CORRECTIONS RESEARCH, EVALUATION & STATISTICS
Governance & Continuous Improvement

An investigation into the development and maintenance of professional and personal boundaries among CSNSW psychologists

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Principal investigator's biography

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Dr Abilio Neto is a registered psychologist with the Australian Health Practitioner Regulation Agency and a Psychology Board approved supervisor. He holds a Bachelor of Science (Psychology) with Honours from the University of New South Wales and a PhD in psychology from the University of Sydney in the area of professional standards. He currently works in the capacity of Senior Research Analyst at CSNSW Corrections Research, Evaluation and Statistics. He formerly held the position of Research and Development Manager at the National Prescribing Service. He also held an academic position at University of Sydney where he conducted research in the area of standards of practice for the healthcare setting. Dr Neto has been guest speaker at a number of international conferences and has published extensively in scientific journals in the development and implementation of professional standards.

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Executive summary

Background

The current research was supported by a research grant from the Psychology Council of NSW. This research grant followed the identified education and research priority area of the Psychology Council of NSW "Conduct - maintaining appropriate professional and personal boundaries, with specific attention to psychologists in correctional facilities", contained within the Education and Research Guidelines 2013-2014 of the Council.

As a first step towards understanding the development and maintenance of personal and professional boundaries in the correctional setting a comprehensive review of the literature was conducted. The main findings from this literature review are summarised below.

The need to identify and address seemingly trivial boundary challenges

Case studies of clinician client sexual contact show that serious boundary violations are typically preceded by a progressive series of nonsexual boundary crossings; a phenomenon known as the "slippery slope". Therefore, seemingly trivial boundary challenges by clients may in reality be considerably more serious when viewed in the context of a continuum. Dealing with these seemingly trivial boundary challenges openly and honestly in clinical supervision may prevent serious boundary violations. Indeed, good supervision practice is argued to provide the best safeguard against boundary violations.

Cases of serious boundary violations, which are subjected to mandatory reporting to the relevant authorities and public disclosure, represent a very small subset of professional transgressions, with these seemingly trivial minor transgressions representing a larger subset being underreported. The literature advocates identifying and learning from an organisation's own strengths and weaknesses by providing staff with the opportunity to disclose

confidentially situations related to the maintenance of personal and professional boundaries they typically face. In addition, staff must be able to disclose information on both successful and unsuccessful strategies they use to deal with such situations. That is, it is important to "unlock" useful knowledge on what works in what situation when one is dealing with boundary challenges.

Organisational influences

This review of the literature also revealed that boundary violations are unlikely to arise from the solitary actions of individual psychologists alone but also from suboptimal systems of which they are a part. That is, the failure to maintain personal and professional boundaries in the correctional setting is unlikely to be traced solely to an individual practitioner, but to a whole range of contributing factors including organisational influences, such as lack of clear policies and procedures in the area of personal and professional boundaries, lack of a formal set of standards of practice in the area, non-provision of formal professional development in the area, culture of silence and blame, suboptimal supervision practices in relation to boundaries, problems with the physical environment, preconditions, specific acts, etc.

Personal influences

Family of origin issues were identified in the review of the literature as the main distal factors associated with boundary transgressions. Particularly, insecure attachment, childhood adversities, and early maladaptive schemas have been identified as increasing risk of boundary issues. More proximal factors that influence the strength of professional boundaries include current personal relationship problems, feelings of social isolation, and financial difficulties.

The Standards of Practice

In recognition that good clinical supervision is potentially an effective way of optimising the development and maintenance of boundaries in the correctional setting, the current study initially developed the '*Standards of Clinical Supervision Practice for Optimising the Development and Maintenance of Personal and Professional Boundaries in the Correctional Setting*' (the Standards) based on this review of the literature.

Aims of the current study

The aims of the current study were threefold:

1. To obtain a snapshot of practice behaviour of CSNSW psychologists in relation to the maintenance of personal and professional boundaries and therefore "unlock" useful information.
    - Such a snapshot would provide an understanding of the types of situations and challenges CSNSW psychologists face in the performance of their duties. In addition, this snapshot of practice behaviour also would allow for the identification of strategies for handling successfully the challenges faced by CSNSW psychologists in relation to the maintenance of personal and professional boundaries.
2. To evaluate current organisational culture in relation to issues related to the development and maintenance of personal and professional boundaries.
    - Given the role of organisations in supporting the maintenance of strong personal and professional boundaries, investigators tested whether or not the current environment at CSNSW is conducive to supporting psychologists in maintaining strong personal and professional boundaries.

3. To collect baseline data on adherence to the 'Standards of Clinical Supervision Practice for Optimising the Development and Maintenance of Personal and Professional Boundaries in the Correctional Setting' (the Standards).

Method

Procedure

An online survey using SurveyMonkey platform was constructed to adminster qualitative and quantitative survey/questionnaires regarding boundary issues and challenges. Three slightly different qualitative surveys were administered depending on the respondent's role within the organisation - chief psychologist, supervising psychologist, or psychologist. Supervising psychologists and psychologists completed four questionnaires as part of their survey.

Qualitative measures

Survey respondents were asked to provide examples of two types of boundary challenging situations and to state how they had dealt with each situation: 1) challenges that had arisen as a resulted of an offender's behaviour; and 2) challenges that had arisen as a result of behaviour or feelings of the treating psychologist him/herself toward the offender.

Quantitative measures

Four separate questionnaires were used in the surveys administered to psychologists and clinical supervisors:

1. A questionnaire that measured how comfortable the individual psychologist was with discussing issues related to personal and professional boundaries in the workplace.
2. An adapted version of the Client-Staff Interactions Survey (C-SI) instrument that measures domains from over-involvement to under-involvement by clinicians in therapy.

3. An adapted version of the Boundary violations index (BVI) which is a validated measure designed to screen for vulnerability to commit boundary violations.
4. Standards of Practice Questionnaire designed to evaluate 'at baseline' adherence to the Standards of Clinical Supervision Practices for Optimising the Development and Maintenance of Personal and Professional Boundaries in the Correctional Setting.

Participants

Invitations to take part in the survey were sent via email to all CSNSW psychologists, including chief psychologists, clinical supervisors, and psychologists (N=156). Subsequently, two reminder messages were sent inviting those that had not as yet completed the survey to participate. The final sample consisted of 50 completed questionnaires (87% female). However, there were 39 incomplete questionnaires representing a wide range of completeness. Data from incomplete questionnaires were included in the analysis, where meaningful.

Results

Results from the survey of CSNSW psychologists demonstrate psychologists working in the correctional setting are confronted with a range of boundary challenges from offenders. Such challenges include inappropriate sexual behaviour, inappropriate sexual comments, inappropriate propositions, harassment, intimidation, requests for favours, sexual and personal advances, personal information enquiries, offers of gifts, physical touching, attempts to form dual relationships, attunement to psychologists' emotions, attempts to manipulate and split staff, and attempts to maintain contact with the psychologist after release.

There were also reports of boundary issues related to the psychologist-clinical supervisor relationship including lack of confidentiality, negative perception of dual relationships

between supervisors and supervisees, ineffective reporting of boundary issues to supervisors, and lack of faith in supervision.

Results also showed that although most CSNSW psychologists establish a strong boundary verbally when confronted with such challenges (e.g. telling the offender the behaviour is inappropriate), not all CSNSW psychologists responded appropriately to these challenges (e.g. there were reports of psychologists not reacting to boundary challenges). In addition, a significant proportion of CSNSW psychologists reported not feeling comfortable discussing boundary challenges with their clinical supervisors.

The survey found in most instances, positive outcomes were achieved when boundary issues were discussed in supervision. The utility and power of an open and honest supervisory relationship was clearly evident in these reports. However, in a minority of cases where such issues were discussed in supervision survey respondents reported having been reprimanded for minor boundary crossings. This approach to handling instances where a minor mistake is made is problematic. The actual boundary crossings that were reported were very minor, the exact types of behaviours that should be discussed in supervision and successfully addressed. Negative experiences in response to reporting minor boundary crossings are likely to deter psychologists from reporting such incidents to their clinical supervisors in the future.

The current research also demonstrated that in real-life practice of forensic psychology some clinicians will develop affiliative feelings for the offender being treated and a large proportion of clinicians will feel sexually attracted to an offender at some point in their careers. Conversely, it was also found that clinicians are also likely to experience strong negative emotions toward particular offenders, such as anger and feelings of being manipulated, and at times they may even feel helpless or like a failure.

Results also demonstrated a lack of consistency in the reporting of issues related to personal and professional boundaries. Inconsistencies in the outcomes of such reports were also observed. It appears psychologists were not following set policies and procedures on how to handle the reporting of issues related to personal and professional boundaries.

In relation to the baseline measurement of the individual standards of practice, results showed: 1) supervisees were able to organise an extra meeting to discuss boundaries and that such meetings mostly occurred in private; 2) a general lack of professional development opportunities in the area of personal and professional boundaries; 3) a lack of clear policies and procedures being followed by clinical supervisors to assist supervisees to develop and maintain personal and professional boundaries in the correctional setting.

Discussion

Results showed CSNSW psychologists are confronted with a range of boundary challenges when working with offenders. CSNSW psychologists would benefit from the provision of formal education and training on how to respond to the boundary challenges they typically face. Also beneficial would be the implementation of the standards of practice developed as part of the current project to further assist CSNSW psychologists to deal appropriately with such boundary challenges.

Given the high prevalence of ethical challenges faced by CSNSW psychologists, including positive and negative feelings towards one's own client, it is crucial that such challenges and emotional states be normalised and openly discussed as part of clinical supervision. The literature review shows that open discussion between psychologists and their clinical supervisors of even minor ethical challenges is a precondition for preventing serious boundary violations. However, clinical supervision is of little value in the prevention of boundary violations if either party does not feel comfortable discussing issues related to

personal and professional boundaries. Therefore, the challenge for CSNSW is to create an environment where psychological staff feels comfortable openly discussing boundary issues with their supervisors. This will reduce the risk of serious professional transgressions.

Also noteworthy, the education provided to CSNSW psychologists must include information on who is at greater risk of boundary transgressions according to the findings of the literature review. Awareness of being at risk for boundary transgressions is likely to induce greater vigilance in relation to one's personal and professional boundaries.

There are many reasons organisations may be reluctant to address the topic of personal and professional boundaries including fear of damaging the reputation of their workforce by being perceived as being in need of education in the area; fear of the media who could seize on the opportunity to report such efforts negatively; the extra resource expenditure that would accompany such efforts. However, any barriers to addressing boundary issues in the correctional setting must be overcome if CSNSW as an organisation is to successfully prevent boundary violations.

Recommendations

Based on the findings of the current study, it is recommended that:

1. CSNSW provides ongoing education and training in the development and maintenance of personal and professional boundaries through formal professional development at the Brush Farm Academy of Corrective Services and through clinical supervision;
2. Strategies be devised and implemented at an organisational level to create a culture of openness among CSNSW psychologists, thus facilitating ongoing discussion of issues related to personal and professional boundaries in clinical supervision; and

3. CSNSW implements ‘the Standards,’ thus integrating them to systems at an organisational level that promote the development and maintenance of strong personal and professional boundaries, such as policies and procedures for responding to boundary challenges and activities aimed at culture change.
    a. The survey of CSNSW psychologists be replicated at regular intervals to monitor trends in adherence to the Standards and in the reporting of issues related to personal and professional boundaries.

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Introduction

The current research was supported by a research grant from the Psychology Council of NSW. This research grant followed the identified education and research priority area of the Psychology Council of NSW "Conduct - maintaining appropriate professional and personal boundaries, with specific attention to psychologists in correctional facilities", contained within the Education and Research Guidelines 2013-2014 of the Council.

Professional boundaries are the limits of a healthcare professionals' relationship with their clients. Boundary violations refer to instances where such limits are crossed and the therapeutic relationship is compromised. In the correctional setting, boundary violations between psychologists and offenders have the potential to negatively impact on: 1) offenders under the care of CSNSW; 2) the reputation of CSNSW; and 3) the reputation of the psychology profession as a whole. In addition, it is argued that the maintenance of professional boundaries is particularly challenging within a forensic setting due to both the type of clients and the intensity of the environment (Love & Herber, 2001 as sited in Daniels, 2008; Peternelj-Taylor & Johnson, 1995).

The boundary continuum

Several attempts have been made to model client-professional behaviour in terms of boundaries (Glass, 2003; Schoener, 1998). Within this report we adopt the model reported by Daniels (2008), which was firstly proposed by Daniels and Wong (2007), which combines elements of previously proposed models. Traditionally boundaries are considered from the perspective of over-involvement; however models of boundary related behaviours consider a continuum that stretches from under-involvement to over-involvement. The middle ground of this continuum represents an appropriate therapeutic relationship.

Boundary crossings

While boundaries imply a set line beyond which a therapeutic relationship should not venture, boundary crossings - a minor crossing of a boundary - have been suggested to be acceptable and at times a positive influence for a therapeutic relationship (Glass, 2003; Gutheil & Gabbard, G, 1993). Consistent with this approach, Zur (2005) argues that boundary crossings are not to be considered "dangerous" as argued by proponents of the "slippery slope" argument. This grey area presents a challenge for psychologists and organisations employing psychologists as no strict line can really be drawn due to the therapeutic nature of boundary crossings. What makes boundary crossings acceptable and indeed therapeutic is the particular therapeutic context that it occurs in (Glass, 2003). Examples of boundary crossing include treating a client like a friend, disclosing personal information, and extending the length of a session. The therapeutic environment is clearly relevant in deciding if the grey area constitutes a boundary violation, or a boundary crossing. At times, clinicians will engage in boundary crossing behaviours for some therapeutic benefit. A classic example is extending a session because a client is experiencing great distress and cutting the session short would actually constitute unethical behaviour.

Slippery slope

The concept of the slippery slope lacks a clear definition (Daniels, 2008). The concept describes minor crossings of boundaries that may escalate over time into boundary violations. Some have suggested that slippery slope behaviours lie between boundary crossings and boundary violations (Daniels, 2008). In another sense, the slippery slope could be thought of as instances where certain feelings and cognitions associated with possible future boundary violations are felt but not yet acted upon. For example, being attracted to a client does not

constitute a boundary crossing or violation, but if it is not dealt with appropriately, such feelings could lead to boundary violations.

The literature on boundary violations does stress the importance of addressing seemingly trivial boundary issues in clinical supervision. Case studies of clinician patient sexual contact demonstrate that serious boundary violations are typically preceded by a progressive series of nonsexual boundary crossings, the "slippery slope" (Gabbard, 1994; Gutheil & Gabbard, 1993; Sarkar, 2004; Simon, 1989; Strasburger, Jorgenson, Sutherland, 1992). Therefore, seemingly trivial boundary crossings may in reality be considerably more serious when viewed in the context of a continuum (Gabbard & Nadelson, 1995). Addrressing nonsexual boundary crossings in clinical supervision may therefore prevent sexual boundary violations (Gabbard & Nadelson, 1995). In addition, it is acknowledged that “seemingly” harmless boundary crossings could potentially harm the therapeutic relationship regardless of the possibility that they also may lead to sexual boundary violation (Frick, 1994). Inappropriate therapist self-disclosure, more than any other kind of boundary crossing, most frequently precedes serious boundary violations (Smith & Fitzpatrick, 1995).

We argue that boundary violations do not occur without first getting on the slippery slope towards them. It takes a lot to break ethical codes and transgress boundaries, thus these actions are unlikely to be made on the spur of the moment. Such boundary crossings do not constitute criminal or even perhaps reprimandable behaviours. This makes the slippery slope a very important concept in trying to prevent serious boundary violations within an organisation.

Learning from the voluntary disclosure of issues related to the maintenance of personal and professional boundaries

As seen above, the focus of intervention must be on seemingly minor boundary crossings, as case analyses show that typically there is a subtle gradual erosion of personal and professional boundaries before a serious violation occurs. Therefore, to prevent personal and professional boundary violations an organisation must "unlock" useful knowledge and experience on the prevention of seemingly minor boundary crossings to allow for dissemination of such knowledge and experience among colleagues. In addition, in instances where such minor boundary crossings do occur, psychologists must be equipped with the knowledge and skills for preventing their recurrence. One way to learn how to prevent the occurrence or reoccurrence of such minor boundary crossings is to establish a monitoring system (Kohn, Corrigan, Donaldson, 1999) that seeks voluntary disclosure about issues related to the maintenance of personal and professional boundaries by clinicians. In organisations that do not have as yet a culture that allows open discussion of boundary issues, such monitoring system can be established in the form regular anonymous staff surveys.

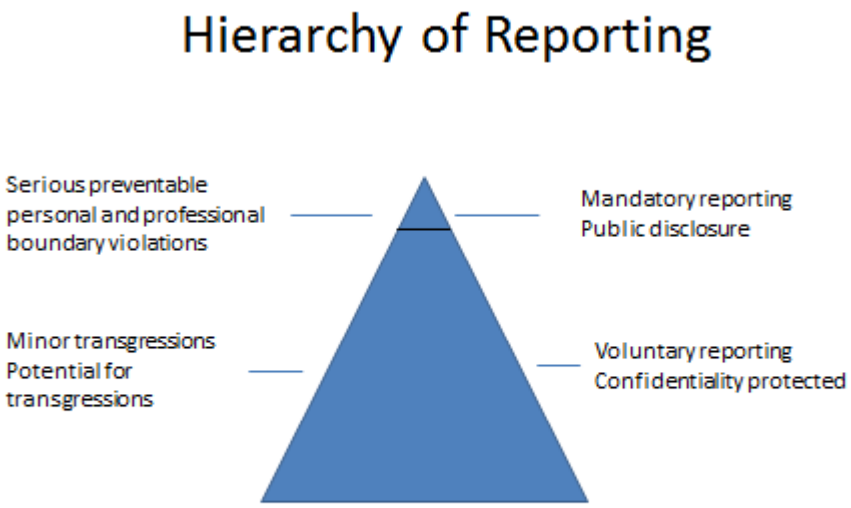
Such monitoring system assists in the measurement of professional performance in relation to boundary crossing and, most importantly, they provide information that forms the basis for further intervention refinement to optimise the development and maintenance of personal and professional boundaries.

Monitoring systems that focus on quality improvement are typically voluntary disclosure systems (Kohn, Corrigan, Donaldson, 1999). As discussed above a voluntary reporting system in the correctional setting must focus on the prevention of professional transgressions that seemingly result in minimal or no harm to the therapeutic relationship. Once such minor transgressions, boundary crossings, have occurred it is imperative they are disclosed in confidence outside the public arena with no form of punishment being issued in relation to a specific case. The aim of such system is to identify and remedy vulnerabilities in systems before the occurrence of a serious violation (Kohn, Corrigan, Donaldson, 1999). A voluntary

monitoring system is particularly useful for identifying types of personal and professional violations that occur too infrequently for an organisation to readily detect based on its own knowledge, and patterns of boundary crossings that point to systemic issues affecting the whole delivery of services to clients.

Serious cases of boundary violations subject to mandatory reporting to the relevant authorities and public disclosure represent a very small subset of professional transgressions, with minor transgressions being underreported and undisclosed (Figure 2).

