Other Papers

Polish Psychological Bulletin
2017, vol. 48(3) 411–422
DOI - 10.1515/ppb-2017-0047

Igor Pietkiewicz[*]
Karolina Skowrońska-Włoch[**]

Attitudes to professional boundaries among therapists with and without substance abuse history

Abstract: *There is no empirical research exploring how substance abuse therapists perceive and manage their professional role or privacy boundaries. This study explores their attitudes associated with self-disclosure and dual relationships. Ten therapists, five who had recovered (neophytes) and five who had never been substance dependent, shared their work experiences during semi-structured, in-depth interviews, which have been subjected to interpretative phenomenological analysis. While non-neophytes were generally reluctant to share personal information or establish alternative forms of relationship with current or former clients, neophytes were more open to using self-disclosure and admitted changing professional relationships into friendships. These findings are discussed in relation to ethical codes, training and supervision in substance abuse treatment.*

Key words: *substance abuse, professional boundaries, therapist privacy, self-disclosure; interpretative phenomenological analysis*

Professional Boundaries in Substance Abuse Treatment

Professional boundaries in psychotherapy and recovery relate to therapists' personal conduct and regulatory issues associated with the setting (i.e., where, when, and how sessions are maintained, what are client and therapist roles), physical touch, dual or multiple relationships, self-disclosure, accepting gifts, etc. (Gutheil & Gabbard, 1993). Boundaries are often explicitly negotiated in order to protect the client, the therapist, and the treatment process, by providing a safe environment and avoiding re-enactment of traumatic experiences. Apart from inappropriate behaviours associated with crossing professional boundaries (e.g., therapist starting late or finishing the session early), there are examples of boundary violations which are unethical and potentially harmful to clients. The latter include dual relationships (e.g., sexual or business), exchanging expensive gifts, breaking confidentiality or exploiting the client in any way (Miller, Forcehimes, & Zweben, 2011). In this study we concentrate on two aspects, namely sustaining a professional relationship instead of establishing an alternative type of relationship, and managing boundaries of privacy by therapists.

Dual and Multiple Relationships

Dual and multiple relationships are terms that describe situations where therapists and clients establish types of bond other than therapeutic, including social, business, communal, or even sexual (Lazarus & Zur, 2002). When they become friends, exchange services, or even establish a love affair, it is likely to produce a conflict of interests (Forrest, 2010) or repeat in clients a pattern of an abusive, exploitative relationship (Davis, 2011). For this reason, sexual intimacies with clients are explicitly forbidden by most ethical codes for healthcare professionals (American Association for Marriage and Family Therapy, 2015; American Counseling Association, 2014; American Psychological Association, 2010). The Association for Addiction Professionals (NAADAC, n.d.) stresses that therapeutic relationships begin with a power differential, making clients especially vulnerable and exploitable. Treatment specialists are thus warned against exploiting current or former clients for social or business gain. Neither can they engage in sexual behaviour with these people, nor offer treatment to someone who had been in such a relationship with them.

However, some dual relationships are unavoidable. For instance, a therapist and a client may realise, during

[*] **Uniwersytet SWPS, WZ Katowice**
[**] **Monar, Kraków**

Corresponding author: Igor Pietkiewicz, e-mail: ipietkiewicz@swps.edu.pl

The authors declare that they have no conflicts of interest.

treatment, that they share a network of colleagues or friends (Pietkiewicz & Włodarczyk, 2014). People living in small communities (e.g., rural areas) are also more likely to discover a shared network of people (Lazarus & Zur, 2002; Zur, 2006). Furthermore, certain therapy settings are likely to produce specific dilemmas and challenges associated with professional boundaries. For example, professionals working in therapeutic communities not only provide individual or group therapy, but are often responsible for organising social events for clients, and have contact with their significant others (De Leon, 2000). Dual relationships may also occur if therapists in recovery participate in Alcoholics Anonymous or Narcotics Anonymous groups. Such therapists may develop concerns about how to behave in an alternative role (De Leon, 2000; Forrest, 2010). The Association for Addiction Professionals (NAADAC, n.d.) generally recommends that therapists should carefully consider circumstances conducive to dual relationships and, if possible, try to avoid them. While it is common for group members to socialise between meetings, such therapists may feel like withdrawing if they perceive socialising with other patients to be in conflict with work ethics. We have found no empirical data regarding how that affects therapists' help-seeking attitudes or coping strategies.

Therapist Self-Disclosure

The topic of self-disclosure is widely discussed in therapeutic literature, elaborating on rules delineating what information therapists can share with their clients and under what conditions (Barnett, 2011). Some authors limit the notion of self-disclosure to verbal acts and differentiate types, such as facts, feelings, insight, strategy, reassurance/support, challenge and immediacy (Knox & Hill, 2003). Zur, Williams, Lehavot, and Knapp (2009) concentrate less on the verbal content but view self-disclosure as the totality of information clients gain in contact with their therapists. These authors describe additional aspects: whether self-disclosure was deliberate (therapist intentionally telling or showing something to a client), avoidable or not (some information is impossible or difficult to hide, e.g., therapist's age, disabilities or emotional expressions), or accidental (self-disclosures resulting from meeting a therapist in his daily life – in a cinema with his family, at a concert or a church). Accidental encounters can be common when therapists and clients belong to the same local communities or live and work in small towns (Zur, 2006). Whereas in some cases self-disclosure can be part of an intentional therapeutic intervention, in others it can be inappropriate and unethical – for example, when it serves to fulfil a therapist's own needs for appreciation, support or closeness (Zur et al., 2009).

Most studies elaborate on self-disclosure as a deliberate technique used by professionals for therapeutic reasons (Forrest, 2010; Knox & Hill, 2003). Attitudes towards therapist self-disclosure vary, however, between representatives of different modalities (Carew, 2009; Gibson, 2012). Forrest (2010) explains that cognitive-behavioural therapists often view it as a potentially advantageous technique for enhancing working alliance, modelling behaviour, sowing hope and trust. For humanistically oriented practitioners, self-disclosure is a way of expressing authenticity, positive regard for clients, and making relationships with them more symmetrical. Psychoanalysts and psychodynamic therapists are least inclined to disclose information about themselves. Pietkiewicz and Włodarczyk (2014) explain why transparency is viewed as interfering with the technique used by these practitioners. Psychodynamic therapists are also concerned about remaining fairly neutral and non-transparent, not to impose their own ideas and values (moral, aesthetic, political, etc.) on clients for whom they represent authority (Forrest, 2010; Pietkiewicz & Włodarczyk, 2014; Stricker & Fisher, 1990).

