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Differences and similarities in cross-cultural perceptions of boundaries: A comparison of results from two studies

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ABSTRACT

There has been substantial literature on boundary excursions in clinician–patient relationships; however, very little empirical research exists. Even less information exists on how perceptions of this issue might differ across cultures. Prior to this study, empirical data on various kinds of boundary excursions were collected in different cultural contexts. First, clinicians from the U.S. and Brazil were asked to rate 173 boundary excursions for both their perceived harmfulness and their professional unacceptability (Miller et al., 2006). In a second study, colleagues from Qatar administered a slightly modified version to mental health care professional staff of a hospital in Doha, Qatar (Ghuloum et al., 2011). In this paper, the results of these two separate studies are compared. The results showed some similarities and some differences in perceptions of the boundary behaviors. For example, both sets of cultures seem to agree that certain behaviors are seriously harmful and/or professionally unacceptable. These behaviors include some frankly sexual behavior, such as having sexual intercourse with a patient, as well as behavior related to doing business with the patient, and some disclosing behavior. There are also significant cultural differences in perceptions of how harmful some of the behaviors are. Qatari practitioners seemed to rate certain behaviors that within therapy mix disclosing or personal behavior with therapy as more harmful, but behaviors that involved interacting with patients outside of therapy as less serious. A factor analysis suggested that participants in U.S./Brazil saw a much larger number of behaviors as making up a set of Core Boundary Violations, whereas Qatari respondents separated sexual behaviors from others. Finally, a Rasch analysis showed that both cultures perceived a continuum of boundary behaviors, from those that are least harmful or unprofessional to those that are highly harmful or unprofessional. One interpretation is that cultural factors may be most influential on those kinds of behaviors that are perceived as relatively less serious. Implications for training and supervision are also discussed.

1. Introduction

A therapeutic boundary, according to Gutheil and Gabbard (1998) is essentially a fuzzy line between appropriate and inappropriate behavior on a therapist's part. Although some behaviors are, from a clinical perspective, considered to be serious violations of where the line should be, many more behaviors may or may not cross the line, depending upon a number of factors; these have been called boundary "crossings" (Gutheil & Gabbard, 1998; Gutheil & Simon, 2002; Kroll, 2001; Lazarus, 1994; Martinez, 2000). Because there are no hard and fast rules for differentiating between different types of what we will call boundary "excursions" (a general term that includes both serious and nonserious behaviors), dealing with issues surrounding these excursions continues to present dilemmas for clinicians. It is notable that while the issues surrounding therapeutic boundary excursions have been extensively discussed since the 1990s in several publications (Gabbard, 2001; Garfinkel, Dorian, Sadavoy, & Bagby, 1997; Gutheil & Gabbard, 1993; Gutheil & Simon, 2002; Kroll, 2001; Norris, Gutheil, & Strasburger, 2003; Remland, Jones, & Brinkman, 1995; Webb, 1997), there are few empirical examinations of boundary violations. The literature that does exist has primarily examined the prevalence of sexual infringements (Birch & Miller, 2000; Epstein, Simon, & Kay, 1992; Kardener, Fuller, & Mensh, 1973), and harm done to patients from such actions (Butler & Zellen, 1977; Pope & Tabachnick, 1991). It seems clear that having more

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empirical information may ultimately benefit clinical practice. Such information is particularly needed with respect to the more ambiguous boundary excursions, also called boundary crossings.

The practices of both forensic and clinical psychiatry, as well as therapeutic practice in general, appear to require and to use, in boundary-violation discourse, a special way of referring to the heightened attention to the ethics of the particular kinds of interpersonal exchanges that take place in a therapeutic relationship. But this discourse and the judgments it expresses are each in need of closer scrutiny. A variety of factors make the classification of certain actions as boundary violations unclear, including the large range of alleged boundary-violating behavior, ambiguities in the fundamental metaphor of boundaries violated or transgressed, and confusion about the explanatory status of the value judgments boundary-violation language is used to express. In addition, disputes and disagreements regarding boundary-violation judgments require analysis — an analysis undertaken in this article through appeal to theories of professional role morality. It should be noted as well that there is significant influence of gender of the recipient and the doer in boundary-violation ethics (Radden, 2001).

The complexities and varieties of contemporary mental health practice settings make a literal application of ethical standards impractical (Walker & Clark, 1999). Mental health professionals now work in settings ranging from formal institutions, such as psychiatric and general hospitals, outpatient clinics, non-profit agencies, schools, private and public sector workplaces, and prisons, to clients' homes, which may include diverse arrangements for assessment and treatment, intensive case management, family preservation, home health care, employee assistance programming, and hospice care. Because of the complexity of these settings and the non-traditional roles of service providers, the boundary rules governing traditional assessment and treatment are not easily applicable. Unfortunately, this situation results in the absence of clear rules or guidelines.

More importantly, many clients involved in these less structured treatment modalities are disenfranchised individuals who are at greatest risk for exploitation. Many are low-income minority clients with serious mental and physical disabilities that include deficits in cognition, judgment, self-care, and self-protection.

The promotion of cultural diversity in treatment environments often encourages expansion of traditional professional roles (Ponterotto, Casas, Suzuki, & Alexander, 1995). The literature in this area calls for more flexible roles and more out-of-office services carried directly to the client in the client's own environment (Alexander & Sussman, 1995). However, these situations can create even greater power differentials between provider and client than are generally found in office-based psychotherapy practices. It can be argued that a higher fiduciary duty exists for mental health professionals who serve clients in less structured settings and that the relaxation of traditional roles carries with it an increased responsibility to define practice-specific ethical guidelines to protect the vulnerable client.

In any case, it seems high time to pull the discussion of boundary excursions out of the older model of one therapist and one patient meeting in an office, a situation from which context was imagined to have been stripped. One way to begin to do so is to examine the issue of boundary violations in other cultural contexts.