Figure 2. Hierarchy of reporting



Boundary violations

Boundary violations are defined as behaviours or activities that cross the limits of what is considered ethical practice into an area where the relationship is compromised and harm is done to the client (Gutheil & Gabbard, 1993). Boundary crossing for over-involvement include but is not limited to gift giving and receiving, self-disclosure, romantic relationships,

taking advantage of a client for personal gain, friendship etc. Conversely, under-involvement is associated with a fractured relationship where the professional disengages from the therapeutic relationship and therefore does not meet the client's needs. Examples of under-involvement include behavioural or emotional hostility towards a client, ending therapy sessions due to boredom or disengagement.

The prevalence of sexual feelings by psychologists towards clients is very high: 80-85% (Garrett, 2002). Reports of such feelings transferring to actual boundary violations are undoubtedly under reported (Simon, 1989) as such admissions constitute a serious breach of ethics. Nevertheless, it is estimated that sexual intercourse between therapists and clients range from 1% to 12% (Williams, 1992), and 5% to 10% (Pope, Keith, Speigel, & Tabachnick, 1986). Most reported transgressions occur between male therapists and female clients, but there are reports of all types of dyads (Schoener, Milgrom, Gonsiorek, Luepker, & Conroe, 1990).

In New South Wales, Grenyer and Lewis (2011) reported that 4% of complaints made by members of the public against registered psychologists comprise of allegations of sexual boundary violations. The authors also report that on average 4 complaints of a sexual nature are made against psychologists per year in NSW, comprising a base rate of approximately one in every 2,500 registered psychologists in NSW.

Factors that support and interfere with maintaining appropriate boundaries

The responsibility for maintaining personal and professional boundaries ultimately lies with the registered psychologist him/herself and the organisation that provides psychological services - in terms of making sure its staff is supported, trained and educated. Professional boundaries are part of the ethics code and adherence to the code is a requirement of maintain

registration (APS Code of Ethics, 2007). Nevertheless, at CSNSW boundary violations have occurred from time to time over the last two decades.

The aim of the current project was to investigate the current status of issues related to the maintenance of personal and professional boundaries among CSNSW psychologists. That is, to identify the situations involving the maintenance of personal and professional boundaries CSNSW psychologists typically face and the strategies they use for dealing with such situations. Further, this project aimed to inform of any further actions that could be taken to enhance personal and professional boundaries in the correctional setting. There are several factors reported in the literature that support and interfere with maintaining appropriate boundaries that are reviewed below. Broadly, factors that support and interfere with boundary maintenance fall into two categories: 1) personal and 2) organisational.

Personal factors that predict boundary violations

Research into personal factors, that tend to predict boundary violations, suggests both distal and proximal personal factors can lead to boundary violations. Family of origin issues have been identified as the main distal factor associated with boundary transgressions (Samenow, Yabiku, Ghulyan, Williams & Swiggart, 2012). Particularly, insecure attachment, childhood adversities, and early maladaptive schemas have been identified as increasing risk of boundary issues (MacDonald et al., 2015). Psychologists are aware of the influence of early life trauma and maladaptive relationships on general psychological vulnerability. However, it may be difficult to see the influence of such factors on one's own personal professionalism. The recommendation with regards to these distal factors is making psychologists within an organisation aware of their possible influence on professional relationships, and bringing them up in supervision at instances where their presence has become problematic.

More proximal factors that influence the strength of professional boundaries include current personal relationship problems (Marquart, Barnhill & Balshaw-Biddle, 2001) and feelings of social isolation and financial difficulties (Worley & Cheeseman, 2006). These findings suggest that employees should be made aware of the personal risk factors for boundary transgressions and undergo yearly self-assessments to ensure vigilance around boundaries. Critically, the distal factors described above are all associated with greater risk of the proximal factors. Thus, professionals that identify with family of origin issues should engage in more frequent self-monitoring to minimise the risk of boundary transgressions.

Strong feelings are often part of therapy, and it is not always the client that experiences such feelings. In one study, 87% of psychotherapists admitted feeling sexual attraction towards their clients on at least one occasion (Pope, Keith-Spiegal, & Tabachnick, 1986). Although only a small percentage of therapists ultimately act upon these feelings, the mere prevalence of such feelings suggests that they are likely to be felt by nearly every psychologist from time to time. Given the prevalence of positive feelings towards clients it is crucial that such states are normalised and discussed in supervision. Jones (2015) reported on a correctional employee that was unprepared for the positive regard she felt towards some offenders. The corrections worker was trained to expect offenders to be manipulators and constantly trying to get the better of her. She was thus unprepared for genuine positive feelings towards an offender and from an offender (Jones, 2015). This lack of normalisation of affiliative feelings towards offenders may render the professional unprepared and unable to respond appropriately when they do occur.

Further, it is not only attraction that is likely to occupy the mind of a therapist; negative feelings towards clients are also common, particularly when working with an offender population (Love & Herber, 2001). Feelings such as anger, frustration, hate, fear, and helplessness are commonly reported in the forensic setting (Dianiels, 2008). These feelings

too need to be normalised and discussions of these strong emotions should be encouraged within individual supervision and group meetings. Clinical supervisors need to equip supervisees with personal coping skills in order to regulate such emotions when they do occur.

It must also be acknowledged that from a psychoanalytic perspective, such positive and negative feelings displayed in therapy can be the product of the redirection of feelings from one individual to another that occurs outside one's conscious awareness. In the context of clinician-client relationship, the redirection of a client's feeling for a significant person to the clinician is known as the phenomenon of 'transference'. Transference has been defined as "the inappropriate repetition in the present of a relationship that was important in a person's childhood" (Kapelovits, 1987). This term 'transference' was originally coined by psychoanalyst Sigmund Freud, who argued transference was an important factor in psychoanalysis allowing for a greater understanding of the client's feelings. When the redirection of feelings occurs from the clinician toward the client the phenomenon is termed 'countertransference'. In such cases of countertransference the client comes to represent for the clinician an object of the past on to whom past feelings and wishes are projected. Those with a psychoanalytic orientation argue that the mishandling of transference and countertransference is the most frequent cause of serious boundary violations in psychological therapy (Sarkar, 2004).

It is also noted that the phenomena of transference and countertransference are also argued to occur in the supervisor-supervisee relationship leading to the same boundary crossings and violations that can occur in therapy (Dewane, 2007). Schamess (2006) argues that there are similarities between the supervisory and a parent-child relationship, involving the need for approval and avoidance of punishment. Transference/countertransference is argued to be just as potent in the supervisory relationship as it is in the therapist-client relationship.

Organisational factors

Supervision

Appropriate supervision is largely recognised as being a crucial aspect of maintaining appropriate boundaries (Chiarella & Adrian, 2014; Grenyer & Lewis, 2012; Gutheil & Gabbard, 1993; Norris, Gutheil & Strasburger, 2003; Smith & Fitzpatrick, 1995; Swiggart, Starr, Finlayson & Jr, 2002). Clinical supervisors must address the complexities of boundary issues through supervision. However, in order to provide good clinical supervision, supervisors themselves must receive adequate training on how to deal with the complex and dynamic issues that are likely to arise in the correctional setting in relation to the maintenance of personal and professional boundaries (Norris, Gutheil, & Strasburger, 2003). Additionally, ethical development is considered a career-long process (Pope, 2003). Thus, adequate lifelong learning is crucial to the development and maintenance of strong personal and professional boundaries in the correctional setting.

Culture of openness

Appropriate clinical supervision is of little use in the prevention of boundary violations if either party is not comfortable discussing issues surrounding personal and professional boundaries. Therefore a culture of openness is an important factor in the prevention of boundary violations. Such a culture of openness was advocated by Jones (2015) who investigated correctional workers that crossed boundaries. There seems to be an assumption that employees in the correctional setting are able to work out the exact placement of a boundary between an offender and themselves, however this is clearly not always the case. In organisations where boundaries are often blurred, employees must feel safe in discussing grey areas with their supervisors if such organisations are to optimise the development and maintenance of personal and professional boundaries.

Standards of practice, policies and procedures

The existence of direct, explicit and clear policies and procedures is essential for preventing boundary violations in an organisation that employs psychologists whose boundaries are frequently being challenged. Without appropriate guidance on what is acceptable and what is unacceptable in the workplace, and on how to respond to challenging situations, it is unlikely that all staff will consistently respond appropriately to situations that challenge their personal and professional boundaries. Standards of practice facilitate self-reflection, self-monitoring and self-correcting behaviour, and the development of the skills necessary to respond appropriately to the challenges provided by the correctional setting (Grenyer & Lewis, 2012). As part of this project, the "Standards of Clinical Supervision Practice for Optimising the Development and Maintenance of Personal and Professional Boundaries" (Standards) were developed.

Education

Education is frequently advocated in research on boundary violations, and most advocate training beyond the ethics course taken at the university level (Grenyer & Lewis, 2012; Ross, 2013; Worley & Worley, 2011). Further, education must go beyond the teaching of principles and standards (Plaut, 2008), instead providing psychologists with adequate knowledge and skills to maintain personal and professional boundaries in their specific work environment.

The use of vignettes and self-disclosure by respected members of the profession (opinion leaders) are also strongly advocated. Vignettes allow those being trained to approach the issue of boundaries deeply and to really explore different approaches and possibilities (Plaut, 2008). Evidence consistently shows that respected members of a profession (opinion leaders) are able to successfully improve practice behaviour of their colleagues by delivering

evidence-based best practice messages themselves (Doumit, Gattellari, Grimshaw, O'Brien, 2007).

The common approach towards organisational perception of boundaries is viewing them as the 'bad apple' problem (Tschan, 2007). This view allows an organisation to externalise the problem and thus focus on hiring the right people, rather than considering any institutional problems that contribute to boundary issues. However, boundary violations within an organisation are unlikely to arise from the solitary actions of individual employees alone but also from suboptimal systems of which employees are a part.

It is common in organisations to attribute instances of boundary violations solely to the offending employee and argue that there is no systemic issue within the organisation (Tschan, 2007). However, case studies show that in general institutional issues cannot be discounted as contributing factors to boundary violations (Plaut, 2008). Indeed the organisation can play a large role in creating an environment where the development and maintenance of personal and professional boundaries are optimised, just as it can create an environment where boundary violations are likely to occur.

The main recommendation for professional organisations in terms of preventing boundary violations can be broadly labelled as the promotion of an open culture surrounding boundary issues. The idea of admitting to boundary crossings to supervisors or colleagues is not a realistic one within organisations that don't have a culture of openness. Such admissions can lead to disciplinary actions, a bad reputation, or even dismissal. An organisation with such a culture is likely to contribute to boundary violations as facilitating reporting is a precondition for preventing such violations (Tschan, 2007). Therefore the taboo of boundary issue discussion must be overcome to create an environment where transgressions are minimised.

One of the main approaches to changing culture is for change to flow from the top (Carroll & Quijada, 2004). Thus, it is up to senior psychologists and upper management to normalise the conversations around boundaries. This includes using self-disclosure to normalise the conversations and to use such disclosures as teaching tools for approaches towards handling issues related to boundary challenges.

Another approach to changing the culture surrounding boundaries is to encourage the disclosure of minor non-criminal transgressions (Jones, 2015). For this to occur, it is essential for an organisation to have and to disseminate clear definitions of where the line is drawn. That is, definitions for what constitutes violations for which disciplinary, rather than fireable, action will be taken by the organisation. Going further still, discussion of thoughts, feelings and behaviours that constitute boundary crossings should be encouraged and applauded. Such disclosures allow the organisation to get stronger by supporting staff members through boundary issues.

Factors specific to the correctional setting

The correctional setting provides psychologists with particular challenges in terms of boundaries. One particular challenge inherent to the correctional setting is the presence of manipulators (Worley, 2010). It has been proposed that offenders create chaos in the prison system by attempting to cross boundaries with prison staff- including psychologists (Worley, 2010).

Several ‘games’ played by prisoners were reviewed and evaluated giving an important insight into the challenges psychologists face in the correctional setting. Firstly, manipulators try to blur professional boundaries by trying to befriend staff. Such attempts may involve doing ‘favours’ for staff such as bringing them food, making them coffee etc. Another tactic identified in Worley (2010) is the offering of protection to staff by offenders. This could be

offers to protect them from particularly difficult clients. This tactic is usually targeted at staff that appears vulnerable and therefore may be susceptible to accept such offers. Offenders may also bring up sexual content unrelated to therapy in order to gage how a staff member will react. Other ways that offenders can push boundaries is by initiating touch. This too is a tactic to see how the staff member will react to minor transgressions. Such behaviours allow offenders to target vulnerable staff members. It is noted that all of these tacts, with the exception of the offering of protection, are consistent with psychologists' accounts of personal and professional boundary challenges reported in the survey of CSNSW psychologists.

In particular danger from manipulators, are psychologists that are not yet familiar with the correctional setting. The recommendation stemming from this research is education of new staff with the types of manipulation efforts they are likely to encounter (Worley, 2010).

In addition to the presence of manipulators in the correctional setting, the literature also argues that as a defence against denigration and rage, clients with a history of sexual abuse are more likely to idealise the therapist, with this idealisation being likely to have a sexual component. An Australian survey of 40 women who had experienced sexual contact with their therapist showed that two-thirds had a history of childhood sexual abuse (Quadrio, 1996). CNSW psychologists must be prepared to handle such clients through appropriate education and supervision and to be constantly alert for their seductiveness and neediness and the risk of boundary crossings.

Summary

The review above summarised the aspects of the continuum of professional behaviours which spans from over-involvement to under-involvement. Of particular importance was the grey line between therapeutic boundary crossings and the slippery slope towards boundary

violations. This grey line is blurry because the same behaviours could be considered to be part of a boundary crossing or the slippery slope. The distinction comes from the motives for the behaviours. If the motivation is to help a client then crossing a boundary is considered ethical and indeed therapeutic. However, if the motivations are personal, these minor crossings act as facilitators to boundary violations.

Given the above, factors that have the potential to send therapists down the slippery slope were summarised, as they constitute behaviours that, if detected, can prevent boundary violations and minimise the negative consequences of violations for staff and clients alike. The need to "unlock" useful knowledge on these seemingly minor boundary crossings that characterise the slippery slope through the establishment of a voluntary disclosure system within the organisation was also discussed.

These factors that contribute to boundary violations were identified in the literature and grouped into personal and organisational categories. Individual factors that contribute to boundary erosion are associated with personal distress that may be situational, or historical. Family of origin issues are associated with the possibility of boundary violations. More proximal personal issues - such as stress and relationship problems- are also associated with a greater risk of violations. Finally, feelings in therapy - both positive and negative - may be the most proximal phenomena that contribute to slipping down the slope towards boundary violations. Interestingly, there are clear associations between the most proximal influences and more distal influences. Family of origin issues (harsh environment) are associated with poorer coping with stress and emotions, as are personal problems. However, most psychologists report having feelings towards clients and thus they should be normalised, and therefore discussed in supervision.

Given the existence of the grey line between boundary crossings and the slippery slope, the role of organisational openness and strong supervision is particularly crucial for correctional psychologists. Most professional roles with offenders do not necessitate at times crossing a boundary for the good of the offender. Since this is the particular case for psychologists, it becomes very important to have a culture of openness within the correctional setting that allows for psychologists to openly discuss boundaries that have been blurred. Such discussion should not carry penalties and punishments, but rather be seen as positive indicators of the maintenance of boundaries and therapeutic relationships.

Organisational factors have the potential to influence the possibility and propensity of boundary violations. Of primary importance is having adequate supervision where early signs of boundary issues can be detected, explored and resolved. However having a supervisor is not enough to prevent boundary violations. A culture of openness surrounding issues associated with boundaries is essential for supervision to work in preventing transgressions. If discussion and issues surrounding boundaries are not normalised within the organisation, there is little to be gained from supervision. Standards and policies surrounding boundary issues are essential for psychologists to know how to act, who to turn to, and what to expect from their organisation. Likewise, education surrounding the issues outlined above is crucial if cultural change and boundary strengths are to be embraced.

Research aims

Based on the literature reviewed above, the aims of the current study were threefold:

1. To obtain a snapshot of practice behaviour of CSNSW psychologists in relation to the maintenance of personal and professional boundaries.
    - Such a snapshot would provide an understanding of the types of situations and challenges that CSNSW psychologists face in the performance of their duties. In addition, this snapshot of practice behaviour also would allow for the identification of strategies for handling successfully the challenges faced by CSNSW psychologists in relation to the maintenance of personal and professional boundaries.
2. To evaluate current organisational culture in relation to issues related to the development and maintenance of personal and professional boundaries.
    - Given the role of organisations in supporting the maintenance of strong personal and professional boundaries, investigators tested whether or not the current environment at CSNSW is conducive to supporting psychologists in maintaining strong personal and professional boundaries.
3. To collect baseline data on adherence to the 'Standards of Clinical Supervision Practice for Optimising the Development and Maintenance of Personal and Professional Boundaries in the Correctional Setting' (the Standards).
    - Investigators developed the Standards in the first stage of this project. The Standards were developed based on the review of the literature to support the staff and the organisation in the prevention of boundary violations.

Method

Procedure

An online survey using SurveyMonkey platform was constructed to collect qualitative and quantitative data related to the development and maintenance of personal and professional boundaries by CSNSW psychologists. Three different surveys were administered depending on the role within the organisation - chief psychologist, supervising psychologist, and psychologist. Due to the sensitive nature of the survey responses were anonymous. To ensure anonymity, different levels of demographic data were collected for each group due to the possible identification of the smaller groups of chief and clinical supervisors.

Participants

Invitations to take part in the survey were sent via email to all CSNSW psychologists, including chief psychologists, clinical supervisors, and psychologists (N=156). Subsequently, two reminder messages were sent inviting those that had not as yet completed the survey to participate. The final sample consisted of 50 completed questionnaires (87% female).The characteristics of survey respondents are presented in table 1.

The high level of missing data on the characteristics of the survey sample (region and area of practice), could be indicative of respondents' fear of being identified, although it was made clear to all participants that the survey was anonymous, with responses not being able to be traced back to any respondent. That is, it could be a reflection of the taboo surrounding the disclosure of boundary issues in the correctional practice setting.

Table 1. Characteristics of survey respondents

Completed survey	50	**Female**	87%
Role	N	**Age**	N
Chief psychologist	3	25-34	14
Clinical supervisor	12	35-44	18
Psychologists	35	45-54	8
		>55	7
Region	N	**Work length of time***	N
North	6	<1 year	3
South	11	1-3 years	2
Metro	18	3-5 years	4
Missing data	15	5-10 years	16
		>10 years	22
Area	N	**Weekly client contact hours**	Mean (SD)
Programs	14	Group	5.44 (2.68)
Services	15	One on one	9.43 (5.73)
Special needs	8		
Missing data	13		

* Chief psychologists not included

Qualitative measures

All three groups (chief psychologists, clinical supervisors, and psychologists) were invited to provide qualitative responses to the questionnaire. Chief psychologists were asked to report on how they *would* respond to a set of boundary challenging situations. The remainder of the sample was asked whether or not they had experienced such situations, and how they had responded to them. The particular situations used in the survey were identified through the literature review and were chosen due to their potential impact on the boundaries of the therapeutic relationship. Psychologists were asked about how they had responded to these situations and whether or not they had discussed them with their clinical supervisor. The situations were of two types: 1) challenges that had arisen as a resulted of an offender's behaviour; and 2) challenges that had arisen as a result of behaviour or feelings of the treating psychologist him/herself. A list of these situations is presented in the "Results" section of this report. In recognition of the sensitivities involved in conducting research into such a private area of practice, personal and professional boundaries, psychologists and clinical supervisors were given assurance their responses would not be published verbatim to protect confidentiality and, therefore, increase response rate.