According to Knox and Hill (2003) therapists should generally use self-disclosure rarely and cautiously, after carefully analysing the specific needs and preferences of particular patients. They stress that levels of intimacy should also be used appropriately, in order not to frighten or burden clients. Disclosures about content-related professional background (degrees and work experience) can be less risky and potentially disturbing than sharing personal information (about religious beliefs, sexual orientation, or one's personal problems). Contrary to that, dependency treatment therapists are sometimes encouraged to talk about their own experience with substance abuse as a method to gain clients' trust (Beck et al., 1993; Forrest, 2010). However, results of the Project MATCH (Kadden, Carbonari, Litt, Tonigan, & Zweben, 1998) show that therapists' personal experience in recovery has no special effect on therapy outcomes, even in the 12-step programme. According to Miller, Forcehimes and Zweben (2011), therapists spend a surprising amount of time on casual conversations with their clients that are not clearly related to therapeutic ends. Forrest (2010) stresses that therapists should be extremely careful about using self-disclosure when they work with certain types of clients – those with boundary problems or dependency, or who suppress emotions and are introspective. This description seems to match many substance abusers (Walter, 2015).

Sharing networks of people and co-participating in certain groups (support groups for alcohol or drug addicts, religious communities, or work teams) can additionally challenge therapists' privacy boundaries, resulting in unintentional or accidental self-disclosure (Pietkiewicz & Włodarczyk, 2014). According to Doyle (1997), therapists may feel inhibited to talk openly about their own difficulties, e.g. relapses, breaking abstinence, or dissatisfaction and interpersonal problems, in front of current clients, former clients or potential clients, for fear of disclosing information which could undermine their authority and skills, or burden others.

There are few guidelines about self-disclosure and rules for managing privacy in contemporary ethical codes (American Association for Marriage and Family Therapy, 2015; American Counseling Association, 2014; American Psychological Association, 2010; NAADAC, n.d.). There is

also no empirical research exploring the meaning therapists of various theoretical backgrounds ascribe to their own privacy, what information they are willing to disclose, and how they make decisions about intentional self-disclosure. It is also crucial to understand how endorsement and internalisation of professional norms, and working in various contexts, affects the way people manage their privacy boundaries (Petronio, 2002).

Professional Boundaries in Polish Ethical Codes for Substance Abuse Treatment

Treatment of substance dependence in Poland is divided into two sectors, monitored by the respective agencies: the State Agency for the Prevention of Alcohol-Related Problems [Państwowa Agencja Rozwiązywania Problemów Alkoholowych, PARPA] and the National Bureau for Drug Prevention [Krajowe Biuro Do Spraw Przeciwdziałania Narkomanii, KBds.PN]. Both agencies supervise prevention programmes, support research and publishing, grant accreditation to training programmes, and organise exams for a certificate in substance abuse treatment. Subsequently, there are two separate ethical codes for specialists in dependency treatment which regulate their professional responsibility in relation to clients. Those with psychological or medical backgrounds must additionally comply with other ethical codes (e.g., the one issued by the Polish Psychological Association or the Polish Psychiatric Association); however, many therapists hold alternative degrees (e.g., in education or sociology), and are formally bound by the PARPA or the KBds.PN codes only. Both of these codes provide limited guidelines relating to professional boundaries or self-disclosure. The code published by PARPA (2008) says that therapists should refrain from offering treatment if its quality and therapists' objectivity could be affected by moral or legal issues, kinship, emotional relationship, or their own mental or physical state. They should also refer clients to another professional if a faulty therapeutic relationship arises; however, the code does not specify when therapeutic relationships become faulty. The code of the National Bureau for Drug Prevention (KBds.PN, 2012) stresses that therapists should not establish personal (especially intimate) relationships with clients or their family members and they should avoid using therapeutic relationships for any personal or financial gain.

When it comes to self-disclosure, PARPA (2008) only refers to therapists' credentials, saying that they should honestly reveal their professional background and qualifications to clients. There is no information whatsoever about rules for managing boundaries of privacy and regulating the disclosure of personal information either for therapeutic or non-therapeutic reasons. The other code (KBds.PN, 2012) only states that therapists should never impose moral views and ideas on their clients, and it makes no reference to, nor provides guidelines about, therapist self-disclosure. Apart from limited regulations referring to professional boundaries in dependency treatment, we have found no empirical studies on how therapists perceive their role and associated obligations, what meaning they ascribe to their privacy, and how they use self-disclosure. The aim of our research is to try to fill this gap.

Method

This study was conducted in Poland in 2014 and 2015 and explored personal experiences associated with establishing client-therapist relationships and perception of professional boundaries in substance abuse treatment. We used interpretative phenomenological analysis (IPA) because it aims at generating rich and detailed descriptions of how individuals experience phenomena under investigation. Pietkiewicz and Smith (2014) explain that IPA synthesises ideas derived from phenomenology, hermeneutics, and idiography. It employs 'double hermeneutics', in which participants share their interpretations of phenomena under investigation, followed by researchers trying to analyse, make sense, and comment on these interpretations. Samples in IPA are small, homogeneous, and purposefully selected. In this particularly idiographic approach, participants 'represent' a perspective, rather than a population (Smith, Flowers, & Larkin, 2009), and data is carefully analysed case-by-case. Although sample representation is not an issue in qualitative research (Willig, 2008), small qualitative studies may still generate hypotheses that can later be tested by methods of the hypothetical-deductive paradigm.

Participants

Participants in this study were 10 substance abuse therapists: five identified themselves as *neophytes* (a term used in local jargon for those who have recovered from substance dependency and become therapists) and five who had never abused substances (in this paper we shall call them non-neophytes). In Poland, it is common to classify substance abuse therapists in one of these categories. The neophytes were two women and three men, ages 28–52. Four of them had been treated for drug dependence and only one for alcohol dependence. Despite that difference we included data collected from him in the analysis, because the main criterion for inclusion was having personal experience in providing treatment for drug and alcohol abuse. Non-neophytes were represented by one man and four women, ages 29-42. All participants were Caucasian and had higher university degrees (nine in education and one in psychology). They all had experience of working in an inpatient setting, and nine of them additionally worked in outpatient clinics. All of them were certified substance abuse therapists and worked under supervision held at institutions in which they were employed. They identified themselves with the cognitive-behavioural approach and used its techniques. Eight participated in therapeutic communities held at inpatient units and five used the Minnesota Model (in either in- or outpatient settings). Their work experience ranged from three to 14 years. All worked as both individual and group therapists. The list of five neophytes and five non-neophytes is presented in table 1 and 2. Their names have been changed to ensure confidentiality.