The current paper began with the purpose of exploring possible cultural differences in two cultural contexts, Brazil and the United States. Miller, Commons, and Gutheil (2006) prepared a questionnaire study assessing a large set of possible boundary violations, in terms of each one's degree of harm and professional unacceptability. They then examined the perceptions of a group of clinicians from Brazil and from the U.S. This study demonstrated that clinicians considered roughly three different degrees of boundary excursions and that there was generally a uniform understanding of what could be considered a boundary violation in these two cultures. There were only some minor cross-cultural differences in the milder boundary excursions, involving greeting behaviors and disclosure practices.

At a later date, a separate group, S. Ghuloum and colleagues in Qatar (A. Bener, F.T. Burgut, & D. Bhugra) located the Miller et al. questionnaire, and used it to collect comparable data in Qatar. There was consultation between the two research groups on changing a few of the items to better fit the new context, as well as on data analysis. This ultimately resulted in a paper about those data, co-authored with the Qatari colleagues (Ghuloum et al., 2011). There seemed to be more potential differences in those results, but it was difficult to compare the two sets of data across two separate papers. In the current paper, some of the original results from each study are presented, and some new analyses are included. Because the differences between the two original cultural groups were so small, data from the United States and Brazil are combined here into one group. These results will then be compared to those from the Qatar sample.

It is expected that two factors may influence how clinicians in the two groups think about boundary violations. One such factor is how perceptions of relationships may differ in the different cultures. In our previous work with the samples from the U.S. and Brazil (Miller et al., 2006), it was found that while there was agreement about some of the major boundary violations, there were some differences as well, particularly in terms of certain kinds of greetings and touches (there was more leeway on these in Brazil), and certain kinds of self-disclosures, particularly those involving displaying credentials and other information in one's office (which were seen as more negative in Brazil). In Qatar, as noted by Ghuloum et al. (2011) there is very little empirical information on psychotherapy practice, but because this constitutes a very different culture, some differences may be expected. In particular, it is more likely that families, especially those that are wealthy may give expensive gifts to treating physicians or therapists. It is also normal in this Middle Eastern culture for doctors to call patients by their first name, but not for patients to be able to do the same.

A second factor that may influence the extent to which there are commonalities in the perceptions of boundary violations is the kind of training that the professionals responding to the questionnaire have obtained. To the extent that professionals have been trained in the United States or highly related contexts, such as Great Britain, or have been trained in primarily Euro-American models of therapy, there may be more commonalities than differences in the perceptions.

In sum, the purpose of the current paper is to explore both the commonalities and the differences found in the two groups. Are there some behaviors for which there is a consensus that these are, in fact, true boundary violations? Are others more clearly identified as boundary crossings? And, in which type of violation are cultures more likely to differ?

2. Method

2.1. Participants: Study 1

There were 61 participants in Study 1: 28 Brazilians (20 females, 7 males, and 1 whose gender was not reported) from the *Institute of Psychiatry, Federal University of Rio de Janeiro*, and 33 Americans (18 females and 15 males) from the *Program in Psychiatry and the Law, Department of Psychiatry, Harvard Medical School, Massachusetts Mental Health Center*, Boston. The American sample was made up of attendees at the Program in Psychiatry and the Law, and the Brazilian sample was made up of attendees at a presentation on boundary issues at the Institute of Psychiatry. In the two samples together, 35 participants (60%) were psychiatrists or had Ph.D.s, and 23 participants (40%) were at the Master's or Bachelor's degree level. All were mental health professionals. Participation was voluntary and anonymous. Although not everyone in either group volunteered, and exact numbers on the return rates are not available, since both groups consisted of professionals working the field with a high degree of interest in these issues, we assume that the return rate for the questionnaires was high. Due to its nature the study was judged to be exempt from review by the

Human Subjects committee at the Massachusetts Mental Health Center, where the Program in Psychiatry and the Law was then located. Separate permission to conduct the study at the Institute of Psychiatry in Brazil was obtained from the head of that Institute, as there was no IRB committee review available at that time.

2.2. Participants: Study 2

The 50 participants in Study 2 were sampled from the mental health care professional staff of the psychiatry department of Rumeilah Hospital at the Hamad Medical Corporation in Doha, State of Qatar. There were 24 psychiatrists, 2 doctorate level psychologists, and 24 psychiatric nurses; of those individuals 26 were male and 24 were female. The questionnaire was distributed to staff after a regular weekly staff meeting. Participation was voluntary and anonymous. We delivered the questionnaire in sealed envelopes and requested all individuals to fill out the questionnaire and return it in the provided blank envelope and drop it in the locked box within the next 4 weeks. The response rate was 80%. Even though there is variation in the degrees held, the individuals in the sample realistically reflect those who work and deliver services to clients in the Psychiatry Department. The study was judged to be exempt from review by the Institutional Review Board at the Hamad Medical Corporation in Doha.

While some results from the Qatar study have been previously published, the analyses of the U.S./Brazil group together are all new. The comparisons of the two groups, especially in terms of their mean rankings of items are also new.

2.3. Instrument

Within Study 1, an 87-item questionnaire was devised from consulting the literature on boundaries, from a large number of actual case examples and from professional experiences shared within the Program in Psychiatry and the Law. Participants were asked to rate (on a 7-point scale) the **percent** of cases it would be ***harmful*** to the patient if a colleague behaved in the manner described, and concurrently, to rate in what **percent** of cases was this same behavior professionally ***unacceptable*** if done by colleagues. This resulted in 174 items that were separately considered in the analysis. The technique of asking about colleagues' behavior, rather than the clinician's own, was used in order to minimize defensive reactions that might occur if we asked individuals to rate how professionally unacceptable a behavior might be if done by themselves. The rating scale asked participants to circle one of the following percentages: 0%, 2%, 16%, 50%, 84%, 98%, and 100%. This scale reflects a linear *z*-score scale that was converted into percentages, using the cumulative normal distribution function, with a probit transformation. This scale was used because (1) it represents the postulated distribution for most psychological characteristics, and (2) the differences at the ends of the scale are more important than the ones in the middle.