In addition to the particular situational responses, clinical supervisors and psychologists were also asked to provide five open ended examples of situations that had challenged their personal and professional boundaries at work. Again, these five responses were divided into two categories: 1) situations that presented boundary challenges that resulted from the actions of others; and 2) situations that presented boundary challenges that resulted from the actions of the psychologist him/herself. For each of these situations, respondents were asked to state whether or not they believed their response to the particular situation had been effective in resolving the boundary challenge.

Quantitative measures

Organisational culture of openness

Several questions were developed to gage the prevalence of, and comfort with, discussing boundary issues in the workplace. Frequency of discussion related to the development and maintenance of personal and professional boundaries was assessed by asking "how often does your supervisor/supervisee bring up issues related to personal and professional boundaries during your regular supervision meetings?" Six items assessed respondent's comfort in discussing matters related to personal and professional boundaries (Appendix 1; e.g. "*I feel comfortable having a discussion with my supervisor regarding boundary issues that result from a feeling or behaviour initiated by me"*) on a Likert scale ranging from strongly agree to strongly disagree. Clinical supervisors answered these questions from the perspective of supervisors (clinical supervisor-psychologist relationship) and also from the perspective of supervisees (Chief psychologist-clinical supervisor relationship). Chief psychologists and psychologists only answered the questions from the perspective of supervisors and supervisees, respectively.

Client-staff interactions survey (C-SI)

The C-SI is a survey instrument (Daniels, 2008) developed based on the continuum of boundary domains from over-involvement to under-involvement by clinicians in therapy and all of the behaviours in between (Daniels & Wong, 2007). The C-SI is made up of scales for boundary crossings (e.g. *"I have conducted a therapy session for longer than normal because an offender was experiencing a crisis"*), slippery slope (e.g. *"I have felt that I was responsible for the offender's behaviour and that his/her misconduct was a reflection of my professional conduct"*), under-involvement (e.g. *"I have ended a session early, due to boredom or disinterest with a particular offender"*), and over-involvement (e.g. *"I have*

experienced sexual attraction toward offender(s), without acting on my feelings"). The C-SI also includes two scales that evaluate the experience of emotions in therapy, both in response to abusive/belligerent offender behaviour and also in response to resistance to treatment. The emotions assessed include (fear, anger, helplessness, etc). All scales assessed the frequency of feelings and behaviours on a 5 point scale ranging from "*never*" to "*about once a week or more*." The full scale can be seen in Appendix 2.

In the current study an adapted version of the C-SI was used to suit the correctional setting. That is, the wording of the questions was changed slightly. For example, the question "*Have you ended a session early, due to your boredom or disinterest with particular client(s)*?" became "*I have ended a session early, due to boredom or disinterest with particular offender(s).*"

Boundary violations index (BVI)

The BVI is a validated measure (Appendix 3) designed to screen for vulnerability to commit boundary violations (Swiggart, Feurer, Samenow, Delmonico & Spickard Jr, 2008). The BVI incudes 25 items (e.g. *"I have told patients personal things about myself in order to impress them"*) answered on a four point frequency scale from "*never*" to "*often*'. The scale has been validated through comparison of controls to a sample of professionals that had been referred for education as a result of misconduct related to personal and professional boundaries at work. The groups were found to differ on the BVI and the authors identified a score of ≥ 6 as suggesting substantial risk for boundary violations (Swiggart et al,. 2008).

In the current study an adapted version of the BVI was used. That is, the wording of the questionnaire was changed slightly to suit the correctional setting. For instance the statement "*I have asked one or more patients to do personal favours for me*" became "*I have asked one or more offenders to do personal favours form me*."

Standards of Practice Questionnaire

A questionnaire evaluating ‘at baseline’ adherence to the Standards was developed and administered. The questionnaire primarily consisted of Yes/No questions regarding current practices associated with personal and professional boundaries. The questions asked supervisees and supervisors to report on aspects of supervision and practice behaviour that were identified as relevant to the maintenance of personal and professional boundaries in the Standards. Table 2 presents the questions that addressed the individual standards from the Standards Document.

Table 2. Survey questions evaluating adherence to the 'Standards'

Standard 1 – Resources

- Clinical supervision is provided in a location that allows for privacy.
- Supervisees are able to organise an extra meeting with their supervisor to discuss boundary issues as they come up.

Standard 3 – Professional development

- Supervisees are aware of professional development opportunities for the development and maintenance of personal and professional boundaries.
- Supervisees are aware of educational materials on the development and maintenance of personal and professional boundaries.
- Supervisees receive ongoing training and professional development on the development and maintenance of personal and professional boundaries.
- Supervisors and supervisees should have a devised plan for education and training regarding the development and maintenance of personal and professional boundaries.

Standard 4 Supervisees' needs

- The development and maintenance of personal and professional boundaries are regularly discussed in supervision meetings.
- Supervisors start each meeting with a working agenda.
- The agenda includes an item on the maintenance and development of personal and professional boundaries.
- Supervisors use role modelling as a technique for developing personal and professional boundaries.
- Supervisors actively encourage supervisees to seek consultation and supervision in relation to personal and professional boundaries.
- Supervisors encourage supervisees to identify any personal issues that may influence the maintenance of personal and professional boundaries.
- Supervisors provide feedback and guidance on the performance of their supervisees in relation to maintaining and developing personal and professional boundaries.
- Supervisors strive to anticipate supervisees needs in relation to the development and maintenance of personal and professional boundaries.
- Supervisors assist supervisees in recognising and enhance their personal strengths in relation to personal and professional boundaries.
- Supervisors strive to have a good professional relationship with their supervisees.
- Appropriate technologies are available for long distance supervision when required.
- Supervisees go through a yearly self-assessment regarding boundaries and discuss the assessment with their supervisor.

Standard 5 – Supervisors needs

- Supervisors maintain communication and interaction with chief psychologists in relation to the promotion of effective personal and professional boundaries.
- Supervisors have access to technologies that allow for the provision of long distance supervision by chief psychologists.
- Supervisors receive feedback and guidance on their performance in the promotion of effective personal and professional boundaries.
- Chief psychologists anticipate supervisors' needs in relation to the promotion of personal and professional boundaries.
- Chief psychologists begin supervision sessions with a working agenda.
- The working agenda includes issues related to the promotion of personal and professional boundaries.
- Supervisors are aware of the policy dictating when boundary issues should be referred to the statewide manager.
- Supervisors are aware of guidelines for when a therapeutic relationship must be terminated.
- Supervisors are aware of the limits of confidentiality in relation to the disclosure of boundary crossings and violations.
- Supervisors complete annual self-assessment forms on their adherence to the standards of clinical supervision practice for optimising the development of personal and professional boundaries.

Data analysis

Qualitative data obtained from open-ended questions in the survey of CSNSW psychologists were analysed using general analytical procedures which entail the identification and categorisation of common themes (Miles & Huberman, 1994). These qualitative data were analysed using the statistical package NVivo Version 11. To determine interater reliability, a second assessor re-coded 15% of open-ended responses from the survey. The investigators who did the coding also re-coded 15% of survey open-ended responses to determine intra-rater reliability. Reliability was calculated by k statistic (Altman, 1991).

Data from the three qualitative questionnaires were analysed descriptively to better understand professional and personal boundary issues experienced by CSNSW psychologists. When appropriate, internal consistency of scales in the questionnaires was measured using

Cronbach's alpha statistic. Scores for the adapted BVI was calculated by adding the total amount of points, with each question representing a specific amount of points depending on the respondent's choice: Never (0), Rarely (1), Sometimes (2), Often (3).

Results

Qualitative results

The main aim of the qualitative aspect of the survey was to get an understanding of the types of situations involving the maintenance of personal and professional boundaries typically faced by CSNSW psychologists and also an understanding of how they respond to such situations. The two parts of the qualitative survey included open-ended responses regarding situations identified by the respondent him/herself, and to particular situations identified through the literature review. The thematic tree (Figure 3) was constructed using all responses provided by survey respondents. Such responses can be used to create educational materials for current and future psychologists working for CSNSW, including an "Induction Booklet" to make newly hired psychologists aware of the challenges they are likely to face working in the correctional setting and how to effectively deal with such challenges.

The inter-rater reliability *k* values were above 0.8 for the "type of challenges" experienced by CSNSW psychologists representing a very good result. Likewise, *k* values for intra-rater reliability were also above 0.8 for the types of challenges experienced by CSNSW psychologists.

Boundary correcting behaviour employed by CSNSW psychologists

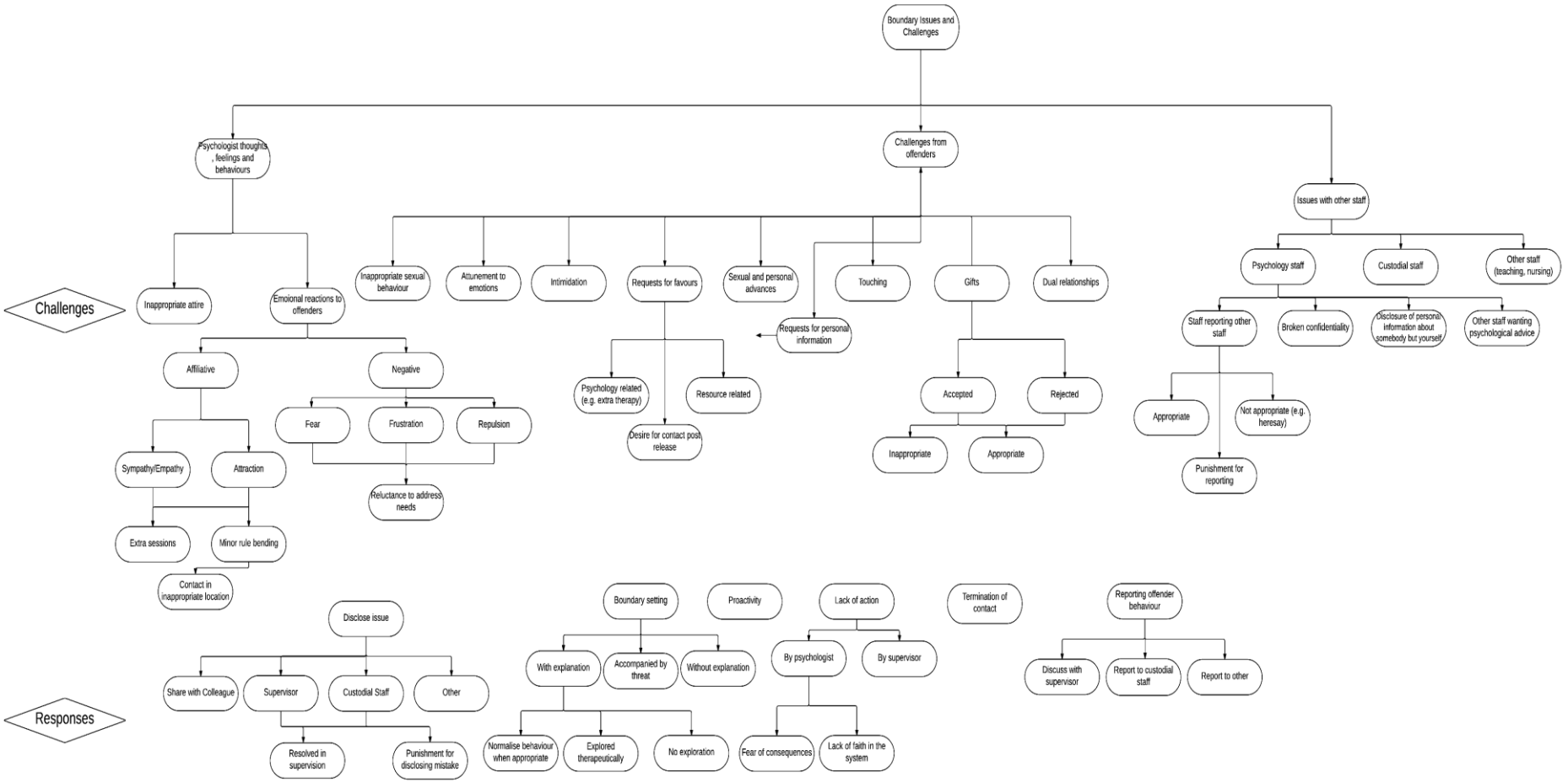
Not surprisingly the largest theme within all qualitative responses comprised of psychologists employing boundary correcting behaviour when confronted with the boundary challenge by the offender. Altogether there were 33 reported instances of such situations. Boundary correcting behaviour by psychologists was divided into subthemes (Figure 3):

1. Psychologists' handling of boundary challenges on their own by verbally setting strong boundaries with the offender without the involvement of their clinical supervisor or custodial staff.
    - The vast majority of such instances comprised relatively minor boundary challenges and, as discussed above, were resolved by simply drawing a strong boundary verbally with the offender. Some clinicians also provided the offender with an explanation of the need for boundaries within the therapeutic relationship.
2. Normalising the boundary challenge.
    - There were two instances where the psychologist normalised the boundary challenge. Both instances occurred in response to an offender's disclosure of physical attraction toward the treating psychologist. Clinicians attempted to normalise the offender's attempt to cross boundaries as being due to the nature of the therapeutic relationship and also due to factors related to the offender being incarcerated.
3. The exploration of the therapeutic meaning of the offender behaviour that challenged the therapeutic boundary.
    - This exploration was also reported as a response to an offender's disclosure of physical attraction toward the treating psychologist. The psychologist worked with the offender to explore where feelings for the treating psychologists were

coming from and how these feelings were linked to the offender's risk (confusion related to sexual attraction and intimacy and to the appropriate understanding of relationships).

All three of the above subthemes of boundary setting were reported by psychologists to have been effective. Furthermore, it is likely that instances where reasons for the need for boundaries were explained, and instances where challenges were explored therapeutically not only ensured boundaries were set, but possibly were more likely to have led to their maintenance, and to have been of therapeutic benefit for the offender.

Figure 3. Thematic tree arising from open-ended responses



Proactivity in boundary setting

There were also eight reported instances where the psychologist was proactive in setting personal and professional boundaries. CSNSW would profit from the dissemination of some of the proactive strategies reported by survey respondents as part of education in the development and maintenance of personal and professional boundaries. Strategies included: ensuring that offenders sit in a different place every group session to avoid participants permanently sitting next to the clinician; moving around to different areas of a gaol not to become too familiar with long term inmates; applying to have details removed from electoral commission; thinking beforehand about what kind of minor information to reveal about oneself during 'ice-breaking' exercises; telling offenders from the outset that the focus of the group sessions is on them and that information on the clinicians would not be provided; creating a fictional family to disclose information on; and having a set of responses ready for when offenders ask personal questions.

The value of good supervisory practices

Another strong theme that arouse from the survey was instances where challenges to boundaries were discussed in supervision. These instances are quoted throughout the current paper and they were reported from the perspective of both, supervisors and supervisees. Almost all instances where boundary issues were discussed in supervision led to positive outcomes. The utility and power of an open and honest supervisory relationship was clearly evident in these reports. Within this category there were several subcategories that warrant mention. In some instances, through supervision, the boundary issue was resolved and the offender-psychologist relationship continued with the boundary issues addressed following the advice of the supervisor. In other instances the decision was made to reassign the offender to a different psychologist. Reassignment occurred for different reasons. For example, the

psychologist was uncomfortable with the offender due to personal circumstances being associated with the nature of their crime; or the therapeutic relationship having been damaged due to offender behaviour.

Suboptimal coping with boundary issues

Whilst most reports of boundary issues were associated with effective handling of the situation, there were some instances that led to less than desirable outcomes. For instance, as evidenced throughout the current paper, the reporting of issues related to boundaries was inconsistent in terms of to whom boundary challenges were reported. Issues were reported to supervisors, custodial staff, local management, senior psychologists, as well as others. While all of these stakeholders seemed to be appropriate avenues for reporting, there was a lack of consistency in reporting procedures, and in the outcomes of such reports. Furthermore, some instances were documented in EDRMS and OIMS while others were not. It appears that there was no policy or set procedure being followed by psychologists on how to report and also on how to handle the reporting of issues related to personal and professional boundaries.

Fear of negative consequences in response to self-reporting of boundary crossings

There were also instances where psychologists were hesitant to discuss boundary issues with their supervisor and colleagues due to fear of negative consequences. This fear was understandable as some psychologists reported negative consequences of reporting minor boundary crossings. The negative consequences included being reprimanded for the minor crossing and even being told by colleagues that they were better off not reporting the incident. This approach to handling an instance where a minor mistake is made is problematic. The actual boundary crossings that were reported were very minor, the exact types of behaviours that should be discussed in individual supervision and corrected. There is no doubt that such negative experiences in response to the reporting of minor boundary

crossings ensured that the psychologists involved would no longer report such instances to their clinical supervisors. Minor mistakes always will be present when humans are involved, therefore psychologists should be encouraged to report such mistakes without fear of being punished or reprimanded but rather with the belief that they will be supported.

Non-reaction to the boundary challenge

There were also instances where psychologists did not engage in boundary correcting behaviour in response to the boundary challenge by an offender. Such instances include psychologists ignoring comments on their appearance by offenders or just saying "thank you" in response.

Emotions in therapy

Affiliative feelings

Affiliative feelings for offenders were frequently reported. As would be expected with any helping profession, sympathetic/empathic feelings were a part of the responses. Most of such reports were associated with the psychologist relating to the offender is some way. For example, the psychologist may have related to the offender in terms of the family history or background. At other times psychologists felt sympathy for the plight of an offender and how they had got to be where they were. Other times affiliative emotions were experienced due to the commitment an offender demonstrated towards therapy.

Physical attraction to offenders

Although over a quarter of the sample reported having felt physically attracted to an offender at some point in their careers (this is discussed later in this report), only three survey respondents felt comfortable describing how they had handled such situation. This result

could be indicative of a culture of silence surrounding the phenomenon of physical attraction toward one's own client.

Physical attraction to an offender was handled in different ways by the three individual psychologists. This included: 1) discussing the issue with the clinical supervisor and devising strategies for maintaining personal and professional boundaries; 2) discussing the issue with a colleague and devising strategies to maintain boundaries; and 3) not discussing the issue with anyone at all for fear of being judged.

The first instance described above demonstrated the value of open supervision on the issue of personal and professional boundaries. Such response followed a process where physical attraction toward the offender was discussed in supervision, which led to a thorough plan on how to continue the therapeutic relationship, including clear criteria for determining when maintaining boundaries had become too hard and a clear exit plan for terminating the therapeutic relationship and the reassignment of the client to another clinician. The relationship was carefully monitored and frequently discussed in supervision. The honesty and awareness demonstrated by the psychologist and his/her supervisor in such situation was directly related to the eventual good outcome for all of those involved, the psychologist, the clinical supervisor, and the offender.

