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The Effects of Caregiver Stress Upon Ethics at-Risk Behavior Among Florida Licensed Marriage and Family Therapists

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THE EFFECTS OF CAREGIVER STRESS UPON ETHICS AT-RISK BEHAVIOR AMONG FLORIDA LICENSED MARRIAGE AND FAMILY THERAPISTS

BY

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This dissertation is dedicated to Charles R. Figley, Ph.D.

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ABSTRACT

A critical review exploring “at-risk” ethical practice of marriage and family therapy determined that there existed no empirical literature focusing upon the antecedent, correlative, or causal factors of unethical behaviors among LMFTs. Responding to this gap, this study was designed to test the hypothesis that a significant relationship would be found between caregiver stress and at-risk ethical practice among a sample of LMFTs of Florida. Two research questions were developed to help guide an exploratory component of this study with the hope of identifying factors contributing to the understanding of at-risk practice.

Surveys containing a demographic collection tool, an instrument to measure the dependent variable (at risk ethical practice), and three instruments to measure five independent variables (caregiver stress, compassion fatigue, burnout, and satisfaction with life) were sent to a randomly selected sample of one-half (n=549) of the LMFTs in the state of Florida. After a 90-day data collection window, 82 useable surveys were returned (15%). The data were found to be significantly non-normal.

Upon analyses, no significant relationship between caregiver stress and at risk practice emerged; therefore the null hypothesis was not rejected. In the exploratory portion of the study, only compassion fatigue emerged with a significant predictive relationship (R^2=.140; *p*=.002) for at-risk practice among all the independent variables and demographic data. Nearly all respondents (86.4%) identified at least one area for which they were at-risk for practicing outside the boundaries of the AAMFT Code of Ethics. The sample for this study was remarkably healthy with positively non-normal scores for caregiver stress, compassion fatigue, burnout, and satisfaction with life.

The validity of this study was challenged by a very low response rate, a non-normal and very healthy sample, and unacceptably poor psychometric performance of the Ethics At-Risk Test for Marriage and Family Therapists *(*Brock, 1997)—the instrument utilized to measure the dependent variable.

Recommendations for future research resulting from the findings of this study primarily advocate studies designed to resolve the psychometric problems of measuring at-risk ethical practice. Following the resolution of the scaling problems, a program of research that recruits larger and more representative samples of cross-discipline professionals and compares this sample with professionals who have been adjudicated for ethical violations is suggested to begin to determine the antecedent, correlative, and causal factors related to professional caregivers' practice outside the boundaries of ethical and legal constraints.

CHAPTER 1

INTRODUCTION

This chapter introduces the key concepts, scope, biases, definitions, research questions, and procedures used in this study of the relationship between at-risk ethical behavior and caregiver stress.

Introduction

The practice of marriage and family therapy challenges practitioners' values, assumptions, and functioning in their own marriages and families. For a therapist, bearing witness to the anger and anguish that accompany the dissolution of a marriage and/or family–so often the state in which clients present themselves–can be heartbreaking. To help clients make sense of the experiences and responses that have led to their suffering, therapists must listen to the stories of those experiences and assimilate and understand them. At the same time, therapists are challenged to help clients develop more effective and satisfying meanings and behaviors to confront their present and future.

Abuse and torture; neglect and other developmental injuries; gratuitous acts of violence; along with overwhelming fear, anger, sadness, and despair are just some of the past experiences and current emotional states that torment the clients of the daily caseload of a marriage and family therapist. The conscientious practitioners cannot escape confronting the pain, despair, or trauma of their client's lives. This confrontation can and does generate significant deleterious effects upon practitioners in the forms of emotional exhaustion, depression, physical and somatic distress, heightened anxiety, relational difficulties, despair, substance abuse, and, in extreme cases, suicide (Deutch, 1984; Farber, 1983; Freudenberger & Robbins, 1979; Pearlman & McCann, 1990; Pope & Tabachnick, 1991; Rodolfa, Kraft, & Reiley, 1988).

Some of the terms associated with these negative effects of therapeutic helping are *countertransference* (Danieli, 1980; Hellman, Morrison, &

Abramowitz, 1986; Karakashian, 1994; Wilson & Lindy, 1995), *burnout* (Farber & Heifetz, 1982; Freudenberger, 1979; Deutch, 1984; Maslach, 1976, 1982), compassion fatigue (Figley, 1995, 2002; Gentry, 2002; Gentry, Baranowsky, & Dunning, 2002 Salston, 2000), *secondary traumatic stress* (Stamm, 1995; Lee, 1995), *vicarious traumatization* (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Pearlman, 1995), and *therapist/caregiver stress* (Farber, 1983; Hellman et al., 1987; Marsh, 1997; Rodolfa et al., 1988). The data from these studies point toward one common theme–the provision of services to suffering clients impacts and is potentially hazardous to the caregiver.

In addition to the personal stressful effects that come from working with their clients, marriage and family therapists must also confront their own life demands and stresses in addition to the day-to-day management of a professional practice. Some of these professional demands and stressors include the changing requirements of third-party billing and payment systems, financial concerns, liability and malpractice risk, licensure and continuing education demands, office management, community service, and networking.

The difficulties of treating the troubled and traumatized individuals are compounded for the marriage and family therapist who also routinely provides services to other interconnected members of troubled and traumatized family and social systems. In addition to the negative aspects of care giving, practitioners often confront their own personal challenges from their past and present lives outside the professional arena. Faced with these challenges, how do marriage and family therapists continue to be effective agents of change and growth for the individuals, couples, and families they treat.

To answer this question, one must first consider what constitutes the effective practice of marriage and family therapy. An entire issue of the *Journal of Marriage and Family Therapy* (AAMFT, 1995) was dedicated to examining effective practice. Each article in this issue focused on either reduction of symptoms and/or client satisfaction as the primary indicators of efficacy or effectiveness. Several articles presented compelling evidence that marriage and

family therapy and marriage and family therapists are effective in treating many of the problems that clients bring to therapy (Pinsoff & Winne, 1995; Shadish, Ragsdale, Glaser, & Montgomery, 1995). However, is the ability to help clients lessen their symptoms the only criteria by which we measure effective practice? Is there perhaps another important facet to the issue of therapist effectiveness, one often overlooked? For instance, what about these effective therapists themselves?

Shifting the focus from the client to the therapist caregiver brings new issues into considerations, such as (a) the price therapists pay for their effectiveness, (b) the degree of satisfaction effective therapists have with their practices, (c) the quality of life of effective therapists experience, and (d) self-care and self-management regimens that make effective therapists resilient to the effects of the stressors of professional practice. Furthermore, do effective therapists feel that the benefits of their success are worth the costs? These issues regarding the intrapersonal and subjective effectiveness in the professional and personal lives of marriage and family therapists are often as important as the therapist's ability to assist clients with their problems (Wetchler & Piercy, 1986).

What tools and skills do marriage and family therapists utilize to navigate through and cope effectively with these demands, stresses, and hazards? This question is currently unanswered in the published scientific literature. By learning more about the challenges practitioners face, researchers in the field of marriage and family therapy can possibly provide therapists with some clear empirically-based guidelines and strategies for managing the difficulties and stressors of professional practice so that they may continue to offer these effective services without deleterious intrapersonal effects. Some researchers (Borys & Pope, 1989; Brock & Coufal, 1994; Epstein, Simon, & Kay, 1992; Montgomery, Cupit, & Wimberly, 1999; Nickell, Hecker, Ray, & Bercik, 1995; Pope, Tabachnick, & Keith-Spiegel, 1987) have suggested that such deleterious effects may lead therapists toward destructive methods of self-soothing (i.e., substance abuse),

violations of their own integrity, violations of ethical principles, or resignation from the active provision of marriage and family therapy.

While a gap exists in the literature as to what, intrapersonally, constitutes effective and satisfying practice of marriage and family therapy, some interpersonal benchmarks have become clear for determining ineffective practice (Borys & Pope, 1989; Brock & Coufal, 1994; Epstein et al., 1992; Montgomery et al., 1999; Nickell et al., 1995; Pope et al., 1987). Violations of ethical standards, for example, emerge as clear indicators that a therapist has failed to successfully navigate through and cope with the demands of professional practice. In other words, practicing consistently within the bounds of the American Association of Marriage and Family Therapy's Ethical Code (AAMFT, 1982, revised 1988, 1991, 1998, 2001) could be considered the a priori requirement for the effective practice of marriage and family therapy.

The focus of this dissertation was the investigation into marriage and family therapists' maintenance and violation of this baseline requirement as a starting point toward developing guidelines and strategies for effective practice. This study featured a quasi-experimental design that utilizes survey data collected from a sample of licensed marriage and family therapists (LMFTs) in the state of Florida (N = 1,099) for hypothesis testing. It also explored the stresses therapists face, their effects, and specifically, the relationship between level of caregiver stress and ethics at-risk behaviors (Ethics at-risk behaviors are those hypothesized to be correlated with and/or precursors to boundary violations and other unethical behaviors.) Data collected from a sample of this population reported general levels of stress, anxiety, compassion fatigue, secondary traumatic stress, burnout, resiliency, and general health. One goal of this study is the hope that the results will contribute toward the development of effective prevention and rehabilitation for care providers who are at risk for ethical violations.

A Personal Bias

Attempting to develop a nascent understanding of the sources of ethical violation that would lend themselves to treatment and prevention rather than just sanctions and punishment, the data from scientific journal articles and the authors' interpretations of these data in the literature review were scrutinized with the bias that no therapist violates ethical codes with the intent of causing harm. While it is recognized that many clients can be harmed, some irreparably, from the actions of their therapists, the author believes that offending therapists commit these violations in two categories, both of mitigating culpability.

The first category includes therapists who are simply ignorant or under-informed of the ethical codes of their professional organization and legal statutes of their state. In these scenarios, therapists breach ethics or break laws because they are unfamiliar with the codes or laws and therefore are not cognizant that they have committed a wrongdoing. While this does not excuse the offending therapist–all therapists are compelled to swear allegiance to maintain their professions ethical code as part of their licensure, an act that makes ignorance of their ethical code a prima facie violation–it does offer an indication of simple cause and solution.

The second category includes therapists who breach ethics and break laws knowing they are doing so, as opposed to therapists that commit these acts unwittingly. Those who chose to put their clients and their careers in jeopardy and knowingly breach their own integrity, the integrity of their profession, and/or break the laws of their community are more difficult to understand. The author believes that there are past and present stressors active in the lives of such therapists at the time they breach ethics and break laws, to such a degree that they are suffering a diminished capacity to understand the intent and consequences of their own behaviors. The author believes that they violate ethics and break laws in an attempt to extricate themselves from these pressures and stresses, not to intentionally cause harm to others or themselves. In the literature review of this study, the data from scientific journal articles and the

authors' interpretations of these data were scrutinized through the lens of this bias.

Definitions

To begin this exploration it is important that some of the definitions of the phenomena being discussed herein be operationalized. For the purposes of this dissertation, the following definitions will be used:

1. **AAMFT Code of Ethics**. The American Association of Marriage and Family Therapy (AAMFT) Code of Ethics, revised July 1, 1998, will be accepted as the standard of ethical behavior and used to determine the definition of ethics. Some of the articles reviewed in this paper utilized previous versions of the Code (1982, revised 1988, 1991, 1998, 2001). It will be noted when and where alternative versions of the Code have been utilized.

2. **Ethics and/or ethical**. In this dissertation, ethics and ethical behavior are defined as behaviors and beliefs that are consistent with and circumscribed by the American Association of Marriage and Family Therapy in the Code of Ethics (AAMFT, 1998). Doherty and Boss (1991), in their seminal chapter on marriage and family therapy ethics and values, have defined ethics as "how we think about moral choice, i.e., good or bad, right or wrong" (p. 610). The narrow definitions of the AAMFT Code of Ethics (AAMFT, 1998) will be used as the mechanism to determine whether a specific action is considered "good or bad, right or wrong." Stated simply, all those behaviors that are practiced within the guidelines of the Code will be considered ethical, and all those behaviors that are practiced outside these guidelines will be considered ethical violations.

3. **Ethical complaint**. An ethical complaint will include all reports received by any licensing and/or regulatory board for marriage and family therapists regarding an ethical violation. The reporting of an ethical complaint does not in itself mean the therapist has committed an ethical violation; it means

only that a formal complaint has been logged against a marriage and family therapist by a client, peer, and/or concerned community member accusing the therapist of ethical wrongdoing.

4. **Ethical violation**. An ethical violation is defined as any behavior that a marriage and family therapist engages in that breaches the AAMFT Code of Ethics (AAMFT, 1998). It may or may not include review, adjudication, and/or sanctions levied by a state licensing or regulatory board, although all therapists found guilty by either of these entities will have committed a *mea culpa* ethical violation.

5. **Malpractice**. Malpractice is defined as the legal liability for improper treatment by a marriage and family therapist as determined through civil courts. According to Schultz (1982), the four key elements that constitute malpractice include (1) a therapist-patient relationship existed, (2) the therapist's conduct fell below the acceptable standard of care, (3) the conduct was the proximate cause of injury, and (4) an injury actually occurred.

6. **At-Risk Ethical Behavior**. At-Risk Ethical Behavior is defined by the participant's scores on the Ethics At-Risk Test (Brock & Coufal, 1994; Brock, 1997). The Ethics At-Risk Test was designed to augment the preventive role of an ethics code in that it sensitizes practitioners to their current level of vulnerability/liability for violations of the AAMFT Code of Ethics (AAMFT, 1998). See Chapter III for a complete review of this instrument.

7. **Caregiver Stress**. Caregiver stress is operationally defined as the scores each subject receives on the State Trait Anxiety Inventory (Spielberger et al., 1983). For purposes of this study and in alignment with appropriate use criteria published by Spielberger et al. (1983), the administration directions of State Anxiety, or S-Anxiety, subscale of the STAI have been modified to encourage the subjects to report the anxiety and stresses they

experience from their *work* and *work situations*. Directions for the Trait-Anxiety, or T-Anxiety, will remain unmodified; this subscale measures the subject's baseline anxiety (see Chapter III). Thus, for purposes of this study, the STAI scores and these scores' interactions will determine the subject's level of caregiver stress. Additionally, this study will explore how burnout, compassion fatigue, compassion satisfaction, and satisfaction with life relate to both caregiver stress and at-risk ethical behavior.

Epidemiology

Brock and Coufal (1994) in their landmark study of 540 marriage and family therapists' responses to a 124-item survey that explored ethical behavior and attitudes found that most respondents indicated violating at least one ethical principle, at least rarely. However, the most frequently endorsed items that reflected Code violations in this study (failure to gain permission before recording or observing a session, unintentional discussion of client material with others–without names) were behaviors with minimal potential for harm and reflected more absentmindedness or omissions than harmful, wanton violation of ethics. The authors found, in exploring specific practice behaviors that corresponded to each of the seven principles of the AAMFT Code of Ethics (AAMFT, 1988), that between 71% and 100% of the AAMFT members reported that they rarely or never behave contrary to the Code. Nickell et al. (1995) in their investigation of marriage and family therapists' sexual attraction toward clients found that a near negligible number of their sample reported any behavior that was contrary to the Code.

Brock and Coufal (1994) found that only 1.7% of their sample of 540 marriage and family therapists reported ever engaging in sexual activity with a current client, one of the most serious ethical violations and the one that has received the most attention in the literature. In a large study of psychologists, psychiatrists, and social workers, Pope et al. (1987) found that their respondents engaged in this behavior at similar rates (1.9%), and Nickell et al. (1995) found

none of their sample of 189 marriage and family therapists reported engaging in this behavior.

The American Association for Marriage and Family Therapy (AAMFT) Ethics Committee reported that there were 1,099 total cases of reported ethical violations received and investigated by that office since 1961 (Celeste Zbikowski, personal communication, April, 25, 2001). With a clinical membership of nearly 23,000 members and with these total 1,099 cases occurring over a span 40 years, the prevalence rate becomes very small (between 0% and 4.78% of the clinical membership). These 1,099 cases were categorized into specific types of ethical violations:

1. Dual Relationships, Furthering Own Interests, Harassment (65% of these involved sexual attraction/behavior [40%])
2. Competency, Impairment (13%)
3. Disciplined by Licensing Board (9%)
4. Confidentiality (6%)
5. Principle 1, Client Autonomy, Termination & Referral (6%)
6. Advertising (6%)
7. Felony or Misdemeanor (5%)
8. Non-Cooperation with the Ethical Committee (5%)
9. Financial (4%)
10. Disciplined by Professional Organization (3%)
11. Principle 3.1, Unspecified (3%; AAMFT, 2001a)

In the state of Florida, the Department of Health reported that there were 10 ethical complaints levied against marriage and family therapists during the 1999 calendar year (Kristen Walker, personal communication, February, 20, 2001).

With a population of 1,350 licensed marriage and family therapists in that state, this makes the epidemiological rate approximately .0074, or 1 complaint for every 135 therapists.

While violations of the ethical code by marriage and family therapists appear to occur at an infrequent rate, it is clear that clients are harmed and exploited by marriage and family therapists' violations of these professional boundaries. Any time a client is harmed and/or exploited by therapist acts of omission or commission, it is cause for alarm, investigation, and proactive behavior.

Theoretical Foundation

The theoretical foundation for this study was grounded in Bowenian Family Systems Theory (Kerr & Bowen, 1988). Bowen believed that much of psychopathology was caused by the inability of the individual to regulate anxiety. He believed that an individual's capacity to regulate anxiety was initially determined by their family-of-origin's ability to manage anxiety in productive ways. If a family was unable to effectively regulate and manage the anxiety caused by internal and external stressors, then the individual members of the family suffered a diminished capacity to tolerate anxiety. This diminished capacity, according to Bowen, often led to difficulties in relationships, addiction problems, depression, and other psychological and physical illnesses. Bowen further developed his theory to include the construct of differentiation, or the ability of the individual to retain a clear sense of self in the context of significant others (Kerr & Bowen, 1988). The hallmark of the differentiated person was their ability to self-regulate anxiety, without having to turn to an external agent of person to lower their levels of stress. This is how he helped individuals in therapy—assisting them in better regulating their anxiety so that they could become intentional, rather than reactive, in their daily lives.

Recent research (National Institute of Mental Health, 2004), utilizing positron emission tomograpgy (PET) scans, has demonstrated that stress can and does impair thinking, judgment, motor skills, impulsivity, and distractibility.

This research, which strongly supports Bowen's theories, leads this researcher to believe that much of the cause for ethical violations committed by therapists is rooted in the level of stress they experience, coupled with their inability to regulate this stress. It was hypothesized that those therapists who experienced high levels of caregiver stress and lack the ability to internally lower this stress were more likely to breach ethical boundaries than those who experience lower levels of stress. Said differently in language consistent with Bowenian Family Systems Theory—those therapists with lower levels of differentiation were more likely to engage in at-risk ethical behaviors.

Research Questions

In Section I of this study, Hypothesis Testing, the data collected from the surveys were utilized to test the null hypothesis (H_0): *There is no relationship between caregiver stress and ethics at-risk behaviors among licensed marriage and family therapists in the state of Florida.* Caregiver stress,was defined by the levels of both S-anxiety *and* T-anxiety reported by the sample on the State-Trait Anxiety Inventory (Spielberger et al., 1983). Ethics at-risk behavior was defined by the sample's scores on the EARTMFT (Brock, 1997). The alternative hypothesis for this study (H_1) states: *There is a significant relationship between caregiver stress and ethics at-risk behaviors among licensed marriage and family therapists in the state of Florida.*

In Section II, the Exploratory Section, the data collected from this population was utilized to report levels of state-trait anxiety, compassion fatigue, burnout, compassion satisfaction, and satisfaction with life among the sample. Relationships among these variables, along with demographic and work-related data, were explored and analyzed using various descriptive and correlational statistics to determine if there were any significant trends among these relationships. The following two research questions guided the exploratory phase of this study:

Research question 1. *Is there a relationship between ethics at-risk behaviors and the demographic/work situation factors reported by the sample of this study?*

Research question 2. *Are there significant relationships between ethics at-risk behaviors and the remaining variables of this survey (compassion fatigue, burnout, compassion satisfaction, satisfaction with life) with this sample?*

This study also had a longer-range purpose. It was hoped that this study would provide preliminary empirical evidence toward grounding the development of a causal model for boundary violations and other unethical practices among care providers. It was believed that the results of this study may also begin to point toward the development of effective prevention and rehabilitation practices for care providers who are “at-risk” for ethical violations.

Additional Questions

Chapter 2 of this dissertation contains a critical review of the studies that pertain to ethical and unethical practice of marriage and family therapy. The review is guided by the following questions: What does current research and statistics tell us about the occurrence, prevalence, and nature of ethics violations? What is the condition and maturity level of research into the experience and causes of ethics violations; have causal models been offered and studied? What are the antecedents, threats, or warning signs of ethics violations identified in the existing research? What are the concomitant systemic dynamics in the life of the offender that contribute to violations of ethics? And, what has research demonstrated as best practice for preventing, treating, and resolving ethics violations? These questions are explored using the data and language of the researchers and authors of the studies contained in the literature review of Chapter 2.

CHAPTER 2

LITERATURE REVIEW

> *The relatively young field of family therapy can be proud that part of its evolution as a profession has included a willingness to examine its own ethical conduct* (Wendorf & Wendorf, 1985, p. 443).

The purpose of this chapter was to review all of the critical literature that focuses on marriage and family therapy ethics, compassion fatigue/burnout, and the relationship between the two. It contains a critical review of selected and applicable scientific and popular literature on these subjects.

The AAMFT Code of Ethics

History

While hundreds of non-empirical articles and book chapters in the literature explore, argue, attack, and decry the ethical violations and questionable ethical practices of marriage and family therapists (Margolin, 1982; Patten, Barnett, & Houlihan, 1991; Woody & Woody, 2001), very little empirical research, to date, has focused on understanding the occurrence, frequency, causes, and prevention of at risk ethical practices by these therapists. From the writings reviewed within this chapter, however, we do learn of the rich history and development of the ethics and Ethical Code of the American Association of Marriage and Family Therapists (AAMFT).

The first Ethical Code developed for LMFTs was published in 1962 by the Association for Marriage and Family Counselors (AMFC) and entitled *The Code of Professional Ethics* (Celeste Zbikowski, personal communication, April, 25, 2001). According to a Professional Standards Specialist at AAMFT, this first document, originally drafted in 1960, was disseminated to the membership of the

Association for input and review and was finally accepted at the May 1962 Business Meeting of the AMFC. According to the same source, the Code has undergone nine revisions since then; the tenth, most recent, revision took effect July 1, 2001 (AAMFT, 2001b). Three separate works that review the history and development of marriage and family ethics cite publication of the first AAMFT Code of Ethics as 1982 (Doherty & Boss, 1991; Patten, Bennet, & Houlihan, 1991; Wendorf & Wendorf, 1985). This oversight of the original 1962 document, according to Zbikowski, may be due to a change in the organization's name from Association of Marriage and Family Counselors to American Association for Marriage and Family Therapy in 1978.

According to Doherty and Boss (1991), Grosser and Paul (1964) published the first article on the topic of ethics in family therapy, which appeared in the *American Journal of Orthopsychiatry*. In this early article, the authors addressed many of the issues that continue to highlight ethical discussions of marriage and family therapy today. These issues include the therapeutic management of secrets and their disclosure, the potential harm resulting from catharsis and other displays of intense affect, the potential undermining of authority that can occur when parental shortcomings are disclosed, and the disclosure of personal sexual data. Three separate groups of authors that completed reviews of ethics in marriage and family therapy identified this article as the first most important work toward establishing a family therapy ethic (Doherty & Boss, 1991; Patten et al., 1991Wendorf & Wendorf, 1985).

These same authors also identified two other important early writers in the area of family therapy ethics, Haley (1976) and Boszormenyi-Nagy (Boszormenyi-Nagy & Spark, 1973). Haley (1976), with his strategic interventions, brought to light the issues of social exchange, manipulation, deception (i.e., "the benevolent lie"), and paradox. He also brought to the emerging family therapy debate the opinion that the therapist should take a great deal of responsibility for the outcomes of therapy. At this same time, Boszormenyi-Nagy (Boszormenyi-Nagy & Spark, 1973) was developing his

contextual therapy approach that argued, as a central organizing principle, that the therapist is both a teacher and model of ethical relationships for family members. He also claimed that family dysfunction diminished, as family members were able to adopt more ethical relational styles with each other. Boszormenyi-Nagy continued his development of contextual therapy for the next two decades during which he was able operationally to define and develop interventions to help family members adopt *relational ethics* (Boszormenyi-Nagy & Krasner, 1986; Hargrave, Jennings, & Anderson, 1991). According to Patten et al. (1991), these horizontal and vertical relational ethics served as early building blocks for the development of the 1982 edition of the AAMFT Code of Ethcis.