Table 1. Participants: neophytes (N = 5)

No	Pseudonym (age)	Clin. experience (years)	Educational background	Work setting	Work forms	Professional Certificate
1	Monica (28)	8	Pedagogy	InP, OutP	TherCom	KBdsPN
2	Margaret (42)	6	Pedagogy	InP, OutP	TherCom, Minn	KBdsPN
3	Peter (40)	7	Pedagogy	InP, OutP	TherCom, Minn	KBdsPN
4	Darek (42)	14	Pedagogy	InP, OutP	TherCom	KBdsPN
5	Adam (52)	8	Pedagogy	InP, OutP	TherCom	KBdsPN

Note. InP – inpatient centre, OutP – outpatient unit, TherCom – therapeutic community Minn – Minnessota Model

Table 2. Participants: non-neophytes (N = 5)

No	Pseudonym (age)	Clin. experience (years)	Educational background	Work setting	Work forms	Professional Certificate
1	Anna (29)	5	Psychology	InP, OutP	Minn	PARPA
2	Jasmine (33)	5	Pedagogy	InP, OutP	TherCom	KBdsPN
3	Catherine (40)	8	Pedagogy	InP, OutP	TherCom, Minn	KBdsPN
4	Agnes (42)	12	Pedagogy	InP, OutP	Minn	PARPA
5	Jacob (26)	3	Pedagogy	InP	TherCom	KBdsPN

Note. InP – inpatient centre, OutP – outpatient unit, TherCom – therapeutic community Minn – Minnessota Model

Procedure

Recruitment and data collection was carried out by the second author (KSW) who holds a degree in resocialisation and psychology, and is a certified substance abuse therapist (non-neophyte). Following the approval of the local University Committee for Research Ethics, she used her personal network to approach potential candidates. The rationale behind purposive sampling in IPA was to find people for whom the problem under investigation was relevant, were available and willing to share their experiences (Smith, Flowers, & Larkin, 2009). Thirteen people were invited to participate and initially agreed, but one did not subsequently answer her telephone and another two later said they did not have enough time. KSW knew all participants from conferences or trainings, although they were not in close personal or professional relationships. Her experience in substance abuse treatment was crucial in recruitment and developing trust. Interviews were held at places chosen by the interviewees – eight at their homes and two in their offices. They were semi-structured and audio-recorded, ranging from 40 to 100 minutes in length.

Interview protocol

A protocol designed by both authors included key areas to be explored and included open-ended questions and prompts about participants' perception of role boundaries, experience in self-disclosure and dual relationships with clients. Example questions were: How much do clients know about you as a person, your thoughts, emotions, likes or dislikes? What kind of information do you share with them about your professional or personal life, when, and how? In what other circumstances do you meet your current or former clients outside the therapy room? How would your role change at different stages of therapy and when the treatment is over? What areas do you think therapists should avoid during therapy? How does this depend on individual clients or the stage of their therapy? The second author, who was also the interviewer, covered relevant areas with every participant and asked additional questions to explore topics which emerged spontaneously during the conversation. During each interview, clarification questions were used to negotiate the meaning that participants wanted to convey. At the end of the interview, they were also asked questions to check that their responses were thorough. If a situation of transgressing professional boundaries was reported, at the end of the interview participants were encouraged to consult their supervisor for more insight into their difficulties and responsibilities.

Data analysis

The analysis was performed by the first author (IJP) who is a psychodynamic therapist and supervisor, specialising in treatment of personality disorders and trauma-related disorders. It was also supported by the second author. We produced detailed, verbatim transcriptions for all interview recordings and analysed them in Nvivo10 (computer-assisted qualitative data analysis software). We used the consecutive analytical steps recommended for IPA (Pietkiewicz & Smith, 2014). First, we listened to each recording and read the

transcripts carefully several times. We wrote comments about the content, language use, and meaning using the 'annotation' feature in Nvivo10. Then, we categorised the notes into emergent themes, by allocating descriptive labels (nodes). We followed the same procedure for each interview, comparing our interpretative notes about the meaning of data (the second hermeneutics) to identify potential differences. There were no disagreements about the face value of data. In some instances, the second author struggled to understand participants' reported behaviour and found her supervisor's explanations about the psychological mechanisms involved, comforting and enlightening.

We also compared the themes between participants to check how often they were represented, and analysed the connections between themes in each interview and between cases. This helped us group themes according to conceptual similarities into superordinate ones and sub-themes. This paper elaborates on themes present in all interviews, and investigates how therapists perceived and managed privacy and role boundaries.

Results

All participants discussed their perception and experience associated with managing privacy and professional boundaries in relationships with their clients. We discuss four superordinate themes and sub-themes (listed in table 3), illustrating them with verbatim excerpts from the interviews.

Table 3. Superordinate Themes and Subthemes

Theme 1:	Awareness of professional boundaries
Theme 2:	Neophyte's credibility
Theme 3:	Maintaining privacy boundaries a) Working in a therapeutic community b) Disclosing one's own problem with substance abuse
Theme 4:	Changing roles a) Becoming friends b) Working together c) Having a romance

Theme 1: Therapist Role and Awareness of Professional Boundaries

All participants talked in detail about their professional role. They listed qualities attributed to good therapists, such as having the ability to establish rapport, listen actively, show empathy, understanding or, as Margaret put it: "using knowledge to support and assist clients on their path to recovery". Participants also stressed the necessity of integrating the knowledge and principles that therapists have endorsed and internalised during their training in substance abuse treatment. They were also aware of actions therapists should avoid, such as: exploiting clients, establishing sexual relationships with them, or doing things that would be scandalising and unacceptable (breaking the law, being drunk in public, or behaving in an outrageous way). Most participants also declared that therapists should be neutral and avoid imposing their own views. On the other hand, they should navigate clients towards recovery and model behaviour.

> I think the therapist should use his knowledge and experience to become a model for the client. He should embody the proper way of functioning, feeling, and communicating with the environment. – Anna

This apparently involved great responsibility if participants felt they should represent healthy functioning and serve as objects for identification.

