1998

# Questioning the "Slippery Slope": Ethical Beliefs and Behaviors of Private Office-Based and Church-Based Therapists

Barrett W. McRay

Mark R. McMinn
*George Fox University*, mmcminn@georgefox.edu

Katheryn Rhoads Meek

# Questioning the "Slippery Slope": Ethical Beliefs and Behaviors of Private Office-Based and Church-Based Therapists

**BARRETT W. McRAY**
**MARK R. McMINN**
**KATHERYN RHOADS MEEK**

*Counselors and other mental health professionals whose primary office is in a church building often face unique challenges in maintaining appropriate client–therapist boundaries. A sample of 497 Christian counselors responded to an 88-item survey of their ethical beliefs and behaviors. Of the respondents, 148 reported a church as their primary work setting and 162 reported a private office as their primary work setting. Survey results were factor analyzed, then church-based therapists were compared with private office-based therapists regarding their views of ethical behaviors. Although church-based therapists take greater liberties with multiple-role relationships than private office-based therapists, they appear similar with regard to other ethical beliefs and behaviors. Results suggest that church-based therapists who take liberties in nonsexual multiple-role relationships are no more likely than other therapists to violate other ethical standards.*

In any context and for any psychotherapist, regardless of religious conviction, the identification of role boundaries, priorities, and loyalties in a psychotherapeutic relationship is a delicate and stressful concern (Keith-Spiegel & Koocher, 1985). Accordingly, the American Psychological Association (1992) established principles and standards regarding the boundaries of the role of psychologists in psychotherapeutic relationships, as have other professional mental health organizations (American Association of Marriage and Family Therapy, 1991; American Counseling Association, 1988; American Psychiatric Association, 1986; National Association of Social Workers, 1993). The ongoing development of these standards relies heavily on systematic research. Unfortunately, church-based therapists have been underrepresented in previous research.

An important ethical standard on which church-based therapists may differ from other therapists is that of multiple-role relationships. A multiple-role relationship involves the combination of a professional, fiduciary relationship with a second, significantly different relationship—whether concurrent or sequential (Keith-Spiegel & Koocher, 1985; Pope, 1991). "Role conflicts arise when the expectations attached to one role call for behavior which is incompatible with that of another role" (Gottlieb, 1993, p. 41). The overrid-

---

Barrett W. McRay and Katheryn Rhoads Meek are doctoral students in clinical psychology at Wheaton College, Wheaton, Illinois. Mark R. McMinn is a professor at Wheaton College. Correspondence regarding this article should be sent to Barrett W. McRay, Department of Psychology, Wheaton College, Wheaton, IL 60187.

ing concern is that multiple-role relationships interfere with objectivity and increase the likelihood of exploiting clients (Kitchener, 1988).

Historically, discussions of multiple-role relationships have often focused on the combination of a psychotherapeutic relationship with a sexual relationship. However, nonsexual multiple-role relationships may also cause concern for counselors, because they sometimes place clients in positions in which their roles are poorly defined, and the power dynamics of therapy cannot be clearly delineated from the roles of the other relationship. Moreover, some have assumed that blurred boundaries in nonsexual relationships may also make therapists more likely to violate other ethical standards and to engage in sexual misconduct (see Pope, Sonne, & Holroyd, 1993).

Avoiding multiple-role relationships is especially difficult for counselors whose primary office is in a church building. Church-based therapists are sometimes called upon to counsel those with whom they attend church and socialize. Some forms of pastoral counseling require a prior relationship before a trusting counseling relationship can be established. It is important to know if there is a "slippery slope" that makes these church-based therapists more likely than others to enter into sexual relationships with clients.

The present study represents an attempt to address this question by examining the ethical beliefs and practices of psychotherapists who practice in a church context as compared with those who practice in a private office.

## METHOD

### *Participants*

Participants for the study were randomly selected from the 11,000 members of the American Association of Christian Counselors. Three hundred with doctoral degrees, 300 with master's degrees, and 300 with no graduate degree were selected. Of the 900 individuals to whom surveys were sent, 29 returned personal responses explaining why they could not complete the survey (e.g., retirement, not currently practicing), and 5 were undeliverable. Of the 866 who could have responded, 498 returned completed or partially completed surveys, resulting in a return rate of 58%.