Another influential writer of early marriage and family ethics development was Rachel Hare-Mustin (1978; 1980; Hare-Mustin, Marececk, Kaplan, & Liss-Levinson, 1979). According to Doherty and Boss (1991), Hare-Mustin's work "signaled the entry into the family-therapy literature of two important cultural issues of the 1960s and 1970s: feminism and concern that individual rights were being sacrificed to group needs" (p. 607). She challenged therapists to address their personal biases and practices around family and marital unity, especially where individual members suffered for the sake of this unity. She also challenged therapists and society at-large to examine their beliefs and practices relative to gender roles. She advocated strongly toward a more equivocal and power-balanced practice of family therapy in regard to these roles. These same themes continue their heuristic generativity in the present literature (Hicks & Cornille, 1999).

In the same year that Hare-Mustin (1978) published her treatise on feminist family therapy, Gurman and Kniskern (1978) published an article on the deteriorating effects of family therapy. They declared that family therapy was inappropriate in some conditions and for some disorders. According to Doherty and Boss (1991), 1978 was the year that "marked the end to the age of innocence for the field of family therapy" (p. 607). Two other important works that emerged that same year were Margolin's (1982) comprehensive overview of

family therapy ethics published in the *American Psychologist* and *Values, Ethics, Legalities and the Family Therapist* edited by L'Abate (1982). Margolin's work helped pinpoint many of the different and, according to her, more complex issues of marriage and family therapy as compared with traditional individual psychotherapy. Issues such as identification of the client (individual vs. couple vs. family), therapist values (especially when in conflict with those held by the family), confidentiality, disclosure of secrets, and therapist manipulation were all addressed in her important work. Additionally, she attempted to bring a systemic orientation to the discussion of family therapy ethics and argued that future development of ethical codes in this field must remain loyal to the systemic focus. However, Wendorf and Wendorf (1985) criticized her for failing to do just that. They stated that she neglected to address some of the most important systemic precepts in her analysis, including failing to view symptoms as behaviors designed to maintain homeostasis in the system and the metacommunications of interactions in the therapy arena.

L'Abate (1982), in his book *Ethics, Values, Legalities and Family Therapy,* also attempted to advance a systemic approach to the problem of ethics. This work, specifically the chapter by Taggart (1982) entitled "Linear Versus Systemic Values: Implications for Family Therapy," explores the evolution of family therapy ethics as "borrowed" from individually oriented psychotherapy professions and pronounces these as inadequate and inappropriate for the field of family therapy. In this same chapter, Taggart also addressed the importance for the practitioner and researcher of family therapy to be ever mindful of the dialectic, the "reciprocal determinism," between the individual and the systems in which the individual lives.

Wendorf and Wendorf (1985), Doherty and Boss (1991), and Patten et al. (1991) all concur that 1982 was a "watershed year" for publications on ethics in family therapy. The highlight of this important year was the publication of the *Ethical Principles for Family Therapists* by the AAMFT(1982, revised 1988, 1991, 1998; 2001b). This document prescribed and prohibited specific behaviors for

AAMFT clinical members in the areas of responsibility to clients, competence, integrity, confidentiality, professional responsibility, professional development, research responsibility, and social responsibility. Although the AAMFT had been established 40 years earlier, the development of a code of ethics may have been the most important act of the Association since incorporation. Doherty and Boss state: “By 1982 . . . ethics and values in family therapy had come of age” (p. 608).

During the nearly two decades since the AAMFT Code of Ethics was first published, scores of important writings have discussed marriage and family therapy ethics (Johnston, 2004; Simon, 1992; Woody & Woody, 2001). Based in part on these articles, the AAMFT Ethics Committee continues to revise frequently the AAMFT Code of Ethics to integrate and assimilate new legislation and public demand while also continuing to move this code toward a more systems-promoting epistemology (Patten et al., 1991). Recent evidence, collected from both the Clinical Membership of AAMFT and marriage and family therapy students, indicates a trend away from the individualistic, philosophical, and moral under girding of ethical principles upon which the earlier versions of the Code of Ethics were established toward a position that is more relational and systemic in nature (Hicks & Cornille, 1999; Wall, Needham, Browning, & James, 1999). Wall et al. (1999), in a national survey of 1,035 marriage and family therapists, found that respondents tended to endorse items of their survey that support a relational, rather than individualistic, view of ethical principles. For example, 40% of the respondents identified “creating and fostering loving and caring relations” as the most important indicator of “understanding a good moral life” (p. 143), and 23.8% reporting “acting toward others as you ideally wish them to act toward you” as the next most important indicator. Wall et al. identified these responses as *relational*, as they “emphasize intersubjectivity; the back and forth that takes place *between* individuals and connects them together” (p. 144). These responses are in contrast to the more individualistic oriented responses of “being true to the unfolding potential of ones inner self” (14.7%) and “increasing the good of the individual self without directly harming another” (5.8%).

Wall et al. (1999) concluded that their findings suggest three things: First, therapists do in fact appear to endorse a particular moral point of view, relationally, over its individualistic alternative. Second, the hypothesis that the most frequently endorsed ethic is individualistic was not supported. They write: "The therapists we questioned were on the whole less committed in their *general* ethical orientations to individualistic forms of ethics than to an ethical view which favors some form of relationality. Equality between relating individuals, although important, is less highly valued than the quality of the relationship itself" (p. 144).

Patten et al. (1991), in the conclusion of their review offered some proposals for expanding existing and future ethical guidelines. These are as follows:

1. "Ethical training should be an integral part of professional training programs.
2. Workshops, seminars, and in-service training should be used to facilitate discussion and development of feasible ethical guidelines.
3. Present ethical principles should be spelled out sufficiently to be of value in the day-to-day endeavors of family therapists.
4. Ethical standards are empirically derived and thus become dated; they should be periodically updated.
5. Therapists must continually scrutinize themselves regarding their honesty, competency, stereotypes and biases.
6. Family therapists must use the knowledge of persons in other disciplines, particularly in regard to the legalities of therapy.
7. The formulation of policies to be presented to legislators should be a major focus of psychotherapy conventions" (p. 174).

The AAMFT has seriously considered and integrated many of these suggestions in its subsequent 1998 revision of the Code of Ethics. In the most recent revision (AAMFT, 2001b), adjustments have been made in the language

regarding specific behaviors, such as sexual intimacy between clients (Hovestadt, 2001). For example, the revised code more accurately prescribes and prohibits specific behaviors of the AAMFT clinical membership than did the previous versions. Additionally, recent additions to the AAMFT clinical membership requirements have made it compulsory for students and potential licensees to complete course work that addresses these professional and ethical issues and to receive supervision specifically focused upon these ethical dimensions.

With the recent focus on and demand for evidence-based treatment (AAMFT, 2001c), the revision of the Code of Ethics (AAMFT, 2001b), and the explosion of scientific literature (much of which addresses the issues of marriage and family therapy ethics), it could be said that the field of marriage and family therapy has successfully navigated its developmental period and is now entering a period of adult maturity that combines both continued growth and recursive self-reflection. In part, this self-reflection requires that we develop empirical models for the investigation into the understanding, utilization, observance, and violation of the Code of Ethics by the practitioners of marriage and family therapy.

The Code

Before beginning the critical review of articles selected for this work, it is important to provide a brief overview of the current AAMFT Code of Ethics (AAMFT, 1998). The 1998 version of the Code is divided into eight sections, or principles, which govern the actions of the Clinical Members of the AAMFT. These eight principles are:

1. **Responsibility to Clients**. *Marriage and family therapists advance the welfare of families and individuals. They respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately* (AAMFT, 1998). This principle provides sanctions against discrimination, exploitation, and dual relationships that might impair judgment or involve sexual engagement,

self-interest, continuing a therapist-client relationship when it is not helpful, and abandonment of clients. Additionally, this principle clearly articulates that any decision regarding marital status is that of the client.

2. **Confidentiality**. *Marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard confidences of each individual client* (AAMFT, 1998). This principle provides specific guidelines for the maintenance and release of client information by marriage and family therapists.

3. **Professional Competence and Integrity**. *Marriage and family therapists maintain high standards of professional competence and integrity* (AAMFT, 1998). This principle addresses a wide variety of issues including criteria for revocation of clinical membership in AAMFT if the therapist is convicted of a felony or any other behavior related to his or her functioning in the capacity of a marriage and family therapist (e.g., misdemeanor, incompetent practicing while impaired, disciplinary action by another professional organization, and failure to comply with an AAMFT ethical violation investigation). This principle also includes guidelines for behaviors such as seeking professional assistance for personal problems; dedication to high standards as teachers, researchers, and supervisors; maintaining current knowledge of developments in the field; prohibition of sexual harassment; restricting therapeutic practice to areas of competency; maintenance of integrity in reporting research findings; and a prescription to exercise special care when making public professional recommendations and opinions.

4. **Responsibility to Students, Employees, and Supervisees**. *Marriage and family therapists do not exploit the trust and dependency of students, employees, and supervisees* (AAMFT, 1998). This principle provides guidelines for ethical behavior when working with students, employees, and supervisees. It clearly prohibits exploitation or the use of influence to

cause harm to anyone from this group and provides for the confidentiality of these apprentices.

5. **Responsibility to Research Participants**. *Investigators respect the dignity and protect the welfare of participants in research and are aware of federal and state laws and regulations and professional standards governing the conduct of research* (AAMFT, 1998). Seeking ethical advice when planning studies, avoiding diminished consent, avoidance of dual relationships, and confidentiality of research participants are all addressed in this principle.

6. **Responsibility to the Profession**. *Marriage and family therapists respect the rights and responsibilities of professional colleagues and participate in activities which advance the goals of the profession* (AAMFT, 1998). This principle advises marriage and family therapists to provide appropriate credit to authors of original material and to accept credit only for material that they themselves have produced when creating publications. Additionally, this principle encourages members to become active in social change and community development.

7. **Financial Arrangements**. *Marriage and family therapists make financial arrangements with clients, third party payers, and supervisees that are reasonably understandable and conform to accepted professional practices* (AAMFT, 1998). Four items related to ethical management of fees make up this principle: (a) prohibitions against accepting payment for referrals, (b) prohibitions against charging excessive fees, (c) provision of fee disclosure, (d) and suasion to represent fact truthfully to clients, third-party payers, and supervisees.

8. **Advertising**. *Marriage and family therapists engage in appropriate informational activities, including those that enable laypersons to choose professional services on an informed basis (*AAMFT, 1998). This final principle offers several specific regulations for ethical advertising of

professional services that include parameters for the use of AAMFT trademarked intellectual properties and logos.

Critical Review

Method for Selecting Literature

The databases of PsychINFO, PsychLit, and PsychFirst were searched in preparation for this study. Keywords including *marriage*, *family*, *marriage and family*, *marriage and family therapy*, and *MFT* cross referenced with *ethics*, *ethical violations*, *ethical practice*, and *malpractice* were utilized. This search yielded over 3,000 entries of scientific articles, book chapters, and popular writings. When this sample was limited to only those scientific articles that were based on empirical quantitative research and were appropriate to the ethical practice of marriage and family therapy, this number dropped to six articles. For example, when *marriage and family*, *malpractice* and *empirical* were used as descriptors in a literature search using both PsychINFO and PsychFirst databases, only two articles emerged; neither of which was appropriate for inclusion in this review. This initial search revealed a paucity of empirical research in the area of ethical practice of marriage and family therapy.

In an effort to expand this review, articles from other disciplines were utilized, especially psychology, that directly address the ethical practice and ethical violations of professional psychotherapists and that have served to inform and direct the research into the ethics of marriage and family therapy. Nine articles from this pool were selected. The following critical review of literature addressing ethical violations and ethics at-risk behavior is based upon these articles. Four of these articles deal expressly with marriage and family therapy ethics and represent four of the seven total empirical articles generated from the search. The remaining five articles, although from professional disciplines outside marriage and family therapy, have a high degree of applicability to this topic.

The nine critical works discussed in this section are as follows: Pope, Tabachnick, and Keith-Spiegel, (1987); Borys and Pope, (1989); Thoreson,

Miller, and Krauskopf, (1989); Hargrave, Jennings, and Anderson, (1991); Epstein and Simon (1990); Epstein and Kay, (1992); Brock and Coufal, (1994); Nickell, Hecker, Ray, and Bercik, (1995); and Montgomery, Cupit, and Wimberly, (1999). Each of these articles is discussed and reviewed below.

Ethical Practice Literature

Pope, Tabachnick, and Keith-Spiegel (1987*).* The groundbreaking Pope, Tabachnick, and Keith-Spiegel (1987) empirical study utilized a survey to explore and report the degree to which 456 APA Division 29 (Psychotherapy) members engaged in 83 potentially unethical behaviors. It also explores the degree to which they believe these behaviors to be ethical. The data were reported and examined in categories related to five principles derived from the Hippocratic Oath. This study also investigated what resources the respondents found most and least useful for guiding their ethical behaviors. This article could easily be called the “gold standard” of ethics research. No preceding article had provided empirical data on ethical practice or beliefs of psychotherapists. This article is probably the most frequently cited article in ethics research, and it has generated many replication and quasi-replication studies.

Pope et al. (1987) found that 90% of the respondents engaged, at least on rare occasions, in the following behaviors: using self-disclosure as a therapy technique, telling a client you are angry with him or her, having a client address you by your first name, addressing your client by his or her first name, accepting a gift worth less than $5 from a client, and being sexually attracted to a client. They found that 1.9% of the respondents reported engaging in sexual contact with a client and that only 2.6% reported erotic activity with clients (previous studies had reported 6.5% to 7.7%). They also found that over half (59.6%) of the respondents admitted to having worked when too tired or distressed to be effective. An additional 5.7% admitted to practicing while under the influence of alcohol.

The authors found that “many of the walls that prevented therapists from engaging in simple human interactions, for example, therapists revealing their emotions, have come down, although therapists are still in a quandary about some of these issues” (p. 1002). Seven Hippocratic-type principles of ethical practice for therapists emerged from this study: (a) Above all, do no harm; (b) practice only with competence; (c) do not exploit; (d) treat people with respect for their dignity as human beings; (e) protect confidentiality; (f) act, except in most extreme instances, only after obtaining informed consent; and (g) practice, insofar as possible, within the framework of social equity and justice.

The respondents from this study identified informal networks of colleagues as the most potent source of information and guidance in establishing and maintaining ethical practice. More importantly, the authors concluded that too little research has been devoted to ethical issues to be useful to the practicing psychologist as a resource for ethical guidance.

Borys and Pope (1989*).* In their peer-reviewed journal article, Borys and Pope (1989) compared the results of surveys sent to 4,800 randomly selected psychologists, psychiatrists, and social workers on their attitudes and practices regarding potentially unethical behaviors including dual professional roles, social involvements, financial involvements, and incidental involvements. Half of the participants selected received a questionnaire that asked them to rate their beliefs and attitudes about 20 potentially unethical behaviors, and the other half were asked to rate their frequency of practice of these behaviors. This split was utilized to prevent interactional effects of beliefs and attitudes influencing the participants’ responses.

Borys and Pope found a lower reported rate of sexual involvement with clients than in previous studies (0.5%). There were only two potentially unethical behaviors that participants had engaged in with at least one client: accepting a gift worth less than $10 (85.2%) and providing therapy to a client’s significant other (61.2%). In many situations participants saw the formulation and dissemination of formal standards as intended to increase their ethical

awareness and improve behaviors of a professional association. Regarding dual relationships, the authors found no significant difference among practitioners in the three professions in regard to their beliefs and practices. For example, the authors found that a significant number of professionals, at some point in their careers, do engage in dual relationships with clients. Male professionals are more likely to engage in dual professional roles, while women are more likely to be the target of these roles by professionals.

Thoreson, Miller, and Krauskopf (1989*).* Thoreson, Miller, and Krauskopf (1989) report the results of a questionnaire study that sampled 379 professional psychologists. These psychologists answered questions about the level and types of distress they experience in their lives. This article describes the relationship psychologists' distress has with their work and work environment. The authors discovered that approximately 10% of the sample was significantly distressed in the form of relational difficulties, depression, physical/somatic illness, and alcohol use.

In the sample of psychologists Thoreson et al. (1989) studied, the large majority were healthy, well-adjusted, non-smokers, non-drinkers, who exercised regularly and were satisfied with their jobs. However, between 9% and 19% of these psychologists experienced distress in one or more areas. Specifically, 10% reported frequent (often or very often) levels of distress in the following areas: depression (11%), marriage/relational dissatisfaction (11%), problems with alcohol use (9%), and feelings of loneliness (8%). Nine percent of the psychologists sampled indicated that they had problems with drinking.

The authors found that when a psychologist reports distress in his or her significant relationships there is a strong likelihood that she or he is also experiencing distress in the form of feelings of loneliness, depression, and problems with alcohol use. A small portion of the sample suffered from more serious distress issues, such as major depression. A small percentage may also have been experiencing the depersonalization and depression of career burnout. In analyzing treatment-seeking behavior, the authors found that 27% of the

respondents sought help from a private psychologist, 14% from a private psychiatrist, 14% from a private physician, 3% from a mental health center, and 2% from an employee assistance program. While alcohol misuse appears to be a cause for dissatisfaction and higher levels of distress among problem drinkers, participants in abstinence-based recovery reported high levels of satisfaction with their careers and low levels of distress in the present.

Hargrave, Jennings, and Anderson (1991). Hargrave, Jennings, and Anderson's (1991) peer-reviewed journal article, which is both empirical and technical as well as quantitative and qualitative, chronicles the five-stage process used to develop the Relational Ethics Scale (RES). The RES is an instrument utilized to measure the constructs of relational ethics described in contextual family therapy (Boszormenyi-Nagy & Krasner, 1986). The article lends empirical data to support the construct of relational ethics in an attempt to begin testing the theoretical components of contextual family therapy. This article is included in this critical review because of the RES' potential to identify professionals who may be compromising their ethical integrity in their client-therapist relationships.

Hargrave et al. (1991) report that trust and justice may be the basis on which all other relational ethical constructs operate and suggest in the article that trust itself may simply be the process of relational justice repeated over a period of time. They conducted a factor analysis of six elements: vertical trust and justice, vertical loyalty, vertical entitlement, horizontal trust and justice, horizontal loyalty, and horizontal entitlement. The authors reported that statements pertaining to vertical and horizontal trust and justice loaded at the highest levels, and these loadings corresponded with Boszormenyi-Nagy and Krasners' (1986) belief that these two elements are essential constructs of relational ethics. The strength of the trust and justice constructs in both the horizontal and vertical relationship statements in their scale may indicate that the emotional turmoil of individuals in the dysfunctional groups may be "rooted" in these two factors, consistent with Contextual Therapy theory.

The authors concluded that the Relational Ethics Scale is a reliable and empirically valid measure for the constructs of relational ethics and is useful in a wide variety of contexts. The authors succeeded in creating a useful instrument to measure the horizontal and vertical dimensions of relational ethics with good psychometric properties. This was an important advent for practitioners and researchers of Contextual Therapy because they now have an instrument by which to measure accurately the central constructs of their treatment and theory.

Epstein and Simon (1990). In the next peer-reviewed journal article, Epstein and Simon (1990) introduced the 32-item Exploitation Index (EI) as a potential empirical tool in the early detection of boundary violations by psychiatrists with their patients. The authors surveyed 2,500 randomly selected psychiatrists from the East Coast of the United States to investigate the usefulness of the EI in this capacity. The authors also investigated the degree to which the respondents were alerted to behaviors they thought could be counterproductive to treatment and the degree to which the respondents were stimulated by the items on the EI to make changes in their practice. The article also features a discussion that suggests important dimensions for further study, assessment, and prevention of boundary violations by psychotherapists.

Epstein and Kay (1992). Epstein and Kay (1992) found that 43% of the respondents indicated that their positive responses to items on the EI alerted them to activities and behaviors that they thought might be counterproductive to treatment and maintaining a positive therapeutic relationship; 29% found that their positive responses to items on the EI had stimulated them to make specific changes in their treatment practice.

The authors studied eight categories of exploitation by therapists: generalized boundary violations, eroticism, exhibitionism, dependency, power seeking, greediness, and enabling. While the hypotheses associated with these categories received some support from the data, perhaps more important was the identification of predictor factors for future exploitation of clients. For example, excessive self-disclosure and meeting intimacy needs through

relationships with clients were two factors that emerged as primary predictors for future exploitive behavior with clients. The authors also found it likely that demographic factors, psychological attributes of the therapist, and the eventual behavioral outcome (e.g., therapist-patient sex, financial transgressions, therapeutic stagnation) may relate to the subtype of exploitation that the therapist endorses as indicated by the EI. Specifically, the authors found a number of therapist characteristics (gender, theoretical orientation, type of practice, and type of community) that were significantly related to subcategories of boundary violations as measured by ethical attitudes and practice behaviors. The EI was found to be valid and reliable and able to be used as an educative and (self) supervisory tool. For example, with a certain patient in mind, the EI could be utilized to determine whether the clinician is maintaining appropriate boundaries, thereby serving as an early warning system for prodromal at-risk ethical behavior.

Brock and Coufal (1994). Brock and Coufal (1994), using a survey design, conducted an empirical study of marriage and family therapists' attitudes and practices relative to the AAMFT Ethics Code. The study is a near-replication of Pope, Tabachnick, & Keith-Speigel's (1987) study with the exception of utilizing a sample of LMFTs instead of psychologists. Brock surveyed participants on personal attitudes and practices regarding 124 specific potentially unethical behaviors. His survey provides data on the frequency of these behaviors and attitudes as well as the respondents' compliance with and support of the AAMFT Code of Ethics.

Respondents to the study reported they rarely or never behave contrary to the AAMFT Code of Ethics in all seven principle areas (97 to 100% compliance). Ninety percent reported never engaging in behaviors that were similar to examples of prohibited behaviors outlined in the AAMFT Code of Ethics. When participants were asked about their most relied upon resource for ethical guidance among practitioners, "informal networks among colleagues" was the most frequent response, followed by supervision, graduate course work, AAMFT

Ethics Committee, and continuing education. Slightly more than 75% of the respondents reported that they had read the AAMFT Ethics Code thoroughly, and an overwhelming majority (97%) reported that the effectiveness of their therapy was not hampered by the Code. However, 48% of the respondents acknowledged that they had at times tailored diagnoses to meet insurance criteria. Even though this behavior was recognized as “dishonest and fraudulent,” 50.9% responded that it was ethical sometimes or more often.

According to the findings in this study, when compared with other mental health professionals, marriage and family therapists as a group are less likely to report engaging in sexual contact with a supervisee or student. However, they are near equal to other mental health professionals when it comes to sexual activity with clients. In their study the authors proposed a typical sequence of behaviors that they believe often leads therapists to overt sexual exploitation of client. This sequence begins with sexual attraction, then sexual fantasy followed by inappropriate intimacy, self-disclosure, and/or touch. Of the respondents, 59.2% reported engaging in sexual fantasies about their clients; 60% said such fantasies were ethical, at least under rare circumstances; and 1.7% reported engaging in erotic activity with their clients during the period of therapy. However, 7.5% of the respondents reported sexual activity with a client within the first year after the termination of therapy, and that number jumped to 25.9% two years after termination. Marriage and family therapists seem to be able to distinguish between these internal experiences of attraction or fantasy and overt sexual contact (59 to 90% vs. 1.7%).

Brock and Coufal (1994) also found that marriage and family therapists were more likely than psychologists to engage in the following marginal ethical behaviors: charging a client no fee for therapy, filing an ethics complaint against a colleague, hugging a client, terminating therapy when clients cannot pay, accepting services in lieu of therapy fee, seeing minor clients without parental consent, tailoring a diagnosis to meet insurance criteria, breaking confidentiality to report child abuse, providing therapy to student or supervisee, avoiding certain

clients for fear of being sued, going to a client's special event (wedding, birthday party), seeking involuntary hospitalization of client, giving medical advice in the context of therapy, treating homosexuality as pathological, and charging for missed appointments. In contrast, psychologists were more likely than marriage and family therapists to practice when too distressed or tired, raise fees during the course of therapy, and allow a client to run up a large bill. Furthermore, 86.9% of the marriage and family therapists participating in the study reported seeking therapy for help with their own problems.