Two neophytes perceived their profession in a unique way. Peter was convinced that "helping others is a mission, a kind of calling". He mentioned striving to be a better person and that being a therapist might have reduced his guilt for things he had done under the influence of drugs. Seeing one's own conflicts or weaknesses in the clients and actively helping them could also provide a sense of power and control. Derek also admitted that being successful with his clients was meaningful at the beginning of his career, because it boosted his confidence and self-efficacy.

> When I had professional success, I was proud that I had actually cured that client. I thought I was so good in this profession. I don't think I need that gratification so much, anymore. – Derek

Theme 2: Neophyte's Credibility

Interestingly, every participant spoke about people with personal experience of substance abuse who, after recovery, trained in dependency treatment to become therapists themselves. Personal experience with addiction has become an attribute separating neophytes from non-neophytes. Both groups perceived advantages and disadvantages associated with being an 'expert by experience'. The neophytes claimed that sharing such experiences allowed them to identify with clients and understand better the difficulties people encounter during treatment. Monica said she "could have more tolerance and understanding for the emotional mess they experience, trying to stop drugs". Jacob, a non-neophyte, thought personal experience of one's own treatment helped neophytes notice subtle manifestations of breaking the therapy rules or other processes between members of a therapeutic group.

> They have greater sensitivity and ease in recognising all these situations in a therapeutic community, when people are dishonest or break rules. – Jacob

Participants emphasised that clients had more faith in therapists who were living examples that recovery was possible. On the other hand, clients sometimes questioned the ability of non-neophytes to help them. Catherine said that some people she treated undermined her skills because she did not have a problem with addiction herself.

> Some patients simply say that only an addicted therapist could understand what they are going through. This can be difficult. It's as if they are saying: "You are not good enough. I am looking for someone who will understand, who was also an addict". – Catherine

It is possible that undermining her therapeutic skills reflected her clients' reluctance to establish a relationship of dependence, and start treatment. Those who feared therapy or felt their self-esteem was threatened by comparing themselves with 'healthy' individuals, might have used devaluation and preferred to work with another former addict. Nevertheless, in her counter-transferential reaction Catherine questioned her own ability as a good therapist. Neither she nor other participants understood the psychological mechanisms which could trigger such dynamics. None of them considered the unconscious reasons behind the division of their professional community into neophytes and non-neophytes, either.

Participants were concerned that neophytes could project their own experiences and feelings onto clients. Margaret, Derek, and Adam (all neophytes) said they knew how to work with substance abusers because they could relate to their own treatment experience. They were aware, however, that identifying with clients could result in losing perspective and the ability to look critically at the interventions they were considering. Derek said "it is difficult to detach from your own experience".

> Some therapists think: "If this helped me, surely it is the best solution". They will defend what worked for them. I disagree with that because people are unique and you need to plan treatment and select suitable methods of interventions for each individual client. – Margaret

Two non-neophytes (Anna and Agnes) also stressed that their neophyte colleagues often faced challenges regarding managing their own craving for alcohol or drugs when working with addicted individuals and identifying with clients.

Theme 3: Maintaining Privacy Boundaries

All the non-neophytes said they tried to maintain rigid boundaries of privacy. They usually limited their self-disclosure to such topics as professional credentials and general information about themselves (whether they were married, had children). They said that self-disclosure was not explicitly regulated by any professional codes.

> I don't talk about my private life, my family, how I spend my free time or who I socialise with. I give examples of how people spend their free time but I don't say what activities I personally prefer. If a client asks about my family, I usually ask why that is important to him. I make sure that we concentrate on the client and not me. – Anna

Jasmine stressed that a therapist's self-disclosure could potentially reduce emotional distance. On the other hand, she thought that therapists could never be certain what kind of impact their disclosure would have, how clients would react, and what might be the hidden motives behind asking questions. She gave an example of disclosing information about her faith.

> I generally disclose very little; if I do it is only to encourage clients. I offer hope by giving examples of other people who managed to overcome difficulties. Once, someone asked if I was religious. When I said I was, the client made fun of it. He was a bit shocked because he did not expect that of me. – Jasmine

Neophytes, though, varied in the degree to which they informed clients about their personal life, relationships, and feelings. Margaret preferred to protect her privacy, but other neophytes confided in their clients with information about their own past such as regrets, or marriage problems.

> I talk about my interests or even regrets for what might have been. I dreamt about being an artist, but my parents would not let me, which I resented. This is something I can say to a client. – Monica

Monica said she would feel awkward disclosing information about her sexual life and partnership, but intentional self-disclosure could enhance transference and idealisation of the therapist. This could be used to "lure the patient by making an illusion of a special bond, closeness, and importance". In this way, she tried to "seduce a client" and motivate him for treatment. Peter said he was fairly open about his personal life but would not like to talk about violence he had experienced. For Adam, his family was a taboo topic, but he felt fine about expressing his mood, likes or antipathy towards clients. He thought "the therapist should be himself" and openly disclose his feelings or emotions. Paradoxically, if he exhibited his preferences and dislikes, this would contrast with the notion of a neutral therapist he mentioned earlier. Despite multiple examples of self-disclosure, participants could not identify any specific rules for managing privacy boundaries (what could be disclosed, to whom and when), apart from having positive feelings towards particular clients. Although self-disclosure was then associated with counter-transferential feelings towards individuals in treatment, therapists were not aware of the underlying unconscious dynamics that made them like or identify more with certain clients.

> I don't know why but some clients seem closer to you than others. You begin to like them more, you single them out from others and establish a more personal relationship. You are still in a therapist role, of course, but you become aware that you like certain clients and you protect them more. You may share similar interests. – Margaret

Working in a therapeutic community

Both groups stressed that the amount of self-disclosure depends on the setting. Professionals who work in therapeutic communities disclose more due to greater exposure to their clients (they spend more time with them during all-day shifts, holidays or therapeutic retreats) which results in establishing closer relationships.

> Apart from therapy you spend time together outside the group. During your shift you participate in their lives

> and meals, celebrate holidays with them, and take part in organised trips. There is much more going on between you and the clients compared to an out-patient centre or brief therapy programme. Patients see their therapist not only during sessions, but also when he climbs a mountain and gets short of breath. They watch your skills when you go camping or bake biscuits for Christmas. By this very form of treatment, you open your private world to them, whether you want to or not. – Catherine

Margaret said this can affect the boundaries of privacy and result in a more intimate relationship with some clients.