### *Materials*

The survey questionnaire was based on the survey instrument used by Pope, Tabachnick, and Keith-Spiegel (1987) and was divided into three main sections. First, participants responded to a list of 88 behaviors by reporting how often they engaged in the behavior and whether or not they believed it was ethical. Pope et al.'s (1987) list included 82 behaviors, with one item being repeated to allow for a reliability check. Gibson and Pope (1993) added 5 behaviors at the end of the original 83 and replaced the repeated item, resulting in a total of 88 items. These same 88 items were used in this sur-

vey, except that we retained Pope et al.'s (1987) repeated item (Items 66 and 82: "Being sexually attracted to a client") rather than using Gibson and Pope's (1993) replacement item for Item 66 ("Advertising accurately your counseling techniques"). Frequency of engaging in the behavior was rated on a 5-point scale: 1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *fairly often*, or 5 = *very often*. Participants also had an option of reporting that a behavior was not applicable to their counseling practice. Beliefs about the ethics of the behavior were also rated on a 5-point scale: 1 = *unquestionably not*, 2 = *under rare circumstances*, 3 = *don't know/not sure*, 4 = *under many circumstances*, and 5 = *unquestionably yes*. A general analysis of the response patterns on these 88 items, including differences based on sex, age, highest degree, and professional license, is reported elsewhere (McMinn & Meek, 1996). No reliability or validity data have been reported for this instrument to date.

Second, participants evaluated the usefulness of 14 resources for providing direction and regulation of their practice. These included resources such as graduate training, internship, state ethics committees, and so on. Usefulness for each was assessed on a 5-point scale: 1 = *terrible*, 2 = *poor*, 3 = *adequate*, 4 = *good*, and 5 = *excellent*. Participants also had the option of reporting that a resource was not applicable to their situation. Information from the second part of the survey is reported elsewhere (McMinn & Meek, 1997)

Third, participants reported demographic and professional information, including their sex, age, primary work setting, major theoretical orientation, organizational memberships, highest degree held, and number of professional journals received. They also rated the prevalence of several different psychiatric disorders among those for whom they provide services—information that was used as part of another study (McMinn & Wade, 1995).

### *Procedure*

Surveys were mailed in March 1994 with a cover letter describing the purpose of the study, and participants were asked to put their completed survey in an inner envelope which, in turn, was placed in an outer postage-paid envelope. The outer envelope was sent to a psychologist in Oregon who separated the inner and outer envelopes and then sent them to the primary investigators in Illinois. The outer envelopes had a code to identify who had returned the survey, but because the inner envelopes had been previously separated, none of the survey responses could be traced to individual respondents. This assured confidentiality for those completing the survey. Those who had not yet returned the survey after 3 weeks were sent a reminder postcard. After 2 additional weeks, they were sent another questionnaire packet.

## RESULTS

Of those responding to the survey, 302 (61%) were male, 181 (36%) were female, and 15 did not report their sex. One hundred ninety respondents

(38%) were 45 years of age or less, 217 (44%) were between 46 and 60 years, 86 (17%) were over 60 years, and 5 did not report their age. With regard to their highest academic degree, 72 (14%) reported no graduate degree, 229 (46%) reported a master's degree, 172 (35%) reported a doctoral degree, and 25 did not provide information. Approximately one third (33%) of the respondents identified a church as their primary work setting, another third (37%) reported a private office as their primary work setting, and the remaining respondents were distributed throughout a variety of primary work settings, including clinics, hospitals, universities, and other settings. One hundred fifty-three (31%) reported being licensed as mental health professionals.

The overall response patterns to each of the survey items are reported elsewhere (McMinn, Meek, & McRay, in press). To simplify interpretation of this large response set, we implemented a series of principal-components factor analyses, using varimax rotation. We computed separate factor analyses for belief and behavior ratings. To confirm the factor structure, we randomly divided the sample into two subsets. The larger subset included 398 respondents and the smaller included the remaining 100 respondents. Thus, we computed four factors analyses: ethical beliefs–large sample (exploratory), ethical beliefs–small sample (confirmatory), ethical behaviors–large sample (exploratory), and ethical behaviors–small sample (confirmatory). In each case we included only factors with eigenvalues of 1.5 or greater to simplify the numbers of factors produced. Items with factor loadings of .45 or greater were used to create factor scales, and only those scales with two or more items were included. More details about the factor analysis and a listing of the items loading on each factor are reported elsewhere (McMinn et al., in press).