The following two accounts are counterexamples to the one discussed above. The following two psychologists admitted to having been physically attracted to an offender, but were not willing to discuss the issue in supervision, with one psychologist stating this was so due to fear of negative consequences. Such fear is concerning, as emotions in therapy are common especially in helping relationships. The appropriate action in such instances is to discuss such feelings in individual supervision, yet the psychologist felt that such discussion would have had a detrimental impact on her career. In addition, the reporting psychologist indicated she

was prepared to place the offender's treatment in jeopardy by terminating the relationship prematurely without appropriate reassignment rather than discussing the issue in individual supervision.

Negative feelings towards individual offenders

Negative emotions towards offenders were also reported. States such as fear of offenders, frustration with offenders, feeling helpless, and repulsion for offenders were all grouped in this category.

Negative consequences of these feelings included not addressing the offender's risk factors adequately out of fear of the offender. Indeed, within the context of the boundary continuum these negative emotions may lead to under-involvement and reluctance to address the needs of offenders. In instances of fear, reassignment was one of the solutions reported. Interestingly, reports of negative feelings were not usually associated with discussion with supervisors. This could be due to under-involvement not being traditionally considered as a boundary issue and therefore may have been under reported and thus under discussed. Such feelings indicative of under-involvement also form an important aspect of professional boundaries and they must be normalised and dealt with appropriately in individual clinical supervision.

Offender games and challenges

As expected there were many reports of boundary challenges coming from offenders. These included inappropriate sexual behaviour, inappropriate sexual comments, proposion, harassment, intimidation, requests for favours, sexual and personal advances, personal information enquiries, offers of gifts, physical touching, attempts to form dual relationships,

attunement to psychologists' emotions, and attempts to maintain contact with the psychologist after release.

Offenders' physical attraction toward the treating psychologist

There were also many instances where offenders were perceived as being physically attracted to the treating psychologist and also instances where offenders actually disclosed their physical attraction to the treating psychologist.

Coping strategies

Coping with the many challenges stated above took many forms. For minor challenges psychologists primarily reported verbally setting a strong boundary as soon as the boundary challenge occurred. Surprisingly serious boundary challenges tended not to be reported. In instances where serious boundary challenges were actually reported, they tended to be reported to various stakeholders, with no apparent set procedure being followed.

The range and frequency of boundary challenges coming from offenders highlights the difficulties involved in working as a psychologist in the correctional setting. The investigators do recognise that each situation is unique and it will require responses that take into account the nature of the situation and the context it occurs in with no exact 'right' or 'wrong' way of responding. However, the many different ways psychologists responded to similar boundary challenges may be reflective of a lack of training in the area and a lack of any formal set of professional standards being followed to guide clinicians when confronted with such challenges.

Since one knows that offenders will engage in certain types of boundary challenging behaviours, such as requests for favours, attempts to physical touch, etc, the organisation will

profit from the provision of training to clinicians on how to successfully deal with these challenges upon their joining the organisation.

It is noted that as part of the Standards chief psychologists are to write an induction booklet, based on the findings of the current study, to be given to newly hired psychologists stating the challenges they may encounter in the correctional setting and providing guidance on how to behave in these situations. It is noted that as part of the current study, responses regarding the handling of such challenges were also collected from chief psychologists who reported on what they *would* do if faced with such challenges. The responses from the chief psychologists provide a vast collection of positive coping methods with the challenges inherent in the correctional environment that must be used for educational purposes (Appendix 4).

Boundary issues with non-clinical staff

Apart from issues related to psychologist-offender relationships, other themes were apparent in the data. One of the most frequently occurring responses were related to issues with other staff within CSNSW. There were several instances where psychologists described boundary issues with custodial staff, psychology staff, and other support professions within CSNSW. Reported issues with custodial staff were mostly related to inappropriate behaviour toward offenders and also toward psychologists. Such instances were comparatively frequent suggesting different perspective on boundaries between psychologists and custodial staff.

Personal and professional boundaries in supervision

There were also many reports of boundary issues related to the supervision process itself. For instance, some psychologists reported making use of peer supervision to address issues related to professional boundaries, a clinical supervisor reported employing strategies for building and maintaining strong professional boundaries in supervision, and some survey

respondents also reported poor supervisory practices. Such poor supervisory practices included lack of confidentiality in supervision, poor boundaries by the clinical supervisor, the provision of no formal supervision, lack of faith in supervision, ineffective reporting of boundary issues to supervisors, negative perception of dual relationship (friendship) between senior psychologists and supervisees, etc.

The positive aspects of supervision in relation to personal and professional boundaries reported by survey respondents, such as peer supervision after a group session, which allows clinicians to review their conduct in relation to personal and professional boundaries, could be encouraged and further developed by the organisation. In addition, the establishment of a forum for clinical supervisors to discuss supervisory issues at the annual psychology conference, as advocated by the Standards (Standard 5, Criterion 11) would allow for the dissemination of good supervisory practices, such as strategies for building and maintaining strong boundaries in supervision.

Regarding the negative perception of dual relationships between a supervisor and a supervisee, undoubtedly psychologists are extensively trained in the use of good interpersonal skills with the development of such skills fostering secondary relationships in the form of friendships. These secondary relationships usually include nonsexual and legitimate interactions between the supervisor and the supervisee, many of which are unplanned and inadvertent, yet they still have ethical ramifications. Undoubtedly, the issue is multifaceted and complex and if dual relationships between supervisors and supervisees are not managed appropriately they can potentially hurt clients and psychologists alike.

The above results reinforce the concept that adequate lifelong learning in good supervisory practices must be consistently provided to CSNSW clinical supervisors to overcome deficiencies in supervisory practice, including the building of strong professional boundaries

in supervision. It is noted that the provision of education on the building of strong professional boundaries in supervision is part of the Standards (Tool 3A).

Hypothetical and actual responses to particular situations involving boundaries

The situations involving the maintenance of personal and professional boundaries that psychologists were asked to report on are presented in Tables 3 and 4. Also presented are the percentages of psychologists who reported having experienced such situations, whether or not the situation was discussed in supervision, and percentage of chief psychologists that recommend discussing the situation in supervision.

Table 3. Personal boundary challenges reported by psychologists by proportion of chief psychologists who believed the issue should have been discussed in supervision by actual instances the issue was actually discussed in supervision.

Personal boundary challenges	**% of psychologists who experienced**	**% of chiefs who believe it should be discussed in supervision[1]**	**% of those who experienced who actually discussed**
I have shared aspects of my personal life with an offender	29	100	29*
I have 'bent' the rules (in a minor way) for a client	20	100	46
I have discussed other offenders or staff with an offender	31	100	40
I have derived great satisfaction from client's praise or affection	27	100	62
I have insulted a client as a reaction to their behaviour	15	100	100
I have been anxious to please a client	11	100	100

*Psychologists primarily reported disclosing information like their favourite football team to build rapport

[1] Three chief psychologists responded to the survey.

Table 4. Boundary challenges from offenders reported by psychologists by proportion of chief psychologists who believed the issue should have been discussed in supervision by actual instances the issue was discussed in supervision.

Boundary challenges from offenders	% of psychologists who experienced	% of chiefs who believe it should be discussed in supervision[1]	% of those who experienced who actually discussed
An offender has brought/made me coffee or food	49	67	42
An offender has made romantic advances towards me	41	100	75
An offender has tried to befriend me	51	100	77
An offender has asked me about my personal life	94	100	54
An offender has brought up and wanted to discuss other offenders	71	67	29
An offender has brought up sexual content which is not relevant to therapy	33	100	56
An offender has offered me a gift	46	100	82
An offender has showed sympathy to the difficulty of my job	40	67	42
An offender has touched me during a therapy session	32	100	73

[1] Three chief psychologists responded to the survey.

Challenges coming from offenders (Table 4) were reported by a larger percentage of survey respondents compared to challenges originating from their own behaviour (Table 3). This finding points to a particularly important and prevalent source of boundary challenges when working with offender populations. It could also be indicative of fear of discussing issues that were originated by the psychologist's own feelings and behaviour although the survey was anonymous.

Discrepancies were also observed between the tendency to discuss such situations and recommendations from chief psychologists to discuss such issues. These discrepancies must be approached with caution, as chief psychologists only saw the short description of the

situations and were asked whether or not it should be discussed in supervision. Conversely, psychologists described an actual situation that had happened and how they had handled it. In most instances where the issue was not discussed, the psychologist reported having drawn a clear boundary (in the examples of challenges from offender behaviour) and moved on with the session. Likewise, for personal boundary challenges, the statement of the situation alone (which was all chief psychologists saw) may indicate that this issue should be discussed in supervision - all chief psychologists indicated that every personal boundary issue should be discussed in supervision. However, it is possible the actual situations may not always warrant disclosure in supervision. For example, many psychologists disclosed personal information such as their favourite team to build rapport. Although this would be considered a therapeutic boundary crossing it would not necessarily warrant discussion in supervision.

Quantitative results

Frequency, tendency and comfort discussing boundaries

All psychologists and clinical supervisors reported on the frequency of discussing boundary issues, both in terms of how often they brought up matters related to personal and professional boundaries themselves and how often their supervisors or supervisees brought up such matters in supervision.

Psychologists (supervisees) reported bringing up matters related to personal and professional boundaries with their clinical supervisors as they came up in the practice of forensic psychology (74.5% of psychologists), rather than on a regular basis (Table 5). Nevertheless, a small percentage of the sample reported never discussing such matters with their clinical supervisor (3.6%).

When clinical supervisors were asked how often their supervisees (psychologists) brought up matters related to personal and professional boundaries during supervision, 72.7% of clinical supervisors reported they do so as issues come up in practice rather than on a regular basis (Table 6). A result that somewhat concurred with the above mentioned reports from the supervisees themselves. It is also noted that 9.1% of clinical supervisors reported that their supervisees never discuss issues related to personal and professional boundaries (Table 6). When asked how often they (clinical supervisors) discussed issues related to personal and professional boundaries with their chief psychologist, clinical supervisors reported that they do so primarily as the issue came up in practice (82.6% of clinical supervisors, Table 7).

Table 5. Psychologists' (supervisees') responses to the question *'On average, how often do you bring up issues related to personal and professional boundaries during your regular supervision meetings?'*

Frequency	**% (n)***
Almost every/Every monthly meeting	**9.1%** (5)
About once every 6 months	**12.7%** (7)
About once a year	**0.0%** (0)
As they come up in practice	**74.5%** (41)
Never	**3.6%** (2)
Total	55

Table 6. Clinical supervisors' responses to the question *'On average, how often do your supervisees bring up issues related to personal and professional boundaries during your regular supervision meetings?'*

Frequency	% (n)
Almost every/Every monthly meeting	**4.5%** (1)
About once every 6 months	**9.1%** (2)
About once a year	**4.5%** (1)
As they come up in practice	**72.7%** (16)
Never	**9.1%** (2)
Total	22

Table 7. Clinical supervisors' responses to the question *'On average, how often do you bring up issues related to personal and professional boundaries during your regular supervision meetings with your chief psychologist?'*

Frequency	% (n)
Almost every/Every monthly meeting	**8.7% (2)**
About once every 6 months	**8.7% (2)**
About once a year	**0.0% (0)**
As they come up in practice	**82.6% (19)**
Never	**0.0% (0)**
Total	**23**

Fifty per cent of clinical supervisors reported bringing up matters related to personal and professional boundaries with their supervisees in supervision meeting as they came up

(Table 8) and 45.5% reported they did so either on a monthly or a six monthly basis, with none of the supervisors reporting that they never do so. However, when supervisees were asked how often their clinical supervisors brought up matters related to personal and professional boundaries in supervision, only 23.6% of supervisees stated that their supervisors did so either on a monthly or a six monthly basis, with 14.5% of supervisees reporting that their supervisors never brought up such matters in supervision (Table 9). That is, reports on how often supervisors brought up matters related to personal and professional boundaries were discrepant between supervisors and supervisees.

When clinical supervisors were asked how often chief psychologists brought up matters related to personal and professional boundaries in supervision, 65.2% of the clinical supervisors reported that their chief psychologists did so as issues came up and 17.4% of clinical supervisor reported that their chief psychologists never do so (Table 10).

Table 8. Clinical supervisors' responses to the question *'On average, how often do you bring up issues related to personal and professional boundaries during your regular supervision meetings in your role as supervisor?'*

Frequency	**% (n)**
Almost every/Every monthly meeting	**22.7%** (5)
About once every 6 months	**22.7%** (5)
About once a year	**4.5%** (1)
As they come up in practice	**50.0%** (11)
Never	**0.0%** (0)
Total	22

Table 9. Psychologists' (supervisees') responses to the question *'On average, how often does your supervisor bring up issues related to personal and professional boundaries during your regular supervision meetings?'*

Frequency	% (n)
Almost every/Every monthly meeting	**5.4% (3)**
About once every 6 months	**18.2% (10)**
About once a year	**3.6% (2)**
As they come up in practice	**58.2% (32)**
Never	**14.5% (8)**
Total	**55**

Table 10. Clinical supervisors' responses to the question *'On average, how often does your supervisor (chief psychologist) bring up issues related to personal and professional boundaries during your regular supervision meetings?'*

Frequency	% (n)
Almost every/Every monthly meeting	**8.7% (2)**
About once every 6 months	**8.7% (2)**
About once a year	**0.0% (0)**
As they come up in practice	**65.2% (15)**
Never	**17.4% (4)**
Total	**23**

The scales assessing openness to discussing boundary issues in supervision (Appendix 1) for both supervisors (alpha = .82) and supervisees (alpha = .72) demonstrated good internal consistency suggesting that the items are reliably assessing the same construct. For both supervisors, $t(24) = 7.83$, $p < .00$, and supervisees, $t(72) = 7.67$, $p < .001$, the mean of the scale was significantly higher than the midpoint of the scale which indicates that on average supervisees and supervisors are open to discussing boundary issues.

However, a closer look at the data suggested that while the average of the sample was above the mean, there were a number of supervisees that scored below the mean of the scale. Approximately 9% of psychologists reported not being comfortable discussing matters related to personal and professional boundaries with their clinical supervisors. Also noteworthy is the proportion of psychologists (11.5%) who reported being uncertain as to what can and what cannot be discussed with their supervisors in relation to boundary issues. Conversely, none of the supervisors scored below the mean of the scale. In addition, only 65.4% of psychologists endorsed the following statement "*I feel comfortable having a discussion with my supervisor regarding boundary issues that result from a feeling or behaviour initiated by me*" (Appendix 1). That is, 34.6% of psychologists report not feeling comfortable discussing boundary matters resulting from their feelings or behaviour with their clinical supervisor.

Remarks on the results on the tendency and comfort discussing boundaries

Based on the finding that a significant proportion of CSNSW psychologists reported not being comfortable discussing issues related to personal and professional boundaries with their supervisors, it is recommended that specific activities be provided to CSNSW aimed at creating a culture of openness among CSNSW psychologists. As noted in the literature review, educational activities that include vignettes and self-disclosure by respected members

of the profession (opinion leaders) are strongly advocated as tools for creating a culture of openness within CSNSW. In addition, clinical supervisors must also disclose how he/she has handled issues related to the maintenance of personal and professional boundaries in the correctional setting to normalise the discussion of such issues in supervision meetings.

Adapted Client-staff Interactions Survey (C-SI)

The complete descriptive statistics for the adapted client-staff interaction survey are presented in Appendix 2a and the added scale of offender challenges are presented in Table 11. The over-involvement scale was excluded from the internal consistency analysis due to low reliability (alpha = .22) which was observed due to a low rate of reporting of behaviours in this scale. All other scales had acceptable internal consistency.

Table 11. Descriptive statistics and correlations for the adapted client-staff interaction survey scales.

	Mean	SD	1	2	3	4	5	6
1. Emotions to behaviour	2.00	0.78	(.86)	.85	.44	.68	.49	.56
2. Emotions to resistance	1.67	0.63		(.82)	.53	.65	.44	.51
3. Therapeutic boundary crossings	2.51	0.87			(.86)	.62	.60	.78
4. Slippery slope	1.30	0.35				(.71)	.58	.54
5. Under involvement	1.41	0.33					(.68)	.58
6. Offender challenges	2.05	0.71						(.88)

Note: N = 47; All correlations significant at the 0.01 level; Internal consistencies reported on the diagonal.
Note: Statistics presented in this table pertain to responses from both psychologists (n=39) and clinical supervisors (n=8).

The strong positive relationships between the scales suggest an overlap between all of the elements of the boundary continuum. This could be interpreted in two ways. It could mean that those that feel emotions and cross boundaries for therapeutic reasons also tend to get on the slippery slope and be over and under involved with their clients. Alternatively this could

suggest an honesty factor. That is, those that are honest about some behaviours in the correctional setting, were also honest with regards to all of them.

Emotions in therapy

Emotions in therapy as a response to offenders' behaviour was frequently reported (Appendix 2a), with psychologists reporting at some stage to have felt fearful (87.2%), angry (79.5%), manipulated (74.4%), apathetic (66.2%), deceived (61.5%), inadequate (43.6%), resentful (41.0%), hopeless (41.0%), helpless (41.0%), like a failure (30.8%).

Over-Involvement

Generally, all of the behaviours measured by the survey were infrequently reported (Appendix 2a). This was particularly the case for behaviours related to over-involvement (mean = 1.07). In the Over-Involvement scale, only four items received endorsement by some of the psychologists: 1) *"I have experienced sexual attraction toward offender(s), without acting on my feelings,"* which was reported by 25.6% psychologists; 2) *"I have had fantasies about offender(s) (i.e., fantasies that were romantic or sexual or violent in nature),"* which was reported by 5.1% of psychologists; 3) *"I have kept secrets about offender(s) that I thought I should have shared with other staff members,"* which was reported by 5.1% of psychologists; and 4) *"I have disclosed personal problems to offender(s),"* which was also reported by 5.1% of psychologists.

It is noted that this lower than expected rate of psychologists admitting to have experienced sexual attraction to a client (25.6%) is not consistent with rates reported in the literature. For example, as previously discussed, Pope et al. (1986) reported 87% of psychotherapists admitting having had sexual attraction toward their clients on at least one occasion. Such discrepancy could be indicative of several factors: a culture of silence surrounding the

phenomenon of attraction toward one's own client in the correctional setting; a generalised fear of being open about the phenomenon; and a reflection of the differences between an offender population and the general population of psychology clients.

Boundary crossings in therapy

Therapeutic boundary crossings were the most commonly reported behaviours in the adapted C-SI (Appendix 2a). All but two items in this scale were reported by the majority of psychologists, with the following boundary crossings being the most commonly reported: 1) *"I have conducted a therapy session for longer than normal because an offender was experiencing a crisis"*, reported by 92.3% of psychologists; 2) *"I have conducted a therapy session for longer than normal due to the therapeutic nature of the session,"* reported by 82.2% of psychologists; and 3) *"I have arranged to see an offender on a more frequent basis due to the nature of the psychopathology or due to the nature of the therapeutic work,"* reported by 82.2% of psychologists. The least frequently reported boundary crossings were: 1) *"I have touched offender(s) during therapy sessions for therapeutic reasons (i.e., to console or to demonstrate a point),"* reported by 20.5% of psychologists; and 2) *"I have socialised with offender(s) in their living area, with a clear therapeutic purpose in mind,"* reported by 43.6% of psychologists.