> You get closer to them because you spend 24 hours a day with them during your shift. You might be in your pyjamas when someone knocks at your door to get some keys, or brushing your teeth when someone comes in, because they need something. These barriers collapse. – Margaret

Addressing someone by their first name (in Polish culture this is typical of casual relationships but not formal ones) is an important factor which shortens the emotional distance between people. Monica stressed that it was more challenging keeping secrets in inpatient centres, where clients were curious about their therapists and used a variety of ways to learn more about them.

> Clients here often have no life of their own and become meddlesome and curious about others, especially therapists. They try to eavesdrop when we talk with other therapists or group members, and they gossip with one another. Information about your everyday life starts circulating among people ... whether you are overworked, or in love, are doing up your house, or learning to swim. – Monica

Disclosing one's own problem with substance dependence

All neophytes admitted to disclosing information about their own dependency treatment, coping with crisis, or relapses. They justified this as an intentional therapeutic technique for modelling behaviour, giving hope, and building trust.

> I generally protect my privacy but, if it might help my client, I would disclose such information. Not because I feel like sharing with someone; I have close friends I can confide in. However, I do so if I think it will provide a lesson to help my client feel better by seeing that others went through a similar crisis and managed to recover. – Margaret

Monica and Derek also thought their personal experience in addiction treatment was a positive attribute and that sharing information about it could have beneficial effects on the therapeutic relationship. Derek said that many clients would then treat him as 'our man' which puts him in a more privileged position than non-neophytes. Monica also felt the therapeutic group could more easily accept experts by experience, so this was her 'bargaining chip'. Despite that, participants also thought that some therapists concentrated too much on themselves and their own life stories, not leaving enough space for clients.

> I wonder – when I hear a therapist talking about himself, giving too many examples from his own life – if the therapist has forgotten his role? Therapy is all about the client. This is why we use supervision. Our team can point out if you get lost, that you feel more important than your client. – Derek

Neophytes also observed that they used self-disclosure less and less often as they gained more therapeutic experience. They explained this in terms of feeling more secure in their role and having endorsed professional norms taught during training.

> When I began my career, it was easier to disclose information about myself. Nowadays, when clients ask me questions, I still respond, but only when they ask me. – Derek

Peter related to his own experiences as a drug addict, but was more likely to talk about them as a metaphor or a story about someone else. During training, he had learnt to be more neutral and less transparent to his clients.

> I don't disclose my experiences in public anymore. Sometimes I say things like: "I know a guy who... " You can use that example or not. – Peter

Theme 4: Changing Roles

All non-neophytes except Jacob were clear that therapists should not establish alternative forms of relationship with their clients, even when therapy has been terminated. They thought that having once been in a professional role would always determine the future contact, and dual relationships should be avoided.

> No matter how long the therapy lasted, whether a month, a few months, a year, or two, the therapist must not change this relationship into a non-therapeutic relationship, in which his role would also change. – Agnes

For Jacob, on the other hand, it was not entirely clear how he should treat clients who finished therapy but remained in contact with him.

Attitudes towards changing roles were different among neophytes. All of them admitted to maintaining non-therapeutic relationships with former clients. They stressed that these relationships changed only after therapy was over. They saw it as a condition *sine qua non* for establishing friendships or working with former clients. Although therapists believed that there should be some time period before both parties met in different roles, they were unable to define that length.

Becoming friends

Derek said that establishing close bonds with former clients was unacceptable. Later in his interview, he expressed doubts whether professional relationships should remain unchanged and admitted he continued relationships with some clients he really liked. As in Adam's case, a few of his former clients became close friends and they would socialise together, going out for a beer. Derek said this led to unfortunate consequences – he could no longer provide them with treatment if they used substances again. He felt

guilty and ashamed about socialising with a former client, a drug addict, who he had met for a beer and had gossiped with about other therapists, when he learnt that the client started abusing alcohol and would be returning to the healthcare system.

> This is unacceptable from the therapeutic point of view, although I did it. I feel guilty because I should not have done that … I feel responsible for him starting drinking. I would not be telling you this unless it was anonymous. I think that when someone starts using substances again, it is the therapist's fault because he opened that door to him. I think this is my biggest therapeutic sin. – Derek

Monica said that although she tried to avoid dual relationships she had established a friendship with a former client, who won her trust and became close to her during treatment.

> We've been friends for three years. We spent New Year's Eve together and he visited me at home. I also went to his home. I lent him my car once. We became close friends. – Monica

Adam said he sometimes offered clients a change of relationship as a reward for success in treatment. He promised them friendship if they sustained their abstinence.

> When I worked with drug addicts, I had good relationships with some of them. I told them: "If you are good and abstain from drugs for a year, you can invite me to be your friend on Facebook." – Adam

Interestingly, all neophytes except Peter recall similar experiences with their own therapists: shortening the distance, and therapist self-disclosure, was common for them. They later copied these behaviours with their own clients.

> It was important that she invited me to her home. I think it was part of my treatment. I was also happy when she agreed to meet me at a café for coffee and a chat, and not necessarily treatment. It is important for someone who is trying to recover. – Adam

Peter said he had no contact with his former therapist outside her office, because she treated him in an out-patient clinic rather than as an in-patient in a therapeutic community.

Working together

Becoming work colleagues with former clients was another theme brought up during the interviews. None of the non-neophytes reported having such relationships, although Anna mentioned one neophyte who worked in the same institution as his therapists. On the other hand, three neophytes (Monica, Adam, and Peter) now worked in the centre where they had been treated for substance abuse, and regularly met their therapists in different roles. Peter was angry with his former therapist and devalued her, perhaps because she never established a friendship with him. Monica felt there was nothing unusual about working in a team with her group therapist, but thought it was a challenge for people to work with therapists with whom they had had individual treatment. Monica said it was difficult to establish a symmetric relationship with someone who once represented authority and knew her secrets. She was concerned about confidentiality and the therapist's attitude towards her.

> It is awkward working in a team with your own therapist. He knows I had a troubled relationship with my father and about some shameful secrets. I wonder if he might seem friendly but perhaps use this knowledge if there were problems at work. – Monica

Margaret, Peter, and Derek also worked with former clients who had subsequently trained as therapists in one centre, but not on the same therapeutic team. Otherwise, they said it would be difficult to attend supervision and disclose personal secrets in the presence of former clients. Margaret was concerned about protecting a client's information learnt during treatment, and separating that from other details. Peter stressed he was able to establish distance, but the clients would often transfer expectations and feelings associated with former roles.