Those factors that appeared in both the exploratory and confirmatory factor analyses were used as scales for subsequent analyses. Only items that loaded on the same factor for both samples were included in the scales. For ethical beliefs, two large scales emerged: blatant ethical violations and multiple roles. For ethical behaviors, four smaller scales emerged: multiple roles, confidentiality, sexual countertransference, and immoral violations. The final scales and their internal consistency (coefficient alpha) ratings are listed in the Appendix.

In addition, we identified several specific items on a rational basis that pertain to the sexual beliefs and behaviors of counselors. Although these items did not always cluster together with the factor analyses (perhaps because several of the items had low variance among respondents), they are logically related as items that reflect sexual behavior. They include the following items: telling client "I'm sexually attracted to you" (Item 15); using sexual surrogates with clients (Item 31); leading nude group therapy or "growth groups" (Item 41); becoming sexually involved with a former client (Item 47); kissing a client (Item 54); engaging in erotic activity with a client (Item 55); engaging in sex with a clinical supervisee (Item 58); engag-

ing in sexual contact with a client (Item 62); allowing a client to disrobe (Item 68); and disrobing in the presence of a client (Item 78).

To test differences based on work setting and professional preparation, we computed a series of analyses of variance (ANOVAs), with the dependent variables being the sum of ratings on the scales derived in the factor analyses. The independent variables were church-based versus private office-based therapists and professional licensure versus no mental health license. Those who reported being a psychiatrist, psychologist, licensed or registered social worker, or national certified counselor were considered to be licensed counselors, and others were considered to be nonlicensed counselors. Because few church-based therapists reported having professional counseling licenses, the distribution of respondents was not evenly spread throughout the four cells of the 2 × 2 design. This creates interpretive difficulties, because practice setting and licensure status are correlated variables and because of the very small cell size ($n = 7$) for licensed, church-based counselors. The average scale scores for each group are reported in Table 1.

Main effects were found for both independent variables on the multiple-role belief and behavior scales but not on any other scales. No interaction effects were observed. Church-based therapists were more likely to have engaged in multiple-role behaviors, $F(1, 184) = 12.0, p < .01$, and to endorse their ethical acceptability, $F(1, 179) = 8.2, p < .01$. Similarly, nonlicensed therapists were more likely to have engaged in multiple-role behaviors, $F(1, 184) = 5.7, p < .05$, and to endorse their acceptability, $F(1, 179) = 5.0, p < .05$.

We were also interested in knowing the effects of graduate training on ethical behaviors and beliefs among church-based therapists. Church-based

**TABLE 1**

**Average Scale Ratings for Office-Based and Church-Based Licensed and Nonlicensed Counselors**

| | Office-Based | | Church-Based | |
|---|---|---|---|---|
| Scale | Licensed ($n = 64$) | Nonlicensed ($n = 49$) | Licensed ($n = 7$) | Nonlicensed ($n = 68$) |
| Beliefs | | | | |
| Blatant errors | 29.36 | 31.18 | 29.83 | 30.83 |
| Multiple roles[a,b] | 21.31 | 25.64 | 30.67 | 28.64 |
| Behaviors | | | | |
| Multiple roles[a,b] | 11.17 | 12.73 | 13.00 | 15.34 |
| Confidentiality | 9.12 | 8.47 | 10.29 | 9.59 |
| Sexual countertransference | 5.55 | 5.31 | 5.14 | 4.74 |
| Immoral violations | 3.20 | 3.43 | 3.14 | 3.47 |
| Rationally derived scale | | | | |
| Sexual behaviors | 10.44 | 10.27 | 10.17 | 10.20 |

[a]Main effect for licensed versus nonlicensed ($p < .05$). [b]Main effect for office-based versus church-based ($p < .05$).

therapists were divided into three groups: no graduate degree, master's degree, and doctoral degree. Scale scores were compared for these groups using one-way ANOVAs. The average scale scores for each group are reported in Table 2. No differences were observed among groups.