Nickell, Hecker, Ray, and Bercik (1995). In their empirical study using both quantitative and qualitative data, Nickell, Hecker, Ray, and Bercik (1995) surveyed 189 Clinical Members of the American Association of Marriage and Family Therapy on their sexual attraction to clients, behaviors of therapists with clients to whom they are sexually attracted, beliefs about sexual attraction in therapy, and influences on decision making about sexual attraction. This article also addresses specific training implications for clinical education programs.

In the Nickell et al. study, 55% of the respondents reported that their graduate programs provided no training on resolving sexual attraction towards clients, and 47% reported little or no supervision in the area of sexual attraction. While this number is significantly lower than American Psychological Association's psychologists of the Pope et al. (1986) study, it still represents an alarming gap in the training of marriage and family therapists. Marriage and family therapists may not be trained well enough to recognize their inadequacies in handling their sexual attraction to clients. In contrast, 25.4% reported much coverage of the topic in their graduate programs.

Significant differences were found between males (34%) and females (14%) who identified themselves as at least sometimes sexually attracted to clients. Males reported fantasizing about their clients more frequently than females; females engaged in hugging clients more frequently. The study suggests that therapists who receive substandard training, who lack knowledge of professional boundaries, and those who experience stressors have increased

vulnerability to mishandling their attraction to clients. All the respondents ranked the AAMFT Code of Ethics the highest among sources of influence in making ethical decisions. At least 74% identified the Code as good-to-excellent in this regard.

Regarding sexual attitudes and behaviors, the respondents of this study scored lower than the participants of previous studies (for example, no respondent of this study reported engaging in sexual activity with a client during the previous two years). The authors believe this is due, in part, to the increased publicity and punitive consequences levied against clinicians who engage in sexual behaviors with clients. Underreporting may also contribute to this finding. Finally, the authors hypothesize that marriage and family therapists may actually engage in sexual activity with clients at a lower rate than other professionals. Many respondents seek supervision to resolve their feelings of sexual attraction toward clients (46% of the males and 34% of the females), which suggests that many of the marriage and family therapists of this study are seeking assistance instead of acting out their sexual attraction toward clients.

While there was consensus on the issue that sexual exploitation of and sexual behavior with clients is strictly forbidden, there continues to remain ambivalence in the area of sexual attraction and sexual fantasy. The authors suggest that this ambivalence is further evidence of the need for research training in this area. The authors also believe that training programs should address such areas as gender differences, with attention given to sexual fantasizing about clients; the use of touch in therapy; increased awareness of sexual attraction issues; the AAMFT Code of Ethics and its limitations; and the appropriateness of discussing sexual feelings toward clients. They also suggest that therapists' beliefs about issues of sexual attraction to clients should be included as a component of training programs and in supervision. Finally, the authors suggest that studies that compare marriage and family therapists convicted of sexual involvement with clients with those from the general

population of therapists would be helpful in identifying characteristics, such as faulty beliefs, that lead to boundary violations.

Montgomery, Cupit, and Wimberly (1999). In their empirical study containing both quantitative and qualitative elements, Montgomery, Cupit, and Wimberly (1999) surveyed a random sample of 284 Texas psychologists' on professional awareness, personal experience, and practice activities related to ethics complaints, malpractice lawsuits, and risk management. The article makes a strong case for continuing professional education as a means to minimize personal and professional risk for complaints and malpractice litigation.

Montgomery et al. noted that among various "complaints," the five events/activities to receive the highest rating for probability were sexual misconduct with a client or patient, child custody decisions, breach of confidentiality, sexual misconduct with a student, and billing for services not provided. Among the Texas psychologists, 65.1% considered the probability of having an ethics complaint filed against them to be less than 20%. While 14.4% responded that they had been threatened with a complaint, only 39% of these stated that the threat resulted in a complaint. Thirty-one respondents (10.9%) reported at least one complaint logged against them with the state licensing board. Violations in the area of supervision/supervisory relations emerged as the most frequent reason for complaint.

The authors also found that among the various reasons for malpractice lawsuits, the five highest ranked activities/events were sexual misconduct, failure to warn with resulting injury, child custody decision case, client suicide (not being seen by physician), and client suicide (currently being prescribed psychotropic medication by physician). Among the Texas psychologists, 7.4% indicated that they had been threatened with a malpractice lawsuit. Of these respondents, 57.1% indicated that the threat resulted in a lawsuit. Furthermore, a significant percentage of the respondents had no concern about complaints (69.3%) or malpractice lawsuits (70.4%) being filed against them. In managing risk, respondents reported release of information forms, case documentation, and

informed consent procedures as the most important activities. The least important were identified as practice brochures and peer review of treatment. In the article, the authors urge all practicing psychologists and psychotherapists to develop a formal written document that outlines the clinician's and patient's responsibilities, as well as standard operating procedures as a protection for potential malpractice suits.

Summary of the Ethical Practice Literature

While ethical violations and client exploitation by marriage and family therapists occurred only occasionally, their occurrence is undeniable. As Brock and Coufal (1994) stated: "Any amount of exploitation, any amount of fraud, any amount of negligence is too much" (p. 199). Many clients continue to be exploited and harmed by these violations, and it remains incumbent upon the field of marriage and family therapy practice and research to develop a better understanding of these phenomena in order to develop effective prevention and rehabilitative strategies.

None of the studies of this sample and none of the studies read in preparation for this review offered more than intimation of the intrapersonal and systemic dynamics of ethical violations. Thoreson et al. (1989) found that 9% to 19% of the psychologists of their study experienced significant distress in the form of relational difficulty, depression, loneliness, and alcohol/drug usage. Such distress has been demonstrated, at least in part, to be caused by the work itself (Deutch, 1984; Freudenberger & Robbins, 1979; Pearlman & McCann, 1991; Pope & Tabachnick, 1991; Rodolfa, Kraft, & Reiley, 1988).

Pope and Vasquez (1999), in their article addressing the distorted beliefs often accompanying ethical violations, state: "Faced with the complex demands, human costs, constant risks, and often limited resources of our work as psychologists [psychotherapists], we may experience the very human temptation to try to make life easier for ourselves by nullifying some of our fundamental ethical responsibilities" (p. 1). Study of the accompanying intrapersonal dynamics

and distress experienced by psychotherapists who violate ethics and/or those at risk for these violations is long overdue.

Is it not likely that there exists a correlation between therapist distress and ethical violation? In this literature review, some important tools have been identified that could aid in answering this question. The Exploitation Index (Epstein et al., 1992) and the Psychologist Health Questionnaire (Thoreson et al., 1989) could be utilized to study currently practicing therapists in order to compare them with therapists who have previously violated ethics; they could also be used to begin to determine the role that therapist stress/distress plays in the violation of ethical principles. Additionally, Brock and Cofal (1994) have developed an Ethics At-Risk Test (Brock, 1997) that may have some utility specifically for marriage and family therapists in determining risk factors. Additional factors such as anxiety, depression, compassion fatigue, secondary traumatic stress, and burnout may also be important potential contributors to ethical violations.

Even if such a study found little relation between distress and ethical violation among marriage and family therapists, a more empirical understanding of the stresses of professional practice and their effects upon the practitioner could begin to point the way toward helping marriage and family therapists develop and retain resiliency in dealing with these stressors and help improve the quality of life for both the clinician and, recursively, their clients.

As stated earlier in this review, evidence is growing that the field of marriage and family therapy is evolving away from an individualistic philosophical belief underlying the Ethical Code toward a more relational and systemic orientation (Hicks & Cornille, 1999; Wall et al., 1999). Hicks and Cornille (1999) in their article explore the roles of gender, power, and relationship ethics in MFT education. This study employs a qualitative method to explore the unequal relationships between a small number of therapists (n=5) and their supervisors-in-training (n=2). The authors found that there was a clear difference between males and females their perceptions of power imbalances, with women more

likely to express perceptions of gender biases. They also found that both men and women MFTs' perception about gender are interpreted in the context of personal, dyadic, or cultural elements more than in terms of systemic elements. From this basis, the authors argue for the utilization of "relational ethics" instead of "gender sensitivity" in the training and supervision of MFTs.

Hargrave et al. (1991) produced an excellent instrument that may have some utility, with little modification, in examining the relational ethics *between* therapist and client, instead of just focusing on clients as it was originally intended. Examining the systemic dynamics, specifically the recursive effects of interpersonal and intrapersonal stressors in the lives of marriage and family therapists, may help to understand the prevalence, prevention, causes, and cures of ethical violations.

Because this study sought to determine whether there is a relationship between at-risk ethical behavior in Licensed Marriage and Family Therapists (LMFT) and caregiver stress, this chapter also provides a brief review of some of the recent figural research and writings important in defining and operationalizing the construct of caregiver stress. This review covers the three main foci—burnout, caregiver stress, and compassion fatigue—involved in defining this construct for purposes of this study.

Burnout, Caregiver Stress, and Compassion Fatigue

Because it is clear that ethical violations in marriage and family practice are due in part to the strains and stressors of practice, this section reviews the research and practice literature that applies to marriage and family therapist practice. In the following section, scientific and popular writings on the three similar areas of burnout, caregiver stress, and compassion fatigue are reviewed.

Burnout

In the early 1970s, Freudenberger (1974) was one of the first to discuss and describe burnout in caregiver populations. He noticed that the original

excitement, hope, and charisma of community volunteers were gradually replaced by exhaustion, fatigue, and somatic complaints. He further noted that those volunteers who struggled internally with a self-committed pressure to perform and achieve and externally with the pressure to serve the needs of suffering people were most at risk for developing these symptoms. Freudenberger defined burnout as: “a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward” (p. 13).

Maslach (1976) described the key characteristics of burnout as (a) overwhelming exhaustion; (b) feelings of frustration, anger, and cynicism; and (c) a sense of ineffectiveness and failure, which impairs both personal and social functioning. In her later work, she described burnout as “a psychological syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment” (Maslach & Goldberg, 1998, p. 64). According to Maslach, burnout is a “grass-roots” phenomenon, grounded in the realities of people’s workplace experiences, rather than in scientific study and theory, and it has been difficult to ascribe clear sources to these conceptual definitions (Maslach, 1982). To address this problem, Maslach created the Maslach Burnout Inventory (Maslach & Jackson, 1982), which is recognized by clinicians, managers, and researchers as one of the most effective and most utilized measures of this phenomenon in existence (Maslach & Leiter, 1997).

Pines, Aronson, and Kafry (1981) defined burnout as a situation involving personal symptoms consisting of “three basic components: physical, emotional, and mental exhaustion” (p.17). Pines (1983) differentiated between burnout and stress by indicating that many persons experience stress but only those who entered their professions with high ideals and motivation experience burnout. She also emphasized that a typical burnout symptom is a gradual depletion of spirit and loss of faith in the capacity to make a difference.

Mental, physical, and emotional exhaustion, or the chronic condition of perceived demand being unmet by the perceived resources, can have a

significant negative impact on the work of helping professionals, their effectiveness with clients, and their personal lives. Pines and Aronson (1988) indicated that the effects of burnout manifest themselves far beyond the work environment, spilling over into negative attitudes toward self, colleagues, friends, and family members. These negative attitudes, coupled with the exhaustion typical in burnout, can result in marital discord and deteriorating personal relationships. A wide range of symptoms has been associated with burnout (Cherniss, 1980; Farber & Heifetz, 1982; Grosch & Olsen, 1995; Sussman, 1992) and can be identified in several areas of the caregiver's life:

1. **Physiological:** fatigue, physical depletion, muscle tension, lowered resistance to disease, irritability, headaches, gastrointestinal disturbances, back pain, weight change, and change in sleep patterns

2. **Affective:** anxiety, depression and despondency, loneliness, fearfulness, emotional exhaustion, helplessness, anger, guilt and self-doubt, lack of concern, desire to withdraw from clients, friends, and colleagues

3. **Behavioral**: decreased productivity, loss of enthusiasm, coming late to work, accomplishing little despite long work hours, quickness to frustration and anger, becoming increasingly rigid, difficulty making decisions, closing out new input, increased dependence on drugs and alcohol

4. **Psychological***:* depression, emptiness, negative self-concept, pessimism, intolerance, defensiveness, boredom, guilt, self-blame for not accomplishing more, feelings of omnipotence

5. **Spiritual***:* loss of faith, loss of meaning, loss of purpose, feelings of alienation, feelings of estrangement, despair, changes in values, changes in religious beliefs, change in religious affiliation

6. **Clinical:** cynicism toward clients, daydreaming during session, hostility toward clients, boredom with clients, quickness to diagnose, quickness to medicate, blaming clients, and boundary violations in the therapeutic

relationship (Dalgleish, 1984; Kahill, 1988; Sussman, 1992; Grosch & Olsen, 1995).

It is not a far stretch to see how these symptoms could lead to diminished capacity for good clinical judgment and the potential for at-risk ethical behavior for any care provider.

As both personal factors of those affected and the situational variables of their workplace have been explored over the past two decades, debate has emerged in the scientific literature about the causes of burnout (Farber, 1983; Pines & Maslach, 1978; Kahill, 1988; Maslach, 1987; Maslach & Goldberg, 1998). Based on her review of the empirical literature, Maslach (1987) argued that situational variables, such as job demands and available resources, are more strongly predictive of burnout than are the individual qualities of caregivers and workers. While work overload and personal conflict emerge as the major demand areas, lack of resources such as coping skills, social support, skills use, autonomy, and decision involvement is the critical component in predicting burnout. Figley (1995) identified mental exhaustion as the key component for burnout among mental health professionals. Maslach (1987) noted in her review: “In general, both negative environment and negative personal factors are linked to burnout although the causal nature of these linkages is not at all clear” (p. 98). In a later publication, however, she stated: “The conventional wisdom is that burnout is primarily a problem of the individual. Thus, people burn out because of flaws in their character, behavior or productivity, but our research argues most emphatically otherwise. As a result of extensive study, we believe that burnout is not a problem of people themselves but of the *social environment* in which people work” (Maslach & Leiter, 1997, p. 18).

Much of the burnout research has pointed toward work-related factors as contributing more to the problem than personality factors. For instance, in a study of 106 social workers, LeCroy and Rank (1986) found that job situational variables were responsible for more variance than personality variables. Moreover, the data did not indicate that assertiveness, as a personality factor,

was an important contributor in the development of burnout. They did find, however, that job variables, such as professional self-esteem, work autonomy, discrepancy between present attainment and aspirations and salary, were significantly associated with burnout. The discrepancy between present attainment and desired aspirations emerged as the strongest factor in predicting this malady. The convergence of a subjective sense of present attainment and desired aspirations has been used by Diener (1983) to describe the phenomenon of "satisfaction with life" and to develop his Satisfaction With Life Scale (SWLS) used in this study. From Diener's point of view, burnout could be described as the opposite or absence of life satisfaction, and it is expected that the scores on the burnout measure will have a high negative correlation with the scores on the satisfaction with life measure in the population of this study.

Role ambiguity, role conflict, workload/caseloads, intent to quit, social support, and interactional factors have all been identified as important factors in the prediction of burnout (Gibson, McGrath, & Reid, 1989; LeCroy & Rank, 1986; Farber, 1983; Stav, Florian, & Shurka, 1986). Himle, Jayarante, and Chess (1986) surveyed 617 social workers to explore work-related variables, psychological factors, and gender differences relative to burnout. In their correlational and multiple regression analyses, they found role ambiguity to be a significant predictor of burnout for both men and women. "Intent to quit" emerged as the best predictor of emotional exhaustion in both men and women. Coady, Kent, and Davis (1990) compared the effects of job environment factors on burnout among social workers in a hospital setting. Their sample of 105 social workers from 45 different states completed job-related demographic questionnaires along with the Maslach Burnout Inventory (Maslach & Jackson, 1982). Using an ANOVA design, these authors found a significant relationship between team or supervisory support and low burnout scores. Interactional factors, such as individual differences and beliefs and coping styles, have been shown to have a significant impact upon the development of burnout but have received minimal attention in the literature (Kahill, 1988; Maslach & Goldberg, 1998).

Maslach and Goldberg (1998) believe that burnout is a process that moves through sequential progression and that the three indices of burnout—exhaustion, cynicism/depersonalization, and diminished accomplishment/efficacy—are caused by the interactional effects of a lack of resources (coping skills, social support, skill use, autonomy, and decision involvement) and workplace demands (work overload and personal conflicts). They described this process as follows: “Currently, the research supports the amended version of the sequential process: emotional exhaustion occurs first and leads to the development of depersonalization, whereas reduction of personal accomplishment develops separately” (p. 65).

These findings suggest that LMFTs who are experiencing significant levels of burnout are also potentially compromised in their skill level and clinical judgment, leaving them vulnerable to violations of boundaries and other unethical practices with their clients. The synthesis of from the review of burnout literature has helped guide this study toward the exploration of the role that caregiver stress plays in LMFTs’ ethical behavior.

Caregiver Stress

Closely related to burnout, but with its own independent body of literature, is the phenomenon of caregiver stress. Most of this literature focuses on the causes, effects, and prevention/treatment of stress in psychotherapists (Farber, 1983; Rodolfa, Kraft, & Reiley, 1988; Hellman, Morrison, & Abramowitz, 1987; Marsh, 1997). While the outcomes of much of this scientific literature indicate that psychotherapists overall are satisfied with their careers (Farber & Heifetz, 1982; Farber, 1983; Hellman et al., 1987) and employ effective coping (Deutsch, 1984; Rodolfa et al., 1988), they often suffer from the effects of their stressful work.

Farber (1983), in his study of 36 psychotherapists (two-thirds of whom were psychodynamic in theoretical orientation), demonstrated that these psychotherapists’ work experiences significantly affected their behavior and attitudes outside the workplace. He reported that the most salient changes in

personality among the participants of his study were that they became more "psychologically-minded," or attempted to ascribe motivation and intention to their own and others' behaviors. He further stated that his participants found this quality to be a "double-edged sword," insofar as it enriched their lives with deeper meanings and assisted them in their careers but also negatively impacted their close personal relationships. In discussing his data, Farber quoted Henry (1966): "The career of the mental health professional, at least those in direct therapeutic practice, is a commitment to a lifestyle, as well as an investment in a line of work" (p. 54). Farber's study also identified positive effects of psychotherapeutic practice upon psychotherapists. These positive changes in the personality of therapists include professional commitment, greater self-insight, more mature social relationships, increased self-assurance and humility, reduced alienation and authoritarianism, and greater self-ideal congruence (p. 175).

Deutch (1984) found that suicidal statements, expressions of anger toward the therapist, severely depressed clients, apathy/lack of motivation, and client premature termination were the most significant sources of stress for 264 private and agency psychotherapists in a Midwestern state. These results were almost identical to those Farber (1979) and Farber and Heifetz (1981) discovered in surveys of psychotherapists in an urban area of the eastern United States. Another interesting aspect of this study (Deutch, 1984) was the frequency of stressful events in the professional lives of psychotherapists. She reported that such stressful events occur weekly, if not daily, in the lives of full-time practicing psychotherapists and make them a vulnerable target for the effects of stress. She found significant differences in stress scores between younger, less experienced therapists and older, more seasoned ones, and she suggested that therapists either develop effective skills for coping with these stresses or they leave the field while they are still young. Finally, this study addressed the mitigating value of the therapist's belief system on levels of stress. Deutsch found that those therapists with higher levels of stress utilized more irrational beliefs about themselves, their abilities, and their demands. What is not known, and appears to be an important area in need of study, is whether these beliefs are a source of the stress the

therapist experiences or a result of the stress. An additional question, and the focus of this study, is: What relationship does caregiver stress have with at-risk ethical behavior?

Rodolfa, Kraft, and Reiley (1988) compared professionals and trainees at both APA-approved counseling and VA medical center internship sites and found results similar to those of the above authors. For example, they found beginning therapists (practicum students) experienced more stress than novice therapists (interns) and both experienced significantly more stress from their work than did seasoned therapists (supervisors). While “suicidal statements” and “anger expressed toward the therapist” appeared as the first and second sources of stress in the Farber (1983) and Deutch (1984) studies, they appear as third and fifth sources of stress, respectively, in this study. “Physical attack on therapist” and “suicide attempt by client” ranked as the most stressful client behaviors for all groups in this study.

Hellman, Morrison, and Abramowitz (1986; 1987) have published two studies that explore the relationship between stress and psychotherapeutic work. In their review of the literature, they made the following statement: “These patterns suggest that psychotherapy is perceived by its practitioners as a fulfilling career that may generate personal as well as professional strains” (1987, p.171). They also provide a synthesis of the preexisting literature that suggests novice therapists experience greater degrees of stress than experienced therapists. Furthermore, they conclude that novice therapists are more likely to respond to stress with rigid, stereotyped, and less effective methods than seasoned therapists. Thus, ineffective stress management can contribute to burnout and flight from the field by novice therapists.

In their first study, Hellman et al. (1986) replicated the Farber and Heifetz (1983) study of the stresses of psychotherapy work with a larger (N = 227), more diverse population. The results were virtually identical to those of Farber and Heifetz’s study, except that the overall level of stress for this sample of psychologists from the West Coast was lower than Farber and Heifetz’s sample

on the East Coast. By employing factor analysis on types of stresses that confront psychotherapists, Hellman et al. found that they could be grouped into five areas: maintenance of the therapeutic relationship, scheduling difficulties, professional doubt, work overinvolvement, and personal depletion. According to the authors, “These five work stress factors are descriptive of the tension between empathy and professional distance in which the therapist gives so much, receives so little, and remains vulnerable to doubts about effectiveness” (1986, p. 203).

In their second study, Hellman et al. (1987) returned to their original data set of 227 licensed psychologists in northern California for further analysis. In this analysis, they utilized multiple regression to examine the relationship between stress, covariates (e.g., social desirability, sex, and four therapeutic style variables), and experience (both years of work and hours per week). These regression analyses were completed for the five stress-of-work factors (therapeutic relationship, scheduling, professional doubt, work overinvolvement, and personal depletion) and five stressful patient behaviors (negative affect, resistance, psychopathological symptoms, suicidal threats, and passive-aggressive behaviors).

Predictably, the more experienced therapists found all five work areas less stressful. However, the therapists’ years of experience was not predictive of stress resulting from patient behaviors; aberrant patient behaviors seemed to stress therapists equally regardless the number of years of experience. Another interesting finding of this study was the curvilinear relationship between therapist stress and therapist caseload. The results of the multiple regression analysis indicate that therapists have a “threshold” of vulnerability in their caseload above or below which they find their work more frustrating and difficult.

Caregiver stress, defined for the purposes of this study by heightened levels of anxiety associated with work and work situations, clearly has a negative effect upon professional caregivers. This heightened anxiety can potentially cause a clinician to become diminished and compromised in her/his ability to

effectively help others. The degree to which this heightened anxiety, caused by work or other factors, leaves the clinician vulnerable to potential ethical violations in his/her practice of marriage and family therapy is the focus of this study.

Compassion Fatigue

Compassion fatigue (Figley, 1995) is the convergence of primary traumatic stress, secondary traumatic stress (Stamm, 1995), and cumulative stress/burnout in the lives of helping professionals and other care providers. One suffers from compassion fatigue when the act of helping others precipitates a compromise in the caregiver's well being. Figley (1995) defines compassion fatigue in professional helpers as: "A state of tension and preoccupation with the individual or cumulative trauma of clients as manifested in one or more ways: re-experiencing the traumatic events, avoidance/numbing of reminders of the traumatic event, and persistent arousal combined with the added effects of cumulative stress (burnout)" (p. 11).

The many symptoms of compassion fatigue in caregivers often parallel those symptoms of the traumatized clients with whom they work. Some of the symptoms of compassion fatigue include: intrusive thoughts/images of clients situations/traumas (or the clinician's own historical traumas); increased negative arousal and anxiety; avoidance of painful client material; difficulty separating work life from personal life; lowered frustration tolerance/outbursts of anger or rage; dread of working with certain clients; marked or increasing transference/ countertransference issues with certain clients; depression; Perceptive/ "assumptive world" disturbances (i.e., seeing the world in terms of victims and perpetrators, decrease in subjective sense of safety); increase in ineffective and/or self-destructive self-soothing behaviors; hypervigilance; feelings of therapeutic impotence with certain clients; diminished sense of purpose/ enjoyment with career; diminished ego-functioning (time, identity, volition); decreased functioning in non-professional situations; loss of hope; and ethical violations (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Figley, 1995,

Lee, 1995; Pearlman, 1995; Stamm 1995; Gentry, 2002). Any of these symptoms could signal the potential for or presence of compassion fatigue.