> It was the clients who often transferred the experience relating to former roles. They remembered that and remained in that role. I concentrated on my work and could keep my distance, but they would recall our therapy, ask questions. – Peter

Having a romance

All participants declared that establishing intimate, sexual relationships with clients was ethically forbidden. They denied ever having a love affair with a client or their own therapist. Despite that, neophytes said such relationships were common and saw nothing wrong in it unless it involved a group therapist rather than an individual therapist, and after the therapeutic relationship had been terminated. They gave examples of people they personally knew who had had a romance with former clients.

> I know three colleagues who paired up with their clients. In one case it was a client who had had individual treatment with her, but the others had been in a group. – Monica

This was seen as interesting news and discussed in the therapeutic community, but participants were not critical about such events. On the contrary, Adam talked about a therapist who "had a very good sense of timing, because she resigned from work before getting married to my buddy".

Discussion

This study aims to explore how substance abuse specialists perceive their role boundaries, the meaning they ascribe to their own privacy, and how they use self-disclosure. They all stressed the importance of endorsing and internalising principles learnt during professional training; however, they mostly focused on the norms

that are expressed *expressis verbis* in professional codes of conduct. They seemed to have less certainty and understanding of rules for managing the boundaries of privacy or the relationships with former clients, because training and codes provide limited guidelines in these areas.

Therapists' Self-disclosures

All participants revealed personal information about themselves in therapy sessions. While non-neophytes tried to maintain firmer privacy boundaries than neophytes, they still disclosed considerable personal information. In most cases, their technique was based on the cognitive-behavioural modality and did not require them to be more non-transparent, as would be expected from psychodynamic professionals. Although they justified self-disclosure as potentially beneficial for the working alliance, they did not question why clients asked certain questions, and what were their conscious or less conscious reasons for learning more about their therapists. According to Pietkiewicz and Włodarczyk (2014), reflection about potential consequences of disclosing, intentionally or not, one's moral values or preferences (political, aesthetic, religious, etc.) is necessary from the ethical point of view, because therapists become important identification figures and role models for their clients, and can have considerable impacts on clients' views and life choices. Three neophytes in our study also emphasised that therapists should be 'natural', which they understood as having the right to express their feelings about clients, their likes and dislikes. De Leon (2000) also postulates that therapists should give realistic feedback and can disclose their disappointment, frustration or anger for therapeutic motives. On the other hand, there is a risk that in some cases this will lead to therapists' acting-out behaviour. Our participants also gave examples of self-disclosure that clearly violated professional boundaries, such as gossiping about members of the therapeutic team. This was apparently motivated by a wish to reduce distance, befriend clients, or get emotional support from them, and not by therapeutic objectives. Therapists were aware that this behaviour was inappropriate and against ethical codes (KBds.PN, 2010; PARPA, 2008), but may have been reluctant to disclose it during supervision because of shame. This confirms that early stages of recovery can disrupt effective treatment, because therapists can identify with clients more and have stronger counter-transferential reactions (Miller, Forcehimes, & Zweben, 2011). Inexperienced therapists are only just beginning to develop their awareness of these phenomena.

Psychotherapeutic literature reports that self-disclosure is rarely used by therapists with little professional experience (Henretty & Levitt, 2010) and those who perceive their clients as less stable or more symptomatic (Kelly & Rodriguez, 2007). These observations are contradictory to ours. Our participants, especially neophytes, said that they revealed less information about themselves as they became more confident and reflective as therapists. This may be the result of being able to distinguish between therapeutic ends and one's own needs. Supervision was mentioned as an important factor that gave therapists more insight into their personal psychological mechanisms.

This study also confirms that certain types of setting (e.g., therapeutic community) are conducive to self-disclosure (Forrest, 2010). De Leon (2000) compares the therapeutic community to a small village where information swiftly circulates via informal channels. Clients can easily learn about therapists' personal lives and difficulties. Both neophytes and non-neophytes reported that spending more time with clients and participating in various activities with them shortened the distance and challenged their privacy boundaries. How therapists feel about being observed by clients in everyday activities at a rehabilitation centre, or accidental, involuntary self-disclosures, requires further examination.

Establishing Dual Relationships

While some kind of self-disclosure may have positive effects, there is no evidence about advantages of dual relationships (Chapman, 1997) and many professional codes warn against them (American Counseling Association, 2014; American Psychological Association, 2010; NAADAC, n.d.). Our participants reported that dual relationships with former clients were not uncommon, and often driven by therapist and client sharing positive feelings about each other. Interestingly, they revealed no clinical understanding of the psychological mechanisms in therapeutic relationships that could fuel such dynamics (i.e., transference and counter-transference). Psychodynamic theories could aid substance abuse therapists to develop greater understanding of many phenomena that occur in therapeutic relationships. While some therapists did consider establishing an alternative form of relationship with former clients, they said it would only be possible after therapy had been terminated, but could not specify how long this period should be. There is a risk, here, that some therapists may (consciously or unconsciously) attempt to bring therapy to an end if they developed a desire for a non-therapeutic relationship with a client.

When it comes to sexual relationships with clients and their family members, most ethical codes (NAADAC, n.d; PARPA, 2008; KBds.PN, 2012) clearly forbid them. An earlier study by St. Germaine (1996) shows that most complaints about substance abuse therapists actually relate to intimate contacts with current or former clients, but we found no contemporary data about how frequently therapeutic affairs are reported. While it was clear for our participants that sexual relationships were inappropriate, they did refer to such examples. Some justified these cases by saying that therapy had already been terminated. It seems that therapists differ in their understanding of when a therapeutic relationship terminates. Psychodynamically-oriented professionals maintain that therapists should disengage from contact with former clients, allowing them to process experiences gained during treatment, experience separation, and maintain an inner representation of the therapist as a good object, to which they can relate in daily life. Pietkiewicz and Włodarczyk (2014) highlight the risk that clients would most probably bring a variety

of expectations and transferential feelings that were present during treatment (and not necessarily resolved) into a new type of relationship, but the therapist would no longer be in a position to interpret them. This could lead to constant acting-outs and be challenging for both parties. Another potential threat is that conflicts that arise in such relationships could have a negative impact on therapy outcomes. While therapists are ascribed with expectations that clients remain sober and function well, some of these clients may attack their relationship and internalised representation of the therapist by breaking abstinence. In other words, they punish the therapist by attacking what they have both achieved during treatment. Unfortunately, if a dual relationship has been established, the therapist could no longer help clients if they relapse (Pietkiewicz & Włodarczyk, 2014).