All the questions and instructions were in English for the US sample and in Portuguese for the Brazilian sample. The translation into Portuguese was carried out jointly by two individuals. One was a born English speaker, a trained developmental psychologist in the English language, who had grown up in Brazil and speaks Portuguese fluently. The other was a born Portuguese speaker, a trained clinician in the Portuguese language, who worked as a clinician for several years in the US with English and Portuguese speaking clients and colleagues.

The same questionnaire was used in Study 2, with some minor revisions. In order to better assess certain culturally-based professional experiences seen in Qatar, a few questions were rephrased slightly and two questions were added. For example, the question about shaking hands was rephrased to include the factor of gender (e.g. would it be harmful to shake the hand of someone of the opposite gender versus the same gender). All the questions were in English as all participants had a good command of English with only 4% stating the local Arabic as their preferred language.

In the Qatar sample, Cronbach's alpha reliability coefficients were calculated for assessing the internal consistency of the Clinicians' behaviour scale scores. The Cronbach's Alpha for the questions about harm to patient (0.977), questions about the professional unacceptability of a behavior (0.936) and Combined (0.968) were all quite high. In general, the level $p<0.05$ was considered as the cut-off value for significance.

3. Results

Whereas an examination of the published results of the two studies suggests that the cultures may show certain commonalities, the purpose of the analysis here is to illustrate differences that also exist. The first step of the analysis is an item-by-item analysis, to see which items participants generally agreed upon and which they differed on. Mean ratings were calculated for each of the 174 items that both studies had in common. For the purpose of the analyses here, the ratings percentages were converted into numbers (1 to 7); this means that a score of 4.0 would be at the midpoint. Scores above 4 would be toward the more "harmful" and more "professionally unacceptable" end of the scale. The possible significance of the differences between the means for the two cultural groups was calculated using *t*-tests. In order to minimize the probability that too many t-tests would appear significant by chance alone, a Bonferroni correction was used. In effect, only t-tests with a $p<.0002$ or less were considered to be at an acceptable level of significance. With this conservative procedure 70/174 (40.46%) of the means were found to be different in the two studies, which while less than half still means that over one-third of the behaviors listed were responded to differently by participants from the two groups.

Table 1 shows three sets of comparisons of these means. At the top are comparisons of items that Qatari participants rated as significantly more harmful or professionally unacceptable. The second set of comparisons show items that the U.S./Brazil participants rated as significantly more harmful or professionally unacceptable. Note that within each group, only the top 18 or 19 are shown (only differences with a $p=.0001$ or less are shown); this was done both so as to include those comparisons that were maximally different and also so as to reduce the number of comparisons. The additional items not shown are similar in nature.

One reasonably clear difference seen between the first group of means (Qatar > US/Brazil), and the second group of means (US/Brazil > Qatar) is that the second group seems to have a much larger number of items that concern mixing social occasions with therapy (going for coffee with the patient, making home visits along with social activity, attending a patient's graduation or wedding, sitting with them at a cafeteria, socializing with them at an outside event, or phoning them after hours), whereas the first set of means seem to concern events that either take place within therapy or immediately surrounding therapy (making sexist remarks, embracing patient with a long kiss, yelling at the patient, telling patient your history of sexual abuse, seducing the patient, and so forth). Four of these involve frankly sexual behaviors, but the rest do not. Note that the effect sizes (in terms of Cohen's d statistic) suggest that the vast majority of these differences in either group would be classified as large, not medium or small. There are a few mean ratings that seem in some cases surprising. Why, for example, would the U.S./Brazil clinicians have a mean rating of 3.37 on the item "embracing the patient with a long kiss", which is an item one might expect condemnation on? It is possible that some participants interpreted this more in terms of sexuality, whereas others interpreted more in terms of caring or comforting.

The third set of means shown are for the top twelve items that participants from both cultural groups rated as highly harmful and/or professionally unacceptable (both cultures' *mean* ratings were above 6.0). Three of these involved sexual behaviors, four involved mixing financial issues with therapy, three involved disclosing the therapist's personal sexual or financial information, and the others involved either a behavior

Table 1
Significant differences in mean ratings of items seen among participants in U.S./Brazil versus Qatar (Standard deviations included in parentheses), and effect sizes.