Although compassion fatigue has been most often described as an emotional contagion passed from client to clinician, there is also a growing discussion of the notion of trans-generational and societal transmission of this condition (Baranowsky et al.,1997; Bloom, 1997; Danieli, 1994, 1996).

Abuse, rape, natural and man-made disasters, motor vehicle accidents, assault, deaths of a loved ones, combat trauma, domestic violence, and theft are just a few of the traumatic events that people from all over the world confront on a daily basis. Such traumas can result in symptoms of Posttraumatic Stress Disorder (PTSD). Posttraumatic stress effects individuals differently but is identified by three categories of symptoms: (a) intrusive thoughts, images, and sensations; (b) avoidance of people, places, things, and experiences which elicit memories of the traumatic experience; and (c) negative arousal in the forms of hypervigilance, sleep disturbances, irritability, and anxiety (APA, 1994). These symptoms combine to form a state of physical, emotional, cognitive, and spiritual volatility in traumatized individuals, families, and groups (van der Kolk, 1996). Persons who work closely with such groups and individuals are vulnerable to the contagion of this volatility. Some caregivers appear to be more resilient or resistant than others to the transmission of traumatic stress; however, any caregiver who continually works with traumatized individuals is at-risk for developing compassion fatigue (Figley, 1995). Marriage and family therapists, in their work with couples and family members who have experienced abuse, violence, loss, and catastrophe, are an especially vulnerable population (Lee, 1995; Salston, 2000).

Vicarious traumatization (McCann & Pearlman, 1990) is described as the "cumulative transformation in the inner experience of the therapist that comes about as a result of empathetic engagement with the clients' traumatic material" (p. 31). In other words, vicarious traumatization describes the process of the therapist's inner experiences—his or her assumptions about the world and the

schemas used to make sense of the world—undergoing negative transformations through empathic contact with the client's traumatic material (Pearlman & Saakvitne, 1995).

Whereas countertransference occurs in all psychotherapies and is a temporary response to a particular client, vicarious traumatization seems to be the result of an accumulation of experiences across many therapy situations. Among therapists, vicarious traumatization is recognized as normal and predictable, as well as inevitable. However, if the therapist does not recognize and intentionally address such a transformation, it can have a serious effect on the therapist as an individual and as a professional providing therapy, as well as within personal relationships (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The "memory system" is added to this concept to explain the disruption in imagery when someone has been traumatized; intrusions into the memory cause reexperiencing of a traumatic event. In the Pearlman and Mac Ian (1995) study, the newest therapists (i.e., those who had most recently begun practicing) without trauma histories, had scores more closely linked with burnout and experienced the most disruptions in regard to self-esteem. The most experienced therapists with histories of personal trauma had fewer disruptions on self-trust, self-esteem, and self-intimacy. Those therapists without a history of trauma and who were most experienced had the most disruptions on self-intimacy and other-esteem. Overall, those with trauma histories had more disruptions.

Schauben and Frazier (1995) found those therapists with the heaviest caseloads of sexual violence survivors to have the highest rate of cognitive disturbances, thereby supporting the theory that a source of vicarious traumatization is the empathic connection with the client's traumatic material. Both countertransference and vicarious traumatization are explained as a cyclical process, whereby one affects the other. However, unlike countertransference, vicarious traumatization is not limited to the therapeutic setting.

Therapist and client factors proposed to "influence vicarious traumatization include personal trauma history, the meaning of traumatic life events to the

therapist, psychological style, professional development, and current stressors and supports. . . the material [clients] present in therapy, stressful client behaviors, work setting and social-cultural context" (Pearlman & Mac Ian, 1995, p. 558), as well as empathic connection, graphic client material, client reenactments, and other contextual factors such as the nature of the therapist's clientele.

Vicarious traumatization can be mitigated through accepting and recognizing the changes that are bound to occur, giving oneself permission to limit exposure, naming the reenactments that occur during therapy for the benefit of the client as well as for the benefit of the therapist, setting limits with clients, and continuing education in the field of traumatology and client care.

Lee (1995), in her dissertation entitled *Secondary Traumatic Stress in Therapists Who Are Exposed to Client Traumatic Material*, assessed compassion fatigue in a national sample of clinical members of the American Association of Marriage and Family Therapists using the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979). She found that marriage and family therapists experience a moderate level of secondary stress as compared to other sampled groups. She found the level of satisfaction with total client caseload (i.e., compassion satisfaction) was significantly negatively correlated with secondary traumatic stress (i.e., compassion fatigue). Results from this current study were compared to Lee's findings in an effort to direct and refine the continued research into the causes and effects of caregiver stress among marriage and family therapists.

Whether it is labeled *compassion fatigue*, *secondary traumatic stress*, or *vicarious traumatization*, the effects of helping suffering individuals, families, and communities—especially those with acute traumatic stress—can be debilitating to the helper. The degree to which this factor influences at-risk ethical behavior and caregiver stress (anxiety) in Licensed Marriage and Family Therapists in Florida is a partial focus of the exploratory portion of this study. Additionally, this study will investigate the overall level of compassion fatigue reported by the

respondents in this population. It is expected that those respondents reporting high scores on the compassion fatigue subscale of the ProQOL (Stamm, 2002) will also report high scores for caregiver stress on the STAI; (Spielberger et al., 1983).

Rejected Measurement Instruments

The process of selecting the measurement instruments to operationalize the dependent and independent variables of this study involved an exhaustive search and review of the clinical and research literature. Deciding upon the 20-item Ethics At-Risk Test for Marriage and Family Therapists (EARTMFT; Brock, 1997) as the measurement for the dependent variable, at-risk ethical practices, was simplified because this was the only instrument of its kind found in the review. Selecting the instruments utilized to define the independent variables was less straightforward and involved a lengthy review and analysis. Three additional instruments, with a total of six subscales or factors, were selected to ground the independent variables of "care-giver stress," "compassion fatigue," "burnout," "compassion satisfaction," "caregiver resilience," and "caregiver satisfaction with life" with empirical data. The three instruments selected to operationalize the independent variables of this study were the STAI (Spielberger et al., 1983), ProQOL (Stamm, 2002; Stamm, 1998; Figley, 1995), and the Satisfaction with Life Scale (SWL*S*) (Diener et al., 1985). Additionally, a demographic data collection instrument was created by the writer for the purposes of this study. A review of these instruments that articulates inclusion criteria, psychometric properties, strengths, and weakness of each is included in the "Instrument" section of Chapter III. In deciding upon the most appropriate and useful instruments for this study many were reviewed and rejected. A discussion of these rejected instruments follows below.

Impact of Events Scale (*IES*, Horowitz, et al., 1979). The 15-item IES has been a mainstay for research in posttraumatic stress over the past two decades. It enjoys solid psychometric properties in its measurement of intrusion and avoidance symptoms associated with a specific traumatic event. The reason for

its exclusion from this study is two-fold. First, the instrument requires the respondent to identify a specific event and then answer the subsequent 15 items, questions about intrusion and avoidance symptoms, relative to this event. Because the present study wishes to evaluate the amount of stress the respondent experiences from their personal work as LMFTs over time, the identification of one particular event would fail to capture the cumulative stress associated with their care giving work. Additionally, Beth Stamm (1998; 2002) in her Compassion Satisfaction/Fatigue Self-Test, a revision of Figley's (1995) original Compassion Fatigue Scale, and in her latest version of the ProQOL she used the IES to establish convergent validity for the subscale of "compassion fatigue" and has found acceptable levels of correlation between the IES and the "compassion fatigue" subscale of her instrument (see below). The IES' inability to accurately assess "caregiver stress" coupled with the probable redundancy of measure with the ProQOL, that more accurately articulates the intrusion and avoidance items relative to the respondent's care giving experiences, are the two main reasons for the rejection of the IES for use in this study.

General Health Questionnaire-12 (GHQ-12, Goldberg, et al., 1997). The GHQ-12 is an often-utilized instrument for measuring the quality of health of a population or sample. This self-report inventory focuses upon the components of ill health (Goldberg, et al., 1997) and, potentially, could offer an interesting dimension to assist in measuring "caregiver stress." The GHQ-12 was included in the original version of the "pre-prospectus" for this study but was removed, with permission from my major professor, due to the instrument's cost, difficulty in acquiring rights for use, and the addition of another 12 items to an already taxing survey. While these represent a parsimonious rationale for the removal of this instrument from the survey, the most compelling reason is that the five-item SWLS (Diener, et al., 1985) has demonstrated a significant correlation with the GHQ-28 (Goldberg & Williams, 1987), a previous and longer version of the GHQ-12 (Arrindell et al., 1991). While Arrindell et al., (1991) are pointed in their argument that satisfaction with life is a distinct phenomenon separate from a subject's quality of health, they indicate that the shared variance seems to

indicate those who enjoy satisfaction with life also enjoy reasonably healthy lifestyles. Add to the above reasons of cost, difficulty, and additional items in the survey to the correlation of measure between the GHQ-12 and the SWLS and there seems to be ample rationale for the removal of the GHQ-12 from the survey.

Maslach Burnout Inventory (MBI, Maslach & Jackson, 1982). The MBI has been utilized in numerous studies to ascertain the level of job stress experienced by the respondent (Maslach & Goldberg, 1998). However, Stamm has demonstrated significant convergent validity between the MBI and the "burnout" subscale of her Compassion Satisfaction/Fatigue Self-Test (Stamm, 2002b), the precursor to the ProQOL utilized in this study. The ProQOL preserves this relationship with the "burnout" subscale making the use of the MBI unnecessary. In addition, copyrights for the MBI are owned by CPP, Inc. That company charges over one dollar per copy for the instrument, thus making its use prohibitive for this study.

Index of Clinical Stress (ICS, Abell, 1991). The ICS is a 25-item instrument designed to measure the magnitude of stress in clinical populations. While the instrument enjoys good reliability and validity data, it is difficult to score and use by a researcher. Additionally, the State-Trait Anxiety Inventory is a much more well-known and utilized instrument for measuring this phenomenon. Finally, the ICS has been normalized and is indicated for use with clinical populations (Fisher & Corcoran, 1994). A publishing company that owns the rights for the ICS charges for its use and would make it prohibitive for this study.

Conclusions

This conclusion addresses each of the questions that guided this critical review.

(1) What does current research and statistics tell us about the occurrence, prevalence, and nature of ethics violations? The information obtained from the studies reviewed here has demonstrated that marriage and family therapists, as

a whole, conform to the AAMFT Code of Ethics (AAMFT, 1998) in providing professional service. In the sample populations of the studies of this review, approximately 10% of therapists, at any one time, are engaged in some type of ethical violation, with decreasing likelihood as the violation becomes more overt, harmful, or exploitive. Marriage and family therapists report engaging in sexual activity with their clients at a very low rate (0% to 1.5%), and there is evidence that this low rate is both accurate (AAMFT, 2001a) and diminishing (Nickell et al., 1995). Very little is known about the nature of these violations, either in terms of the interpersonal dynamics between therapist and client or in the intrapersonal dynamics of the therapists, although it is hypothesized that both quality of training and therapist distress have some important relation to these occurrences. Male therapists in a suburban solo practice who are psychodynamic in their theoretical orientation are the group at highest risk for violating ethics (Borys & Pope, 1989; Brock & Coufal, 1994; Epstein et al., 1992; Montgomery et al., 1999; Nickell et al., 1995; Pope et al., 1987).

(2) What is the condition and maturity level of research into the experience and causes of ethics violations; have causal models been offered and studied? The condition and maturity level of the research on ethical violations across disciplines is greatly improving, thanks to efforts of researchers like Gregory Brock and Kenneth Pope. However, it is still very young, and no causal models have been offered or studied in the review of existing literature. In this important area of study, marriage and family therapy lags behind the disciplines of psychology and psychiatry, with only one peer-reviewed study and one textbook chapter that explores ethical violations among marriage and family therapists.

(3) What are the antecedents, threats, or "warning signs" of ethics violations identified in the existing research? Some effort has been made to establish a demographic pattern among therapists who violate ethics, but this has proved inconclusive (Epstein et al., 1992). Both Epstein et al. (1992) and Brock and Coufal (1994) have generated instruments designed for this purpose. However, neither of these instruments has been empirically validated. Pope and

Vasquez (1999) offered a set of rationalizations and justifications that they believe to be concomitant with ethical violations, but no data has emerged on the validity or utility of these beliefs.

While empirical research has failed to offer clear indicators to the antecedents, threats, or warning signs of ethics violations, the research included in this review does offer some hints toward understandings in this area. Practitioners impaired with stress, mental illness, physical illness, and/or chemical dependency may be at higher risk for ethically compromised practice than those practitioners who enjoy health in these areas. Males are three-to-ten times more likely to be reported for ethical violations than females (Borys & Pope, 1989; Brock & Coufal, 1994; Epstein et al., 1992; Nickell et al., 1995; Pope et al., 1987). It seems safe to assume from this data that male therapists actually violate ethical standards more often than females.

The questions of whether violations of ethical standards are more a function of the violators' personalities and development (trait) or a function of their current life status with all their professional and personal stressors (state), and to what degree ethical violations are a function of combinations of these factors remain virtually unexplored in the writings of current researchers in this field.

(4) What are the concomitant "systemic dynamics" in the life of the offender which contribute to violations of ethics? As previously discussed, no research found for this review has addressed this important question. It seems only common sense that practitioners impaired with a physical or mental illness, or even with overwhelming stress, are more likely to engage in ethically compromised practice. Is a therapist who is navigating through the stresses and loss of a divorce or the death of a loved one more vulnerable during this time than at other times during his/her career? Although it would seem so, we have no empirical evidence to confirm this assumption.

The recent focus of attention on the effects upon caregivers of providing treatment to troubled and traumatized individuals has conclusively demonstrated that for some practitioners there is a significant deleterious effect to treating this population (Deutch, 1984; Freudenberger & Robbins, 1979; Pearlman & McCann, 1991; Pope & Tabachnick, 1991; Rodolfa et al., 1988). The degree to which the negative effects of care giving, along with other concomitant stressors, influence the caregiver's likelihood of committing ethical violations is a fascinating area of inquiry that is ripe for investigation life.

(5) What has research demonstrated as "best practice" for preventing, treating, and resolving ethics violations? The question of how to prevent ethical violations, despite the breadth of scientific literature, has been almost entirely focused upon the need for further education. The studies reviewed in this paper identify education or lack of education, in training programs and/or continuing education, as both the cause and cure of ethical violations. Brock and Coufal (1994), Borys and Pope (1989), Epstein et al. (1992), Nickell et al. (1995), and Montgomery et al. (1999) all have made specific suggestions for enhancing educational programs, both in training and in continuing education, for preventing ethical violations. These authors have indicated that the following are important areas for educational concerns: gender differences, with attention given to sexual fantasizing about clients; the use of touch in therapy; increased awareness of sexual attraction issues; the AAMFT Code of Ethics and its limitations; the need to feel that it is acceptable to discuss sexual feelings toward clients; assessment of student and therapist beliefs about issues of sexual attraction to clients; advising clients on marital status; (h) failing to obtain client consent to tape or record sessions; failing to report child abuse; treating homosexuality as pathological; failing to warm victims of lethal threats; failing to participate in continuing education activities; giving medical advice; practicing when too tired or distressed; providing therapy to students or supervisees; tailoring diagnoses to meet insurance criteria; failing to have research reviewed to protect human subjects; and inclusion of ethical issues in psychotherapy and counseling texts

Nickell et al. (1995) found that therapists who receive substandard training, who lack knowledge of professional boundaries, and who experience stressors have increased vulnerability to mishandling their attraction to clients and are therefore more vulnerable to ethically compromised practice. This finding may contain the most significant keys for future exploration in this area because it addresses ethical violations as a multi-determined phenomenon that will undoubtedly require multiple strategies for effective treatment, prevention, and resolution. While it has been made clear that preventive strategies must include enhanced training and continuing educational practices, it seems obvious that other strategies, such as supervisory practices, self-awareness, psychotherapy, competency examinations, and electronic media learning events, would also prove useful. Additionally, the articles reviewed and data presented regarding burnout, caregiver stress, and compassion fatigue have demonstrated that professional caregiving takes its toll on therapists working with traumatized and suffering individuals and families. This stress suffered by professional caregivers, LMFTs in the case of this study, may point toward significant influencing factors in these therapists' engagement in at-risk ethical behaviors.

CHAPTER 3

METHODOLOGY

The design and methodology for data collection and analyses for investigation into the relationship between at-risk ethical behavior and caregiver stress for Licensed Marriage and Family Therapists in Florida is presented in this chapter. Included in this chapter is an identification of the sample population, procedures for data collection, a review of the instruments, and statistical analyses utilized in this study.

Sample

According to the Florida Department of Health (2001) professional regulation data, there were 1099 marriage and family therapists licensed in Florida in 2000. One-half (N=549) of this population of licensed marriage and family therapists (LMFTs) in the State of Florida was randomly selected for the sample of this study. Judging from previous surveys of this kind (Brock & Coufal, 1997; Brock, in press; Pope et al., 1987), a return rate of 30-60% (168-357) was expected. Results from the demographic data collection were compared with the demographic data from the American Association of Marriage and Family Therapists (AAMFT) and data collected from a previous national survey of Clinical Members of AAMFT (N = 540; Brock & Coufal, 1997) to determine potential generalizability for the results of this study.

Procedure

Survey packets were sent on February 1, 2004 to 549 of the 1099 LMFTs in the State of Florida. Participants were randomly selected by choosing every other name in the Excel Spreadsheet alphabetical list of licensees. A coin was tossed to determine whether the selection would begin with the first name (and all subsequently odd-numbered names) or second name (and all subsequently

even-numbered names) of the licensees. The first and subsequent odd-numbered names were selected in this method.

Included in these survey packets were nine items: a cover letter, an informed consent document, two stamped return envelopes, and five questionnaires. These five questionnaires contained self-report instruments utilized to measure dependent and independent variables. These measures are discussed later in this chapter.

In addition to the above, survey packets included a 9 x 12 stamped envelope for participants to use to return their surveys. A post office box was rented in Tampa, FL (P.O. Box 280037, Tampa, FL 33682) by the researcher before mailing surveys to participants. The return envelopes were printed with this P.O. Box number for return. A copy of the complete survey packet sent to the sample participants may be found in Appendix A.

Upon receipt, all returned instruments were assigned an identification number for each respondent (e.g., 0001, 1002, etc). Scoring of the survey instruments and entry of this data into SPSS 13.0 began with the return of the first packets and continued throughout the data collection period. Preliminary and statistical analyses of these data commenced when all the scores, for all the instruments, of all the respondents were entered into SPSS 13.0 (see Statistical Analyses section below).

Participants of this study were instructed to read, sign, and return the informed consent in a separate enclosed envelope. They were then asked to complete all 106 items of the data collection instruments and return within 90 days. The final date of data collection was April 30, 2004.

Following the survey research protocol recommended by Dillman (1983) and with the hope of increasing response among the chosen sample, all participants were sent a complete second survey packet on March 3, 2004. This packet contained the same instruments with a slightly different cover letter (See Appendix B), requesting the selected sample therapists to respond to the survey

using the enclosed stamped envelope. Return envelopes were addressed to the United States Post Office Box in Tampa.

To assure anonymity no identifiers were utilized on any of the survey materials or mailing material. A volunteer was enlisted to collect the returned survey packets from the special post office box each week. To further assure anonymity of the respondents, the volunteer immediately discarded the return envelopes in the trash receptacle at the Post Office. She also reviewed responses for any identifying information and was instructed to cover this information with a black marker before presenting these surveys to the researcher. No returned questionnaires had any additional identifying information.

Instruments

All the instruments of this survey study, comprising a total of 106 response items and approximately 20-30 minutes of response time, are included in Appendix B and are discussed below.

Demographic data. A Demographic and Work Data collection instrument was designed for use in this study. It contains 11-items and is fashioned after previous studies that have investigated this area of ethical violations (Pope et al. 1987; Brock & Coufal, 1997; Brock, in press). Data on demographic/work situation factors collected by this instrument include age, gender, marital status, education, professional identity, work setting, primary theoretical orientation, years licensed as an marriage and family therapist, total hours per week worked, total clinical hours per week, and history of traumatic experience. All these items, with the exception of the last, are the same as those collected by Brock and Coufal (1997) in their national survey of Clinical Members of AAMFT. The last item (*Have you survived at least one traumatic experience during the course of your life?)* was included to determine whether or not a history of personal trauma reported by the respondent has any relationship to ethics at-risk scores.

Dependent variable. In 1994, Brock and Coufal completed a study that investigated the ethical beliefs and practices of 540 Clinical Members of AAMFT. This commissioned study was published as a chapter in an AAMFT Ethical Casebook, reviewed in Chapter 2 of this dissertation. One of the results of this study was the development of the 20-item EARTMFT (Brock, 1997).

According to Brock (in press), the EARTMFT was designed to augment the preventive role of an ethics code by alerting practitioners to their current level of vulnerability/liability for violations of AAMFT Code of Ethics (AAMFT, 1998). The EARTMFT directs therapists to answer yes or no to 20 items from several categories of at-risk behavior pertinent to this code. The test is constructed, according to Brock (in press), of items from three different categories. In the first category of items, therapists are asked whether or not they engage in behaviors that are de facto violations of the Code (e.g., "During the past two months, have you seen clients while you were hung over or under the influence of drugs even if only a little?"). The second category of questions assesses the presence of what might be called precipitating conditions, which themselves are not unethical but may lead to an ethics violation (e.g., "Do you fantasize about kissing or touching a present client?"). These also include sexual fantasy, dual relationships, relaxing of professionalism, and marginal financial practices. The final category of items assesses a therapist's willingness to violate ethical practices (e.g., "Does the Ethics Code interfere somewhat with the quality of your therapy or research?").

The EARTMFT features a bifurcated, forced dichotomous (i.e., yes or no) response and a scoring key that is designed to alert the respondent to possible violations of ethical behavior. Scores are interpreted as follows: (a) 0 is "Excellent, you are nearly risk free"; (b) 1-2 is "Review your practice. Read and follow the Ethics Code"; (c) 3-4 is "Review your practice for problem areas. Consider needed changes"; (d) 5-7 is "Consult a supervisor. You are engaging in high risk behavior"; and (e) 8+ is "Probably you have already harmed clients. Seek therapy and supervision. Come to terms with your situation by making immediate changes." In his text, *Ethics At Risk: A Research Based Instrument for*

Determining A Therapists Potential For Harm (in press), Brock states that "after answering the items, respondents total their score to determine their risk potential for harming clients: The higher the score, the higher the risk. At the highest risk level, 10 points or half of the items, respondents are presumed to have already violated the *AAMFT Ethics Code*" (p. 4).

In this study the EARTMFT was used to assess a level of at-risk ethical behavior. Because it provides a numerical value to this potential for ethical violations, the test is appropriate to measure for the dependent variable of this study. There is one glaring caveat for the use of this instrument, however. Nowhere has Brock published the measurement validity or reliability data for this instrument. While the EARTMFT clearly enjoys face and construct validity and could be said to demonstrate some convergent validity with the AAMFT Code of Ethics, the failure to publish validity and reliability data seems nearly catastrophic for the instruments utility in continued research. Disturbed by the lack of reliability data, this researcher contacted Dr. Brock, via email (personal communication, Brock, 2002) and he stated that he did not have these data. He indicated that he had recently completed a second survey with the instrument (in press) and that he would attempt to acquire the original data set and allow me to calculate this reliability data. He wrote back a few days later to indicate that he was unable to offer this original data and requested that this researcher, resulting from this study, provide him with the results from any reliability and/or factorial analyses that are completed in the course of this study.

Brock's failure to identify or produce any reliability data for the EARTMFT lead to the request by the committee directing this dissertation research for the researcher to complete a pilot study of the test's reliability. This pilot study was conducted between November 1, 2002 and January 1, 2003. The Ethics At-Risk Test was given to 44 professional caregivers (licensed marriage and family therapists, licensed clinical social workers, licensed professional psychologists, licensed mental health counselors, registered interns for marriage and family therapy, registered interns for clinical social work, and registered interns for

mental health counseling) who were attending a seminar conducted by this researcher. Each participant was provided with a stamped return envelope and was instructed to not place any identifying identification on the instruments.