## DISCUSSION

### *Problems With Design*

Several limitations of this study should be noted when interpreting the results. First, the two independent variables used for this study—practice setting and licensure—are not completely independent. From our sample, most church-based therapists tend to have no professional license whereas most licensed therapists tend to practice in a private-office setting. Consequently, the licensed, church-based cell in our 2 × 2 design contained only 7 respondents. Second, we chose a cross-sectional design for our study, which carries with it certain limitations for generalizabilty. Ideally, research regarding the effects of multiple-role relationships would be longitudinal in design. This would allow for tracking the actual behaviors of counselors over time and a more specific examination of the impact of nonsexual dual relationships on counselors' ethical behaviors. Third, respondents omitting any item in the survey were dropped from the data pool, which further decreased our cell sizes. After we eliminated surveys from those not practicing in office-based or church-based settings and those with missing data, 188 respondents remained for the ANOVA described here. Fourth, 42% of those contacted in the initial survey did not respond, and although this represents a good return rate for survey research, these nonrespondents poten-

**TABLE 2**

**Average Scale Ratings for Church-Based Therapists by Highest Degree**

| Scale | No Graduate Degree ($n$ = 29) | Master's Degree ($n$ = 35) | Doctorate ($n$ = 16) |
|---|---|---|---|
| Beliefs | | | |
| Blatant errors | 33.07 | 28.90 | 29.64 |
| Multiple roles | 29.13 | 26.87 | 29.57 |
| Behaviors | | | |
| Multiple roles | 15.48 | 13.89 | 15.39 |
| Confidentiality | 9.00 | 10.02 | 9.36 |
| Sexual countertransference | 4.47 | 5.03 | 4.94 |
| Immoral violations | 3.58 | 3.16 | 3.47 |
| Rationally derived scale | | | |
| Sexual behaviors | 10.67 | 10.10 | 10.28 |

tially may differ in some way from those who did respond. Fifth, actual behavior is not always accurately reflected by self-report measures.

*Questioning the "Slippery Slope"*

A central theme in the literature on multiple-role relationships is that these relationships decrease the ability of psychotherapists to distinguish between professional and nonprofessional relationships with clients, thereby lowering the standard of care provided. Kitchener (1988) summarized the issue in this way:

> As the incompatibility of expectations increases between roles, so will the potential for harm. . . . As the obligations associated with different roles diverge, the potential for loss of objectivity and divided loyalties increases. . . . As the power and prestige between the professional's and consumer's roles increase, so does the potential for exploitation. . . . In such situations what comes into question is the willingness and the ability of the professional to place the interests of those who are served above his or her own. (pp. 217–218)

This slippery slope assumption holds that multiple-role relationships place professionals in a compromising situation in which their competence to make ethical decisions and serve the best interests of their clients is questionable.

At least two previous articles have highlighted specific settings in which multiple-role relationships are common or unavoidable. Stockman (1990) addressed the ethics of practicing psychotherapy in rural settings, and Sobel (1992) discussed the unavoidable multiple-role relationships experienced by psychotherapists in small-town practice. In these situations, psychotherapists inadvertently and inevitably encounter clients in restaurants, community events, PTA meetings, churches, and so on. The boundaries between the psychotherapy relationship and other social relationships become difficult to distinguish, and according to the slippery slope argument, issues of confidentiality and privacy become problematic, objectivity is lost, and the potential for exploitation increases. In general, the quality of care is jeopardized.

In response to these concerns, varying degrees of restriction are offered as guidelines (see Gottlieb, 1993; Gross & Robinson, 1987; Keith-Spiegel & Koocher, 1985; Kitchener, 1988). All of these echo concern over potential harm; however, Kitchener takes the most rigid stance, arguing that the risk is too great to allow for latitude. Thus, Kitchener supports prohibition of multiple-role relationships, assuming that participation in multiple-role relationships is an ethical compromise that will inevitably propel a clinician down a slippery slope toward gross unethical behaviors. Our data do not support this assumption.

In fact, although appropriate guidelines that will enable psychologists to better serve their clients are indeed important, such inflexible positions may alienate people who desperately need services. For many potential patients

in rural and small-town settings, the presence of at least a minimal prior relationship is often necessary before they will trust a therapist enough to begin treatment (Sobel, 1992; Stockman, 1990). Therefore, to a certain degree, nonsexual dual relationships in rural settings can be beneficial, if not necessary, to effective treatment.