Qatar > U.S./Brazil	Qatar Mean	U.S./Brazil Mean	Cohen's d
Making sexist remarks (Unacceptable)	6.70 (0.85)	2.83 (1.73)	2.84
Embracing a patient with a long kiss (Unacceptable)	6.78 (0.99)	3.27 (2.12)	2.12
Paying patient to do any of the above (Unacceptable)	6.88 (0.33)	3.57 (2.32)	2.00
Yelling at patient (Harmful)	6.64 (1.09)	3.52 (1.99)	1.94
Telling patient your history of sexual abuse (Unacceptable)	6.48 (1.09)	3.81 (1.91)	1.72
Pretending sex is therapy (Unacceptable)	6.52 (1.46)	3.57 (2.12)	1.62
Making fun of patient (Unacceptable)	6.51 (1.21)	4.03 (2.04)	1.48
Physically pushing patient (Unacceptable)	6.78 (0.92)	4.86 (1.70)	1.41
Coming on to or trying to seduce a patient (Unacceptable)	6.73 (0.86)	5.03 (1.74)	1.24
Seeking patient data outside prof. channels (Unacceptable)	6.29 (1.60)	4.09 (1.96)	1.23
Lowering fees for one patient only (Unacceptable)	6.02 (1.52)	3.95 (1.85)	1.22
Getting your child to play with patient's child (Harmful)	4.50 (2.32)	2.03 (1.70)	1.21
Telling patient your history of physical abuse (Harmful)	5.44 (1.79)	3.46 (1.62)	1.16
Patient passing thru living area to Home office (Unacceptable)	2.86 (1.63)	4.53 (1.73)	0.99
Telling patient re: personal medical condition (Unacceptable)	5.94 (1.33)	4.49 (2.06)	0.84
Having photos of your family in the office (Unacceptable)	5.04 (2.06)	3.39 (2.09)	0.80
Accepting a valuable present during treatment (Unacceptable)	5.22 (1.31)	6.50 (1.96)	0.77
Evaluatively commenting on patient's partner (Unacceptable)	4.30 (1.70)	5.64 (1.85)	0.75
U.S./Brazil > Qatar	**US/Brazil Mean**	**Qatar Mean**	**Cohen's d**
Going out for coffee/tea with patient (Harmful)	6.33 (1.23)	3.60 (2.13)	1.57
Employing a patient (Harmful)	6.40 (1.20)	3.91 (2.05)	1.48
Making home visits with social activity (Harmful)	5.52 (1.81)	3.02 (1.69)	1.43
Attending patient's graduation (Harmful)	6.20 (1.33)	3.60 (2.22)	1.42
Attending patient's wedding (Unacceptable)	6.63 (1.01)	4.13 (2.50)	1.31
Hugging a patient (Harmful)	6.34 (1.31)	3.87 (2.37)	1.29
Telling patient your marital status (Harmful)	6.78 (0.88)	4.54 (2.38)	1.25
Giving reasons for your scheduled absence (Unacceptable)	6.03 (1.41)	3.92 (1.99)	1.22
Necking with patient (Harmful)	6.68 (0.99)	4.51 (2.36)	1.20
Making home visits with social activity (Unacceptable)	5.85 (1.68)	3.58 (2.28)	1.13
Sitting with patient in cafeteria both go to (Harmful)	6.22 (1.38)	4.21 (2.33)	1.05
Socializing with patient at outside event (Harmful)	5.75 (1.62)	3.71 (2.30)	1.03
Seeking advice from patient (Harmful)	5.45 (1.73)	3.37 (2.26)	1.03
Phoning patient about treatment after office hours (Harmful)	5.93 (1.40)	4.29 (2.02)	0.94
Emotional reacting to patient's statements (Harmful)	6.35 (1.23)	5.06 (1.54)	0.93
Buying product recommended by patient (Harmful)	5.33 (1.75)	3.48 (2.16)	0.94
			0.91
Going along with patient's advances (Harmful)	6.76 (0.90)	5.28 (2.12)	
Giving patient inexpensive gift during treatment (Harmful)	6.13 (1.33)	4.37 (2.33)	0.93
Pretending not to see patient when in public (Harmful)	5.80 (1.44)	4.37 (1.83)	0.87
Cultural agreement on "most harmful" practices	**US/Brazil Mean**	**Qatar Mean**	**Cohen's d**
Having sexual intercourse with patient (Unacceptable)	6.94 (0.24)	6.87 (0.88)	n.a.
Hitting patient (Unacceptable)	6.77 (1.09)	6.98 (0.15)	n.a.
Touching each other's breasts or sexual organs (Unacceptable)	6.88 (0.79)	6.81 (0.91)	n.a.
Borrowing money from patient (Unacceptable)	6.78 (0.72)	6.84 (0.87)	n.a.
Telling your romantic involvements to patient (Unacceptable)	6.85 (0.79)	6.67 (0.85)	n.a.
Selling products/non-therapy services to patient (Unacceptable)	6.70 (0.95)	6.68 (1.06)	n.a.
Phoning patient about non-therapeutic issues (Unacceptable)	6.80 (0.84)	6.51 (1.18)	n.a.
Telling patient your sexual orientation (Unacceptable)	6.88 (0.78)	6.10 (1.81)	n.a.
Submitting false bills with patient's knowledge (Unacceptable)	6.79 (0.82)	6.65 (1.01)	n.a.
Telling your financial status to patient (Unacceptable)	6.49 (1.16)	6.46 (1.01)	n.a.
Being employed by patient outside of treatment (Unacceptable)	6.47 (1.35)	6.21 (1.57)	n.a.
Kissing patient on lips (Harmful)	6.31 (1.19)	6.22 (1.58)	n.a.

that almost everyone found frankly unacceptable (hitting the patient, or submitting false bills with the patient's knowledge) or phoning the patient to discuss non-therapy issues.

Perhaps these differences at the individual-item level can be better understood if we used results from factor analysis to compare the two groups. A separate factor analysis was done for each group (U.S./Brazil versus Qatar). Here the strategy is different from studies in which there is an initial attempt to establish measurement invariance (see Vandenberg & Lance, 2000 for a review). The purpose here is to see the extent to which individuals in different cultures in fact responded differently to the same items. The assumption is NOT that the measure is invariant but that it will vary in different contexts and cultures. It is the nature of that variability that we are exploring.

A summary of the results, in terms of the overall factors found, are shown in Table 2. The two groups differed in terms of how many major factors were found, with the U.S./Brazil group having only three factors. Some of the more specific information about the factors is included in the discussion that follows. For the first factor in the U.S./Brazil group, which we have called **Core Boundary Violations**,

Table 2
Brief comparison of factor analysis results from both studies.

U.S./Brazil factors	Qatar factors
Core boundary violations: sexual and business	Building personal relationships and business excursions
Intermixing therapist and patient lives	Sexual violations
Disclosure and greeting behaviors	Touching or greeting items
	Mixing personal and professional

49 items loaded with coefficients of .6 or higher. The items that loaded were made up of several types of therapist behaviors. For example, 32.65% (16 items) involved mixing therapy with personal or social considerations (for example, telephoning the client to speak about matters besides therapy). The next largest number of items from this first factor (28.57%) involved sexual behavior (for example, necking with the client, having sex with the client, seducing the client). The remainder of the items in this factor included either those involving financial transactions (such as selling non-therapy products to the client) or those involving physical or hostile aggression toward clients. The second factor, **Separation of Therapist and Client Lives**, contained 34 items that asked about situations in which the client and the therapist might encounter each other outside of the therapist's office. The third factor contained **Disclosure and Greeting Items**.