Slippery slope

Items in the Slippery Slope scale were not reported frequently. The most commonly reported items by psychologists were: 1) "*I have derived great satisfaction from offender's praise or affection*," reported by 41.0% of psychologists; 2) *"I have had difficulties setting limits with offender(s),"* reported by 35.9% of psychologists; and 3) *"I have felt that I was responsible for the offender's behaviour and that his/her misconduct was a reflection of my professional conduct,"* reported by 30.8% of psychologists. The least frequently reported items in this

scale were: 1) *"I have needed the approval of offender(s) for my own self-worth,"* reported by 10.2% of psychologists; and 2) *"I have socialised with offender(s) without a therapeutic purpose in mind,"* reported by 12.8% of psychologists.

Under-Involvement

Items in the Under-Involvement scale were also reported somewhat infrequently. The most commonly reported items by psychologists were: 1) *"I have 'let my mind wander' to other things during a session,"* reported by 87.2% of psychologists; 2) *"I have avoided conflict with offender(s) and let other staff deal with the issues,"* reported by 46.2% of psychologists; and 3) *"I have ignored an offender's requests (e. g., I disengaged from the offender),"* reported by 43.6% of psychologists. The least frequently reported items in this scale were: 1) *"I have called offender(s) derogatory names to their face in reaction to their behaviours,"* reported by 5.1% of psychologists; and 2) *"I have belittled offender(s) as a reaction to their behaviour,"* reported by 5.1% of psychologists; and 3) *"I have called offender(s) derogatory names to their face in reaction to their behaviours,"* reported by 5.1% of psychologists.

Offender challenges

Offender challenges were also reported to have been experienced by psychologists relatively frequently (Appendix 2a). The most commonly reported items in this scale were: 1) *"An offender has asked me about my personal life, such as: my age, sexual preferences, relationship status, what I did on the weekend, or other personal questions,"* reported by 97.4% of psychologists; 2) *"An offender has tried to engage me in conversation about other psychologists or other staff"*, reported by 84.6% of psychologists; 3) *"An offender has brought up and wanted to discuss other offenders that I also see for therapy,"* reported by 82.0% of psychologists. The least frequently reported offender challenges were: 1) *"An offender has touched me during a therapy session (e.g. flicked a bit of dust off my clothing or*

placed their hand on my shoulder in a supportive manner)," reported by 43.3% of psychologists; 2) *"An offender has made romantic advances towards me,"* reported by 51.0% of psychologists; and *"An offender has offered me a gift*, "reported by 51.0% of psychologists.

Emotions in therapy as a response to offenders' behaviour was frequently reported (Appendix 2a), with psychologists reporting at some stage to have felt fearful (87.2%), angry (79.5%), manipulated (74.4%), apathetic (66.2%), deceived (61.5%), inadequate (43.6%), resentful (41.0%), hopeless (41.0%), helpless (41.0%), like a failure (30.8%).

Remarks on the results of the adapted Client-staff interactions survey

Results from the adapted C-SI show that in real-life practice of forensic psychology: clinicians will experience strong emotions, such as anger and feelings of being manipulated, and at times may even report feeling helpless or like a failure; clinicians will cross boundaries for therapeutic reasons; clinicians will be ethically challenged by offenders; clinicians will experience under-involvement at some stage; and some will experience over-involvement, with a significant proportion of clinicians at some stage feeling sexually attracted to an offender, with some even going on to fantasise about the offender exhibiting behaviours consistent with the 'slippery slope.'

It is also noted that the results from the adapted C-SI are consistent with the qualitative results in relation to the emotions and behaviours exhibited by psychologists. These results support the point argued in the literature review that adequate lifelong learning in the area of professional ethics is crucial for the development and maintenance of strong personal and professional boundaries in the correctional setting. It is noted that as part of the Standards a structured curriculum for psychologists was created addressing both boundary violation

prevention and response (Tool 3A of the Standards). It is recommended that the education contained in this curriculum be delivered to all CSNSW psychologists.

Adapted Boundary Violations Index (BVI)

The adapted BVI scores contained minimal variance with 57% of the sample having a score of 0 (indicating no endorsement of any items) and all but one person having a score ≤ 6 (Appendix 3). As discussed before, according to the norms of the BVI a score of ≥ 6 suggests substantial risk for boundary violations (Swiggart et al., 2008). However, the current score ≥ 6 must be approached with caution as Australian norms for the BVI have not been developed.

Due to the low rates of item endorsement the internal consistency of the scale was very low (.53). This is perhaps not surprising given the behaviours that are asked about on the BVI are quite extreme (e. g. "*I have asked one or more patients to do personal favours for me*") and in a lot of cases constitute a boundary violation rather than any grey area before a violation. The scale is proposed to be used for personal self-evaluation and to be discussed with supervisors if the respondent feels comfortable doing so.

Of the entire adapted BVI questionnaire there were only two items that obtained some level of endorsement by clinical supervisors: 1) *"I have made exceptions for some offenders because I was afraid he/she will otherwise become extremely angry or self-destructive,"* with 12.5% of clinical supervisors stating they "*sometimes*" engage in the behaviour; 2) *"I have told offenders personal things about myself in order to impress them,"* with 12.5% of clinical supervisors stating they "*rarely*," as opposed to never, engage in the behaviour.

In relation to psychologists' responses, the following items of the adapted BVI obtained some level of endorsement: 1) *"I have found myself fantasizing or daydreaming about an*

offender," with 12.8% of psychologists stating they "*rarely*" engage in the behaviour as opposed to "*never*"; 2) *"I have used language other than clinical language to discuss an offender's physical appearance or behaviours I may consider seductive,"* with 5.1% of psychologists stating they "*rarely*" and 5.1% stating they "*sometimes*" engage in the behaviour; 3) *"I have felt a sense of excitement or longing when I think of an offender or anticipate his/her visit,"* with 7.7% of psychologists stating they "*rarely*" engage in the behaviour; 4) *"I think about what it would be like to be sexually involved with an offender,"* with 5.1% of psychologists stating they "*rarely*" engage in the behaviour, as opposed to "*never*"; 5) *"I have accepted social invitations from particular offenders outside of scheduled clinic visits,"* with 5.1% of psychologists stating they "*rarely*" engage in the behaviour; 6) *"I have resisted or refused consultation with appropriate professionals, when others have told me I have problems that cause difficulty in my work or personal relationships,"* with 5.1% of psychologists stating they "*rarely*" and one psychologist (2.6%) stating he/she often engages in the behaviour; 7) *"I have initiated or engaged in a personal relationship with a person over whom I have power, authority, or decision-making ability,"* with one psychologist stating he/she "*often*" engages in the behaviour; 8) *"I have found myself trying to influence other employees in my workplace over whom I have supervisory influence, to support political causes, or positions in which I have personal interest,"* with one psychologist stating he/she "*rarely*" engages in the behaviour.

Remarks on the findings from the adapted BVI

Results from the adapted BVI are somewhat consistent with some of the behaviours reported in the adapted C-SI. That is, in real-life practice of forensic psychology some clinicians at some stage will exhibit behaviours consistent with the "slippery slope." Therefore, it is crucial that CSNSW psychologists receive adequate ongoing education that will enable them to deal with complex cases involving the maintenance of personal and professional

boundaries in an optimal manner. That is, good supervisory practice must be supported by the provision of correctional-setting-specific education to clinicians on the optimal maintenance of personal and professional boundary violations. In addition, it is recommended that the development and maintenance of personal and professional boundaries be discussed, not exclusively in the context of professional ethics, but also in clinically oriented supervision, as they are the fabric of the clinician-client relationship.

It is also noted that the implementation of the Standards will facilitate self-reflection, self-monitoring and self-correcting behaviour, all of them being skills necessary to cope with the many challenges provided by real-life forensic psychology.

Standards of Practice Questionnaire

As previously mentioned, the main goal of the standards of practice questionnaire was to collect baseline data to be used as a comparison after the standards have been fully implemented by CSNSW. In addition, the questionnaire provided insight into the current psychological practices within CSNSW on the topic of personal and professional boundaries.

Standard 1 – Resources

Table 12 reports adherence to the first standard evaluating the availability of resources to ensure the maintenance of personal and professional boundaries.

Table 12. Supervisors' and supervisees' reports on the level of adherence to professional standards related to availability of resources.

Standard's Criteria	Supervisees Yes % (n)	Supervisors Yes % (n)
Individual monthly supervision meetings are held in a location that allows for privacy.	**87.2% (34)**	**87.5% (7)**
My clinical supervisor has indicated that if I require a meeting regarding issues related to personal and professional boundaries, I am able to contact him/her to organise it.	**82.0% (32)**	**N/A**
When issues related to personal and professional boundaries come up and I feel that I need supervision, I am able to organise an extra meeting with my clinical supervisor.	**94.8% (37)**	**N/A**
My chief psychologist has indicated that if I require a meeting regarding issues related to personal and professional boundaries, I am able to contact him/her to organise it.	**N/A**	**50.0% (4)**
When issues related to personal and professional boundaries come up and I feel that I need supervision, I am able to organise an extra meeting with my chief psychologist.	**N/A**	**87.5% (7)**

The results above suggest that mostly, supervisees are able to plan an extra meeting to discuss boundary issues as they come up in practice. Likewise, such meetings are held in locations that allow for privacy. Supervisees mostly report that their supervisors have informed them of their ability to organise an extra meeting should they require it.

Standard 2 – Professional development

Table 13 reports on adherence to "Standard 2" regarding availability of resources for professional development.

Table 13. Supervisors' and supervisees' reports on the level of adherence to professional standards related to availability of resources for professional development.

Standard's Criteria	Supervisees Yes % (n)	Supervisors Yes % (n)
Supervisees are made aware of the professional development opportunities that are available to them regarding the maintenance of personal and professional boundaries.	**51.3% (20)**	**62.5% (5)**
Clinical supervisors inform supervisees of professional development opportunities associated with the maintenance of personal and professional boundaries.	**33.3% (13)**	**37.5% (3)**
I have access to educational materials on the development and maintenance of personal and professional boundaries in the workplace.	**76.9% (30)**	**N/A**
I receive ongoing training on the development and maintenance of effective personal and professional boundaries in the correctional setting.	**25.6% (10)**	**N/A**
I receive continuing professional development opportunities in relation to the establishment and maintenance of personal and professional boundaries provided by CSNSW.	**30.7% (12)**	**N/A**
My supervisor and I have devised a plan for education, training, and supervision regarding the maintenance of personal and professional boundaries.	**10.3% (4)**	**12.5% (1)**
Supervisees are informed of training opportunities regarding the maintenance of personal and professional boundaries.	**12.8% (5)**	**37.5% (3)**

These results suggest that professional development in relation to the development and maintenance of personal and professional boundaries is not currently part of the practices of CSNSW. Alternatively, these results may indicate that some access to professional

development is available, but this information is not known. Either way results indicate professional development opportunities are not plentiful regarding the maintenance of personal and professional boundaries in the correctional setting. This is perhaps not surprising given that part of the education and registration requirements involved some training on ethics which includes issues related to boundaries, and thus correctional organisations may not feel the need for further training and development in the area. Nevertheless, instances of boundary violations in the psychology profession as a whole indicate otherwise. Given the particularly challenging environment that CSNSW psychologists work in, and in terms of the detrimental impact of violations on both clients and clinicians, formal training and development opportunities on the development and maintenance of personal and professional boundaries in the correctional setting must be made available to CSNSW psychologists.

Standard 4 – Supervisees' needs

Table 14 reports on adherence to "Standard 3" related to the needs of supervisees in relation to the development and maintenance of personal and professional boundaries.

Table 14. Supervisors' and supervisees' reports on the level of adherence to professional standards related to the needs of supervisees regarding the development and maintenance of personal and professional boundaries (PPB).

Standard's Criteria	Supervisees Yes % (n)	Supervisors Yes % (n)
My supervisor and I maintain communication and interaction in relation to the development and maintenance of personal and professional boundaries.	74.4% (29)	N/A
The development and maintenance of personal and professional boundaries is regularly discussed between the supervisee and his/her supervisor.	35.9% (14)	75.0% (6)
Clinical supervision sessions begin with a working agenda.	48.7% (19)	75.0% (6)
The working agenda includes issues related to the development and maintenance of personal and professional boundaries.	17.9% (7)	25.0% (6)
Supervisor uses role modelling and self-disclosure as techniques to train supervisees in the development and maintenance of effective personal and professional boundaries in the correctional setting.	48.7% (19)	75.0% (6)
Supervisor has actively encouraged supervisee to seek consultation and supervision as needed in relation to the maintenance of personal and professional boundaries.	53.8% (21)	100.0% (8)
In supervision meetings, supervisee is encouraged to identify any personal issues that may influence the maintenance of personal and professional boundaries.	56.4% (22)	100.0% (8)
Supervisees receive feedback and guidance on their performance in the development and maintenance of personal and professional boundaries in the correctional setting.	51.3% (20)	100.0% (8)

Standard's Criteria	Supervisees Yes % (n)	Supervisors Yes % (n)
My supervisor strives to anticipate my needs in relation to the development and maintenance of boundaries, rather than simply reacting to events.	35.9% (14)	N/A
Supervisee is assisted by his/her supervisor to recognise and enhance his/her personal strengths in relation to the maintenance of personal and professional boundaries.	48.7% 19	87.5% (7)
Supervisees have a good professional relationship with their supervisor.	100.0% (39)	100.0% (8)
Every year I complete the boundary maintenance self-assessment form which I discuss with my supervisor.	0.0% 0	0.0% 0
I am aware of the organisational policy and procedure for evaluating reported issues related to the maintenance of personal and professional boundaries, including for when a matter must be referred to the Statewide Manager.	41.0% 16	25.0% (2)
I am aware of the guidelines for when a therapeutic relationship must be terminated.	61.5% 24	25.0% (2)
Supervisor has made supervisee aware of the limits of confidentiality in relation to the disclosure of boundary crossings and violations.	46.1% 18	62.5% (5)
Supervisee has been familiarised (by his/her supervisor) with the Rights and Needs of Supervisees policy.	12.8% 5	0.0% (0)
Supervisee is aware that issues that he/she discusses with his/her supervisor related to personal and professional conduct pertaining to an individual psychologist have to be discussed in private.	92.3% 36	100.0% (8)

There were discrepancies between how supervisors and supervisees answered the questions for this standard. For example, while 75.0%% of supervisors reported regularly discussing boundary issues, only 35.9% of supervisees endorsed the same question. While 75.0% of supervisors reported starting supervision meetings with an agenda, only 48.7% of supervisees reported this experience. Similarly, sized discrepancies were observed for encouragement to seek consultation, feedback and guidance regarding boundary issues, feedback and guidance on personal and professional boundary performance, and supervisors assisting supervisees to recognise their strengths. Overall, it appears that there are some gaps with how much support supervisees receive in relation to the maintenance of personal and professional boundaries. It appears that supervisors at least have the intention to support supervisees in maintaining boundaries, but this intension does not seem to be evident from the perspective of supervisees. This is perhaps indicative of a lack of proactivity in being vigilant in relation to boundary issues, but it is such vigilance that will allow CSNSW to detect and correct minor boundary crossings before they turn into violations.

Standard 5 – Supervisors' needs

Table 9 reports on adherence to "Standard 5" the needs of supervisors in promoting personal and professional boundaries among supervisees.

Table 9. Supervisors' reports on the level of adherence to professional standards related to the needs of supervisors in relation to promotion of the development and maintenance of personal and professional boundaries (PPB) by psychologists they supervise.

Standard's Criteria	Yes % (n)
My chief psychologist and I maintain communication and interaction in relation to the promotion of effective personal and professional boundaries.	37.5% (3)
My chief psychologist provides me with feedback and guidance (on a yearly basis) on my performance in the promotion of effective personal and professional boundaries.	25.0% (2)
My chief psychologist and I begin our supervision sessions with a working agenda.	62.5% (5)
The working agenda includes issues related to the promotion of personal and professional boundaries in the correctional setting.	12.5% (1)
I have been trained on the policy and procedure for evaluating supervisees' issues related to personal and professional boundaries, including when a matter must be referred to the Statewide Manager.	25.0% (2)
I have been trained on the guidelines for when a therapeutic relationship must be terminated.	25.0% (2)
I have been trained on the limits of confidentiality in relation to the disclosure of boundary crossings and violations.	50.0% (4)
Every year I complete the boundary maintenance self-assessment form for supervisors which I discuss with my chief psychologist.	0.0% 0

The results for adherence to the Standard's criteria related to supervisors' needs suggest that communication regarding the promotion of effective personal and professional boundaries does not regularly occur between chief psychologists and clinical supervisors. While some

chief psychologists are reported to start their supervision meetings with an agenda, the promotion of boundary issues is not reported to have been discussed at all. Some supervisors indicated that they have been trained in policies and procedures that were part of the Standards of Practiced developed for this project. This is surprising since these policies and procedures that are part of the "Standards" have not been implemented as yet. These could have been mistaken for guidelines that are taught as part of the registration process or internal policies and procedures that the investigators are not aware of. The latter is unlikely as the investigators tried to access such documents from the chief psychologists but were not informed of their existence. Overall it appears that current practices could be improved in terms of helping supervisors to promote effective boundaries.

Discussion

Based on a review of the literature, the current study initially developed the Standards of Clinical Supervision Practice for Optimising the Development and Maintenance of Personal and Professional Boundaries in the Correctional Setting. Subsequently, a survey of CSNSW psychologists was conducted that provided a snapshot of the kinds of challenges in relation to personal and professional boundaries psychologists face at CSNSW. This survey also identified strategies for dealing with such challenges used by CSNSW psychologists and the level of support provided by the organisation to the development and maintenance of personal and professional boundaries. The Standards were subsequently amended according to results from this survey.

As stated earlier in the current report, the goal of the project was to prevent personal and professional boundary violations among psychologists working for CSNSW. Steps taken towards the prevention of boundary violations positively impact on: (1) the offenders under

the care of CSNSW; (2) psychologists working for CSNSW; (3) the reputation of CSNSW; and (4) the reputation of the psychological profession as a whole.

The need for education and training of newly hired and current psychologists

Psychologists are at the forefront of boundary issues and ultimately bear the brunt of the blame in cases of professional transgressions. While the literature supports the important role of organisational influences in promoting strong professional and personal boundaries among staff, it would be remiss to diminish the role of psychologists in maintaining such boundaries. No matter how great the boundary challenge is, the onus of boundaries lies with psychologists and no transgression is possible without their consent. The following is a discussion of the types of education and training that can prepare CSNSW psychologists to face the ethical challenges reported in the current study.