Twenty-one (N=21) responses were return and analyzed using SPSS 13.0. Data collected from the volunteers who agreed to participate in this pilot produced a Chronbach's alpha score of .66 and a Guttman's split-halves score of .60 (N=21). These scores are at the lower end of what is traditionally acceptable as levels of reliability for a dependent variable (Thompson, 1989). However, since this was the only instrument in existence that measured "ethics at-risk" with MFTs, the instrument was utilized to measure the dependent variable for this study

Independent Variables.

Three instruments were selected for use to assess the level of caregiver stress in the population of this study. These instruments were chosen after reviewing a pool of several potential scales and measures. All instruments were reviewed and evaluated in the areas of psychometric properties, ease of use, foci of measure, cost, and availability. The three instruments selected were (1) The State-Trait Anxiety Inventory (STAI) (Spielberger et al., 1983), (2) Professional Quality of Life Scale: Compassion Satisfaction/Fatigue Scale-Revised-III (ProQOL) (Stamm, 2002; Stamm, 1998; Figley, 1995), and (3) the Satisfaction With Life Scale (SWL*S*) (Diener et al., 1985). The STAI contains two subscales (state and trait anxiety), the ProQOL has three subscales (compassion fatigue, burnout, and compassion satisfaction), and the SWLS is one integrated measure of life satisfaction. The inclusion of each of these subscales yields a survey research design with six independent variables and one dependent variable.

Several instruments were reviewed and rejected for use in this study. These instruments, along with rationale for rejection, are detailed in Chapter 2. The instruments selected to measure the independent variables of this study are reviewed with a rationale for their inclusion in the following section.

The State-Trait Anxiety Inventory (STAI; Spielberger et al., 1983). The STAI was developed in the early 1960s, published first in 1970 (Spielberger, Gorsuch, & Lushene), and revised in 1983 (Spielberger et al.) The STAI emerged during a time when all existing instruments measured an individual's anxiety associated with the *trait* (relatively enduring personality characteristics) rather than *state* (personality characteristics that change in relation to external events). The careful construction of the STAI, which measures both these domains, led Levitt (1967) to identify this instrument as the "most well developed instrument from both theoretical and methodological standpoints" (pp. 71-72).

The STAI uses two similar but different forms, with different sets of instructions, to achieve the measures of both trait and state anxiety in the subject. The trait or T form (Y2) asks subjects to identify how they *generally* feel, and the state or S form (Y1) instructs them to rate how they feel *at this moment.* These two 20-item instruments are rated on a four point Likert-scale with half the items measuring positive symptoms (anxiety present) and half measuring negative symptoms (anxiety absent).

These scales have undergone thorough development and testing, and the good psychometric properties have withstood the rigors of nearly four decades of utility as one of the most relied upon measures for anxiety in research and clinical contexts (Thompson, 1989; Nerella, Franzen, & Schill, 1983). The T form of the STAI enjoys test-retest reliability correlations between 0.65-0.82. The S form, designed to be sensitive to temporal fluctuations in anxiety, does less well with reliability scores ranging from 0.16 to 0.62 (Spielberger et al*.,* 1983). The concurrent validity for the T scale of the STAI against other personality scales of anxiety ranges from good to excellent (0.53 to 0.85). On the T scale, the STAI offers validity coefficients with other personality assessments that measure anxiety (i.e., Minnesota Multiphasic Personality Inventory, Cornell Medical Index, Mooney Problem Checklist) and enjoy significance with *r* values ranging between .25 - .61 (Spielberger, et al., 1983).

While the STAI is one of the most frequently used measures for anxiety, there are some criticisms of the instruments from other researchers. Thompson (1989) reported that the non-specific nature of STAI's S scale is problematic: "It [The STAI] is so sensitive (theoretically a good thing for a scale to measure change) that it responds markedly to test anxiety and is really designed as a measure of perceived stress. This may not be appropriate for severely anxious patients" (p. 136). Other researchers reviewing the STAI have indicated that the T-Anxiety scale fails to measure an unvarying trait of the respondent since it is likely that trait anxiety is significantly influenced by changes in state anxiety (Nerella et al., 1983).

The potentially confounding non-specific nature of the S-Anxiety scale of the STAI has been addressed, for the purposes of this study, by requesting the respondents to answer all the items of the S-Anxiety scale as they would if they were at work or in their work situations as LMFTs. Spielberger et al. (1983) prescribed this potential use of the S-Anxiety scale of the STAI stating: "Although the T-Anxiety scale should always be given with the instructions printed on the test form, instructions for the S-anxiety scale may be modified to evaluate the intensity of S-Anxiety for any situation or time interval of interest to the experimenter or researcher" (p. 3).

For the purposes of this study, the STAI was a very useful instrument. The two forms of the STAI provided a global measure of anxiety, or stress, for each respondent. These scores were utilized to identify and assess the level of caregiver stress (i.e., anxiety caused by the respondent's work as an LMFT and preexisting levels of T-Anxiety) experienced by the respondent. In the hypothesis-testing portion of this study, these STAI scores were compared to the scores on the Ethics At-Risk Self-Test (Brock, 1997) to determine if there is significant correlation between high levels of caregiver stress and self-reported at-risk ethical behavior. The rejection/fail-to-reject if the null hypothesis for this study (*There is no relationship between caregiver stress and ethics at-risk*

behaviors among Licensed Marriage and Family Therapists in the state of Florida) was determined based upon these findings.

By comparing differences in scores on the state and trait forms, it can be determined which LMFTs are experiencing heightened, normal, or lowered current anxiety relative to their normal, or trait, levels of anxiety. Aligned with the alternative hypothesis of this study, it is reasonable to expect that those respondents who scored higher on the state form (S-Anxiety) than the trait form (T-Anxiety) of the STAI would have higher scores for at-risk ethical behaviors than those respondents with state scores equal to or lower than the trait form.

The STAI is scored by reverse scoring all twenty "anxiety absent" items so that the numerical value for each item is ascending, thus allowing the sum of scores for the twenty items of each form (Y-1 and Y-2) to reflect the score for that particular subscale (e.g., state-anxiety or trait-anxiety). A sample item from the S-Anxiety form is: *(1). I feel calm*. A sample item from the T-Anxiety form is: *(21). I feel pleasant.*

In the exploratory portion of this study, the scores of the STAI state and trait forms were first compared to the collected demographic data to determine if there are any significant demographic correlates to these scores. Next, the relationship between the STAI scores with the other independent variables were explored and reported. It was expected that STAI scores will correlate positively with compassion fatigue and burnout scores and will correlate negatively with life satisfaction and compassion satisfaction scores.

Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales Revised III (ProQOL; Stamm, 2002). The ProQOL is the third revision of the Compassion Satisfaction/Fatigue Self-Test (Figley, 1995; Stamm, 1998). This scale was originally developed as a 25-item instrument measuring compassion fatigue (secondary traumatic stress) and burnout. It was developed and published by Figley (1995) in his book *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized.*

Figley, Stamm, and Rudolph (1996) completed the psychometric review of this instrument for inclusion in Stamm's (1996) *Measurement of Stress, Trauma and Adaptation.* They report original alphas ranging from .96 to .86 on the two subscales of this instrument, compassion fatigue and burnout, resulting from a sample of 142 respondents. They further report a structural reliability coefficient (Tuckers) of .91.

In 1998, Stamm revised this instrument to a 66-item scale to include a subscale for compassion satisfaction. The author has recently completed a review of the psychometric properties of this Compassion Satisfaction/Fatigue Self-Test in preparation for the development of the ProQOL (Stamm, 2001). Her results are based upon data collected from a pooled sample of 370 respondents. These respondents included *trauma professionals* (n=58; 16%), *business volunteers* (n=130; 35%), *Red Cross volunteers* (n=30; 8%), *caregivers in training* (n=102; 27%), and an additional sample of *lay mental health caregivers in rural Africa* (n=16) who did not complete the compassion satisfaction subscale of this instrument. Stamm offers no explanation for why the individual group samples (N=316) do not compute to the total number of pooled samples (N=370) claimed in this on-line report. In this report, she identifies the alphas for the three subscales as 0.87 for the compassion satisfaction subscale, 0.90 for the Burnout subscale, and 0.87 for the compassion Fatigue subscale. No validity data is available for any of the subscales of this instrument; however, many of the 16 items for burnout are drawn from the Maslach Burnout Inventory which consistently enjoys alphas of above .90 (Maslach, 1986). Additionally, Stamm reported that there is significant convergent validity with the Compassion Fatigue subscale and the Impact of Events Scale (Horowitz, 1979).

The ProQOL (Stamm, 2002) was first published on-line in October, 2002. The ProQOL is scored by identifying the 10 items from the instrument that correspond with each of the three subscales—compassion fatigue (secondary traumatic stress), burnout, and compassion satisfaction. These 10 items are then summed to get the score for each subscale and then compared to cut-points identified by

Stamm (on-line at http://www.isu.edu/~stamm/Pro-QOL_ psychometric.html). A sample question from the ProQOL is: “(2). I am preoccupied with more than one person I help”.

The ProQOL was used in this study to (a) determine the overall level of compassion fatigue, burnout, and compassion satisfaction reported by the population of LMFTs in Florida; (b) determine if there were any significant relationships between demographic factors and the reported scores on the three subscales of this instrument; and (c) determine if there was are significant relationships between the scores on these three subscales and Ethics At-Risk Test scores for the population. It was hypothesized that compassion fatigue and burnout subscale scores would correlate positively with EARTMFT scores while compassion satisfaction scores, identified also as “professional resiliency” (Stamm, 2002a), would correlate negatively with this at-risk behavior. Dr. Stamm will utilize data collected from this study in her ongoing development of the psychometric properties for the ProQOL (personal communication, Stamm, 2002).

Satisfaction With Life Scale (SWLS; Diener et al., 1985). The SWLS is a simple, easy-to-use 5-item instrument designed to measure the sense of subjective well being or, as defined by Shin & Johnson (1978), “a global assessment of a person’s quality of life according to his [sic] chosen criteria” (p. 478). Diener et al. (1984) indicated that judgments of one’s satisfaction are derived by comparison of one’s current situation and what is thought to be an appropriate standard, not by some externally imposed criteria. While positive affect, absence of general psychiatric distress, good health, and the ability to effectively execute daily living functions all correlate positively with satisfaction with life, this subjective self-assessment has emerged as a stable “stand alone” measure of a respondent’s level of global satisfaction with the conditions of his or her present life (Arrindell, Meeuwesen, & Huyse, 1991).

Two articles exploring and reporting on the psychometric properties of the Satisfaction With Life Scale were found in a search of the scientific literature. The

first one (Diener et al., 1985), co-authored by the scale developer, features three separate studies on the instrument. The second article (Arrindell et al., 1991) describes a study conducted by independent researchers in the Netherlands and provides important cross-cultural information on the scale's performance. In the Diener et al. study, the 5-item scale was derived through factor analytic methods from a pool of 48 items administered to a sample of 176 undergraduates at the University of Illinois. Two months later, 76 of these students were re-administered the 5-item scale. The two-month test-retest correlation coefficient was .82, and the coefficient alpha was reported at .87. Using an inspection of the scree plot of eigenvalues, a single factor emerged that accounted for the variance in 66% of the scores. The factor loading of the five items were all between .61 and .84, with item-total correlation between .57 and .75. The second study described in this article was designed to test the criterion-referenced validity of the SWLS. A total of 339 undergraduate students were administered the SWLS and a battery of 16 established instruments used to measure phenomena associated with subjective well being (i.e., positive affect, general happiness, general psychiatric distress, general health, neuroticism, affect balance, and life satisfaction in 10 key life domains). The authors reported moderately strong correlations with the scores of the SWLS and the nine instruments of this study measuring life satisfaction (.50 - .75). They also report that individuals who are satisfied with their lives are "in general well adjusted and free from psychopathology" (p. 73). In the third study featured in this article, the authors surveyed a geriatric sample of 53 respondents with the SWLS. In addition, these participants were interviewed by a pair of trained interviewers in a structured format and assigned values on a 7-point scale in five areas corresponding to the items of the SWLS. There was a .73 correlation between interviewers on assigned scores and a composite correlation of .68 between the interviewer-assigned scores and the participants' self-assessment on the SWLS. This study provides a good argument for the stability and internal consistency of the SWLS.

In the Arrindell et al. article, researchers from The Netherlands completed a study of 107 medical (non-psychiatric) outpatients comparing the SWLS with seven other instruments measuring functional impairment of health, impairment associated with alcohol abuse, somatization, general health, general psychiatric distress, locus of control, and a lie scale (Arrindel et al., 1991). These authors reported nearly the same results as Diener et al. (1985) in respect to the internal consistency of the SWLS. As in the previous study, Arrindell et al. reported a single factor emerging that accounted for 67% (66% in Diener et al.) of the variance in scores and also reported the exact same reliability coefficient (.87) as Diener et al. It is interesting to note that Arrindell et al. found marriage or involvement in a long-lasting intimate relationship the only demographic item that was significantly positively correlated with SWLS scores.

The SWLS was a helpful and parsimonious tool for use in this study. It is easily scored by a simple sum of scores. It was expected that respondents of this study who report low levels of caregiver stress, compassion fatigue, and burnout will report higher levels of satisfaction with life. Conversely, those reporting low levels on these scores and higher levels of compassion satisfaction were expected to indicate higher SWLS scores.. Because of the high positive correlations between the SWLS and other measures of well-being and its high negative correlations with measures of physical and psychological symptomology, this instrument has the potential to become an early-warning “screening” device for caregiver stress and, potentially, provide an indication for the therapist when he or she may be at risk for ethical violations.

Statistical Analyses

A variety of parametric statistical procedures and analyses were employed to test the hypotheses and to answer the research questions of this study. As with all parametric statistics, several preliminary steps were taken to minimize the potential for Type I error before beginning the primary analyses. These steps include: (a) reviewing all cases for missing data and determining a method for addressing any missing data; (b) generating and reviewing all scatterplots for

outliers and goodness of fit for regression models; (c) determining a procedure for addressing the potential problems generated by outliers and overly influential observations (d) determining if there are significant violations to the distributional, independence, and exact IV assumptions; (e) determining the analyses' robustness to violations of assumptions; and (f) creating remedies for any violations of these assumptions. (Tate, 1998).

Each of these steps was completed for the data and analyses of this study. The results of these preliminary analyses, along with any measures of correction employed, are reported and discussed in Chapter IV.

This study is divided into two separate sections: Hypothesis Testing and Exploratory Analysis. The statistical analyses procedures for each of these sections is detailed below and the results are reported in Chapter IV.

Hypothesis Testing

The first phase of statistical analyses for this study was the testing of the hypothesis. The null hypothesis for this study states: *There is no relationship between caregiver stress and ethics at-risk behaviors among licensed marriage and family therapists in the state of Florida.* Caregiver stress, as described above, was defined by the score obtained on the S-anxiety and T-anxiety subscales reported by the population on the State-Trait Anxiety Inventory (Spielberger et al., 1983). Ethics at-risk behavior was defined by the population's score on the Ethics-At Risk Test (Brock, 1997).

The data were analyzed by multiple regression using State Anxiety and Trait Anxiety as factors expressed below as:

$$Y_i = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + e_i$$

where:

Y_i = the Ethics at-Risk score for therapist *i*,

β_0 = the intercept or expected value of Y if all variables equal 0,

β_1 = the standardized regression coefficient for State Anxiety,

X_1 = the State Anxiety score for therapist *i*,

β_2 = the standardized regression coefficient for Trait Anxiety,

X_2 = the Trait Anxiety score for therapist *i*, and

e_i = the standard error for therapist *i.*

The null hypothesis, expressed as:

$H_0 : \rho^2 = 0$

And were tested for statistical significance with the following formula:

$$F = \frac{R^2/k}{(1-R^2)/(N-k-1)}$$

where:

k = number of variables

N = sample size

Then it was compared with the critical value *F (.05; 2; n-2-1)* to determine whether the null is accepted or rejected. In addition, a power analysis examining the probability of having made a Type II error was conducted. First, the effect size was computed as follows:

$$f^2 = \frac{R^2}{1-R^2}$$

To obtain the power estimates, the effect size was converted to a "non-centrality parameter":

$$\lambda = f^2 (df_{\text{numerator}} + df_{\text{denominator}} + 1)$$

In the event that the null hypothesis was rejected, the part correlations for each IV (S-anxiety and T-anxiety) would have been be computed as follows:

$$r_{12.3} = \frac{r_{12} - r_{13}r_{23}}{\sqrt{1-r_{13}^2}\sqrt{1-r_{23}^2}}.$$

These squared partial correlations would have been used to describe the proportion of variance accounted for by these variables in ethics at-risk scores (ΔR^2).

Exploratory Analyses

Several analytical procedures were employed to address each of the research questions that guide the exploratory portion of this study. The analyses selected for each research question are discussed below.

First, the overall level of ethics at-risk behaviors, caregiver stress, compassion fatigue, burnout, compassion satisfaction, and satisfaction with life were computed and reported for the sample. These computations were completed by use of descriptive statistics that included the mean, range, variance, and standard deviation of the respondents' scores on each of the instruments measuring these variables. Following the report of the scores for these six factors, the data from the sample was utilized to address the remaining two research questions of this study.

Research question 1. *Is there a relationship between ethics- at-risk behaviors and the demographic/work situation factors reported by the population of this study?* Semi-partial Correlation Coefficients are computed using the following formula:

$$r_{12.3} = \frac{r_{12} - r_{13}r_{23}}{\sqrt{1-r_{13}^2}\sqrt{1-r_{23}^2}}$$

between all the demographic/work situation factors (age, gender, marital status, education, professional identity, work setting, primary theoretical orientation,

years licensed as an marriage and family therapist, total hours per week worked, total clinical hours per week, and history of traumatic experience) reported by the respondents and ethics at-risk behaviors.

Research question 2. *Are there significant relationships between ethics at-risk behaviors and the remaining variables of this survey (compassion fatigue, burnout, compassion satisfaction, satisfaction with life) with this population?* Multiple regression analysis using these four variables as predictors was utilized to build the following prediction model:

$$Y_i = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + e_i$$

where:

Y_i = the Ethics at-Risk score for therapist *i*,

β_0 = the intercept or expected value of Y if all variables equal 0,

β_1 = the standardized regression coefficient for compassion fatigue,

X_1 = the compassion fatigue value for therapist *i*,

β_2 = the standardized regression coefficient for burnout,

X_2 = the burnout score for therapist *i*,

β_3 = the standardized regression coefficient for compassion satisfaction,

X_3 = the compassion satisfaction score for therapist *i*,

β_4 = the standardized regression coefficient for satisfaction with life,

X_4 = the satisfaction with life score for therapist *i*, and

e_i = the standard error for therapist *i.*

Each of the variable's standardized regression weight in the four-predictor model was examined to determine which predictors are statistically significant at a

0.05/k level of significance. In addition, the Browne (1975) formula was computed as follows:

$$R_B^2 = \frac{(N-k-3)\left(R_E^2\right)^2 + R_E^2}{(N-2k-2)\left(R_E^2\right) + k}$$

to describe how well the model with variables determined to contribute significantly to explaining the variance will predict given new data. The results from the analyses of the hypothesis testing and exploratory sections of this study are reported in Chapter 4 and discussed in Chapter 5.

CHAPTER 4
RESULTS

Introduction

This chapter presents the results of the data analysis regarding the relationship between caregiver stress and “ethics-at-risk” behavior among licensed marriage and family therapists in the state of Florida. First, procedurally, the chapter includes the contents of the survey packets that were designed to collect the data for the study and discusses the group of respondents that made up the actual sample of the study. Second, it describes and discusses the distribution of the sample respondents according to a number of demographic variables. Third, the chapter presents the statistical results for the testing of the null hypothesis of the study, which sought to discover whether there is a significant relationship between caregiver stress and “ethics-at-risk” behaviors among this group of therapists in the State of Florida. Finally, this chapter reports and discusses the results of the statistical analyses for the eight other exploratory research questions related to licensed marriage and family therapists in Florida related to the issues surrounding “ethics-at-risk” behavior.

Sample

Eighty-three survey packets were returned by April 30, 2004. One was returned blank and discarded thus making the sample size 82 (14.9% of 549). This response rate was lower than expected and less than similar studies.

Data Review

Upon review of the 82 returned surveys, 12 (14.6%) had instances of missing data (28 items). These 28 items of missing data were scattered throughout all the instruments of the survey. Each unanswered item was replaced with the mean for that item computed from the remaining sample (Cohen & Cohen, 1983).

Scores from each of the six instruments used in this study were reviewed using scatter plots and statistical analyses to determine outliers, skewness, and

kurtosis (See Appendix C for scatter plots). In review of the scores of the Ethics At-Risk Test, one outlier (ID # 51) was discovered and removed from the sample. The relatively high scores for skewness for this sample prompted the researcher to test this sample for normality using the One-Sample Kolmogorov-Smirnov Test (SPSS, 2003). Scores for the Ethics At-Risk Test (Z=1.67; p=.007), Compassion Fatigue Subscale (Z=1.26; p =.082), and the Satisfaction with Life Scale (Z=1.45; p=.031) were all significantly non-normal in their distribution when comparing predicted scores with actual scores. According to Sterns (1996), however, as long as the points on the graph of the standardized residuals (r_i) versus the predicted values ($\hat{y}_i$) are scattered evenly along a horizontal line defined by $r_i = 0$ showing no patterns or clustering then, even though the sample may be non-normal, then the assumptions of the linear regression remain tenable. A copy of these plots may be found in Appendix C.

Table 1

Descriptive Statistics

	Mean	Median	Mode	SD	Variance	Skewness	Kurtosis
Ethics At-Risk (n=81)	2.48	2.00	2.00	1.86	3.48	.64	-.15
STAI (n=82)	57.86	55.00	48.00	8.79	77.32	-.97	.52
Compassion Fatigue (n=82)	6.68	6.00	4.00	4.42	19.53	.90	.24
Burnout (n=82)	8.74	8.50	12.00	4.06	16.49	.35	.26
Compassion Satisfaction (n=82)	42.29	43.00	48.00	5.50	30.24	.92	1.14
Satisfaction With Life (n=82)	28.49	29.50	30.00	5.66	32.03	-1.90	2.97

Table 1 provides a synopsis of the descriptive statistics for the instruments measuring the dependent and independent variables of this study.

Demographic Data

The demographic data of the sample for this study is summarized in Table 2 below.

Table 2

Demographic Data

Demographic Characteristic	Gentry (2004)	Brock and Coufal (1994)
Response rate	82/549 (14.9%)	540/1000 (54%)
Age	52.88 years (mean) 28 to 77 years (range)	30-45 years (48.7%) 46-55 years (32.6%) 55+ years (17.9%)
Gender	64.6% female 35.4% male	49.7 % female 50.3% male
Marital Status	75.6% married 9.8% divorced/ separated 6.1% monogamous partnership 4.9% single 3.7% widowed	None reported
Highest Degree Completed	56.1% master's 37.8% doctoral 1.2% bachelors 4.9% other	56.9% master's 41.1% doctoral
Professional Identification	96.3% MFTs 2.4% psychologists 1.2% social workers	52.2% MFTs 13.7% psychologist/ psychiatrist 12.2% social worker 4.1% clergy 2.4% educator
Work Setting	46.3% solo practice 30.5% group practice 9.8% multiple work settings 7.3% clinic/mental health agency 1.2% hospital 1.2% residential 3.7% other	56.5% private office 20.6% clinic or agency None further reported
Primary Theoretical Orientation	21.3% cognitive behavioral 20.0% other systems theory 15.0% Gestalt 11.3% structural systems theory 11.3% strategic systems theory 8.8% Bowenian systems theory 8.8% psychodynamic 3.7% trauma model	28.9% family systems 13% psychoanalytic None further reported

Table 2 continued

Years Licensed as MFT	13.96 years (mean) One to 44 years (range)	Not reported
Total Hours Worked per Week	34.14 hours (mean) Five to 60 hours (range)	Not reported
Total Hours Worked per Week (Clinical)	22.85 hours (mean) Zero to 55 hours (range)	< 10 hrs 12.8% 10-20 hrs 21.1% 20-25 hrs 31.9% 25-34 hrs 24.0% > 35 hrs 10.2%
Traumatic Event	86.3% at least one traumatic event	Not reported

Hypothesis Testing

The central objective of this study is to determine whether there is a significant relationship between caregiver stress and EAR behaviors in the collected sample. In Chapter I the null hypothesis of this study was identified as H_0: *There is no relationship between caregiver stress and "ethics at-risk" behaviors among a sample of Licensed Marriage and Family Therapists in the State of Florida.* In this hypothesis caregiver stress is defined as the combined scores of the State-Trait Anxiety Inventory (Speilberger et al., 1984) for each participant. EAR behaviors, the dependent variable, are defined by sample scores on the EARTMFT *(*Brock, 1997).