In the Qatar factor analysis, four distinct factors were found. The first factor was called **Building Personal Relationships and Business Excursions**. Of the 31 items that loaded on this item 26 (83.87%) consisted of items in which therapy was mixed with personal or social considerations. Three items that involved either buying a product recommended by the patient (judged as both harmful and unacceptable) or entering into a joint venture with the patient concerned business. There were two items that were somewhat related to sexual violations also loaded on this factor (hugging a patient and going along with a patient's advances). A second, and separate factor, **Sexual violations**, contained16 items that mostly involved sexual behaviors, or disclosing one's history of sexual or physical abuse, as well as physically or verbally aggressing against the patient. It also included one financial item (borrowing money from the patient). Note that these two factors together are not dissimilar from Factor 1 for the U.S./Brazil group. The third factor, **Touching or Greeting**, with only 5 items loading on it, included 2 items on hugging the patient, either in greeting or to comfort, 2 items about either disclosing information to the patient or displaying professional awards. The fifth item, which loaded negatively, was an item about selling products or non-therapy services to a patient. Finally, the last factor, **Mixing Personal and Professional**, had 4 items that loaded highly on it (.86 to .88), that were items in which having sexual intercourse with the patient, hitting the patient, kissing the patient and physically pushing the patient, were all judged as unacceptable. Finally, selling products or non-therapy products being unacceptable also loaded on this factor.

The results from the factor analyses, while somewhat different for each group on the surface, do allow us to see that there are certain commonalities, particularly in the first factor for U.S./Brazil and the first two factors for Qatar.

What the factor analyses do not tell us is how serious each different violation is perceived to be. One way to examine whether all of the possible violations can be placed on a scale from least serious to most serious, is to use a scaling method called Rasch analysis. In order to understand these results, a basic knowledge of Rasch analysis is necessary. The Rasch Model (e.g. Andrich, 1988; Wright & Stone, 1979) was originally developed to scale the difficulty of items on large-scale achievement tests. Its use has since exploded in a variety of disciplines and for a wide range of topics. A Rasch Model converts raw ratings of items into scales of Rasch scores. The Rasch score scale is objective, additive and single-dimensional scale. Such a scale can then be used as a type of objective ruler against which to measure the data on survey items as well as on respondents. This means that a change of severity of the Rasch scores of 1 unit, is the same going from −2 to −1 as going from 0 to +1.

A Rasch scale can be across any variable that can be examined in terms of its "amount", from the least of that variable to the most of that variable. Here, the dimension to be examined is how serious a boundary violation is perceived to be. We calculated a separate Rasch analysis using Winsteps for each of the data sets (Linacre, 2003; Rasch, 1980; Wright & Stone, 1979). These are shown in Figs. 1 and 2. It should be noted that although a larger sample size would be recommended, a sample size of at least 30 assures 95% confidence and a sample size of 50 assures 99% confidence (Linacre, 1994).

The Rasch analysis results for the U.S./Brazil data are shown in Fig. 1. Note that the primary purpose of showing this kind of figure here is to demonstrate graphically that the items do form a scale. The figure shows that the scale values vary from −2 logits to +2 logits, with −2 indicating violations rated as most serious. Variable names in the figure are in terms of brief abbreviations, and many will not be easily 'translatable' by readers. The point, however, is not for the reader to be able to see where each and every item is placed. What we will do here is simply mention the placements of some of the specific items, to illustrate that the scale formed does conform to a dimension of more serious violations to less serious violations. There was one behavior that was seen as the most extreme: The therapist going along with a client's sexual advances (which was the lowest, at close to −2). Only slightly less extreme were four violations that fell in between −1.6 and −1.7. These were: "having sex with a client (sex)", "touching breasts or genitals together (feelie)", "pretending that sex with a client was for therapy (pretend)", and "kissing a client on the mouth (kiss)". On the other end, things such as "greeting clients with only a handshake" (shake) was the least serious with a positive Rasch scaled value of 2. Other items toward the positive end of the scale included "going to a client's funeral" (funeral), "visiting a client for a medical activity" (visit), "visiting a client at home for a social activity" (home), "patting a client on the back" (pat), and "displaying one's diplomas" (diploma). Many of the most severe items were sexual in nature (11/18 = 61%), about violence (2/18 = 11%) or money and gifts (4/18 = 22%).

The other important aspect of the data shown in Fig. 1 is that there are no large gaps between most of the items, except at both the positive and the negative end. This suggests that the vast majority of the items form a continuum from most to least serious, without a clear dividing line separating what might be boundary violations from boundary crossings.

The Rasch analysis results for the Qatar data, seen in Fig. 2, show a similar range between least serious (at close to +1) to most serious (at −2.56). The behavior that was rated as most serious was "Hitting the patient" (−2.56). Only slightly less extreme was "Kissing the patient on the lips" (−2.01). The items, "Having sexual intercourse with the patient" and "Paying the patient to do any of the above" both had Rasch scores of −1.29, indicating these were seen as somewhat less serious. On the other end, things such as "Greeting clients with only a handshake" (Rasch scaled value = .9) and "Patting patient on the back" (.72) were seen as not at all serious, as in Fig. 1. Again, as in Fig. 1, there is no bright line separating serious violations from less serious ones. This again suggests that there is a continuum of items.