The current study shows that boundary challenges come frequently and in many forms for psychologists working with offenders. Incarcerated offenders are, by definition, isolated and limited in their interaction with the outside world. This fact makes meeting with a psychologist - often of the opposite sex - a welcome distraction from the harshness of prison life. Additionally, results show that attempts to manipulate clinicians are common in the correctional setting. This finding is consistent with reports in the literature that, indeed, some offenders see staff interactions as a possibility for manipulation (Worley, 2010). Whether an offender's attempt to cross boundary is part of manipulative behaviour or not may not always be easy to distinguish. Regardless of motivation, such attempts are part of the ethical challenges faced by psychologists in the correctional setting and thus coping with these challenges proves to be a challenge for current and especially inexperienced psychologists.

Results from the current study provided an extensive menu of strategies from psychologists, clinical supervisors, and chief psychologists on how to cope successfully with the many boundary challenges inherent in the correctional setting. As it is recommended in the 'Standards', such strategies must be compiled by psychological services to form part of an induction booklet aimed at preparing current and newly hired psychologists to face the many ethical challenges typically present in the correctional setting.

While prison manipulators exist, it would be misleading to suggest that all, or even most of, the boundary challenges from offenders reported in the current study were attempts to manipulate psychologists. As mentioned above, isolation and the prison environment could mean that the offender-psychologist relationship may be the most meaningful, friend like relationship for many offenders. Thus, the boundary lines are likely to be blurred from the offender's perspective. Results showed that the handling of such boundary confusion, and therefore boundary challenges, varied from psychologist to psychologist. Most responses reported by psychologists in the current study were appropriate ways to handle boundary challenges, with psychologists typically drawing a strong boundary verbally. However, the most therapeutically beneficial responses went beyond just boundary setting. Chief psychologists suggested and many psychologists reported explaining why the boundary exists and clarifying the nature of the therapeutic relationship. CSNSW psychologists would benefit from formal training on how to respond to the many boundary challenges they typically face accordingly. Further reinforcing the need for such training, some chief psychologists approached boundary challenges as opportunities for therapeutic and personal growth. Such, therapeutically oriented approach has two clear advantages. Firstly, they are more likely to lead to future reductions in boundary challenges as they clarify the professional relationship, and the reasons and importance of boundaries - thus making the psychologists' job easier. Secondly, they provide the psychologist with content on which they can work on

therapeutically with the offender - thus increasing the effect that a psychologist can have on the behaviour of an offender.

Another type of boundary challenge - not frequently reported yet of great importance - came from thoughts, feelings and actions of the clinician him/herself. As summarised in the introduction segment of the current report, personal characteristics associated with boundary issues are associated with early childhood trauma, current relational and psychological problems, and strong feelings in therapeutic relationships. The more distal of these factors contributing to boundary issues are best dealt with via psychological services outside of CSNSW. However, it is also imperative for CSNSW to provide education to its staff on who might be at risk and to equip them with strategies for dealing with such risk. Awareness of being at risk for boundary transgressions is likely to induce greater vigilance in relation to one's personal and professional boundaries.

Such heightened vigilance by those at risk must address both, positive and negative feelings. The most proximal factor of feelings is something that this report addressed extensively. Feelings were reported by CSNSW psychologists to happen in interactions with offenders. Such feelings were frequently reported and tended to be either negative or affiliative. Such negative feelings toward some offenders, when acted upon, not only crossed therapeutic boundaries, but they also could have contributed to the development of positive feelings for offenders that were not as difficult. Juxtaposition can be a powerful phenomenon.

It is noted that both, positive and negative feelings toward offenders that lie on the border between therapeutic boundary crossings and the slippery slope were extensively reported by CSNSW psychologists. Results showed that feelings in the context of therapeutic boundary crossings are expected if the psychologist is motivated to help a client. Some psychologists also reported experiencing positive feelings in response to a client's progress through

therapy. Negative feelings in response to resistance to therapy were also reported by CSNSW psychologists. Within a therapeutic context such feelings can both contribute to positive outcomes where a psychologist is invested in helping the client (positive feelings), or is motivated to 'get through' to a client that is resistant. However, the same emotions could be indicative of being on the slippery slope in relation to both, over and under involvement. As results showed, some psychologists at times become fed up with a client and disengaged, thereby crossing the boundary of the therapeutic framework. Conversely, results also show that some psychologists at times became over-involved and developed personal feelings for the client.

The current study shows that challenges to professional boundaries – originated from both, offenders and psychologists - occur frequently in the correctional setting and that they arise from different motivations. While recommendations on how to address such challenges are provided throughout this report, they are not fix-all solutions. Relationships are not simple and linear, with some challenges being a lot more problematic than others. It is also difficult at times to step away from personal feelings toward an offender and approach a particular boundary challenging situation objectively. Further complicating the issue, some of the boundary crossings reported by CSNSW psychologists may, indeed, be of therapeutic benefit to the client providing these psychologists with a rational reason to step into the grey area that may lead to the slippery slope. Given these challenges, one of the recommended solutions, based on past research findings and the results from the current study is for all but the most trivial issues to be discussed in supervision. Clinical supervision play a key role in the development and maintenance of effective boundaries, ensuring that professional interactions with offenders are ethical and safe, with clinical supervisors potentially intervening when necessary.

Open and honest discussion of boundary issues in clinical supervision is crucial for successfully addressing the boundary challenges identified in the current study. Indeed, chief psychologists recommended bringing all but the most trivial issues to clinical supervision, and supervisors indicated that they were comfortable discussing boundary issues with their supervisees. Furthermore, instances where boundary issues were brought to clinical supervision almost always led to positive outcomes. In order for supervisees to feel comfortable bringing boundary issues to supervision, the organisation needs to ensure they are encouraged to do so and that they genuinely feel comfortable and safe doing so. That is, they must not feel that their careers will be placed in jeopardy by discussing boundary challenges, including minor boundary crossing, in clinical supervision and that confidentiality will be maintained.

Finally, the current study also identified issues needing to be addressed in relation to the maintenance of professional boundaries within the supervisory process. As previously discussed, boundary crossings and violations that occur in therapy can be paralleled in interactions between supervisors and supervisees. Professional development of CSNSW clinical supervisors must also address the development and maintenance of personal and professional boundaries in the supervisory process.

The need for organisational efforts to support the development and maintenance of professional boundaries

Psychological services in the correctional setting must be delivered by a system that has been carefully and consciously designed to promote the development and maintenance of personal and professional boundaries. Both the literature review and the results of the current study point to the importance of organisational support for the promotion of strong professional

boundaries in the correctional setting. The current study demonstrated psychologists were not following clear, well-defined policies and procedures for the reporting and for dealing with issues related to personal and professional boundaries. That is, there was no consistency in how such reports were made and handled pointing to a possible lack of organisational fluency in the area. Further aggravating the problem, guidelines as to what is to be reported and discussed and why appeared to be non-existent.

It is also noted that in relation to boundary challenges originated by psychologists, as opposed to offenders, although instances were relatively infrequent, when reported to clinical supervisors, responses lacked consistency. As previously discussed, there were instances where such reports were handled admirably by supervisors, with psychologists being appropriately assisted throughout the situations resulting in positive outcomes for both psychologists and offenders alike. There were also instances where such reports were handled in a less than desirable fashion, with psychologists feeling they had been unfairly punished (implicitly and explicitly) for reporting the incident and that their professional reputations had been permanently damaged. Clear policies and procedures must exist to provide psychologists with the expectation that they will be appropriately assisted and confidentiality will be maintained when such instances are reported in clinical supervision. Clear policies and procedures on how to handle such reports are needed.

Again, it is reiterated that open discussion about boundary issues between psychologists and their clinical supervisors without fear of negative consequences is a precondition for preventing serious boundary violations. CSNSW must understand that boundary issues are common and normal. Not in the sense that boundary violations are something that should be normalised, but that thoughts and feelings associated with the slippery slope are to be expected. There should not be a psychologist that has never felt strong negative and/or positive emotions toward a client. The finding that a significant proportion of CSNSW

psychologists do not feel comfortable disclosing boundary related issues in supervision is of serious concern. Supervisors and chief psychologists all reported being comfortable having such discussions with their supervisees and also reported bringing up issues related to boundaries themselves although, supervisees did not report such instances as frequently.

This inconsistency in comfort levels related to the discussion of boundary issues in clinical supervision (before there is potential for serious boundary violations), and in the outcomes of such disclosures reinforce the need for organisational efforts in the area. The psychologist that discusses boundary issues in supervision, including minor transgression, should be applauded, rather than punished. Several organisational features need to exist for this to happen. Firstly, as previously discussed, the normalisation of boundary issues needs to flow from the top. Efforts need to be made to take the taboo away from such discussions bringing personal and professional boundaries to the forefront of the psychologist-supervisor relationship. Secondly, there must be policies and guidelines which make it clear to all CSNSW psychologists what constitutes boundary issues, ie. training must be provided on event recognition, and what is expected to be discussed in clinical supervision and why, with limits of confidentiality being clearly delineated so that CSNSW psychologists feel safe disclosing boundaries issues to their clinical supervisors.

We recommend that in addition to implementing the 'Standards of Practice', psychological services at CSNSW invest resources into devising further policies and procedures in relation to the maintenance of personal and professional boundary in the correctional setting.

The need for implementation of the "Standards"

Baseline measurements of the individual standards of clinical supervision practice revealed some strengths and weaknesses when it comes to current practices in relation to clinical supervision, training, and resources. At the time of writing the current report, there was no

formal set of standards for clinical supervision practices in general, particularly in relation to boundaries, therefore adherence to the 'Standards' was not expected to be high. However, many of the individual standards were basic to supervisory practices and therefore expected already to have been met by CSNSW.

In relation to the individual standard related to the availability of resources, results showed supervisees were able to organise an extra meeting to discuss boundaries and that such meetings mostly could occur in private. Although high adherence to this standard was observed, one hundred per cent adherence would be expected. Therefore it is recommend that every single CSNSW psychologist be supervised, be able to plan an extra meeting when needed, and that such a meeting takes place in private.

As expected, results showed a lack of professional development opportunities in the area of personal and professional boundaries. While there was some indication that training and educational opportunities were available to psychologists, the investigators were not made aware of any such education being delivered by CSNSW or outside training opportunities that were available to CSNSW staff during the study period. An expectation of professionalism in the area by psychology graduates is expected, as they have all been trained in the code of ethics which includes a section on boundaries. However, as discussed earlier, ethical development - which includes maintenance of boundaries - is largely accepted as being a career-long process (Pope, 2003). Since results showed that psychologists in the correctional setting work in a particularly challenging environment, more development opportunities in relation to personal and professional boundaries must be made available.

The baseline measurement of the individual standard related to supervisees' needs indicates that CSNSW psychologists could be further supported in the development and maintenance of personal and professional boundaries. This particular standard calls for supervisors to take

a proactive role in the area. Such proactivity would ensure support for all CSNSW psychologists whose boundaries are frequently being challenged. Even in cases where such challenges are not common, the extra support would take little time from current supervision.

Baseline measurement of the individual standard related to supervisors' needs revealed low levels of adherence. This was expected since the main theme of this standard was making sure supervisors are trained and educated in policies and procedures that are yet to be implemented. General agreement by clinical supervisors with most of the questions that evaluated this baseline was actually surprising. Regardless, results demonstrate that currently there are no clear policies and procedures being followed by clinical supervisors to assist supervisees to develop and maintain personal and professional boundaries in the correctional setting.

Conclusion

As previously discussed, the current research was supported by a research grant from the Psychology Council of NSW. This research grant followed the identified education and research priority area of the Psychology Council of NSW "Conduct - maintaining appropriate professional and personal boundaries, with specific attention to psychologists in correctional facilities", contained within the Education and Research Guidelines 2013-2014 of the Council.

Results from the survey of CSNSW psychologists endorsed the Psychology Council's priority educational and research efforts to maintain appropriate professional and personal boundaries among psychologists working in the correctional setting. Research findings demonstrate that psychologists working in the correctional setting are frequently confronted with boundary challenges from offenders. Such challenges include inappropriate sexual behaviour, intimidation, requests for favours, sexual and personal advances, personal

information enquiries, offers of gifts, physical touching, attempts to form dual relationships, offenders' attunement to psychologists' emotions, manipulation, attempts to split staff, etc. One must also bear in mind the current study did not allow for a closer examination of the frequency of the matters reported by CSNSW psychologists.

In addition, results showed that although most CSNSW psychologists draw a strong boundary verbally when confronted with such challenges, not all CSNSW psychologists respond appropriately to such challenges nor all CSNSW psychologists feel comfortable discussing such challenges with their clinical supervisors. Moreover, results showed there is a lack of consistency in the reporting of issues related to personal and professional boundaries by CNSW psychologists. It appears that currently there are no policies or set procedures being followed for how to handle the reporting of such issues.

Therefore, it is imperative that: 1) psychologists working in the correctional setting receive adequate training and education on how to face these boundary challenges successfully; 2) strategies are implemented at an organisational level to create a culture of openness among CSNSW psychologists since clinical supervision is of little value in the prevention of boundary violations if either party does not feel comfortable discussing issues related to personal and professional boundaries; and 3) CSNSW fully implement the 'Standards' thus creating systems at an organisational level that promote the maintenance of strong personal and professional boundaries.

Finally, there are many reasons as to why psychological services from various organisations may be reluctant to address the topic of personal and professional boundaries, such as fear of damaging the reputation of their workforce by being perceived as being in need of education in the area; fear of the media who could seize on the opportunity to report such efforts negatively; and the extra resource expenditure that would accompany such efforts. However,

any barriers to addressing boundary issues in the correctional setting must be overcome if CSNSW as an organisation is to create an environment where serious professional transgressions are successfully eliminated.

Recommendations

Based on the findings of the current study, the following three recommendations are made. It is recommended that:

1. CSNSW provides ongoing education and training in the development and maintenance of personal and professional boundaries through formal professional development at the Brush Farm Academy of Corrective Services and through clinical supervision;
2. Strategies be devised and implemented at an organisational level to create a culture of openness among CSNSW psychologists, thus facilitating ongoing discussion of issues related to personal and professional boundaries in clinical supervision; and
3. CSNSW implements 'the Standards,' thus integrating them to systems at an organisational level that promote the development and maintenance of strong personal and professional boundaries, such as the setting of clear policies and procedures for reporting and managing issues related to professional boundaries and activities aimed at culture change.
    a. The survey of CSNSW psychologists be replicated at regular intervals to monitor trends in adherence to the Standards and in the reporting of issues related to personal and professional boundaries.

Limitations of the study

Although the current study has derived rich data on the development and maintenance of professional and personal boundaries by correctional psychologists, it is acknowledged that the response rate was somewhat low (50 completed questionnaires from a pool of 156 potential respondents). Therefore, the sample may have been under represented. Such under representation of the sample could be a reflection of the taboo surrounding the disclosure of boundary issues in the correctional practice setting.

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Appendices

Appendix 1

Assessment of comfort discussing boundary issues

Psychologists' responses to items assessing comfort discussing issues related to personal and professional boundaries.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Total
My supervisor and I discuss boundary issues that result from the actions of another individual.	**17.31%** 9	**50.0%** 26	**15.38%** 8	**11.54%** 6	**5.77%** 3	52
I feel comfortable having a discussion with my supervisor regarding boundary issues that result from the actions of another individual.	**28.85%** 15	**53.85%** 28	**7.69%** 4	**9.62%** 5	**0.00%** 0	52
My supervisor and I discuss boundary issues that result from a feeling or behaviour initiated by me.	**9.62%** 5	**55.77%** 29	**21.15%** 11	**11.54%** 6	**1.92%** 1	52
I feel comfortable having a discussion with my supervisor regarding boundary issues that result from a feeling or behaviour initiated by me.	**15.38%** 8	**50.00%** 26	**25.00%** 13	**9.62%** 5	**0.00%** 0	52
I am uncertain as to what can and cannot be discussed with my supervisor regarding boundary issues.	**3.85%** 2	**7.69%** 4	**1.92%** 1	**48.08%** 25	**38.46%** 20	52
My colleagues and I discuss boundary issues that result from the actions of another individual.	**23.08%** 12	**59.62%** 31	**11.54%** 6	**5.77%** 3	**0.00%** 0	52
I feel comfortable having a discussion with my colleagues regarding boundary issues that result from the actions of another individual.	**23.08%** 12	**57.69%** 30	**13.46%** 7	**5.77%** 3	**0.00%** 0	52
My colleagues and I discuss boundary issues that result from a feeling or behaviour initiated by me.	**9.62%** 5	**53.85%** 28	**25.00%** 13	**9.62%** 5	**1.92%** 1	52
I feel comfortable having a discussion with my colleagues regarding boundary issues that result from a feeling or behaviour initiated by me.	**17.31%** 9	**48.08%** 25	**21.15%** 11	**13.46%** 7	**0.00%** 0	52

Clinical supervisors' responses to items assessing comfort discussing issues related to personal and professional boundaries.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Total
My supervisee and I discuss boundary issues that result from the actions of another individual.	**13.64%** 3	**54.55%** 12	**4.55%** 1	**27.27%** 6	**0.00%** 0	22
I feel comfortable discussing boundary issues that result from the actions of another individual.	**13.64%** 3	**72.73%** 16	**4.55%** 1	**9.09%** 2	**0.00%** 0	22
My supervisee and I discuss boundary issues that result from a feeling or behaviour initiated by my supervisee.	**9.09%** 2	**72.73%** 16	**13.64%** 3	**4.55%** 1	**0.00%** 0	22
I feel comfortable discussing boundary issues that result from a feeling or behaviour initiated by my supervisee.	**18.18%** 4	**72.73%** 16	**4.55%** 1	**4.55%** 1	**0.00%** 0	22
I am uncertain as to what can and cannot be discussed with my supervisee regarding boundary issues.	**0.00%** 0	**0.00%** 0	**4.55%** 1	**72.73%** 16	**22.73%** 5	22

Appendix 2

The adapted ‘Client-staff interactions survey’ (C-SI)

Emotions to Behaviour
Have you ever felt any of the following feelings in response to an offender's abusive/belligerent behaviours?
Fearful
Angry
Resentful
Helpless
Hopeless
Apathetic
Manipulated
Deceived
Inadequate
Like a failure

Emotions to Resistance
Have you ever felt any of the following feelings in response to an offender's resistance to treatment?
Fearful
Angry
Resentful
Helpless
Hopeless
Apathetic
Manipulated
Deceived
Inadequate
Like a failure

5 point scales ranging from “never” to “about once a week or more”

Boundary Crossings
I have conducted a therapy session for longer than normal because an offender was experiencing a crisis.
I have conducted a therapy session for longer than normal due to the therapeutic nature of the session.
I have touched offender(s) during therapy sessions for therapeutic reasons (i.e., to console or to demonstrate a point).
I have caused offender(s) to feel deep emotions in the therapy session by what I said, in order to help them get past some of the negative coping skills they had been using.
I have disclosed (past, not current) personal information to offender(s) for therapeutic reasons.
I have arranged to see an offender on a more frequent basis due to the nature of the psychopathology or due to the nature of the therapeutic work.
I have socialised with offender(s) in their living area, with a clear therapeutic purpose in mind.
I have changed an offender's original treatment plan under consultation with the treatment team and the offender, for therapeutic reasons.
When offender(s) have been seductive with me, I discuss the behaviours with the offender(s) in a respectful, non-shaming way.
Slippery Slope
I have felt that I was responsible for the offender’s behaviour and that his/her misconduct was a reflection of my professional conduct.
I have derived great satisfaction from offender’s praise or affection.
I have been anxious to please offender(s).