The degree of relationship between the two variables of the hypothesis was tested by Pearson Product-Moment Correlation (r=.205; p=.070). This statistic demonstrated that there is no statistically significant relationship between caregiver stress and ethics at-risk for this sample.

The hypothesis of a significant relationship between caregiver stress and ethics at-risk was suggested by several researchers detailed in Chapter II (Brock & Coufal, 1994; Pope & Vasquez, 1999; Pope, Tabachnick, & Keith-Spiegel, 1987; P Thoreson, Miller, & Kraskopf, 1989) and was adopted as the primary research hypothesis of this study. However, in review of the above data, the null hypothesis for this study could not be rejected. At least among this sample of LMFTs of Florida no claim can be made that caregiver stress is significantly associated with at-risk ethical practice.

Exploratory Research

Each of the exploratory items addressed in this section produced interesting data and raised many questions that have yet to be researched. In hopes of enhancing understanding into some of the potential causes for ethically at-risk behaviors among LMFTs, this study explored several additional measures. While sample size and the exploratory nature of this portion of the study prevent reliable generalization to the population of LMFTs in the United States and the mental health community as a whole, it is hoped that this exploration will point the direction for fruitful future investigation.

Ethics at-risk Behaviors. Simple descriptive statistics of the EARTMFT (Brock, 1997) were utilized to report scores on this variable from the sample. There were a total of 202 affirmative responses on the EARTMFT by the sample of 81 respondents from this sample. The mean score reported by the sample of this study was 2.48 (N=81; SD=1.86). The scores ranged from no "yes" responses on the 20 items to a maximum of eight "yes" responses by one respondent.

Table 3

Scoring Criterion for the EARTMFT*

0	Excellent, you are nearly risk free.
1 – 2	Review your practice. Read and follow the Ethics Code.
2.48	**Mean Sample Score for Ethics At-Risk***
3 – 4	Review your practice for problem areas. Consider needed changes.
5 – 7	Consult a supervisor. You are engaging in high-risk behavior.
8+	Probably you have already harmed clients. Seek therapy and supervision. Come to terms with your situation by making immediate changes.
* Brock's (1997) scoring criterion with the mean from this sample inserted.	

As is represented in Table 3 above, the mean score of 2.48 on the EARTMFT reported by the sample of this study indicate a mild-to-moderate risk for compromising their ethical behavior. The advice to this sample of Marriage and Family Therapists from Brock (1997), the chairperson of the American Association of Marriage and Family Therapist's Ethics Committee, would be between "Review your practice. Read and follow the Ethics Code" and "Review your practice for problem areas. Consider needed changes."

Table 4

EARTMFT Responses

Item	"Yes"	N	%
1. Is it true that you have never taken an academic course on MFT practice ethics.	15	80	18.8
2. Honestly, are you unfamiliar with some parts of the latest version of the Ethics Code?	43	81	53.1
3. Does the Ethics Code interfere somewhat with the quality of your therapy or research?	4	80	5.0
4. Have you ever sent a false bill for therapy to an insurance carrier?	10	81	12.3
5. Do you feel sexually attracted to any of your present clients?	8	81	9.9
6. Do you fantasize about kissing or touching a present client?	3	81	3.7
7. Do you comment to a present client how attractive he or she is or make positive remarks about his or her body?	13	80	16.3
8. Are you tempted to ask out an ex-client even though two years have not passed since termination?	3	81	3.6
9. Do you commonly take off your jewelry, remove shoes, loosen your tie, or become more informal during therapy sessions?	8	80	10.0
10. Presently do you meet a client for coffee or meals or for socializing outside of therapy?	2	80	2.5
11. Has a present client given you an expensive gift or frequently gives you small gifts?	7	80	8.8
12. Are you stimulated by a current client's description of sexual behavior or thoughts?	5	80	6.3
13. Are you in the midst of a difficult personal or family crisis yourself?	17	80	21.3
14. During the past two months, have you seen clients while you were hung over or under the influence of drugs even if only a little?	0	81	0.0
15. Does your personal financial situation cross your mind when considering whether to terminate therapy or to refer a client?	14	80	17.5
16. Do you feel manipulated by a current client such that you are wary of them or are angry and frustrated by them?	19	80	23.8
17. Do you provide therapy to a current student, supervisee, or employee?	1	80	1.3

Table 4 continued

18. Have you wanted to talk to a colleague about a current case but feared doing so would show your lack of skill or lead to an ethics case against you?	4	80	5.0
19. Are you behind on case notes?	20	81	24.7
20. Do you talk about clients with other clients or gossip about clients with colleagues?	6	80	7.6
Total At-Risk Behaviors reported by sample	202		
Mean Score	2.48		

Table 4 above provides a review of number of respondents from the sample who responded affirmatively to each item and the percentage from the sample of valid responses that this number represents. The item of the EARTMFT (#2) with the most responses (n=43) identifies over 50% of the sample as being unfamiliar with parts of the AAMFT Code of Ethics.

An important finding emerges when reviewing the reliability data of the EARTMFT (Brock, 1997) used with this sample. As previously discussed in Chapter III, Brock has failed to report any psychometric properties for his instrument (Brock, personal communication, 2002). Unavailability of this important information led to the pilot testing of the reliability of this scale with a sample of convenience prior to beginning this study. Data collected from the volunteers who agreed to participate in this pilot produced a Chronbach's alpha score of .66 and a Guttman's split-halves score of .60 (N=21). These scores are at the lower end of what is traditionally acceptable as levels of reliability for a dependent variable (Thompson, 1989). However, since this was the only instrument in existence that measured "ethics at-risk" for MFTs, the instrument was included in this study. For this study, the reliability data for the Ethics At-Risk Test was disappointing with a Chronbach's alpha score of .45 (N=78). By removing the first two items from the scale and recalculating the reliability, the

alpha score improves to .55, but this number is still unacceptably low for a dependent variable.

Caregiver Stress. *D*escriptive statistics of the sample's responses on the *State-Trait Anxiety Inventory* (Speilberger et al, 1983) were utilized to address this variable. The mean score reported on the STAI-Y Form 1 Licensed Marriage and Family Therapist Version was (i.e., state anxiety) 29.12 (N=83; SD=7.85)). The mean score of the STAI-Y Form 2 Licensed Marriage and Family Therapist Version (i.e., trait anxiety) was 28.74 (N=83; SD=6.62). The sum mean score of the STAI-Y Forms 1 and 2, which is the score utilized in this study to determine "caregiver stress," is 57.86 (N=83; SD=8.79). The range reported on the combined forms extended from 24 to 64.

Spileberger et al. report reliability alphas of .93 for the state anxiety version (N=1836) and .91 for the trait version (N=1836) of the STAI with this working adult population. The reliability alphas with the sample of this study for the STAI are .87 (N=83) for both the state and trait anxiety versions.

Compassion Fatigue. Investigation into the level of compassion fatigue experienced by the MFT utilizes the compassion fatigue subscale from Stamm's (2002) Pro-QOL. The mean score on this subscale reported by the sample was 6.68 (SD=4.42) with a range of scores from zero to a maximum of 19, still well below any level of risk. According to Stamm, any summative score less than 27 on this subscale is considered low risk for compassion fatigue.

The reliability for this subscale was good for this sample with a Chronbach's alpha score of .78 (N=80). This score compares favorably with Stamm's (2002) reported reliability of .87 as noted in the previous chapter.

Burnout. This sample reported a mean score on the burnout subscale of the Pro-QOL of 8.74 (SD=4.06). As with the scores for compassion fatigue, the risk of burnout for this sample of MFTs is very low (< 28 = low risk). As with the previous research question, no one in this sample came close to high-risk scores.

The reliability for the *burnout subscale* from this sample was significantly lower than that for the *compassion fatigue subscale* and the *compassion*

satisfaction subscale (see below), with a Chronbach's alpha score of .56 (N=80). Stamm (2002) reports a reliability alpha score of .90 for this subscale. It is unclear why this particular subscale suffered a lowered reliability when two other subscales from the same instrument performed excellently in this arena.

Compassion Satisfaction*.* Stamm (2002) reports that the compassion satisfaction subscale of the Pro-QOL measures the respondent's level of satisfaction in their professional caregiving role. However, she also indicates that this subscale measures professional hardiness and resiliency. She demonstrated this by performing convergent validity analyses for the Pro-QOL with accepted measures of these traits in her development of this instrument. In this study's sample of LMFTs, compassion satisfaction was extremely high with a mean score of 42.29 (SD=5.50). The cut-off score (95th percentile) for "moderate to high satisfaction" is 20 and above. The score from this sample more than doubles this cut-off score.

The reliability data of this research subscale is quite good with an alpha score of .87 (N=81). Stamm reports a reliability alpha of .87 in her development of the compassion satisfaction subscale as noted in the previous chapter.

Satisfaction With Life*.* The mean score on the Satisfaction with Life Scale (Diener, Emmons, Larson, & Griffin, 1985) for this sample was 28.49 (SD=5.66). The range of scores was from four to the maximum possible score of 35. The case (#77) with the lowest score of four was due to this participant completing only one response of the SWLS, leaving the other four items blank. When this subject's low score total is replaced with the mean score (28.49), the sample mean score rises to 28.79 (SD=4.95; N=82). Nine respondents (10.8%) from this sample reported the maximal score of 35 on the SWLS.

Table 5

SWSL Scoring Interpretation*

35-31	Extremely satisfied
28.79	**SWLS Mean Scores from MFTs (N=82)**
26-30	Satisfied

Table 5 continued

21-25	Slightly satisfied
20	Neutral
15-19	Slightly dissatisfied
10-14	Dissatisfied
5-9	Extremely dissatisfied
* Diener et al.'s (1985) scoring interpretation for the SWLS with the mean score from this sample inserted.	

Diener et al. (1985) reports reliability data for the SWLS with test-retest coefficients (.82) and coefficient alpha (.87). The reliability alpha for the sample from this study was comparable at .86.

Two additional formal research questions were put forward in Chapter 1. The following section reports the results of the analyses for these questions.

Research Question 1. *Is there a relationship between "ethics at-risk" behaviors and the demographic/work situation factors reported by the sample of this study?*

Table 6

Partial Correlations between Demographic Variables and Ethics At-Risk

Demographics	$r_{x.y}$	***p***
Age	.035	.755
Gender	-.020	.874
Marital Status	.047	.703
Highest Degree Completed	-.157	.204
Professional Identification	.147	.237
Work Setting	-.188	.127
Primary Theoretical Orientation	-.177	.152
Years Licensed as MFT	-.014	.911
Total Hours Worked per Week	.129	.298
Total Hours Worked per Week (Clinical)	.045	.720
Traumatic Event	.039	.756

As is demonstrated in by the partial correlations reported in Table 6, no demographic variable is able to demonstrate a significant correlative relationship with EARTMFT scores for this sample. When these variables are entered into a multiple regression model, the entire model accounts for only 2.8% of the variance (R^2Adj=.028, SE=1.87). No demographic factor or combinations of these factors emerge as significant predictors of variance in Ethics At-Risk scores.

Research question 8. Are there significant relationships between "ethics at-risk" behaviors and the remaining variables of this survey (compassion fatigue, burnout, compassion satisfaction, satisfaction with life) in this sample? The Pearson Product-Moment Correlation statistics between the remaining variables and EAR are reported below in Table 7.

Table 7

Pearson Product-Moment Correlations Among Dependent Variables

Variable	***r***	***p (<.05)***
Compassion Fatigue	.340	.001
Burnout	.287	.005
Satisfaction with Life	-.233	.018
Compassion Satisfaction	-.093	.204

As is reported in the above table, three predictors have a small relationship with EAR scores at the.05 level. These are compassion fatigue, burnout, and satisfaction with life. Compassion satisfaction fails to achieve a statistically significant relationship with ethics at-risk scores.

In Chapter III, it was stated that this research question would be answered by constructing a multiple linear regression model with these four variables. This model is described as:

$$Y_i = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + e_i$$

where:

Y_i = the "Ethics-at-Risk" score for therapist *i*,

β_0 = the intercept or expected value of Y if all variables equal 0,

β_1 = the standardized regression coefficient for compassion fatigue,

X_1 = the compassion fatigue value for therapist *i*,

β_2 = the standardized regression coefficient for burnout,

X_2 = the burnout score for therapist *i*,

β_3 = the standardized regression coefficient for compassion satisfaction,

X_3 = the compassion satisfaction score for therapist *i*,

β_4 = the standardized regression coefficient for satisfaction with life,

X_4 = the satisfaction with life score for therapist *i*, and

e_i = the standard error for therapist *i.*

In building this regression model, however, compassion fatigue is the only dependent variable included by SPSS in its automated modeling analysis. The remaining variables (burnout, compassion satisfaction, and satisfaction) fail to provide significant contributions to the model when the effects of compassion fatigue are partialled out and therefore excluded from the regression model.

Table 8

Regression Summary

Model	R	R Square	Standard Error	Sig F Change
Compassion Fatigue	.340	.115	.098	.002
Burnout	.287	.082		
Satisfaction with Life	-.233	.054		
Compassion Satisfaction	-.093	.009		
Total model	.380	.145	1.76	.018

Table 9

ANOVA for Total Model and Compassion Fatigue

Model	Sum of Squares	df	Mean Square	F	Sig
Regression$_a$	39.360	4	9.840	3.172	.018
Residual$_a$	232.627	75	3.102	232.627	
Total$_a$	271.988	79			

Table 9 continued

Regression$_b$	31.121	1	31.121	10.040	.002
Residual$_b$	244.879	79	3.10		
Total$_b$	276.000	80			

$_a$ = Model with predictors of compassion fatigue, burnout, satisfaction with life and compassion satisfaction included; ethics at-risk is dependent variable

$_b$ = Model with only compassion fatigue as predictor; ethics at-risk is dependent variable

Table 10

Coefficients

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	.719	2.156		.334	.740
Compassion Fatigue	.105	.052	.253	2.025	.046
Burnout	.071	.064	.157	1.111	.270
Satisfaction with Life	.044	.044	.130	.991	.325
Compassion Satisfaction	-.048	.045	-.129	-1.062	.292
(Constant)	1.564	.354		4.411	.000
Compassion Fatigue	.140	.044	.336	3.169	.002

Tables 8 – 10 provide a detailed review of the regression statistics. Tables 8 - 10 compare the total model including all four predictors with the revised model that contains the only significant predictor for EAR scores—compassion fatigue. Therefore, the regression model for EAR scores predicted by the instruments of this study becomes:

$Y_i = \beta_0 (1.56) + \beta_1 (0.14)$ *Compassion Fatigue Score* (x) + $e_i (0.44)$, or

$Y_i = 1.56 + (0.140)$CF Score + 0.44.

This model indicates that compassion fatigue scores account for about 14% of the variance in EAR scores. While the relationship between EAR and compassion fatigues scores does achieves statistical significance with this

sample, the reader is reminded that the R^2 for compassion fatigue is very small predicting only about 14% of variance in EAR scores.

While the results of this study differ from the results that were predicted, many interesting and important findings were discovered. In Chapter V, the researcher will present: (1) a clear and comprehensive summary of the dissertation and its research; (2) certain implications related to the procedures and findings of this study; (3) some practical and logical recommendations for future research; and (4) a sketch of the broader context of the problem that brought rise to this study.

CHAPTER 5
DISCUSSION

Introduction

This final chapter discusses the findings of this study and their relativity to the field of Marriage and Family Therapy It is divided into five sections with the first section providing a review and interpretation of the findings associated with the hypothesis and research questions that guided this study. The next section identifies and discusses the limitations and shortcoming of this study. Informed by this study's findings and limitations, the next section offers implication for research and theory development in this field of investigation. These implications are followed by an exploration into the implications for training, education, and practice in marriage and family therapy. The final section of this chapter provides a succinct review and summary of the study.

Demographic Data

The findings from this study are compared with Brock and Coufal's (1994) similar study in which they surveyed 1000 Clinical Members of the AAMFT. First, in comparing the sample from this study (N=82) with the sample from Brock and Coufal's 1994 study (N=540), the demographic data from this study is in general accordance with their findings. The three figural differences that emerge are response rate, age, and gender differences.

Brock and Coufal (1994) enjoyed a response rate of 54% of their 1000 surveyed while the current study achieved only about 15%. One possible explanation for this gap between the two samples, in addition to those offered above, may be that Brock and Coufal (1994) had the official sanction of the American Association of Marriage and Family Therapists. Respondents may have felt more compelled to respond to such a request from this member organization as opposed to the current dissertation study that offers no such affiliations.

While Brock and Coufal (1994) did not report the mean age of their sample, it is clear from the above table that the participants of the current study (mean=52.88 years; SD=10.48) are somewhat older than those from the AAMFT study. This difference may be, in part, due to the possibility that LMFTs in the State of Florida may be older than the general Clinical Membership of the AAMFT, which has a high student member population. However, without access to these data the causes for the age differences between these two samples is only speculation.

Of the 82 respondents for this study, 53 were female (64.6%) and 29 were male (35.4%). These statistics are contrasted with the nearly equal representation of males and females in the Brock and Coufal study (49.7 % female and 50.3% male). In addition to the possibility that female LMFTs in Florida may be more likely to respond to the survey, one further explanation for the higher number of female responses is that there may be more females than males licensed as LMFTs in Florida. The Florida Department of Health does not identify gender in their published data of licensees so this quantity remains unknown.

In reporting marital status, four were single (4.9%), 62 were married (75.6%), five identified themselves as being in a monogamous partnership (6.1%), eight were divorced/separated (9.8%), and three were widowed (3.7%).

Academically, the highest degree completed by the sample included one bachelor's degree (1.2%), 46 master's degrees (56.1%), 31 doctoral degrees (37.8%), and four "others" (4.9%).

Almost every respondent reporting professional identification (n=79, 96.3%) said their primary professional identity was as a "Marriage and Family Therapist." Two identified themselves as psychologists and one as a social worker.

Regarding work setting, solo practice was the most frequently reported work setting (n=38; 46.3%) followed by group practice (n=25; 30.5%), clinic/mental health agency (n=6; 7.3%), hospital (n=1; 1.2%), residential (n=1;

1.2%), and other (n=3; 3.7%). Eight respondents reported working in multiple work settings (9.8%).

Responses on primary theoretical orientation were more evenly distributed among the several item choices. “Cognitive Behavioral” was the most endorsed theoretical orientation with 17 responses (21.3%). CBT was followed closely by “Other Systems Theory” (n=16; 20.0%) and “Gestalt” (n=12; 15.0%). Nine respondents identified themselves as “Strategic Systemic” and another nine as “Structural Systemic” (11.3%). “Bowenian Systemic” and “Psychodynamic” approaches were tied both with seven responses (8.8%) each. Three respondents identified themselves as primarily following a “Trauma Model” (3.7%).

The sample from this study reported 13.96 (SD=8.36) as the mean number of years licensed as an MFT, while the range reported by the respondents stretched from one to 44 years of practice.

Total hours per week worked by the respondents of this sample averaged 34.14 hours per week (SD=13.56) with a range of five to 60 hours. While these same respondents reported “working” 34 hours per week, they practiced marriage and family therapy only about an average of 23 hours per week (mean=22.85; SD=13.66) with a range from zero to 55 hours worked each week in this capacity.

Finally, 69 of the sample of 82 (86.3%) reported that they had experienced at least one traumatic event throughout the course of their life. Thirteen answered “no” to this question.

Hypothesis Testing

This study was designed with two separate sections of investigation—hypothesis testing and exploratory research. The results obtained from the collection and analysis of data from the participants of this study for both sections are summarized in Table 11 below followed by a discussion of the findings for each of these guiding tenets.

Table 11.

Summary of Findings

Research Questions	Findings
Null Hypothesis: There is no relationship between caregiver stress and ethics at-risk behaviors among Licensed Marriage and Family Therapists in the state of Florida.	• No relationship; could not reject null hypothesis • Poor response • High functioning sample • Poor psychometric properties of the DV instrument
• *What is the overall level of ethics at-risk behaviors reported by a randomly-selected sample of Licensed Marriage and Family Therapists in the state of Florida?*	• Mean of 2 behaviors per respondent; 202 total behaviors reported by 82 respondents • Over 50% were unfamiliar with parts of the AAMFT Code of Ethics • Low number of respondents reported sexual attraction or difficulties with relational/boundary issues • Significant difference between males and females on relational items (males more frequently reported EAR thoughts and behaviors) • Poor psychometric properties of the instrument
• *What is the overall level of caregiver stress reported by this population*?	• Mean score for sample significantly lower (> than one SD unit) than normative population • MFTs report higher stress at work than in other areas of their lives • This study provides baseline data for future utilization of STAI with MFT population
• *What is the overall level of compassion fatigue reported by this sample?*	• Mean score 6.68; high score 19 • Highest score reported by sample still lower than the "high-risk" cut-off for compassion fatigue (> 27) • Even though LMFTs report heightened stress from their work, they do not seem to suffer compassion fatigue symptoms

Table 11 continued

• *What is the overall level of burnout reported by this sample?*	• Mean score 8.74 • Highest score reported by sample still lower than the "high-risk" cut-off for burnout (> 28) • Even though LMFTs report heightened stress from their work, they do not seem to suffer burnout symptoms • Weak reliability for this subscale (r=.56)
• *What is the overall level of compassion satisfaction reported by this sample?*	• Mean score 42.29 • More than doubles the cut-off score for "moderate to high satisfaction" (> 20) • Sample LMFTs are extremely satisfied with their work and very resilient
• *What is the overall level of satisfaction with life reported by this sample?*	• Mean score 28.49 • Between "satisfied" and "extremely satisfied" with life according to scoring criterion • Low psychopathology • Well adjusted • Good health
1. Is there a relationship between ethics at-risk behaviors and the demographic/work situation factors reported by the sample of this study?	• No significant part correlations found with any demographic characteristic or combination of characteristics • R^2 for all demographics = .028
2. Are there significant relationships between ethics at-risk behaviors and the remaining variables of this survey (compassion fatigue, burnout, compassion satisfaction, satisfaction with life) with this sample?	• Compassion fatigue, burnout, and satisfaction with life had small significant correlation (r = .23 to .34) • Only compassion fatigue emerged as significant predictor of variance in EAR scores (R^2 = .14; *p* = 002)

A total of 82 (14.9%) useable responses on the 106-item survey were collected from the randomly selected sample of 549 of the 1099 Licensed Marriage and Family Therapists residing in Florida between February 1 and April

30, 2004. This response rate was less than expected and less than previous studies of similar design. The demographic characteristics of the sample for this study, however, were similar to a large previous study of AAMFT Clinical Members (Brock & Coufal, 1994) with the exception that the current study's sample was older and contained significantly more females.

An attempt was made to compare the demographic distribution of this sample with the larger population of all LMFTs in the State of Florida. However, through telephone contact with the Department of Health's Licensing Division the researcher learned that demographic information is not solicited nor maintained for licensees in Florida.

One possible reason that may partially explain this low response is that the surveys dealt with sensitive material potential respondents may have found uncomfortable answering. Even with assurances of anonymity explained in the cover letter and informed consent, positive answers on some of the survey items could have negative ethical and legal repercussions if their anonymity were breached.

An additional possibility for the lowered response rate may have been is that a survey containing 106 total items could have been perceived as too time-intensive and overwhelming for many potential respondents. Other factors such as time of year, syntax of the cover letter, address errors, and intrapersonal issues of the potential respondents could have also affected the response rate.

Null hypothesis. *There is no relationship between caregiver stress and ethics at-risk behaviors among Licensed Marriage and Family Therapists in the state of Florida.* In testing the research hypothesis of this study, no significant relationship between caregiver stress was found, as defined by scores on the STAI (Speilberger, et a., 1982) and EAR behaviors .Thus, the null hypothesis could not be rejected; that it cannot be said that caregiver stress has a significant effect upon the reporting of EAR behaviors among Florida's LMFTs.

As is discussed below this sample of LMFTs is remarkably healthy, as indicated by the mean scores of the independent variables (e.g., state-trait anxiety, compassion fatigue, burnout, compassion satisfaction, and satisfaction

with life). This significantly non-normal positive skewness, may partially explain why no significant relationship was found between the two variables. However, a significant relationship was discovered between compassion fatigue and EAR scores.