4. Discussion

The analysis of differences in mean ratings of individual ratings, seen in Table 1, does suggest that there are both commonalities across cultures, and differences between cultures. For example, both sets of cultures seem to agree that certain behaviors are seriously harmful and/or professionally unacceptable. These behaviors include some that are frankly sexual, such as having sexual intercourse with a patient, or kissing them on the lips. They also include behaviors related to doing business with the patient and disclosing financial or romantic information. In the case of certain other behaviors that may occur during therapy (the top section of Table 1), Qatari practitioners seemed to more often rate these items, involving the mixing of therapy with personal behaviors, as more serious than practitioners from U.S./Brazil. For other behaviors that involve interacting with patients outside of therapy, during social occasions for example, Qatari therapists seemed to judge these as less serious than therapists from the U.S./Brazil study.

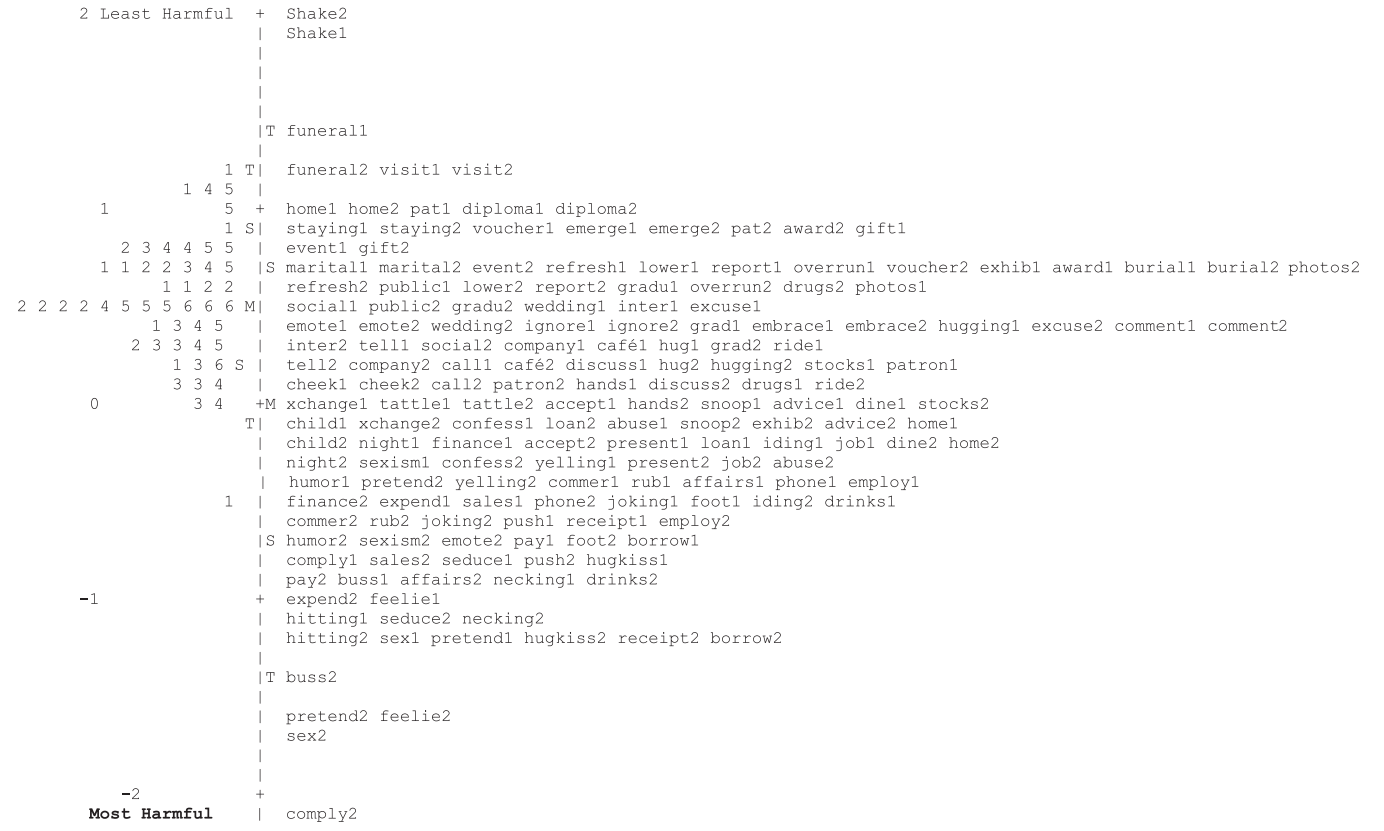

Fig. 1. Crossings and violations: American/Brazil Study.

These results suggest that there are certain behaviors within therapy that are more universally recognized as serious boundary violations. But for many of the other behaviors, there are both some differing perceptions across cultures and potentially disagreement between individuals. This confirms the suggestion in a number of theoretical papers on boundaries that there are both more serious boundary