Whereas non-neophytes were clear that they should not establish dual relationships (although they did not necessarily understand why, except that ethical codes found it inappropriate), neophytes reported many such cases and had limited understanding about potential risks. This shows that there should be more focus during training on discussing unconscious dynamics in client-therapist relationships. Further investigation about how clients use their former therapists and vice versa is needed, and what needs therapists satisfy in themselves. It is evident that transference / counter-transference mechanisms regulate that dynamic because therapists choose to befriend clients they identify with, saying they both like each other. Therapists should be encouraged to discuss such cases during supervision. We would also encourage further studies to investigate how often therapists report crossing professional boundaries in supervision and how these issues are handled.

It is also striking that neophytes who reported dual relationships with former clients also had similar experiences with their own therapists. It is probable that they copied these practices via identification with them. The only neophyte who did not report having had a dual relationship was the one who participated in group treatment for alcohol dependence in an out-patient centre using the Minnesota model. This shows a need for further investigation on how various methods and settings neophytes were treated in affect their own therapeutic habits. It would be useful to compare how various groups of therapists (those treating alcohol dependence, drugs, or behavioural addictions) manage professional boundaries, because the type of substance determines the choice of treatment in Poland (people addicted to alcohol or drugs are referred to different centres).

Finally, work relationships – another type of dual relationship – was discussed in this study. Further analysis is required into why some people choose to work at the centre where they received treated for substance abuse. This could relate to separation difficulties, which may also be why some therapists continue their relationships with former clients. In some cases offering former clients a job may be (implicitly) an extension of their therapy, by giving them an opportunity to work. No data was found about how many people with addictions become therapists, and how often they establish dual relationships with former therapists. This justifies further quantitative investigation. Undoubtedly, admitting former clients to therapeutic teams requires therapists to re-negotiate their roles with them. This can be challenging for some people, especially those who try to maintain rigid privacy boundaries and disclose little to clients, but share private information with team colleagues. Doyle (1997) recommends that therapists seek legal advice when former clients apply for a job in their institution and managers should be aware of potential difficulties and institutional responsibility.

It is interesting how former clients adapt and negotiate their role in a therapeutic team and how they feel about others knowing their intimate, personal secrets (facts shared by a client during treatment and discussed by a team during supervision often expand on the kind of information people share with work colleagues). Such workers may still feel unequal in relationships with former therapists, who can still evoke transferential feelings. It may be difficult to disagree or express dissatisfaction, making new therapists vulnerable and potentially exploitable.

This study also shows that both neophytes and non-neophytes attribute special meaning to therapist's personal experience with substance abuse and how that affects professional identity. This leads us to believe that more attention should be paid to the relationship between neophytes and non-neophytes when supervising teams which include representatives of both groups.

Neophytes versus non-neophytes

It was striking that both types attributed special meaning to therapists' personal experience with substance abuse which had tremendous impact on their professional identity. Interestingly, substance abuse treatment is probably the only area in mental healthcare where experts-by-experience are accepted without any doubts. De Leon (2000) observes that, initially, therapeutic communities were formed by people who were themselves recovering, and only later were they joined by people with a degree in pedagogy (the method and practice of teaching), psychology, or medicine who were trained in substance abuse treatment. While many recovering therapists may feel predestined to help others (some referred to that as a 'calling'), there are certain associated risks which have already been mentioned in the results section. It is possible that choosing this profession allows some people to project their own difficulties and weaknesses onto their clients and, by helping them, gain a sense of control over threatening and unwanted impulses and desires. That would reveal the pathoplastic aspect of the chosen profession, in allowing people to express their own problems in a culturally accepted and valued way.

Although neophytes claimed that past experience with substance abuse was their 'trump card' of which they were proud, this could also mask them feeling ashamed and unequal to non-neophytes. In reaction, some non-neophytes expressed doubts about their skills to guide others, because they did not personally have a problem with

addiction. This can result from unconscious competition between both groups, where projection-introjection mechanisms are utilised to protect the vulnerable self. Similar processes were observed in relationships with clients. Feeling undermined by them for not being experts-by-experience evoked difficult emotions in non-neophytes, but (or because) they did not understood psychological mechanisms utilised by these patients. Providing substance abuse therapists with training in this area to help them understand common defences against establishing a relationship of dependence and feeling vulnerable in it, or the subtleties of transference and counter-transference, is highly recommended.

Implications

A few practical implications result from this study. First, it seems necessary to supplement ethical codes for substance abuse specialists with additional guidelines about professional boundaries, especially in relation to dual relationships and self-disclosure. Codes should explicitly define role obligations with reference to current and former clients. Furthermore, they should define situations when supervision is specifically recommended. Training programs should develop therapists' understanding of the unconscious mechanisms affecting the dynamics between therapists and clients, therapists and their colleagues or the institution in which they work. These issues should also be carefully analysed during clinical supervision. Understanding of the unconscious processes can be helpful, because they affect relationships no matter what modality or technique is used, leading therapists to crossing or even violating established setting and ethical boundaries. Therapists should be strongly recommended to use supervision every time they feel tempted to reduce distance, befriend a client or open up and disclose their privacy. Neophytes could additionally use this opportunity to critically analyse their own experience with dependency treatment to distinguish between good and bad (or potentially risky) practices. They should also be able to discuss personal challenges associated with being a therapist (e.g., dealing with one's own crisis or craving, and perceived limitations in using support groups and disclosing problems, if this leads to creating dual relationships with clients who co-participate in such groups). Analysing personal motives for becoming therapists should also be encouraged.

Limitations and Further Development

In this study we used a small sample and analysed it ideographically, which is characteristic of the IPA framework. Although we found no specific differences how men and women viewed discussed issues, non-neophytes were under-represented by men. This resulted from limited access to them during the recruitment. Further studies should analyse potential gender differences in therapists' attitudes towards self-disclosure and transforming therapeutic relationships into other forms. Also, the participants were not fully anonymous to the interviewer and vice versa. While this seemed to encourage many of them to participate and disclose vulnerable areas, the same factor could also have been an obstacle for the three candidates who eventually did not participate.

We can make no claims about the generalisability of our findings because representation is not an issue in qualitative studies (Willig, 2008). However, we highlight certain phenomena that should alert supervisors and trainers in substance abuse treatment. Our study shows that there were significant differences in how neophytes and non-neophytes understood and managed their professional boundaries. We also found examples where these boundaries had been crossed or even violated. A quantitative analysis is now recommended to check how frequently such situations occur and how they are related to specific variables (e.g., the context and method of treatment, the type of addiction, usage of supervision, the content of the certification programme they attended, etc.).