One interesting interpretation of the findings that merits mentioning is that while the investigation of the relationship between caregiver stress and at-risk ethical practice did not yield significance, the mirror-image of the research hypothesis presently comes into focus. It was hypothesized in Chapter 1 that caregivers who are experiencing higher levels of stress were more likely to engage in at-risk ethical behaviors. Are caregivers who experience *lower* levels of stress and heightened health *less* likely to engage in at-risk ethical practice? With the low scores from the sample on the EARMFT coupled with their scores from the remaining measures, which describe an exceedingly healthy group, the data seemingly supports this idea. If the sample from this study truly represents a portion of the population of caregivers that is significantly skewed in the direction towards health and the absence of stress-related symptoms then the results of this study could be said to support the theoretical constructs underpinning this study. According to this theory (Scaer, 2005) individuals experiencing lower levels of stress enjoy higher levels of neocortical functioning and are thus able to reason and act in ways that are organized and intentional (i.e., ethical). Conversely, individuals who are experiencing higher levels of stress are diminished in their neocortical functioning and are more likely to engage in compulsive, reactive, and disorganized behavior (i.e., at-risk). Or, stated in Bowenian language, more differentiated individuals are less symptomatic and less likely to engage in behaviors which cause harm to themselves or others. The findings from this study, with its healthy and resilient sample, align with this view.

Exploratory Research

Since there were no significant positive or negative correlations between caregiver stress and EAR behaviors, this study explored the possibility of relationships with other variables that may help to determine factors causing

these EAR behaviors among marriage and family therapists. Overall scores for the sample were reported for the variables of: ethics at-risk behaviors, caregiver stress, compassion fatigue, burnout, compassion satisfaction, and satisfaction with life. These data, along with results for the two research questions that helped guide this study, are discussed below.

Ethics At-risk Behaviors. In reviewing the overall level of EAR behaviors reported by the sample it was found that nearly every respondent identified at least two behaviors in which they engaged. According to Brock's (1997) scoring criteria, this number represents that the sample is at mild-to-moderate risk for ethical violations in their practice. Over 50% of the respondents from this study reported that they were unfamiliar with parts of the AAFT Code of Ethics. It is easily reasoned that if an LMFT is unfamiliar with the Code, how can they be certain that they are practicing within its guidelines? This lack of awareness of the Code seems, by definition, to be an at-risk situation for over one-half this sample. Add these responses to Item #1, which indicates that nearly 20% of the sample has never had an academic course on MFT practice ethics, and an argument for continuing education in practice ethics might be a prudent requirement for licensure renewal. Awareness of the AAMFT Code of Ethics and its subsequent integration into MFT practice is an area that bears further investigation. In item # 16, nearly one-quarter of the sample (n=19) indicated that they felt wary of or frustrated by a current client. While this may not represent a breach of practice ethics, it does point towards situations that could potentially produce caregiver stress and subsequent compassion fatigue and/or burnout. A simple correlational analysis failed to yield any significant relationships between this item and any other item of the EARTMFT.

In item # 4 respondents are asked to indicate if they have ever submitted a false bill to an insurance carrier for therapy. Ten subjects reported that they had committed this breach in ethics and illegal activity at least one time in the past. This item is the only one of the twenty that identifies a blatant violation of both ethics code and statute law and that one in eight of the respondents

reported at least one occurrence of this behavior in their professional practice is significant and merits further investigation, if not intervention.

Items #5, #6, #7, #8, #10, and #12 all focus upon the issues of sexual stimulation and potential boundary violations in the therapeutic relationship. Response frequencies were generally low in this subset of items.

According to Borys and Pope (1989), a predictable progression exists for many psychologists, psychiatrists, and social workers who violate boundaries and engage in sexual relations with clients. They identify this progression as beginning benignly with attraction towards a client and then continuing with volitional fantasizing about the client. This process continues when the therapist meets the client outside the therapy relationship for social engagements or "special" work before culminating with the development of a romantic/sexual liaison. Using this model to view the data, Items #5, #6, and #10 can be utilized to represent this progression with the LMFTs of this sample. Eight LMFTs (10%) identified themselves as feeling sexually attracted to their clients. This percentage is significantly lower than Borys and Pope, who reported that 21% of their sample routinely experienced sexual attraction toward clients. It is also lower than Nickell, Hecker, Ray, and Bercik. (1995), in their study of 186 MFTs from which they found that 34% of the males and 14% of the females reported sexual attraction toward clients.

Caregiver Stress. In exploring this variable it was found that the MFTs of this sample's scores on the STAI (Spielberger et al., 1983) were notably lower than those of any of the normative sample groups. While the sample did report higher levels of "state anxiety," or stress during work than their normal levels of stress ("trait anxiety"), the caregiver stress experienced by this sample was minimal.

Spielberger et al. (1983) conducted several normative studies during the development of the STAI. These researchers utilized samples from four different samples: (1) undergraduate college students, (2) incarcerated adult males, (3) geriatric groups, and (4) working adults. The working adults sample was taken from males and females, ages 19 to 68, working as supervisors and high-level

management of a manufacturing company. Of the four different populations used by Spielberger et al. (1983), the working adult sample most closely resembles the sample of MFTs utilized in this study in age, education, life station, and work experience. In their sample they found a mean score for state anxiety (Y Form 1) of 35.72 for males (N=1387, SD=10.40) and 35.20 for females (N=451, SD=10.61). With this same sample, they found mean scores for trait anxiety (Y Form 2) of 34.89 for males (SD=9.19) and 34.79 for females (SD=9.22). Combined state and trait anxiety scores on the STAI for this normative sample were 70.61 for males and 69.99 for females. Since there was not a statistically significant difference between the male and female scores from this normative sample, they are averaged together to achieve a combined score of 70.30 (N=1836).

No other published studies with LMFTs that employ the STAI as a measuring instrument were found when completing the literature review for this study. Because of its utility in differentiating between the anxiety experienced while engaged in a certain activity (i.e., work) and the enduring level of anxiety that a respondent experiences during the activities of daily life this instrument should be included in more research addressing caregiver stress. The STAI data from this study will provide baseline data with professional caregivers to which future researchers may compare scores.

Compassion Fatigue*.* The data from this study showed that the MFTs of this sample reported very low scores for compassion fatigue. The mean score for this sample on the compassion fatigue subscale of the Pro-QOL (Stamm, 2002) was more than four standard deviation units below Stamm's cut-off score identifying "high-risk" for compassion fatigue.

Stamm (2002) reports that this subscale primarily measures the negative effect that the work environment has upon the professional caregiver. Ignoring the lowered reliability data for this sample, one interpretation for the low compassion fatigue and burnout scores, even when viewed with the elevated state anxiety from the STAI, could be that while MFTs of this sample do

experience stress from their work it seems to have very little deleterious effect upon them.

Burnout. Burnout represents the level of stress reported by the respondent that is attributable to work conditions or the work environment. Once again, this sample scored very low on this subscale with *all* respondents scoring well below the cut-off score for high risk.

Compassion Satisfaction. Compassion satisfaction measures the level of job satisfaction and resiliency of professional caregivers. The MFTs of this sample reported very high scores for compassion satisfaction. The mean score was more than one standard deviation until above the cut-off point for "moderate-to-high" satisfaction. Stamm (2002) has identified this subscale as both a measure of professional satisfaction and resiliency among caregiver populations. It can be said that the sample from this study enjoys a high level of professional satisfaction and are very resilient when compared to other professionals in the caregiving field.

Satisfaction With Life. The overall level of satisfaction with life, measured by the SWLS (Diener et al., 1985), for this sample is quite high. The mean score for the sample on this instrument was 28.79 out of a possible 35. This score pronounces the LMFTs of this sample, according to the scoring interpretation criterion, as being between "satisfied" and "extremely satisfied" with their lives.

In their report on the development and validation of the SWLS, Diener et al. (1985) report that their means scores in two separate study groups were 23.5 (N=176 undergraduates) and 25.8 (N=59 geriatrics). The mean scores from this sample of MFTs were significantly higher than these two normative samples. Because this measure has extensive data reporting convergent validity with many different measures, it can be said that the scores from sample from this study reflect a group that is healthy, well-adjusted, and free from psychopathology.

Research question 1. *Is there a relationship between ethics at-risk behaviors and the demographic/work situation factors reported by the sample of*

this study? This study investigated the demographic and workplace data acquired from the sample to determine if any of these factors or combination of factors significantly contributes to understanding EAR scores. No significant relationships between these demographic variables and ethics at-risk scores were found. When all the demographic factors were entered into a multiple regression equation the total R^2 was a slight.028, explaining less than 3% to the variance in EAR scores.

An interesting finding from this study is the participants' reporting of history of traumatic events during their lives. While there was no studies reporting the experience of traumatic events during the lives of caregivers found in the scientific literature, Pope's (1992) study of 290 psychologists, found 33% of the men and 70% of the women in his sample identified themselves as having some history of *abuse* (physical or sexual) sometime during their lives. This statistic seems to synchronize with the LMFTs of this study who answered the *traumatic event* item almost 90% affirmatively. This finding of a high percentage of the participants' experience with traumatic events throughout the course of their lives juxtaposed with their equally high scores for satisfaction with life and inferred physical/emotional health may indicate that this sample is an extremely resilient group and/or professionals who have addressed and resolved the effects of their past upon their present functioning. Further inquiry into this phenomenon may yield useful and interesting results.

Research question 2. *Are there significant relationships between ethics at-risk behaviors and the remaining variables of this survey (compassion fatigue, burnout, compassion satisfaction, satisfaction with life) with this sample?* Finally, the remaining four variables—compassion fatigue, burnout, compassion satisfaction, and satisfaction with life–were analyzed to determine if any of these variables had significant relationship with the dependent variable. Only compassion fatigue scores emerged with a small relationship (R^2=.140; p=.002) of significance. The significance of the part correlation between compassion fatigue and ethics at-risk behaviors (compassion fatigue scores accounting for 14% of the variance in ethics at-risk scores) among the sample, although small,

represents an important potential for future inquiry into the antecedents and correlates of ethical violations among professional caregivers and is discussed below in the Implications for Further Research and Theory Development section of this chapter.

Study Limitations

One of the most glaring limitations of this study is also one of its most important findings. The EARTMFT (Brock, 1997), utilized in this study to measure the dependent variable, was developed from a study that sampled 540 clinical members of AAMFT regarding their adherence to the Code of Ethics in their professional practice. This instrument was perfectly suited for the purpose of this study—to measure the at-risk ethical behaviors among marriage and family therapists. However, nowhere in the published or unpublished literature did the developer, who was then chairperson of the AAMFT Ethics Committee, identify the psychometric properties for this instrument. The omission of this important information in the printed literature led to the personal contact of the developer, via email, requesting this psychometric information for the instrument (Brock, personal communication, 2002). He indicated that he did not compute this information from the data he collected and requested a copy of the findings from this study if the instrument was utilized. Failure to provide psychometric information for the measurement instrument of the dependent variable led the committee directing this dissertation to require, as part of this dissertation, a pilot study of the psychometric properties for the EARTMFT. This task was completed and the reliability analysis yielded a Chronbach's alpha score of .66 and a Guttman's split-halves score of .60 (N=21). While these scores represent the extreme low end of acceptability, the EARTMFT was utilized for this study because there was no other like instruments in existence.

As was reported in Chapter 4, when the reliability data for the EARTMFT was computed for the sample of this study the results were a Chronbach's alpha score of .45 and a Guttman's split-halves score of .28 (N=78). At best, these reliability coefficients render the results of the study disputable and at worst unusable. The poor psychometric performance of the EARTMFT to adequately

and reliably measure EAR behaviors in this sample may contribute to the possibility that the findings of this study represent a Type II error, or false "fail to reject" of the null hypothesis.

The poor psychometric performance of the EARTMFT, however, has underscored the need for further analysis and development to either mature this instrument or create a new one that effectively measures at-risk ethical practice with acceptable psychometric properties. Two of the instruments reviewed previously, *The Relational Ethics Scale* (Hargrave, Jennings, & Anderson 1991) and the *Exploitation Index* (Epstein & Simon, 1990), may prove to be useful tools for quantifying at-risk ethical practice. They both do enjoy solid psychometric properties and utilizing one or both these instruments in future studies could provide baseline data for LMFTs. The need of a stable and practical instrument for measuring at-risk ethical practice is also discussed below in the Implications for Further Research and Theoretical Development section of this chapter.

Another limitation of the study is the low response rate. Based upon previous studies and published literature on survey studies of this type, a response rate between 30 – 60% was expected (Brock & Coufal, 1997; Dillman, 1987; Pope et al., 1987). However, only 83 of the sample of 549 LMFTs (14.9%) who were twice sent packets returned their surveys within 90 days. This low response rate barely satisfied the number required (n =82) for predictive models with power $\geq .80$ and $\alpha = .05$.

In hindsight it seems clear that the systematic study of the relationship between caregiver stress and at-risk ethical practice should have begun by employing qualitative methods. Structured interviews and focus groups with LMFTs would have been very helpful to (a) better understanding the context of caregiver stress and at-risk ethical practice and (b) designing a qualitative methodology that more precisely tested and explored these phenomena. Future inquiry in this area will be much more firmly grounded and greatly enhanced by employing qualitative models.

A limitation that is closely related to the lowered response rate and equally problematic is the non-normal skewness of the sample's scores. As was

reported in Chapter 4, while the data did not violate the non-normality assumptions required for linear regression the scores for the independent variables were significantly skewed in the positive direction when compared to predicted scores. This skewness was supported when the results of the scores were interpreted.

The respondents of this study seem to be of exemplary psychological and emotional health, experiencing minimal stress or stress-related symptoms. They were happy in their work and enjoyed a high level of satisfaction in both their personal and professional lives. It is reasoned that these high functioning individuals would be most likely to complete and return the surveys which asked them to review and report upon areas of their personal and professional lives that may be uncomfortable for those who were not so high functioning. It is hypothesized that the many of the LMFTs who were sent survey packets and indeed experiencing high levels of stress, stress-related symptoms, and/or engaged in at-risk ethical practices would self-select out of this study by simply not completing and returning the surveys. A more normal distribution of response scores across the spectrum of caregiver stress, compassion fatigue, burnout, compassion satisfaction, and satisfaction with life may produce higher levels of correlation with ethics at-risk scores. The significantly positive skewness of this study's sample, along with the previously discussed poor reliability of the measure for the dependent variable, represents the two greatest threats of a Type II error in reporting the results for this study.

Another limitation of the study is reliance on self report through a questionnaire format. Ideally, future research would make contact with the randomly selected research participate by phone and conduct an interview face-to-face. This would enable the investigator to judge the degree of candor and provide opportunities for probing where appropriate.

A final limitation of the study was that only LMFTs in Florida were studied. Future research should seek a national representative sample to adequately test the hypotheses.

Implications for Future Research and Theoretical Development

Emerging from a careful contemplation of the results and limitations of this study, six salient issues for the furthering research and understanding in this area have acquiesced. These five areas represent the foundation and trajectory for a program of research intended to expand the empirical understanding in this area of inquiry.

Qualitative methods. As stated above, using qualitative methods such as interviews and focus groups with LMFTs to better understand the context of caregiver stress and at-risk ethical practice is of primary importance to a program of research in this area. These methods would allow the researcher to better understand the relationship between the variables and to formulate research questions that are grounded in empiricism.

Additionally, it has been suggested that this area of study may benefit from the utilization and application of moral reasoning models. Moral reasoning, first described by Piaget in his developmental research (Bee, 1995), came to light in the late 1970s through the writings of Lawrence Kohlberg (Barger, 2000). Kohlberg believed, and demonstrated through his studies utilizing hypothetical dilemmas, that there were discreet phases through which adults matured their ability to morally reason. Informed by findings from qualitative inquiry into the context of LMFT practice, the researcher could develop a set of hypothetical dilemmas with forced choices that could better understand the factors associated with at-risk ethical practice while better calibrating its relationship with caregiver stress.

Instrument development. As has been thoroughly discussed elsewhere in this chapter, the confounding psychometric problems with the EARTMFT are conspicuous and numerous. The intended purpose of this instrument, articulated by its developer (Brock & Coufal, 1997), was to augment the preventive role of an ethics code by alerting practitioners to their current level of vulnerability/liability for violations of AAMFT Code of Ethics. Additionally, this instrument is an excellent tool for initiates in marriage and family therapy to both learn the AAMFT Code of Ethics and to begin practice within its guidelines. Finally, this instrument is important for furthering research into the antecedents,

mitigating conditions, and modulating factors to violations of ethical practice by identifying the explicit behaviors and implicit beliefs associated with at-risk practice.

This instrument needs further development to first establish acceptable reliability. Some suggestions to aid in this development are to change the instrument from nominal, bifurcated, and forced-choice dichotomous scaling to that of an ordinal Likert-type scaling for responses (i.e., instead of "yes" or "no" answers to the question "*Honestly, are you unfamiliar with some parts of the latest version of the Ethics Code?* The question could be rephrased to read *"How familiar are you with the latest Code of Ethics?"* Answers could range from 1 – not at all to 5 – very much so). This would allow a gradient of responses yielding greater variance among items and respondents. With this modification completed the instrument would then be ready to be piloted for reliability data. Further investigation of this data using factor analysis could point towards specific items of the instrument that possess the greatest strength of measure and which items may be altered or eliminated to strengthen reliability coefficients. Finally, this instrument should undergo discriminant validity development and analysis by recruiting a sample of LMFT respondents who have confessed to and/or been adjudicated guilty of committing ethical violations. By collecting data from this sample, asking them to respond to the questions as though they were feeling, thinking, and acting during the time(s) of their violation(s). When data from this sample are compared to data collected from normative samples of MFT practitioners, a correlational matrix for discriminant validity of the instrument's items would be predicted to emerge.

The maturation of the EARTMFT or the development some similar instrument to emerge with solid psychometric properties is crucial for deepening our understanding into the cause(s), prevention, and cure of ethical violations among marriage and family therapists. Without the development of such an instrument investigation into this important area is thwarted as the scientific community must rely entirely upon ex post facto and/or descriptive research, not able to build causal models for these behaviors.

Recruitment of participants. The results from this study revealed a sample of LMFTs who were healthy, high-functioning, satisfied professionals who infrequently engaged in at-risk ethical behaviors in their practice. It is optimistic to assume that this sample is indeed representative of the population of LMFTs in Florida or the United States. It is more likely that these results are artificially inflated due to both the self-selection of those respondents choosing to participate in this study and the demand characteristics of the questions.

Self-report responses tend to be positively inflated due to: (1) participants wish to provide socially desirable responses in order to appear healthy, (2) reactions to experimenter's expectations, and (3) dependency on the accuracy of the participant's perceptions (Brigham, 1986). It is likely that the self-selection and responses of the participants of this study were influenced by one or more of these factors. This supposition is supported by the results of Lee's (1995) dissertation in which she found a sample of LMFTs in the State of Florida (N=132) and of which she reports: "This study's results showed that AAMFT [LMFT] therapists experience a moderate level of secondary traumatic stress" (p. 116). She utilized the Impact of Events Scale (IES, Horowitz, 1979) to measure and operationalize STSS. The IES is an instrument that has been normalized and is utilized with clinical populations suffering from posttraumatic stress. A mean score of 24, out of a possible 65, indicates that the sample of LMFTs from her study were experiencing intrusive and avoidant symptoms of posttraumatic stress associated with their work at a level equal to that of "moderate" symptoms of a patient suffering from Posttraumatic Stress Disorder. While Lee's (1995) dissertation explored cognitive schemas associated with these STSS symptoms and did not investigate the level of functioning nor other potential areas of effects as did this study it is important to note that her results define a sample of LMFTs who are experiencing a significant level of stress in their professional lives. The results from Lee's (1995) study are contradictory the results reported by the sample of this study, who indicated minimal stress-related phenomena and were generally without negative symptoms.

This discrepancy points toward the need to have greater variance of scores within the sample. A larger sample that included data from student practitioners, who may be more likely to engage in at-risk ethical behaviors as well as more likely to be experiencing caregiver stress symptoms would be useful in establishing normative scores. As was suggested in the previously discussed implication, one method for achieving this variance would be to include as participants in future studies those LMFTs who have been identified as committing one or more ethics violation in their practice. This would allow the researcher to compare scores of the normative group with those of the group who have committed violations to yield more substantive and useful information regarding the correlates to this EAR behavior.

Compassion fatigue and ethical violations. As was previously reported in Chapter 4 and discussed in this chapter, compassion fatigue was the only factor of the exploratory section of this study to emerge with a significant predictive value for EAR scores (R^2=.140; *p*=.002). Even though the part correlation for compassion fatigue in the regression model is small, explaining only 14% of the variance in ethics at-risk scores, it is important because of the lack of variance in *all* scores has likely deflated the strength of this relationship.

The development of the compassion fatigue subscale of the Pro-QOL, according to Stamm (2002), is designed to measure the intrusive, avoidant and arousal symptoms of Secondary Traumatic Stress in professional caregivers. She utilized the Impact of Events Scale (IES, Horowitz, 1979) in developing the convergent validity coefficients for this subscale of the Pro-QOL. Lee's (1995) findings that the sample of 132 LMFTs from her study experienced "moderate" symptoms of secondary traumatic stress is contrasted with this study's sample reporting a mean score of 6.68 and a high score of 19, more than one standard deviation unit below the cut-off score for "high risk."

In light of these findings, a replication of this study utilizing a dependent variable with good psychometric properties and a large sample with greater distribution of compassion fatigue scores is indicated to determine whether

compassion fatigue is a significant and useful predictor of ethics at-risk behaviors.

Expanded scope. Beginning to accurately identify the antecedents and correlates of at-risk ethical practice so that we may predict and potentially intervene to prevent these behaviors has importance beyond Licensed Marriage and Family Therapists and beyond the geographical boundaries of Florida. Clients, practitioners, and the families of both are potentially at-risk for devastating monetary and emotional consequences when professional caregivers practice outside of the boundaries of their ethical codes. Whether these behavioral are intentional or accidental, the potential for harm remains.

If we are able to develop measures and procedures that accurately provide an early warning to ethics violations by caregiving professionals we stand a good chance of intervening early and possibly preventing the harm that might be caused by these behaviors. If this research trajectory begins to become fruitful by accurately identifying antecedents and correlates to at-risk and volatile behaviors in LMFTs in a circumscribed geographical area (i.e., Florida), then it is reasonable that these studies should be replicated across helping disciplines (e.g., medicine, nursing, psychology, and social work) and geographical boundaries.

Knowledge of ethical practice. The final area that begs further research attention emerging from the results of this study is that of knowledge of the ethical practice guidelines by practitioners. In review of the responses by the sample of this study on Item 3 of the EARTMFT ("Honestly, are you unfamiliar with some parts of the latest version of the Ethics Code?"), over one-half of the respondents (53%, n=43) answered affirmatively. It is parsimoniously reasoned that is a LMFT practitioner is unfamiliar with parts of the AAMFT Code of Ethics then this practitioner is at-risk for practicing outside of its guidelines. This becomes figural when we examine the mean years of practice for this sample and find that the average respondent for this sample has been practicing marriage and family therapy for nearly 14 years. While it may argued that this is

not cause for alarm, it is certainly an impetus for concern and further investigation.

The development of a brief questionnaire which tests AAMFT clinical members on their knowledge of ethical practice relative to the eight sections, or principles, which govern the actions of the Clinical Members of the AAMFT could assist the Ethics Committee and training programs in understanding which of these eight areas need the most remediation to assure that practitioners are knowledgeable regarding ethical practice. These eight areas include: (1) responsibility to clients, (2) confidentiality, (3) professional competence and integrity, (4) responsibility to students, employees, and supervisees, (5) responsibility to research participants, (6) responsibility to the profession, (7) financial arrangements, and (8) advertising.

Theory development. How do the findings of this study help advance the theoretical understanding of the causes of violations of ethical practice among LMFTs? This study was predicated on the belief that higher levels of stress experienced by LMFTs would make them more likely to engage in at-risk ethical behaviors. Since this study failed to achieve significant results in hypothesis testing no inferences may be drawn to either support, augment, or diminish the theoretical understanding of this phenomenon. Future research programs, as outlined above, will continue to apply, test, and build upon this theory.

The following section develops suggestions and prescriptions for the applications of the finding of this study to the education, training, and clinical practice of marriage and family therapy.