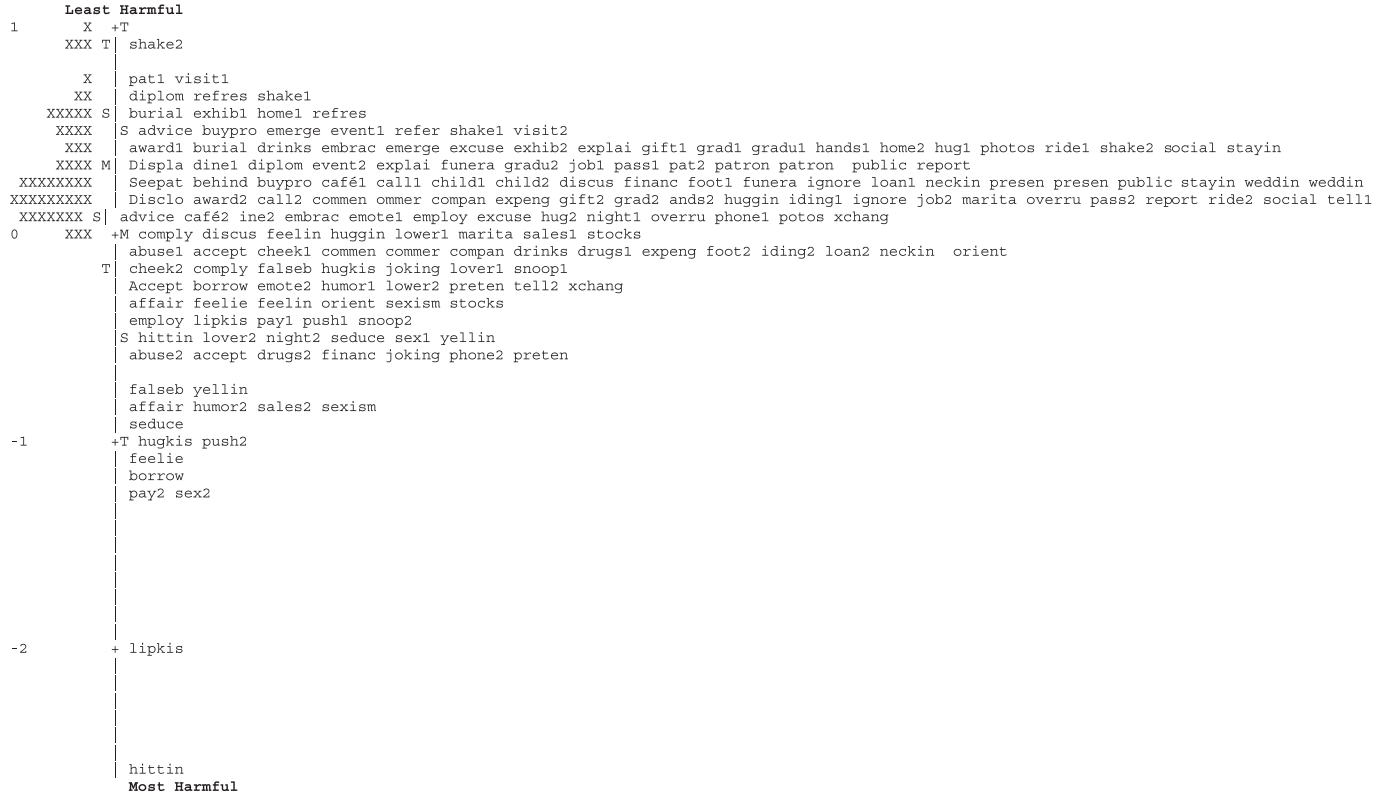

Fig. 2. Boundary crossings and violations 50 raters, 180 crossings and violations: QATAR Study.

violations and less serious boundary crossings (e.g., Gutheil & Gabbard, 1998; Gutheil & Simon, 2002; Kroll, 2001; Lazarus, 1994; Martinez, 2000). A larger and broader study within a culture and/or across cultures could clarify the extent to which some of the differing perceptions seen here are associated with culture, or with different philosophical foundations and training.

The results of the factor analysis showed that the items could be grouped into 3 for US/Brazil sample and 4 for Qatar. These "nameable" factors for each culture suggested in a different way that boundary violations could be thought of differently within the two sets of cultures. For example, in the U.S./Brazil sample, a relatively large number of the items were grouped together into one factor that was called "Core Boundary Violations." These violations included a number of items that concerned mixing therapy with personal considerations, but it also included items about sexual and business related behaviors. In the Qatar sample, the first factor consisted almost entirely of items concerning mixing therapy with personal considerations. The second factor consisted of the sexual items. This suggests that in Qatar the sexual items were seen as distinct from the other items. For the U.S./Brazil sample, the second factor found consisted of items that asked about the intermixing of therapist and patient lives outside of therapy. The third factor for that sample consisted of Disclosure and Greeting items. For the Qatar sample, the third and fourth factors both had very few items that loaded on them, and while the factors were named, the names tended to reflect only half or less than half of the items loading on them; in other words they were not as clear and interpretable as the factors found in the first sample. While the results of the factor analyses are necessarily preliminary, due to the small sample sizes used here, the results do conform with theoretical views on boundary excursions. For example, the therapists in the U.S./Brazil sample seem to accept a prevalent view of boundary-related behavior, which is that many of the less serious boundary crossings may represent a "slippery slope" that leads to more serious boundary violations (Gutheil & Simon, 2002); this is reflected in the large number of items that loaded on the first factor. The U.S./Brazil sample, as seen in the second factor, also considered items in which therapist and patient activities became intermixed outside of therapy as a coherent group. Again, in some of the writing about boundary violations and crossings in the United States (Gutheil & Simon, 2002), these behaviours are also talked about as possibly problematic or as being part of a "slippery slope" that will lead to other more serious violations. This may reflect the fact that the therapists in the U.S. and the Brazil samples were trained in more similar ways.

The Rasch scale results supported the idea that, in both groups, some boundary excursions are perceived as less serious, while others are perceived as more serious. Again, the figures showing the severity of boundary excursions should not be taken as an absolute table of severity. These estimated values of perceived seriousness are based on sample sizes that are not very large. The scaled perceived harms and unprofessional behavior are also not scaled actual harms.

Nevertheless, what is so important is that over 94% of the boundary items fell on a single dimension of perceived seriousness of a boundary issue. This does not contradict the factor analysis, which is about content. But the Rasch analysis results do add to the other findings by showing that participants rated different items as either more or less serious. Less personally invasive excursions (e.g. going to a client's funeral, visiting a client at home in pursuit of medical activity, patting a client on the back or displaying diplomas within the office) were seen as less serious. As boundary excursions became more personally invasive (e.g. "necking" with a client or borrowing money from a client), they were rated higher in severity. This provides some empirical evidence for at least the perception among therapists of their being more serious boundary violations and less serious boundary crossings.