I have thought that I was the only one who understood a particular offender.
I have 'bent' the rules (in a minor way) to certain offender(s).
Over-Involvement
I have given or received a gift (valued at more than $5) to/from offender(s) without my supervisor's permission/knowledge.
I have kept secrets about offender(s) that I thought I should have shared with other staff members.
I have disclosed personal problems to offender(s).
I have had fantasies about offender(s) (i.e., fantasies that were romantic or sexual or violent in nature).
I have experienced sexual attraction toward offender(s), without acting on my feelings.
Offender Challenges
An offender has brought/made me coffee or food.
An offender has made romantic advances towards me.
An offender has tried to befriend me.
An offender has asked me about my personal life, such as: my age, sexual preferences, relationship status, what I did on the weekend, or other personal questions.
An offender has brought up sexual content which is not relevant to therapy.
An offender has brought up and wanted to discuss other offenders that I also see for therapy.
An offender has tried to engage me in conversation about other psychologists or other staff.
An offender has offered me a gift.
An offender has showed sympathy to the difficulty of my job or offered to help me with other offenders that I see.

An offender has touched me during a therapy session (e.g. flicked a bit of dust off my clothing or placed their hand on my shoulder in a supportive manner).

Appendix 2a. Responses to the adapted 'Client-staff interaction survey' (C-SI)

Psychologists' responses to the adapted 'Client-staff interactions survey' (C-SI)

Emotions to Behaviour

Have you ever felt any of the following feelings in response to an offender's abusive/belligerent behaviours? (Please select the option for the appropriate frequency)

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
Fearful	**12.82%** 5	**69.23%** 27	**15.38%** 6	**0.00%** 0	**2.56%** 1	**0.00%** 0	39
Angry	**20.51%** 8	**20.51%** 8	**28.21%** 11	**25.64%** 10	**5.13%** 2	**0.00%** 0	39
Resentful	**58.97%** 23	**17.95%** 7	**10.26%** 4	**10.26%** 4	**2.56%** 1	**0.00%** 0	39
Helpless	**58.97%** 23	**17.95%** 7	**7.69%** 3	**10.26%** 4	**5.13%** 2	**0.00%** 0	39
Hopeless	**58.97%** 23	**20.51%** 8	**7.69%** 3	**12.82%** 5	**0.00%** 0	**0.00%** 0	39
Apathetic	**53.85%** 21	**20.51%** 8	**5.13%** 2	**7.69%** 3	**10.26%** 4	**2.56%** 1	39
Manipulated	**25.64%** 10	**35.90%** 14	**17.95%** 7	**10.26%** 4	**2.56%** 1	**7.69%** 3	39
Deceived	**38.46%** 15	**25.64%** 10	**15.38%** 6	**12.82%** 5	**2.56%** 1	**5.13%** 2	39
Inadequate	**56.41%** 22	**23.08%** 9	**12.82%** 5	**2.56%** 1	**5.13%** 2	**0.00%** 0	39
Like a failure	**69.23%** 27	**23.08%** 9	**2.56%** 1	**0.00%** 0	**5.13%** 2	**0.00%** 0	39

Emotions to Resistance

Have you ever felt any of the following feelings in response to an offender's resistance to treatment? (Please select the option for the appropriate frequency).

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
Fearful	**89.74%** 35	**5.13%** 2	**5.13%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
Angry	**48.72%** 19	**28.21%** 11	**15.38%** 6	**7.69%** 3	**0.00%** 0	**0.00%** 0	39
Resentful	**66.67%** 26	**17.95%** 7	**7.69%** 3	**7.69%** 3	**0.00%** 0	**0.00%** 0	39
Helpless	**51.28%** 20	**23.08%** 9	**17.95%** 7	**7.69%** 3	**0.00%** 0	**0.00%** 0	39
Hopeless	**61.54%** 24	**17.95%** 7	**15.38%** 6	**5.13%** 2	**0.00%** 0	**0.00%** 0	39
Apathetic	**64.10%** 25	**7.69%** 3	**10.26%** 4	**17.95%** 7	**0.00%** 0	**0.00%** 0	39
Manipulated	**58.97%** 23	**15.38%** 6	**17.95%** 7	**2.56%** 1	**2.56%** 1	**2.56%** 1	39
Deceived	**61.54%** 24	**17.95%** 7	**17.95%** 7	**0.00%** 0	**0.00%** 0	**2.56%** 1	39
Inadequate	**41.03%** 16	**35.90%** 14	**10.26%** 4	**7.69%** 3	**5.13%** 2	**0.00%** 0	39
Like a failure	**69.23%** 27	**20.51%** 8	**0.00%** 0	**7.69%** 3	**2.56%** 1	**0.00%** 0	39

Boundary Crossings

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
I have conducted a therapy session for longer than normal because an offender was experiencing a crisis.	**7.69%** 3	**10.26%** 4	**30.77%** 12	**33.33%** 13	**15.38%** 6	**2.56%** 1	39
I have conducted a therapy session for longer than normal due to the therapeutic nature of the session.	**12.82%** 5	**7.69%** 3	**35.90%** 14	**30.77%** 12	**7.69%** 3	**5.13%** 2	39
I have touched offender(s) during therapy sessions for therapeutic reasons (i.e., to console or to demonstrate a point).	**79.49%** 31	**10.26%** 4	**5.13%** 2	**5.13%** 2	**0.00%** 0	**0.00%** 0	39
I have caused offender(s) to feel deep emotions in the therapy session by what I said, in order to help them get past some of the negative coping skills they had been using.	**30.77%** 12	**25.64%** 10	**12.82%** 5	**12.82%** 5	**10.26%** 4	**7.69%** 3	39
I have disclosed (past, not current) personal information to offender(s) for therapeutic reasons.	**38.46%** 15	**20.51%** 8	**20.51%** 8	**20.51%** 8	**0.00%** 0	**0.00%** 0	39
I have arranged to see an offender on a more frequent basis due to the nature of the psychopathology or due to the nature of the therapeutic work.	**12.82%** 5	**12.82%** 5	**25.64%** 10	**33.33%** 13	**10.26%** 4	**5.13%** 2	39
I have socialised with offender(s) in their living area, with a clear therapeutic	**56.41%** 22	**10.26%** 4	**5.13%** 2	**12.82%** 5	**10.26%** 4	**5.13%** 2	39

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
purpose in mind.							
I have changed an offender's original treatment plan under consultation with the treatment team and the offender, for therapeutic reasons.	**25.64%** 10	**17.95%** 7	**25.64%** 10	**17.95%** 7	**12.82%** 5	**0.00%** 0	39
When offender(s) have been seductive with me, I discuss the behaviours with the offender(s) in a respectful, non-shaming way.	**30.77%** 12	**46.15%** 18	**17.95%** 7	**2.56%** 1	**2.56%** 1	**0.00%** 0	39

Slippery Slope

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
I have felt that I was responsible for the offender's behaviour and that his/her misconduct was a reflection of my professional conduct.	**69.23%** 27	**15.38%** 6	**12.82 %** 5	**2.56%** 1	**0.00%** 0	**0.00%** 0	39
I have derived great satisfaction from offender's praise or affection.	**58.97%** 23	**25.64%** 10	**5.13%** 2	**10.26 %** 4	**0.00%** 0	**0.00%** 0	39
I have been anxious to please offender(s).	**82.05%** 32	**10.26%** 4	**5.13%** 2	**2.56%** 1	**0.00%** 0	**0.00%** 0	39
I have thought that I was the only one who understood a particular offender.	**82.05%** 32	**12.82%** 5	**5.13%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have 'bent' the rules (in a minor way) to certain offender(s).	**79.49%** 31	**10.26%** 4	**5.13%** 2	**5.13%** 2	**0.00%** 0	**0.00%** 0	39
I have found myself relating to offender(s) as I might a family member or a friend.	**76.92%** 30	**17.95%** 7	**5.13%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have inconsistently enforced the rules in the treatment setting.	**76.92%** 30	**17.95%** 7	**5.13%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have had difficulties setting limits with offender(s).	**64.10%** 25	**25.64%** 10	**7.69%** 3	**2.56%** 1	**0.00%** 0	**0.00%** 0	39
I have needed the approval of offender(s) for my own self-worth.	**89.74%** 35	**5.13%** 2	**5.13%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	39

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
I have socialised with offender(s) without a therapeutic purpose in mind.	**87.18%** 34	**10.26%** 4	**2.56%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	39

Under-Involvement

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
I have ended a session early, due to boredom or disinterest with particular offender(s).	**71.79%** 28	**12.82%** 5	**10.26%** 4	**2.56%** 1	**2.56%** 1	**0.00%** 0	39
I have ignored an offender's requests (e. g., I disengaged from the offender).	**56.41%** 22	**33.33%** 13	**10.26%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have insulted offender(s) as a reaction to their behaviour.	**89.74%** 35	**10.26%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have belittled offender(s) as a reaction to their behaviour.	**89.74%** 35	**10.26%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have called offender(s) derogatory names to their face in reaction to their behaviours.	**94.87%** 37	**5.13%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have become angry in a session and was unable to control my feelings in the moment towards offender(s), such that I expressed anger.	**66.67%** 26	**30.77%** 12	**0.00%** 0	**2.56%** 1	**0.00%** 0	**0.00%** 0	39
I have physically assaulted offender(s) out of anger or frustration.	**100.00%** 39	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have avoided knowing about my offender(s) history.	**92.31%** 36	**5.13%** 2	**2.56%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	39

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
I have 'let my mind wander' to other things during a session.	**12.82%** 5	**20.51%** 8	**28.21%** 11	**33.33%** 13	**2.56%** 1	**2.56%** 1	39
I have avoided conflict with offender(s) and let other staff deal with the issues.	**53.85%** 21	**23.08%** 9	**17.95%** 7	**5.13%** 2	**0.00%** 0	**0.00%** 0	39

Over-Involvement

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
I have given or received a gift (valued at more than $5) to/from offender(s) without my supervisor's permission/knowledge.	**100.00%** 39	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have kept secrets about offender(s) that I thought I should have shared with other staff members.	**94.87%** 37	**5.13%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have disclosed personal problems to offender(s).	**94.87%** 37	**5.13%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have had fantasies about offender(s) (i.e., fantasies that were romantic or sexual or violent in nature).	**94.87%** 37	**5.13%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have experienced sexual attraction toward offender(s), without acting on my feelings.	**74.36%** 29	**25.64%** 10	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	39

Offender Challenges

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
An offender has brought/made me coffee or food.	**53.85%** 21	**23.08%** 9	**10.26%** 4	**10.26%** 4	**2.56%** 1	**0.00%** 0	39
An offender has made romantic advances towards me.	**48.72%** 19	**43.59%** 17	**5.13%** 2	**2.56%** 1	**0.00%** 0	**0.00%** 0	39
An offender has tried to befriend me.	**35.90%** 14	**46.15%** 18	**7.69%** 3	**10.26%** 4	**0.00%** 0	**0.00%** 0	39
An offender has asked me about my personal life, such as: my age, sexual preferences, relationship status, what I did on the weekend, or other personal questions.	**2.56%** 1	**28.21%** 11	**12.82%** 5	**35.90%** 14	**12.82%** 5	**7.69%** 3	39
An offender has brought up sexual content which is not relevant to therapy.	**46.15%** 18	**41.03%** 16	**7.69%** 3	**5.13%** 2	**0.00%** 0	**0.00%** 0	39
An offender has brought up and wanted to discuss other offenders that I also see for therapy.	**17.95%** 7	**35.90%** 14	**5.13%** 2	**23.08%** 9	**15.38%** 6	**2.56%** 1	39
An offender has tried to engage me in conversation about other psychologists or other staff.	**15.38%** 6	**23.08%** 9	**20.51%** 8	**28.21%** 11	**10.26%** 4	**2.56%** 1	39

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
An offender has offered me a gift.	**48.72%** 19	**46.15%** 18	**5.13%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
An offender has showed sympathy to the difficulty of my job or offered to help me with other offenders that I see.	**43.59%** 17	**30.77%** 12	**10.26%** 4	**15.38%** 6	**0.00%** 0	**0.00%** 0	39
An offender has touched me during a therapy session (e.g. flicked a bit of dust off my clothing or placed their hand on my shoulder in a supportive manner).	**66.67%** 26	**25.64%** 10	**7.69%** 3	**0.00%** 0	**0.00%** 0	**0.00%** 0	39

Clinical supervisors' responses to the adapted 'Client-staff interactions survey' (CSI)

Emotions to Behaviour

Have you ever felt any of the following feelings in response to an offender's abusive/belligerent behaviours? (Please select the option for the appropriate frequency).

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
Fearful	**0.00%** 0	**75.00%** 6	**25.00%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
Angry	**50.00%** 4	**12.50%** 1	**25.00%** 2	**12.50%** 1	**0.00%** 0	**0.00%** 0	8
Resentful	**75.00%** 6	**12.50%** 1	**12.50%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
Helpless	**75.00%** 6	**0.00%** 0	**12.50%** 1	**12.50%** 1	**0.00%** 0	**0.00%** 0	8
Hopeless	**62.50%** 5	**12.50%** 1	**12.50%** 1	**12.50%** 1	**0.00%** 0	**0.00%** 0	8
Apathetic	**62.50%** 5	**25.00%** 2	**12.50%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
Manipulated	**37.50%** 3	**25.00%** 2	**25.00%** 2	**12.50%** 1	**0.00%** 0	**0.00%** 0	8
Deceived	**37.50%** 3	**25.00%** 2	**12.50%** 1	**25.00%** 2	**0.00%** 0	**0.00%** 0	8
Inadequate	**62.50%** 5	**0.00%** 0	**25.00%** 2	**0.00%** 0	**12.50%** 1	**0.00%** 0	8
Like a failure	**75.00%** 6	**12.50%** 1	**12.50%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	8

Emotions to Resistance

Have you ever felt any of the following feelings in response to an offender's resistance to treatment? (Please select the option for the appropriate frequency).

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
Fearful	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
Angry	**50.00%** 4	**25.00%** 2	**12.50%** 1	**12.50%** 1	**0.00%** 0	**0.00%** 0	8
Resentful	**62.50%** 5	**25.00%** 2	**0.00%** 0	**12.50%** 1	**0.00%** 0	**0.00%** 0	8
Helpless	**62.50%** 5	**12.50%** 1	**0.00%** 0	**25.00%** 2	**0.00%** 0	**0.00%** 0	8
Hopeless	**62.50%** 5	**25.00%** 2	**0.00%** 0	**12.50%** 1	**0.00%** 0	**0.00%** 0	8
Apathetic	**62.50%** 5	**37.50%** 3	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
Manipulated	**50.00%** 4	**25.00%** 2	**12.50%** 1	**12.50%** 1	**0.00%** 0	**0.00%** 0	8
Deceived	**75.00%** 6	**12.50%** 1	**0.00%** 0	**12.50%** 1	**0.00%** 0	**0.00%** 0	8
Inadequate	**50.00%** 4	**25.00%** 2	**0.00%** 0	**25.00%** 2	**0.00%** 0	**0.00%** 0	8
Like a failure	**75.00%** 6	**25.00%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8

Boundary Crossings

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
I have conducted a therapy session for longer than normal because an offender was experiencing a crisis.	**12.50%** 1	**12.50%** 1	**25.00%** 2	**50.00%** 4	**0.00%** 0	**0.00%** 0	8
I have conducted a therapy session for longer than normal due to the therapeutic nature of the session.	**25.00%** 2	**12.50%** 1	**25.00%** 2	**37.50%** 3	**0.00%** 0	**0.00%** 0	8
I have touched offender(s) during therapy sessions for therapeutic reasons (i.e., to console or to demonstrate a point).	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have caused offender(s) to feel deep emotions in the therapy session by what I said, in order to help them get past some of the negative coping skills they had been using.	**50.00%** 4	**25.00%** 2	**12.50%** 1	**12.50%** 1	**0.00%** 0	**0.00%** 0	8
I have disclosed (past, not current) personal information to offender(s) for therapeutic reasons.	**37.50%** 3	**25.00%** 2	**37.50%** 3	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have arranged to see an offender on a more frequent basis due to the nature of the psychopathology or due to the nature of the therapeutic work.	**25.00%** 2	**12.50%** 1	**25.00%** 2	**37.50%** 3	**0.00%** 0	**0.00%** 0	8

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
I have socialised with offender(s) in their living area, with a clear therapeutic purpose in mind.	**87.50%** 7	**0.00%** 0	**12.50%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have changed an offender's original treatment plan under consultation with the treatment team and the offender, for therapeutic reasons.	**25.00%** 2	**37.50%** 3	**25.00%** 2	**12.50%** 1	**0.00%** 0	**0.00%** 0	8
When offender(s) have been seductive with me, I discuss the behaviours with the offender(s) in a respectful, non-shaming way.	**25.00%** 2	**62.50%** 5	**12.50%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	8

Slippery Slope

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
I have felt that I was responsible for the offender's behaviour and that his/her misconduct was a reflection of my professional conduct.	**87.50%** 7	**0.00%** 0	**12.50%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have derived great satisfaction from offender's praise or affection?	**87.50%** 7	**12.50%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have been anxious to please offender(s)?	**75.00%** 6	**12.50%** 1	**12.50%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have thought that I was the only one who understood a particular offender?	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have 'bent' the rules (in a minor way) to certain offender(s)?	**75.00%** 6	**25.00%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have found myself relating to offender(s) as I might a family member or a friend?	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have inconsistently enforced the rules in the treatment setting?	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have had difficulties setting limits with offender(s)?	**87.50%** 7	**12.50%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have needed the approval of offender(s) for my own self-	**87.50%** 7	**0.00%** 0	**12.50%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	8

worth?							
I have socialised with offender(s) without a therapeutic purpose in mind?	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8

Under-Involvement

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
I have ended a session early, due to boredom or disinterest with particular offender(s).	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have ignored an offender's requests (e. g., I disengaged from the offender).	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have insulted offender(s) as a reaction to their behaviour.	**87.50%** 7	**12.50%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have belittled offender(s) as a reaction to their behaviour.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have called offender(s) derogatory names to their face in reaction to their behaviours.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have become angry in a session and was unable to control my feelings in the moment towards offender(s), such that I expressed anger.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have physically assaulted offender(s) out of anger or frustration.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have avoided knowing about my offender(s) history.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have 'let my mind wander' to other things during a session.	**25.00%** 2	**37.50%** 3	**25.00 %** 2	**12.50 %** 1	**0.00%** 0	**0.00%** 0	8

I have avoided conflict with offender(s) and let other staff deal with the issues.	**75.00%** 6	**12.50%** 1	**0.00%** 0	**12.50 %** 1	**0.00%** 0	**0.00%** 0	8

Over-Involvement

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
I have given or received a gift (valued at more than $5) to/from offender(s) without my supervisor's permission /knowledge.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have kept secrets about offender(s) that I thought I should have shared with other staff members.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have disclosed personal problems to offender(s).	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have had fantasies about offender(s) (i.e., fantasies that were romantic or sexual or violent in nature).	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have experienced sexual attraction toward offender(s), without acting on my feelings.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8

Offender Challenges

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
An offender has brought/made me coffee or food	**62.50%** 5	**37.50%** 3	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
An offender has made romantic advances towards me	**50.00%** 4	**50.00%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
An offender has tried to befriend me	**62.50%** 5	**37.50%** 3	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
An offender has asked me about my personal life, such as: my age, sexual preferences, relationship status, what I did on the weekend, or other personal questions	**12.50%** 1	**50.00%** 4	**25.00%** 2	**12.50%** 1	**0.00%** 0	**0.00%** 0	8
An offender has brought up sexual content which is not relevant to therapy	**75.00%** 6	**12.50%** 1	**12.50%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
An offender has brought up and wanted to discuss other offenders that I also see for therapy	**62.50%** 5	**25.00%** 2	**12.50%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
An offender has tried to engage me in conversation about other psychologists or other staff	**25.00%** 2	**50.00%** 4	**25.00%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
An offender has offered me a gift	**37.50%** 3	**62.50%** 5	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8

	Never	less than 1x/year	about 1x/year	about 1x/3 months	about 1x/month	about 1x/week or more	Total
An offender has showed sympathy to the difficulty of my job or offered to help me with other offenders that I see	**75.00%** 6	**25.00%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
An offender has touched me during a therapy session (e.g. flicked a bit of dust off my clothing or placed their hand on my shoulder in a supportive manner)	**75.00%** 6	**25.00%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	8

Appendix 3

Adapted Boundary Violations Index (BVI)

Adapted BVI based on the BVI 2002 Version

Questions on the adapted **"Boundary Violations Index" (BVI)©** are based on typical categories of behaviours which comprise boundary violations between professional health care workers and patients:
Please circle the response that best characterizes your behaviors.
N = never (0) R = rarely (1) S = sometimes (2) O = often (3) – Total of points is the score.