## CONCLUSION

The results of this study indicate that therapists who, by virtue of their church-based practice setting, are likely to engage in multiple-role relationships with clients are no more likely to condone or report the practice of gross unethical behaviors than are other therapists. The only difference between the groups of counselors in this survey was their tolerance for nonsexual multiple-role relationships. In light of these findings, we suggest two directions for further research.

First, it is evident that a majority of authors discourage participation in multiple-role relationships because they assume the potential of harm to the clients. There may indeed be harm associated with multiple-role relationships, but we find no evidence of multiple-role relationships increasing risk for other ethical violations. Thus, it seems appropriate to be cautious and tentative in warnings about multiple-role relationships.

> The general message implicit in the ethics code is that psychologists who enter a professional, fiduciary relationship with a client must hold that relationship paramount. When a prior relationship (e.g., a close friendship) exists, superimposing a professional relationships *may* [italics added] be inappropriate. If an opportunity to enter another level of relationship arises after a professional relationship is already established, it should *probably* [italics added] be rejected. It is *probably* [italics added] impossible to create clear guidelines for psychologists with regard to dual-role relationships not involving sexual intimacy, since each situation presents unique features that must be considered. (Keith-Spiegel & Koocher, 1985, p. 267)

The italicized words illustrate the tentative language that is probably appropriate considering our lack of detailed knowledge regarding the effects of multiple-role relationships. Longitudinal research needs to be conducted in this area to better clarify any relationship between multiple-role relationships, harm to clients, and other forms of unethical behavior.

Second, we need additional research to determine if multiple-role relationships are a decidedly negative influence on therapy, or whether there may be a potential benefit in some cases, especially for church-based therapists for whom multiple-role relationships are difficult to avoid.

## REFERENCES

American Association of Marriage and Family Therapy. (1991). *Code of ethical principles for marriage and family therapists.* Washington, DC: Author.

American Counseling Association. (1988). *Ethical standards.* Alexandria, VA: Author.

American Psychiatric Association. (1986). *Principles of medical ethics with annotations especially applicable to psychiatry.* Washington, DC: Author.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597–1611.

Gibson, W., & Pope, K. S. (1993). The ethics of counseling: A national survey of certified counselors. *Journal of Counseling & Development, 71,* 330–336.

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

Gross, D., & Robinson, S. (1987). Ethics in counseling: A multiple role perspective. *TACD-Journal, 15,* 5–15.

Keith-Spiegel, P. C. , & Koocher, G. P. (1985). *Ethics in psychology: Professional standards and cases.* New York: McGraw-Hill.

Kitchener, K. S. (1988). Dual role relationships: What makes them so problematic? *Journal of Counseling & Development, 67,* 217–221.

McMinn, M. R., & Meek, K. R. (1996). Ethics among Christian counselors: A survey of beliefs and behaviors. *Journal of Psychology and Theology, 24,* 26–37.

McMinn, M. R., & Meek, K. R. (1997). Training programs. In R. Saunders (Ed.), *Ethics and the Christian mental health professional.* Downers Grove, IL: InterVarsity Press.

McMinn, M. R., Meek, K. R., & McRay, B. W. (in press). Beliefs and behaviors among CAPS members regarding ethical issues. *Journal of Psychology and Christianity.*

McMinn, M. R., & Wade, N. G. (1995). Beliefs about the prevalence of dissociative identity disorder, sexual abuse, and ritual abuse among religious and nonreligious therapists. *Professional Psychology: Research and Practice, 26,* 257–261.

National Association of Social Workers. (1993). *Code of ethics.* Washington, DC: Author.

Pope, K. S. (1991). Dual relationships in psychotherapy. *Ethics and Behavior, 1,* 21–34.

Pope, K. S., Sonne, J. L., & Holroyd, J. (1993). *Sexual feelings in psychotherapy.* Washington, DC: American Psychological Association.

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. C. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist, 42,* 993–1006.

Sobel, S. (1992). Small town practice of psychotherapy: Ethical and personal dilemmas. *Psychotherapy in Private Practice, 10,* 61–69.

Stockman, A. (1990). Dual relationships in rural mental health practice: An ethical dilemma. *Journal of Rural Community Psychology, 11,* 31–45.