Note that the scales in both figures are largely linear and smoothly continuous. There are no breaks or jumps. This linear scaling of boundary issues is evidence for one aspect of the slippery slope — that it is continuous. This finding provides support for the clinical and forensic observation of progressive boundary excursions (Blatt, 2001; Kroll, 2001; Strasburger, Jorgenson, & Sutherland, 1992) rather than a bright line that the legal systems prefer. As clinical and forensic practice may also demonstrate, there is no bright line dividing the boundary crossings from the boundary violations. This further underscores the critical role of context in analysis of boundary issues (Dattilio, Commons, Adams, Gutheil, & Sadoff, 2006; Gutheil & Gabbard, 1998). For the less serious boundary excursions, context matters greatly.

But is also true that at some level of severity, using Fig. 1 to illustrate, this might be items that start at about −.80 (the item listed there is "seducing your patient is harmful"), behavior begins to occur that experience outside of this study suggests has a high likelihood of ethics complaint or litigation. Almost all the boundary issues with negative values greater than −0.83 may become serious legal issues for practitioners. This finding should strengthen case by case analysis.

The findings together seem to suggest that cultural factors may have the largest influence on boundary behavior that is generally less serious. It is precisely these kinds of behaviours that would seem to merit more study in the future. Currently, there could be said to be a kind of confirmation bias (Nickerson, 1998) in assumptions that are being made about the role of these less serious boundary "crossings" in possibly leading to more serious boundary violations. It is surely the case that when more serious boundary violations have occurred, observers often note that there was evidence of less serious boundary crossings in the therapist–patient interaction (e.g. Gutheil & Gabbard, 1998; Gutheil & Simon, 2002). This does not mean, however, that all of the so-called boundary crossings (or even the majority of them) inevitably lead to the more serious boundary violations. This specific hypothesis has yet to be seriously investigated. A much broader investigation of the actual consequences of both boundary violations and boundary crossings also needs to be conducted, so that information can be gathered from more situations in which things have not escalated to either complaints to licensure boards or litigation.

Although there is as yet no precise or universally accepted definition of "boundaries," there is general agreement that psychotherapy occurs within a framework created by managing parameters such as time, self-disclosure, physical contact, and confidentiality (Gabbard, 2001). Managing these parameters or boundaries in a manner that benefits and protects patients is a basic skill that every practitioner is expected to learn. Recent discussions identifying the cultural relativity of boundaries and the effects that a physician's or patient's culture has on boundary-keeping practices (Gabbard, 2001; Kroll, 2001; Webb, 1997) show that acquiring this skill is more complex than previously assumed. Program directors might need to develop ethical guidelines adjusted to local culture, program aims, and the capabilities of providers. A clear and reasonably specific set of principles or ethical standards is recommended to guide local practice. The standards should be promulgated to all staff and should be signed by each provider, documenting proof of being informed.

However, developing and distributing ethical guidelines or standards does not go far enough. Clinical supervision can support practice within ethical boundaries by following four major principles (Hess, 1998). First, the supervision should be proactive rather than reactive. The supervisor should not wait for calamity to review the supervisee's work. Supervision should be continuous and of varying intensity, based on the clinician's caseload and other characteristics of the practice setting, such as changes in funding, management, or contractual obligations.

Second, the supervision should be sensitive to the supervisee's personal situation. A supervisor should be aware of significant changes in the supervisee's life that might indicate increased vulnerabilities.

Third, the supervisor must pay attention to the details of the supervisee's cases and the interactions between clinician and client. As such it may be more helpful to hear full narrative sequences of clinical encounters at least some of the time, in order to examine patterns or themes that can be found in them.

Fourth, the supervisory interaction should incorporate guided exploration rather than cross-examination (Frantz, 1992). Although focussed investigation can play a role during a crisis, the routine supervisory process will generally discover more useful content through less directive means. We recommend the use of the Socratic method, in which the supervisor asks a series of questions that guide the supervisee to reveal and understand his or her clinical judgments and behavior and, optimally, develop more appropriate views (Walker & Clark, 1999). Using these four principles, clinical supervision can be an effective process for detecting cues of potential boundary problems and exploring them. It is also important to keep in mind that whether a boundary problem is serious or not depends less on what the clinician believes than on the regressive response or other harmful response it evokes from a client.

As administrative, educational, and monitoring resources become more scarce and as cases become more complex, the likelihood of boundary problems increases. Boundary crossings and violations may damage clients, clinicians' careers, agencies' reputations, and programs' credibility (Gutheil & Gabbard, 1998; Miller et al., 2006; Walker & Clark, 1999; Webb, 1997). Programs serving minorities, welfare recipients, persons with severe mental illness, and severely emotionally disturbed children face additional risks with already vulnerable populations. In-home services, case management, and other non-traditional services expose clients and clinicians to informal private settings. Without regular, proactive supervision, clinicians and other providers can easily lapse into boundary problems.

Finally, clinicians should recognize the benefits of self-disclosure as well as its danger (Walker & Clark, 1999). This is especially true for clinicians who work in self-help or peer formats, cognitive-behavioral therapy, psychopharmacologic management, and supportive therapy. It is also especially relevant for community settings and among subgroups of patients who have high expectations of self-disclosure or concrete thinking. Nevertheless, the choice of whether to self-disclose should be an active decision that is balanced against the risks, and the decision should always be based on the patient's best interests. Skill and sometimes supervision are necessary for making the best choices about self-disclosure.

Consideration of the therapeutic benefits of self-disclosure has been hindered by the association between self-disclosure and flagrant boundary violations. We do not dispute the fact that inappropriate self-disclosure is a component of many harmful boundary violations (Psychopathology Committee of the Group, 2001). However, it is erroneous to conclude that self-disclosure inevitably leads to boundary violations. Such a view has diminished our therapeutic repertoire by limiting the potential benefits of clinician self-disclosure. Psychotherapy research should include the study of self-disclosure as one of the prospective active ingredients of the therapeutic process. In these rapidly changing times, we must be open to addressing the positive aspects of therapist self-disclosure in developing new rules for our new roles.

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