Conclusion

This is the first empirical study on how substance abuse therapists perceive role boundaries and use self-disclosure. Significant differences were found between neophytes and non-neophytes: the latter ascribed greater importance to rigid professional boundaries and therapist's privacy, whereas neophytes were more open to disclosing personal information and establishing dual relationships. Working in therapeutic communities is conducive to disclosing more information, either through deliberate or accidental self-disclosure. Therapists also reported reducing self-disclosure as they gained professional knowledge and experience. These results imply that issues associated with professional authority, power differential, and psychological mechanisms present in client-therapist relationships (especially defence mechanisms, transference and counter-transference) should be studied in detail by dependency treatment trainees and analysed during supervision.

References

American Association for Marriage and Family Therapy. (2015). Code of ethics. Retrieved from www.aamft.org/iMIS15/AAMFT/Content/legal_ethics/code_of_ethics.aspx

American Counseling Association (2014). ACA Code of Ethics. Alexandria, VA.

American Psychological Association. (2010). American Psychological Association ethical principles of psychologists and code of conduct. Retrieved from www.apa.org/ethics/code/index.aspx

Barnett, J.E. (2011). Psychotherapist self-disclosure: Ethical and clinical considerations. *Psychotherapy, 48*, 315–321. doi: 10.1037/a0026056

Beck, A.T., Wright, F.D., Newman, C.F., & Liese, B.S. (1993). *Cognitive therapy of substance abuse*. New York, NY: Guilford Press.

Carew, L. (2009). Does theoretical background influence therapists' attitudes to therapist self-disclosure? A qualitative study. *Counselling and Psychotherapy, 9*, 266–272. doi: 10.1080/14733140902978724Chapman, C. (1997). Dual Relationships in Substance Abuse Treatment: Ethical Implications. *Alcoholism Treatment Quarterly, 15*, 73–79. doi: 10.1300/J020v15n02_06.

Davis, B. (2011). Psychodynamic psychotherapies and the treatment of co-occurring psychological trauma and addiction. In B. Carruth

(Ed.), *Psychological trauma and addiction treatment* (pp. 41–69). New York, NY: Routledge.

De Leon, G. (2000). *The therapeutic community: Theory, model, and method*. New York, NY: Springer Publishing Company.

Doyle, K. (1997). Substance abuse counselors in recovery: Implications for the ethical issue of dual relationships. *Journal of Counseling & Development, 75*(6), 428–432.

Forrest, G. (2010). *Self-disclosure in psychotherapy and recovery*. Plymouth, UK: Rowman & Littlefield.

Gabbard, G.O. (2014). *Psychodynamic psychiatry in clinical practice*. Arlington, VA: American Psychiatric Publishing.

Gibson, M.F. (2012). Opening up: Therapist self-disclosure in theory, research, and practice. *Clinical Social Work Journal, 40*, 287–296. doi: 10.1007/s10615-012-0391-4

Gutheil, T.G., & Gabbard, G.O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *The American Journal of Psychiatry, 150*(2), 188–196.

Henretty, J.R., & Levitt, H.M. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review*, 30, 63–77. doi: 10.1016/j.cpr.2009.09.004.

Kadden, R., Carbonari, J., Litt, M., Tonigan, S., & Zweben, A. (1998). Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: Clinical and Experimental Research, 22*(6), 1300–1311.

Kelly, A.E., & Rodriguez, R.R. (2007). Do therapists self-disclose more to clients with greater symptomatology? *Psychotherapy: Theory, Research, Practice, Training*, *44*, 470–475. doi: 10.1037/0033-3204.44.4.470.

KBds.PN. (2012). *Kodeks etyki terapeuty uzależnień* [*The ethical code of a substance abuse therapist*]. Warszawa: The National Bureau for Drug Prevention Retrieved from www.kbpn.gov.pl/portal?id=106417.

Knox, S., & Hill, C.E. (2003). Therapist self-disclosure: Research- based suggestions for practitioners. *JCLP/In Session, 59*, 529–539. doi: 10.1002/jclp.10157

Lazarus, A., & Zur, O. (2002). *Dual relationships and psychotherapy*. New York, NY: Springer Publishing Company.

Miller, W.R., Forcehimes, A.A., & Zweben, A. (2011). *Treating Addiction: A Guide for Professionals*. New York, NY: The Guildford Press.

NAADAC. (n.d.). NAADAC/NCC AP Code of ethics. Retrieved 06.07.2017 from www.naadac.org/code-of-ethics

PARPA. (2008). *Kodeks Etyczno-Zawodowy Terapeuty Uzależnień* [*The professional-ethical code of a dependency treatment therapist*]. Warszawa: The State Agency for the Prevention of Alcohol-Related Problems. Retrieved from www.parpa.pl/index.php/certyfikacja-terapeutow/kodeks-etyczno-zawodowy-terapeuty-uzaleznien.

Petronio, S.S. (2002). *Boundaries of privacy: Dialectics of disclosure*. Albany, NY: State University of New York Press.

Pietkiewicz, I., & Włodarczyk, M. (2014). Crossing the boundaries of privacy in accidental encounters: interpretative phenomenological analysis of therapists' experiences. *Clinical Psychology & Psychotherapy*. doi: 10.1002/cpp.1930

Pietkiewicz, I.J., & Smith, J.A. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Psychological Journal, 20*, 7–14. doi: 10.14691/CPPJ.20.1.7.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage Publications Ltd.

St. Germaine, J. (1996). Dual relationships and certified alcohol and drug counselors: A national study of ethical beliefs and behaviors. *Alcoholism Treatment Quarterly, 14*, 29–44. doi: 10.1300/J020V14N02_03

Stricker, G.E., & Fisher, M.E. (1990). *Self-disclosure in the therapeutic relationship*. New York, NY: Plenum Press.

Walter, M. (2015). Personality disorder and addiction. In G. Dom & F. Moggi (Eds.), *Co-occurring addictive and psychiatric disorders: A practice-based handbook from a European perspective.* (pp. 137–148). New York, NY: Springer-Verlag Publishing.

Willig, C. (2008). *Introducing qualitative research in psychology*. Maidenhead, UK: Open University Press.

Zur, O. (2006). Therapeutic boundaries and dual relationships in rural practice: Ethical, clinical and standard of care considerations. *Journal of Rural Community Psychology, 9*(1), 1–40.

Zur, O., Williams, M.H., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the Internet age. *Professional Psychology: Research and Practice, 40*, 22–30. doi: 10.1037/a0014745.