Naive or poorly trained therapist (i.e., misses important dynamics until it is too late)
- Little awareness of boundaries or unable to spot violations such as breaking rules for clients, special privileges, or behaviors such as walking the client to her car or giving her a ride home
- Therapy style; i.e., "lifelong parenting" contract, vague goals, no clear treatment plan
- Therapeutic "drift" – evolves into a more personal relationship with no termination plan or periodic review of goals. The therapist looks forward to seeing the client for her/his own needs rather than the client's.
- Abrupt change in therapy style
- Working outside area of competency
- Unique characteristics that create attraction and/or over-identification with client – resulting in a blind

spot, conflict in identity or sexual preference

- Recent divorce or interpersonal loss in the life of the therapist
- Family dynamics and resemblances to the therapist's significant others

Note that although sexual intimacies with a client are strictly forbidden by ethical standards, sexual attraction to a client is not equivalent to sexual intimacy. Many professionals and trainees hesitate to address concerns about attractions because they fear experiencing attraction will be equated with acting unethically. This *conspiracy of silence* actually creates increased risk for ethical violation because it blocks important awareness of normal feelings and responses and creates blind spots that increase vulnerability. Clients are aware even when therapists keep silent: McClerian (1972) found that client awareness of sexual feelings between client and therapist was reported in 43.5% of cases, with 22% being uncertain or perceiving weak sexual feelings, and 34% reporting no attraction.

Although feelings of attraction in therapy are widespread, acting out is not. Being capable of experiencing temptation is certainly different from surrendering to temptation. Being able to separate thoughts and feelings from behaviors is an important key to self-awareness. It is crucial to "avoid the avoidance" when acknowledging one's own sexuality (Pope, Sonne & Holroyd, 1993). Acknowledging and accepting complex cognitive, affective, and physical responses is an important part of professional development and functioning. Attempting to avoid awareness of that information leads to a loss of understanding of one's own motivations, intentions, and behaviors. Exploration and understanding of oneself is best done in an environment that is safe, non-judgmental, and supportive.

Learning about typical reactions to sexual attraction to a client can make it easier for therapists to accept and then understand their own response to sexual feelings and accompanying reactions. Knowing that such feelings are normal and experienced by other therapists decreases feelings of isolation and shame, and facilitates discussion and consultation that can reduce ethical violations. The therapist then has active agency to choose strategies and interventions that protect the welfare of both the client and the therapist. Blind spots created by the therapist's defense mechanisms do not then have the

power to catch the therapist unaware.

Common responses by therapists who experience attraction to clients are reported by Pope, Sonne & Holroyd (1993):

- Surprise, startle, and shock
- Guilt
- Anxiety about own unresolved personal issues
- Fear of losing control
- Fear of being criticized
- Frustration at not being able to speak openly with client
- Frustration at not being able to make sexual contact
- Confusion about tasks
- Confusion about boundaries and roles
- Confusion about actions
- Anger at the client
- Fear or discomfort about frustrating the client's demands (Pope, et al, 1993)

Although these thoughts and feelings are common and typical, it is important to remember that the client's well-being always comes first. Indeed, despite such responses, the therapist must stay committed to ethical principles. Sexual intimacies with a client are never therapeutic. It is a sacred trust to bear the burden of one's own frustrations, unmet hopes, and longings in the service of the client's welfare.

Being self-aware can lead to appropriate consultation with another professional or supervisor. A therapist's best protections against ethical problems or false allegations are:

Self awareness: ask, "What am I thinking and feeling? What is triggering this response? How do these thoughts and feelings impact my behavior? What are my own needs, concerns and unresolved issues? How can I address and resolve them other than through my client?" Individual therapy can provide a safe, non-judgmental environment to explore your concerns while protecting your privacy.

Consultation: discuss your concerns about the client with a supervisor or another trusted professional. Don't let shame detract you from consulting; nearly all therapists have had similar situations. Consult professional literature to learn other ways of managing attractions without causing damage to clients. It can be most helpful to process the case with another trusted professional before any confrontation with the client about sexual dynamics

in therapy. Therapists who have offended are less likely to have consulted prior to committing the offense.