Implications for Training and Practice

The findings of this study have brought to light some important regulatory and andragogical concerns for the professional practice and training programs of marriage and family therapy. As has been discussed in Chapter One, scores of LMFTs *are* identified and disciplined by state and national regulatory boards each year for unethical and unlawful practice. It is assumed that these publicly identified LMFTs represent only a fraction of the actual number of LMFTs who do

engage in unethical and/or unlawful practice. The results of this study, in accordance with Brock and Coufal (1994), identified over one-half the respondents as unfamiliar with parts of the AAMFT Code of Ethics. Predicated upon the logic that if an LMFT is unfamiliar with some part of the Code then they are unable to assure their practice behaviors remain within the parameters of the Code and therefore "at risk". Nearly 87% (n=70) of the sample answered affirmatively to at least one item on the EARTMFT and the mean score was 2.48 (N=81; SD=1.86). These findings represent a *de facto* exigency for the field of marriage and family therapy–LMFTs are practicing marriage and family therapy at significant risk for violations of ethical standards. The potential for harm to clients, viewed in light of these findings, are serious and necessitate remediation.

For MFT training programs, it is recommended that at least one course be devoted to professional issues and that these courses require, as a core competency, students to demonstrate understanding and mastery with all eight (8) areas of the AAMFT Code of Ethics. For marriage and family therapist who are in current practice, AAMFT should require demonstration of knowledge of the Code for continued good standing membership. Because the AAMFT Code of Ethics is often revised and updated, LMFTs should be required to complete continued education capsule each licensure period. Finally, on-going intervention research that seeks to measure the impact of these interventions upon at-risk practice along with identifying the trends for at-risk practice among LMFTs should be initiated and supported by AAMFT. Once the EARTMFT has achieved maturity with solid psychometrics it would make an excellent tool for these purposes.

Another finding of this study—the significant relationship between compassion fatigue and at-risk practice—emerges as another important area of attention for MFT training programs and professional practice. As has been demonstrated by many writers (Figley, 1995; McCann & Pearlman, 1990; Stamm, 1995, 2002), compassion fatigue results produces significantly deleterious symptoms among caregivers. The painful and often debilitating symptoms of compassion fatigue have been confirmed among populations of

professional marriage and family therapists (Lee, 1995; Salston, 2002). While the sample from this study was identified as extremely healthy with a mean score on the *Pro-QOL* (Stamm, 2002) of more than four standard deviation units below the cut-off for high risk for compassion fatigue, these scores represent a non-normal distribution among LMFTs in Florida.

If future research does indeed confirm a significant predictive relationship between compassion fatigue symptoms and at-risk ethical practice then it is incumbent upon regulatory boards and training programs in the field of MFT to identify and provide resources for the prevention and treatment of compassion fatigue. These programs for the prevention and treatment compassion fatigue should include a training component for ethical practice. However, since it has been empirically demonstrated that the symptoms of compassion fatigue *do* negatively affect a significant portion of the LMFT population, at least in Florida and Oregon (Lee, 1995; Salston, 2002), the implementation of prevention and treatment into existing training and continuing professional education programs seems prudent. Existing continuing education programs have already demonstrated a significant ameliorative effect upon compassion fatigue symptoms among professional caregivers (Gentry, Baggerly, & Baranowsky, 2004). Already, as a result of the findings of this study, this writer has integrated a learning capsule on “at-risk ethical practice” into the content of the Compassion Fatigue Prevention and Resiliency Training (Gentry & Baranowsky, 1999a) and the Certified Compassion Fatigue Specialist Training (Gentry & Baranowsky, 1999b).

Summary

An exhaustive critical review of the literature exploring unethical and ethically at-risk practice of marriage and family therapy determined that there existed no empirical literature focusing upon the antecedent, correlative, or causal factors of these problematic behaviors among LMFTs. Addressing a gap in the professional MFT literature, this study was designed to test the hypothesis that caregiver stress would demonstrate a significant relationship with at-risk

ethical practice of marriage and family therapy among a sample of LMFTs in the state of Florida. Eight research questions were additionally developed to help guide an exploratory component of this study with the hope of identifying one or more factors contributing to the understanding of EAR behaviors.

Surveys containing a demographic collection tool and instruments to measure the dependent variable (at risk ethical practice) and five independent variables (caregiver stress, compassion fatigue, burnout, and satisfaction with life) were sent to a randomly selected sample of one-half (n=549) of the LMFTs in the State of Florida. After a 90-day data collection window, 82 useable surveys were returned (15%) and these data were analyzed. The sample was found to be significantly non-normal and positively skewed.

No significant relationship between caregiver stress and EAR scores was found and therefore the null hypothesis could not be rejected. In the exploratory portion of the study, only compassion fatigue emerged with a significant predictive relationship (R^2=.140; *p*=.002) for EAR practice among all the independent variables and demographic data. Almost all respondents (86.4%) identified at least one area for which they were at-risk for practicing outside the boundaries of the AAMFT Code of Ethics. The sample for this study was remarkably healthy with non-normal scores for caregiver stress, compassion fatigue, burnout, and satisfaction with life.

The validity of this study was challenged by a very low response rate, a non-normal and very healthy sample, and unacceptably poor psychometric performance of the Ethics At-Risk Test for Marriage and Family Therapists *(*Brock, 1997)—the instrument utilized to measure at risk ethical practice, or the dependent variable. Recommendations for future research resulting from the findings of this study primarily advocate studies designed to resolve the psychometric problems of measuring at-risk ethical practice. Following the resolution of the scaling problems, a program of research that recruits larger and more representative samples of cross-discipline professionals and compares this sample with professionals who have been adjudicated for ethical violations is suggested to begin to determine the antecedent, correlative, and causal factors

for why, when, where, and how often professional caregivers practice outside the boundaries of ethical and legal constraints.

APPENDIX A

Human Subjects Approval
Memorandum

Florida State
UNIVERSITY

Office of the Vice President For Research
Human Subjects Committee
Tallahassee, Florida 32306-2763
(850) 644-8633 FAX (850) 644-4392

REAPPROVAL MEMORANDUM

Date: 4/8/2004

To:
J. Eric Gentry
2727 W. Fletcher Ave. 38-H
Tampa, FL 33618

Dept.: **Interdivisional Program in Marraige and Family Therapy**

From: **John Tomkowiak, Chair** John Tomkowiak M.D.

Re: **Reapproval of Use of Human subjects in Research:**
The Effects of Caregiver Stress Upon At-Risk Ethical Behavior Among Florda Liscensed Marraige and Family Therapists

Your request to continue the research project listed above involving human subjects has been approved by the Human Subjects Committee. If your project has not been completed by 4/6/2005 please request renewed approval.

You are reminded that a change in protocol in this project must be approved by resubmission of the project to the Committee for approval. Also, the principal investigator must report to the Chair promptly, and in writing, any unanticipated problems involving risks to subjects or others.

By copy of this memorandum, the Chairman of your department and/or your major professor are reminded of their responsibility for being informed concerning research projects involving human subjects in their department. They are advised to review the protocols of such investigations as often as necessary to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

Cc: Charles R. Figley
HSC No. 2004.240-R

APPENDIX B

Sample Survey Packet

J. Eric Gentry, MA
2727 W. Fletcher Ave. 38-H
Tampa, FL 33618
(813) 960-5871
jerigen@aol.com

Date

Dear Licensed Marriage and Family Therapist:

You have been selected to participate in THE EFFECTS OF CAREGIVER STRESS UPON AT-RISK ETHICAL BEHAVIOR AMONG FLORIDA LICENSED MARRIAGE AND FAMILY THERAPISTS Study. This study is being conducted through Florida State University's Interdivisional Program in Marriage and Family Therapy as part of the requirements for the completion of a dissertation.

This study utilizes a 15-25 minute, 106-item survey that is designed to investigate stressors, stress levels, resiliency, and "at-risk" ethical behaviors among Licensed Marriage and Family Therapists in Florida. The study seeks to explore the effects that caregiver stress has upon the ethical practice of marriage and family therapy. I have hypothesized that those therapists with higher levels of stress will be more "at-risk" for the violations of the AAMFT Code of Ethics in their practice. The long range goals for this research program are to begin to develop prediction models for "at-risk" situations that can then lead to prevention, early intervention, and treatment protocols for therapists who may, inadvertently, find themselves in these "at-risk" situations. It is my sincere hope that you can see the value and utility of such a study and will chose to become a participant by completing and returning the enclosed survey.

This study has been designed to provide you with absolute anonymity in your responses. Because this survey, and particularly the *Ethics "At-risk" Test for Marriage and Family Therapists* (Brock, 1997), contains items that ask you to identify and report behaviors in which you currently engage that are potential and/or *de facto* breeches of ethical behavior, no one will ever know how you have responded on this survey. This instrument was designed by the Chairperson of the AAMFT Ethics Committee to serve this "early warning" function for MFTs and may be a potential benefit of this study. Conversely, you may find yourself experiencing some discomfort or distress associated with answering some of the questions contained within this survey. I invite you to utilize your support system should this occur. Additionally, my contact information has been included here and I welcome contact from you. I offer you all assurances that I will do

anything that I can to minimize your discomfort and assist you in procuring any services that you may need resulting from any distress associated with participating in this study.

Included in this packet you should find the following:

- Informed Consent Form
- Informed Consent Form return envelope (stamped and addressed)
- Bill of Rights for Participants in Psychological Research
- *Demographic and Work Data* collection instrument
- *The Ethics At-Risk Test* (Brock, 1997)
- *The State-Trait Anxiety Inventory* (Speilberger, et al., 1983)
- *The Professional Quality of Life Scale* (Pro-QOL; Stamm, 2002)
- *The Satisfaction With Life Scale* (Diener, 1984)
- Stamped and addressed return envelope (9 x 12") for the above five (5) instruments

Procedure

1. Review the Informed Consent Form.
2. If you agree to participate in this study, please sign the Informed Consent Form and place only this one page document in the letter-sized return envelope and mail to investigator. (Note: Signed Informed Consent Documents will be kept in a locked file for one year after the close of the data collection window. All Informed Consent Documents will b e destroyed on or shortly after July 31, 2004).
3. Review and keep for your records the Bill of Rights for Participants in Psychological Research
4. Fill out each of the five (5) research instruments [(1) *Demographic and Work Data;* (2) *The Ethics At-Risk Test* (Brock, 1997); (3) *The State-Trait Anxiety Inventory* (Speilberger, et al., 1983); (4) *The Professional Quality of Life Scale* (Pro-QOL; Stamm, 2002); and (5) *The Satisfaction With Life Scale* (Diener, 1984)] according to the directions included at the beginning of each instrument.
5. Place these five (5) completed instruments in the stamped return envelope and mail to the investigator. (Note: Please do not make any identifying marks, other than answering the items, on any of the instruments. This is stressed to preserve your anonymity.)

Thank you in advance for your kind willingness to participate in this important study. My contact information has been included above and I invite you to contact me at anytime if you have comments, questions, or concerns about this study.

In service,

J. Eric Gentry, MA

Consent Form

(Please keep a copy of this form for your records)

I, _____ consent to participate in the research project entitled "THE EFFECTS OF CAREGIVER STRESS UPON AT-RISK ETHICAL BEHAVIOR AMONG FLORIDA LICENSED MARRIAGE AND FAMILY THERAPISTS" conducted by J. Eric Gentry at Florida State University, Tallahassee, FL.

I consent to fill out a paper and pencil survey consisting of several instruments that will take approximately 15-20 minutes to complete. I understand there is no direct benefit from participation in this study other than the satisfaction of contributing to the current understanding of compassion fatigue and ethical violations with care providers.

I understand that answering some of the questions included in this study may cause mild discomfort or even trigger memories of unpleasant experiences. I am aware that a licensed mental health professional is available for telephone consultation to assist with any discomfort that I experience. I agree to contact J. Eric Gentry if consultation is needed.

I understand that my identity will not be connected with any of the data that I contribute and that I will not be identified in any publication or report. All identifying information will be kept separately from my completed survey in a locked file cabinet accessible only by the investigator and his assistant.

I understand that the results of this research will be published and the data derived from my responses may be used for furthering development in this area of study. The information that I provide will be stored for one year after the completion of this project and then destroyed.

I understand that my participation is voluntary with no penalty for withdrawal. I am free to rescind my consent and discontinue my participation at anytime by contacting J. Eric Gentry.

I may contact the investigator J. Eric Gentry with any questions I have about the research at (813) 960-5871or at jerigen@aol.com.

I understand that questions about my rights as a research participant may be directed to the Florida State University Office of Research; Human Subjects Committee; 2035 E. Paul Dirac Drive, Box 15; 100 Sliger Bldg., Innovation Park; Tallahassee, FL 32310. Telephone (850) 644-8673.

Signing my name below indicates that I have read and consented to the contents of this form and that I agree to participate in this study.

Signature: _____ Date:_____

NOTE: Please sign and return this envelope in the separate envelope marked "INFORMED CONSENT". To protect your anonymity, please do not return this document with survey materials.

Demographic and Work Data

DIRECTIONS: Please complete each of the below 11 items.

1. **Age:** _____
2. **Gender**: _____ Female
   _____ Male
3. **Marital Status:**
   - ____ Single
   - ____ Married
   - ____ Monogamous Partnership
   - ____ Divorced/Separated
   - ____ Widowed
   - ____ Other:_____

4. **Education (check highest level completed):**
   - ____ Bachelor's degree
   - ____ Master's Degree
   - ____ Doctorate Degree
   - ____ Other: _____

5. **Professional Identity**
   - ____ Marriage & Family Therapist
   - ____ Psychologist
   - ____ Medical Doctor (Psychiatrist, Family Practice, Other)
   - ____ Social Worker
   - ____ Counselor
   - ____ Chaplain/Pastoral Care
   - ____ Other: _____

6. **Work setting (Where you practice as an MFT)**
   - ____ Solo practice
   - ____ Group practice
   - ____ Clinic/mental health agency
   - ____ Hospital
   - ____ Residential
   - ____ Multiple work settings
   - ____ Other: _____

C. . **Primary Theoretical Orientation** (check one)
   - ____ Systemic (strategic)
   - ____ Systemic (structural)
   - ____ Systemic (Bowenian)
   - ____ Systems (Other, please identify)
     _____
   - ____ Cognitive-Behavioral
   - ____ Psychodynamic
   - ____ Trauma Model
   - ____ Gestalt
   - ____ Other: _____

8. _____ Years licensed as an MFT

9. _____ Total hours per week you work

10. _____ Total hours per week you work in clinical practice as an MFT.

11. Have you survived at least one traumatic experience during the course of your life?
    ___yes ___no

ETHICS "At-Risk" TEST for MARRIAGE AND FAMILY THERAPISTS

Ever wonder how close you are to blundering over the ethics edge and possibly harming your clients, yourself and/or the profession? This "test" may tell you. Of course, you must answer honestly. Add up your score and compare the total with the key at the bottom of the page.

Is it true that you have never taken an academic course on MFT practice ethics.	Yes = 1	No = 0
Honestly, are you unfamiliar with some parts of the latest version of the Ethics Code?	Yes = 1	No = 0
Does the Ethics Code interfere somewhat with the quality of your therapy or research?	Yes = 1	No = 0
Have you ever sent a false bill for therapy to an insurance carrier?	Yes = 1	No = 0
Do you feel sexually attracted to any of your present clients?	Yes = 1	No = 0
Do you fantasize about kissing or touching a present client?	Yes = 1	No = 0
Do you comment to a present client how attractive he or she is or make positive remarks about his or her body?	Yes = 1	No = 0
Are you tempted to ask out an ex-client even though two years have not passed since termination?	Yes = 1	No = 0
Do you commonly take off your jewelry, remove shoes, loosen your tie, or become more informal during therapy sessions?	Yes = 1	No = 0
Presently do you meet a client for coffee or meals or for socializing outside of therapy?	Yes = 1	No = 0
Has a present client given you an expensive gift or frequently gives you small gifts?	Yes = 1	No = 0
Are you stimulated by a current client's description of sexual behavior or thoughts?	Yes = 1	No = 0
Are you in the midst of a difficult personal or family crisis yourself?	Yes = 1	No = 0
During the past two months, have you seen clients while you were hung over or under the influence of drugs even if only a little?	Yes = 1	No = 0
Does your personal financial situation cross your mind when considering whether to terminate therapy or to refer a client?	Yes = 1	No = 0
Do you feel manipulated by a current client such that you are wary of them or are angry and frustrated by them?	Yes = 1	No = 0
Do you provide therapy to a current student, supervisee, or employee?	Yes = 1	No = 0
Have you wanted to talk to a colleague about a current case but feared doing so would show your lack of skill or lead to an ethics case against you?	Yes = 1	No = 0
Are you behind on case notes?	Yes = 1	No = 0
Do you talk about clients with other clients or gossip about clients with colleagues?	Yes = 1	No = 0

0	Excellent, you are nearly risk free.
1 – 2	Review your practice. Read and follow the Ethics Code.
3 – 4	Review your practice for problem areas. Consider needed changes.
5 – 7	Consult a supervisor. You are engaging in high risk behavior.
8+	Probably you have already harmed clients. Seek therapy and supervision. Come to terms with your situation by making immediate changes.

Send comments and questions to Gregory Brock, Ph.D., 315 Funkhouser Building, University of Kentucky, Lexington, 40506-0054, U.S.A.

SELF-EVALUATION QUESTIONNAIRE

(Licensed Marriage and Family Therapist Version)

Developed by Charles D. Spielberger

In collaboration with

R.L. Gorsuch, R. Lushene, P.R. Vagg, and G.A. Jacobs

STAI Form Y-1

DIRECTIONS: A number of statements which people use to describe themselves are given below. Read each statement and then check the appropriate box to the right of the statement to indicate how you have felt over the past month in ***your work*** and ***work situations*** as a ***Licensed Marriage and Family Therapist (LMFT)***. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	NO AT ALL	SOMEWHAT	MODERATELY SO	VERY MUCH SO
1. I feel calm				
2. I feel secure				
3. I am tense				
4. I feel strained				
5. I feel at ease				
6. I feel upset				
7. I am presently worrying over possible misfortunes				
8. I feel satisfied				
9. I feel frightened				
10. I feel comfortable				
11. I feel self-confident				
12. I feel nervous				
13. I am jittery				
14. I feel indecisive				
15. I am relaxed				
16. I feel confident				
17. I am worried				
18. I feel confused				
19. I feel steady				
20. I feel pleasant				

Consulting Psychologists Press

577 College Avenue, Palo Alto, CA 94306

Self-Evaluation Questionnaire

STAI Form Y-2

DIRECTIONS: A number of statements which people use to describe themselves are given below. Read each statement and then check the appropriate box to the right of the statement to indicate how you *generally* feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

	NO AT ALL	SOMEWHAT	MODERATELY SO	VERY MUCH SO
21. I feel pleasant				
22. I feel nervous and restless				
23. I feel satisfied with myself				
24. I wish I could be as happy as others seem to be				
25. I feel like a failure				
26. I feel rested				
27. I am “calm, cool, and collected”				
28. I feel that difficulties are piling up so that I cannot overcome them				
29. I worry to much over something that doesn’t really matter				
30. I am happy				
31. I have disturbing thoughts				
32. I lack self-confidence				
33. I feel secure				
34. I make decisions easily				
35. I feel inadequate				
36. I am content				
37. Some unimportant thought run through my mind and bothers me				
38. I take disappointments so keenly that I can’t put them out of my mind				
39. I am a steady person				
40. I get in a state of tension or turmoil as I think over my recent concerns and interests				

ProQOL – R III

PROFESSIONAL QUALITY OF LIFE
Compassion Satisfaction and Fatigue Subscales – Revision III

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current situation. Write in the number that honestly reflects how frequently you experienced these characteristics ***in the last 30 days***.

0=Never 1=Rarely 2=A Few Times 3=Somewhat Often 4=Often 5=Very Often

_____1. I am happy.
_____2. I am preoccupied with more than one person I help.
_____3. I get satisfaction from being able to help people.
_____4. I feel connected to others.
_____5. I jump or am startled by unexpected sounds.
_____6. I feel invigorated after working with those I help.
_____7. I find it difficult to separate my personal life from my life as a helper.
_____8. I am losing sleep over a person I help's traumatic experiences.
_____9. I think that I might have been "infected" by the traumatic stress of those I help.
_____10. I feel trapped by my work as a helper.
_____11. Because of my helping, I feel "on edge" about various things.
_____12. I like my work as a helper.
_____13. I feel depressed as a result of my work as a helper.
_____14. I feel as though I am experiencing the trauma of someone I have helped.
_____15. I have beliefs that sustain me.
_____16. I am pleased with how I am able to keep up with helping techniques and protocols.
_____17. I am the person I always wanted to be.
_____18. My work makes me feel satisfied.
_____19. Because of my work as a helper, I feel exhausted.
_____20. I have happy thoughts and feelings about those I help and how I could help them.
_____21. I feel overwhelmed by the amount of work or the size of my caseload I have to deal with.
_____22. I believe I can make a difference through my work.
_____23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
_____24. I plan to be a helper for a long time.
_____25. As a result of my helping, I have intrusive, frightening thoughts.
_____26. I feel "bogged down" by the system.
_____27. I have thoughts that I am a "success" as a helper.
_____28. I can't recall important parts of my work with trauma victims.
_____29. I am a sensitive person.
_____30. I am happy that I chose to do this work.

SWLS

Below are five statements with which you may agree or disagree. Using the scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

1	=	Strongly disagree
2	=	Disagree
3	=	Slightly disagree
4	=	Neither agree nor disagree
5	=	Slightly agree
6	=	Agree
7	=	Strongly agree

_____ 1. In most ways my life is close to ideal.

_____ 2. The conditions of my life are excellent.

_____ 3. I am satisfied with my life.

_____ 4. So far I have gotten the important things I want in life.

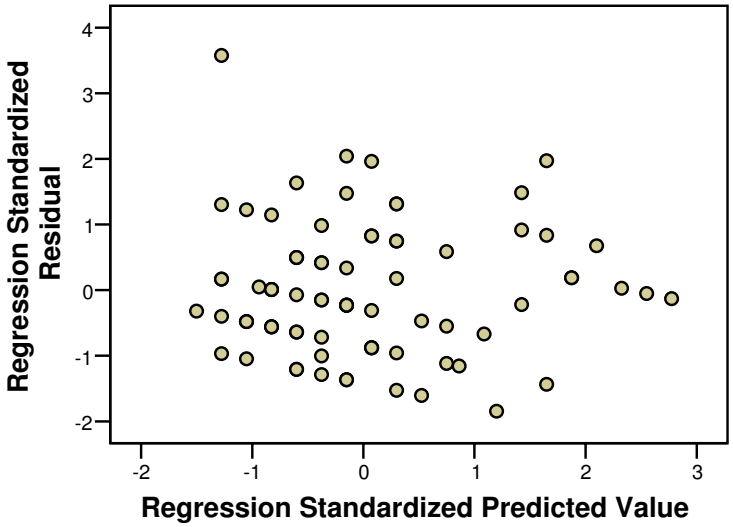
_____ 5. If I could live my life over, I would change almost nothing.

APPENDIX C

RESIDUAL SCATTER PLOTS

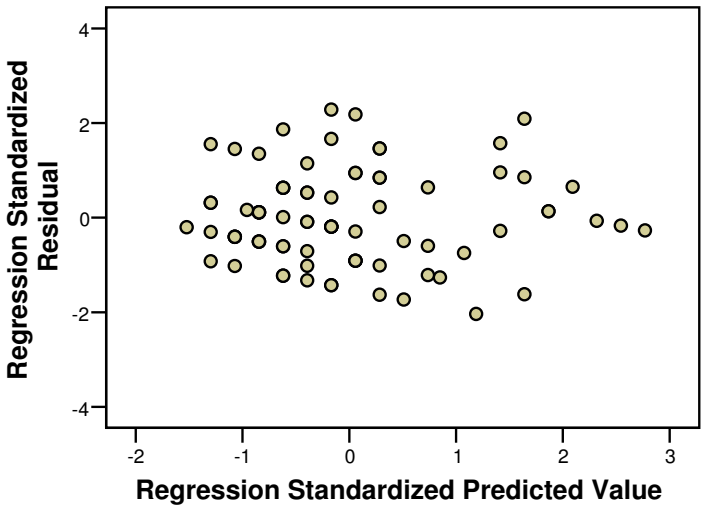
Scatterplot

Dependent Variable: EthicsR



Scatterplot

Dependent Variable: EthicsR



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He is an avid outdoor enthusiast evidenced by his 1996 through-hike of the Appalachian Trail and summiting many of North America's tallest peaks. He is a performing musician/songwriter with recording credits. He currently lives in Sarasota, Florida.