Documentation: include in your notes that you consulted on the case and what the recommendations were. If it is not in the notes, you cannot later document these wise actions. Documenting consultation and subsequent action taken can protect from false accusations. In a training environment, audio or video tapes of sessions also provide documentation of what happens in therapy.

Sometimes a therapist may not directly experience sexual responses because of defenses against self-awareness. Common clues to unacknowledged feelings in therapy may include (see Pope et al., 1993):

- Dehumanizing of the client (i.e., responding to the client as a diagnosis not as a person, or misdiagnosing)
- Dehumanizing the therapist (i.e., keeping distance; acting on a perfunctory, impersonal level)
- Avoidance
- Obsessive thoughts about the client
- Slips and meaningful mistakes
- Fantasies about the client
- Special treatment
- Isolation of client (i.e., disrupting other helpful or meaningful relationships; imposing restrictions)
- Isolation of therapist – avoiding consultation or practicing alone
- Creating a secret
- Seeking repeated reassurance on the same issues from colleagues despite good consultation
- Boredom or emotional numbness as a protective reaction (Pope, et al, 1993).

Unwise treatment practices that should be avoided include (Pope, et al, 1993):

- Routine hugging of clients without carefully evaluating the dynamics of the client and the therapy relationship. The therapist may not always be sure of how the client will experience and receive a hug.
- Face-to-face hugs
- Therapy conducted in other than a professional setting or standard service hours without others nearby. Do not meet alone at night in your office or go alone to a client's home.

- Excessive touching
- Holding the client or allowing the client to sit on your lap
- Socializing with the client
- Excessive or inappropriate self-disclosure
- Attempting to directly affect the client's life (i.e., setting up dates or business contacts for the client) (Pope, et al, 1993)

Awareness of ethical issues and well-reasoned thoughtful decision making can reduce harm and result in more helpful outcomes. Steps in ethical decision-making can include (Kitchner, 1984; Bersoff, 1995; Beauchamps & Childress, 1994; Meara, Schmidt & Day, 1996; Board of Ethnic Minority Affairs of the APA, 1990):

1. Be Aware Of When An Ethical Dilemma Exists

- Ask, "What professional ethical codes apply?" "What legal issues are involved?" "What laws apply?"
- Determine what are the professional and institutional standards of care.
- Look for conflicts between codes, laws, and principles.
- Contact appropriate authorities if in doubt (professional ethics committee, Child Protective Services, institutional director, legal services).

2. Consider What Moral Principles Are Involved

- Some important principles to consider are:
- Autonomy – the right of competent persons to freedom of choice and action so long as the rights of others are respected.
- Non-maleficence – "above all, do no harm."
- Beneficence – contributing to the health and welfare of clients.

- Justice – fairness and equality.
- Fidelity – faithfulness, loyalty, and the expectation that promises will be kept.
- Veracity – truthfulness that leads to trust.

3. Follow a Decision-Making Process

- Define the problem.
- Generate all possible alternatives.
- Analyze and evaluate possible risks and outcomes of alternatives.
- Consider ethical, legal, and moral implications of all alternatives.
- Be alert to client variables that may impact outcome such as culture and diversity.
- Consult with appropriate colleagues.
- Choose a Course of Action while assuming responsibility for that action.
- Consider informed consent and discuss concerns with the client when necessary.
- Implement a Course of Action.
- Evaluate the results of the Course of Action.
- Stay involved in an ongoing decision-making process.
- Be prepared to re-evaluate and change action if necessary

Many individuals enter the helping professions because of a personal attribute of kindness and a desire to ease suffering. Those qualities are strong allies in one's ability to "succor the weak, lift up the hands that hang down and strengthen the feeble knees" (D&C 81:5). It is also important, however, to follow the Lord's admonition to be "wise as a serpent, yet without sin" (D&C 111:11). By thoughtfully following the spirit of both of these inspired statements, therapists will find improved wisdom in managing the ethical dilemmas of dual relationships.

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