1. I have told patients personal things about myself in order to impress them.
   N R S O

2. I have accepted social invitations from particular patients outside of scheduled clinic visits.
   N R S O

3. I have used language other than clinical language to discuss my patient's physical appearance or behaviours I may consider seductive.
   N R S O

4. I have found myself comparing the gratifying qualities I observe in a patient with the less gratifying qualities in my significant other.
   N R S O

5. I have thought that my patient's problem would be helped if he/she had a romantic involvement with me.
   N R S O

6. I have found myself trying to influence other employees in my workplace over whom I have supervisory influence, to support political causes, or positions in which I have personal interest.
   N R S O

7. I have felt a sense of excitement or longing when I think of a patient or anticipate his/her visit.
   N R S O

8. I have found myself talking about my personal life or problems with a patient and expected sympathy.
   N R S O

9. When a patient has acted in a manner I consider seductive, I have experienced this as a gratifying sign of my own sex appeal.
   N R S O

10. I have engaged in a personal relationship with a patient either while I was treating him/her, or after treatment was terminated.
    N R S O

11. I think about what it would be like to be sexually involved with a patient.
    N R S O

12. I have initiated or engaged in a personal relationship with an employee that I supervise.
    N R S O

13. I take great pride in the fact that such an attractive, wealthy, powerful, or important patient is seeking my help.
    N R S O

14. I have found myself talking about my personal life or problems with patients.
    N R S O

15. I have resisted or refused consultation with appropriate professionals, when others have told me I have problems that cause difficulty in my work or personal relationships.
    N R S O

16. I have initiated or engaged in a personal relationship with a person over whom I have power, authority, or decision-making ability.
    N R S O

17. I have asked one or more patients to do personal favours for me.
    N R S O

18. I have found myself trying to influence my patients to support causes, business deals, or positions in which I have personal interest.
    N R S O

19. I have initiated business deals with patients.
    N R S O

20. I have solicited gifts, bequests, or favours from patients for personal benefit or to benefit a business with which I am or plan to be involved.
    N R S O

21. I have recommended treatment procedures or referrals that I did not believe to be necessarily in my patient's best interests.
    N R S O

22. I have found myself fantasizing or daydreaming about a patient.
    N R S O

23. I have made exceptions for patients, e.g., scheduling, benefits, and/or fees, because I found the patient attractive, appealing or impressive.
    N R S O

24. I have made exceptions for some patients because I was afraid he/she will otherwise become extremely angry or self - destructive.
    N R S O

25. I have sought social contact with patients outside of scheduled clinic visits.
    N R S O

Appendix 3a. Responses to the adapted Boundary Violation Index (BVI)

Psychologists' responses to the adapted Boundary Violation Index (BVI)

	Never	Rarely	Sometimes	Often	Total
I have told offenders personal things about myself in order to impress them.	**92.31%** 36	**7.69%** 3	**0.00%** 0	**0.00%** 0	39
I have accepted social invitations from particular offenders outside of scheduled clinic visits.	**94.87%** 37	**5.13%** 2	**0.00%** 0	**0.00%** 0	39
I have used language other than clinical language to discuss an offender's physical appearance or behaviours I may consider seductive.	**87.18%** 34	**5.13%** 2	**5.13%** 2	**2.56%** 1	39
I have found myself comparing the gratifying qualities I observe in an offender with the less gratifying qualities in my significant other.	**100.00%** 39	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have thought that an offender's problem would be helped if he/she had a romantic involvement with me.	**100.00%** 39	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have found myself trying to influence other employees in my workplace over whom I have supervisory influence, to support political causes,	**97.44%** 38	**2.56%** 1	**0.00%** 0	**0.00%** 0	39

	Never	Rarely	Sometimes	Often	Total
or positions in which I have personal interest.					
I have felt a sense of excitement or longing when I think of an offender or anticipate his/her visit.	**92.31%** 36	**7.69%** 3	**0.00%** 0	**0.00%** 0	39
I have found myself talking about my personal life or problems with an offender and expected sympathy.	**100.00%** 39	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
When an offender has acted in a manner I consider seductive, I have experienced this as a gratifying sign of my own sex appeal.	**100.00%** 39	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I think about what it would be like to be sexually involved with an offender.	**94.87%** 37	**5.13%** 2	**0.00%** 0	**0.00%** 0	39
I have initiated or engaged in a personal relationship with an employee that I supervise.	**97.44%** 38	**0.00%** 0	**2.56%** 1	**0.00%** 0	39
I have found myself talking about my personal life or problems with offenders.	**94.87%** 37	**5.13%** 2	**0.00%** 0	**0.00%** 0	39
I have resisted or refused consultation with appropriate professionals, when others have told me I have problems that cause difficulty in my work or personal relationships.	**92.31%** 36	**5.13%** 2	**2.56%** 1	**0.00%** 0	39
I have initiated or engaged	**97.44%** 38	**0.00%** 0	**2.56%** 1	**0.00%** 0	39

	Never	Rarely	Sometimes	Often	Total
in a personal relationship with a person over whom I have power, authority, or decision-making ability.					
I have asked one or more offenders to do personal favours for me.	**94.87%** 37	**5.13%** 2	**0.00%** 0	**0.00%** 0	39
I have found myself trying to influence offenders to support causes, business deals, or positions in which I have personal interest.	**100.00%** 39	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have initiated business deals with offenders.	**100.00%** 39	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have solicited gifts, bequests, or favours from offenders for personal benefit or to benefit a business with which I am or plan to be involved.	**100.00%** 39	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have recommended treatment procedures or referrals that I did not believe to be necessarily in my offender's best interests.	**100.00%** 39	**0.00%** 0	**0.00%** 0	**0.00%** 0	39
I have found myself fantasizing or daydreaming about an offender.	**87.18%** 34	**12.82 %** 5	**0.00%** 0	**0.00%** 0	39
I have made exceptions for offenders, e.g., scheduling, benefits, and/or fees, because I found the offender attractive, appealing or impressive.	**94.87%** 37	**5.13%** 2	**0.00%** 0	**0.00%** 0	39
	74.36%	**23.08**	**2.56%**	**0.00%**	

	Never	Rarely	Sometimes	Often	Total
I have made exceptions for some offenders because I was afraid he/she will otherwise become extremely angry or self - destructive.	29	**%** 9	1	0	39
I have sought social contact with offenders outside of scheduled clinic visits.	**100.00%** 39	**0.00%** 0	**0.00%** 0	**0.00%** 0	39

Clinical supervisors' responses to the adapted Boundary Violation Index (BVI)

	Never	Rarely	Sometimes	Often	Total
I have told offenders personal things about myself in order to impress them.	**87.50%** 7	**12.50%** 1	**0.00%** 0	**0.00%** 0	8
I have accepted social invitations from particular offenders outside of scheduled clinic visits.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have used language other than clinical language to discuss an offender's physical appearance or behaviours I may consider seductive.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have found myself comparing the gratifying qualities I observe in an offender with the less gratifying qualities in my significant other.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have thought that an offender's problem would be helped if he/she had a romantic involvement with me.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have found myself trying to influence other employees in my workplace over whom I have supervisory influence, to support political causes, or positions in which I have personal interest.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8

	Never	Rarely	Sometimes	Often	Total
I have felt a sense of excitement or longing when I think of an offender or anticipate his/her visit.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have found myself talking about my personal life or problems with an offender and expected sympathy.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
When an offender has acted in a manner I consider seductive, I have experienced this as a gratifying sign of my own sex appeal.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I think about what it would be like to be sexually involved with an offender.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have initiated or engaged in a personal relationship with an employee that I supervise.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have found myself talking about my personal life or problems with offenders.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have resisted or refused consultation with appropriate professionals, when others have told me I have problems that cause difficulty in my work or personal relationships.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have initiated or engaged in a personal relationship with a person over whom I	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8

	Never	Rarely	Sometimes	Often	Total
have power, authority, or decision-making ability.					
I have asked one or more offenders to do personal favours for me.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have found myself trying to influence offenders to support causes, business deals, or positions in which I have personal interest.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have initiated business deals with offenders.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have solicited gifts, bequests, or favours from offenders for personal benefit or to benefit a business with which I am or plan to be involved.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have recommended treatment procedures or referrals that I did not believe to be necessarily in my offender's best interests.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have found myself fantasizing or daydreaming about an offender.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
I have made exceptions for offenders, e.g., scheduling, benefits, and/or fees, because I found the offender attractive, appealing or impressive.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8
	87.50%	**0.00%**	**12.50%**	**0.00%**	

	Never	Rarely	Sometimes	Often	Total
I have made exceptions for some offenders because I was afraid he/she will otherwise become extremely angry or self - destructive.	7	0	1	0	8
I have sought social contact with offenders outside of scheduled clinic visits.	**100.00%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	8

Appendix 4

Chief psychologists' reports of how they would handle particular boundary challenges by offenders.

Please describe how you would respond if an offender brings/makes you coffee or food.

Thank the offender and decline the offer. However, when working in a therapeutic community this may be allowable within the context, such as a community BBQ.

I would thank the offender for the offer/kindness etc but politely decline the offer of coffee or food.

This depends on the situation. For example, when I attend Mannus Correctional Centre, offenders work in the staff canteen and so I would accept food there for which I have paid. The only other situation in which I have been offered food by an offender was in the community where an offender brought in a pumpkin that he had grown. After establishing with the offender the reason for the gift was because he was grateful for the support that he had received, I explained that he does not need to provide gifts, my services are paid by government. It was clear that gift-giving was cultural norm for the offender and that he would have been hurt if the gift was refused, so we agreed on a compromise where the gift would be accepted for the Community Corrections office, given that many staff had contributed to his rehabilitation. This was agreed. After the session, I was able to phone my supervisor and discuss the situation. We agreed that this was a low risk option that respected the offender's culture, maintained therapeutic alliance and encouraged pro-social behaviour. Community Corrections staff decided to donate the pumpkin to the local soup kitchen and this was conveyed to the

offender and he was thanked for his contribution that would assist in feeding homeless people in the town.

Please describe how you would respond if an offender made romantic advances towards you.

I would make it clear to the offender that his behaviour/comments were inappropriate and I would assess the context in which the behaviour occurred. This may result in further follow up, or monitoring of any future contact and safety concerns.

Depending upon the strength of these advances, I would politely but firmly remind the offender that I am his/her psychologist and that our relationship is a professional not a personal one.

I would explore with the offender why he or she thought about me in romantic terms. Sometimes this can be because the only form of emotional intimacy that the offender has previously experienced has been in a sexual relationship. This would provide an opportunity to discuss emotional intimacy and help to reframe the feelings that the offender was experiencing. I would certainly explain that any romance between a psychologist and a client is completely inappropriate and counter-productive to therapeutic interventions. I would discuss with my supervisor and assess whether I could continue to work with the offender, or if he or she would need to be referred elsewhere.

Please describe how you would respond if you shared aspects of your personal life with an offender that were not related to therapy.

I do not share personal aspects of my private life with an offender.

I don't share aspects of my personal life with an offender. Sometimes personal disclosures can be useful in therapy/rapport building but I only do this if the information cannot identify me or my family/friend and if it is fairly harmless like what AFL team I barrack for and I don't provide details, just generalities. I do not do this as a matter of course either.

I don't share aspects of my personal life with an offender and don't use personal revelations to assist therapy apart from those that are so general as to apply to anyone, eg, anyone may have experienced loss, grief, etc, without giving details. However, offenders are curious about us personally and may make guesses. In such cases I deflect such enquiries and guesses and later discuss with Manager of Security or manager of Community Corrections office and my supervisor to assess risk.

Please describe how you would respond if an offender tries to befriend you.

It is important to create a therapeutic alliances with the clients we treat whether they are an offender or private client, this would require mutual respect and engaging them on a friendly basis – 'befriending' suggests an intent to blur boundaries by the offender – this would requires monitoring and limit setting or prevention. In extreme cases it may be that the offender is transferred to another psychologist.

So, for example if an offender says, "I think you're cool, when I get out, we should go for a coffee". I would explain to the offender that as their psychologist, I do not socialise with clients and explain professional role vs personal. I still remain polite and I would thank them for their kind offer but politely and firmly refuse. I do not let this change the way I provide service to the offender but I am vigilant to other possible boundary issues. It is important not to become hostile or flustered or make the issue bigger than it is.

Sometimes the only person in an offender's life who has taken time to listen to them with compassion is the psychologist. Offenders can want to maintain or progress this caring relationship beyond appropriate levels to friendship. It can be a useful adjunct to therapy to explore friendship and how the offender can make and keep pro-social friendships, while explaining how any friendship with the psychologist can be counter-productive to therapy. I would discuss the behaviour with my supervisor and the local manager to assess risk and appropriate intervention strategies.

Please describe how you would respond if an offender asked you about your personal life. Such as your age, sexual preferences, relationship status, what you did on the weekend, or other personal questions.

Politely reply that personal information is not shared – some nonspecific information may be offered within limits and with specific goals in mind, such as to create rapport.

I would acknowledge that I am asking the offender a lot of personal questions about them but that they cannot ask the same questions of me. I would clarify the "relationship" - that is professional and not personal and not answer their questions. I would remain calm and approach this is a non-reactionary manner.

I deflect such questions and bring the discussion back to the offender. It can be useful to explore the offender's curiosity and can be revealing of prejudices that may increase risk. Sometimes offenders want to talk about personal questions like what we did on the weekend to try to normalise the relationship. However, therapy is not a normal relationship, and exploring how frustrating it can be for an offender to be talking to someone who knows them intimately and of whom they only have a superficial knowledge. If the offender was persistent, I would discuss with my supervisor and local manager.

Please describe how you would respond if you 'bent' the rules (in a minor way) for a client.

I am not sure if there are minor rules that can be broken – If I were to have disclosed personal information and then regretted it I would likely become more hyper vigilant and limit setting with that offender in the future – over compensate I suppose.

If I did bend the rules in a minor way, I would discuss with my supervisor and look at whether I could do anything to 're-balance' the professional relationship with the offender. I would reflect on the situation and what lead me to 'bend the rules' so that it would not occur again either with that offender or others.

If I felt compelled to bend the rules for a client, I would document my reasons clearly and discuss in detail with my supervisor. I would also explain my reasons to local managers and be prepared to defend my reasons with Professional Standards and Psychology Board of Australia.

Please describe how you would respond if an offender brought up and wanted to discuss other offenders that you also saw for therapy.

If this were to happen you simply explain that this discussion is not appropriate and I would ask them why they are interested - as with any form of inappropriate questioning this discussion is highly likely at the time of in further discussions with the offender.

Sometimes offenders wish to disclose information to me about another offenders risk or mental health status. In this case, I accept the information and do not disclose any information in return to the offender. I may give general information to the offender as to what may happen (seen by staff etc) with the information they have provided to me if the disclosing offender is distressed (about their mate). If the offender just wants to discuss another offender's case, I politely state I am unable to and simply tell them why - confidentiality, privacy etc. I would reflect this back to the offender and remind them that I don't discuss them with other offenders either.

I would listen in a non-committal way because the reasons for bringing up the other offenders may be related to the offender experiencing victimisation of being coerced into antisocial behaviour or may be reporting a potential or

actual risk of harm or indictable crime. I would not respond or provide any information to the offender about the other offenders. I would also discuss this with my supervisor and local managers. It can be anti-therapeutic when clients know each other and can try to set up a psychologist, so it may be important to consider alternative referrals for some of the offenders.

Please describe how you would respond if an offender brought up sexual content which was not relevant to therapy.

As with any form of inappropriate questioning or disclosing of information I would cut the conversation and if it seems appropriate question their motivation for the behaviour – it is always best to address this type of behaviour immediately; however at time this may need to be addressed in follow up. Of course it may also be important to determine if there is a true need for psychological intervention and provide appropriate support or make a recommendation to see an appropriate person in the future.

I would re-focus them to what we were discussing and not react to the information they are providing. If serious and there is a significant therapeutic relationship present, I may discuss this within the confines of therapy.

I would ask the offender why he or she thought that this was relevant to our discussion. There may be a reason that is relevant to therapy although not obvious If it was clear that the offender was being cheeky or salacious, I would explain that this is inappropriate and disrespectful to our relationship and if the

behaviour were to continue would lead to a termination of therapy. I would discuss with my supervisor and local manager.

Please describe how you would respond if you discuss other offenders or staff with an offender.

I would not discuss any staff with an offender - if it were raised I may listen and not provide a direct response, but acknowledge the information – and within context – I may suggest a course of action I may take.

I would keep my discussions to topics related to CSNSW business. For example, I may discuss a staff member with an offender to let the offender know their role or I may point out an offender who is a sweeper in the wing or a cultural delegate.

I don't discuss other offenders or staff with an offender. However, if I were to do so inadvertently, then I would document the incident and report to my supervisor to discuss appropriate action. Risk assessment would be needed to ascertain if the staff member or other offenders had been placed at risk by my action, in which case appropriate action would need to take place to mitigate that risk. I would also discuss with my supervisor the possibility of referring the offender elsewhere given that a boundary breach had been elicited from me.

Please describe how you would respond if an offender offered you a gift.

Thank them and politely decline – if in a therapeutic community the gift may be accepted for the community and become a shared gift to remain there

Thank them for the thought but politely decline. Try to get through to them I am simply doing my job and I am a public servant. If they insist or leave it there, I would speak to my manager and consult the gifts/benefits register.

I would explain the policy on gift-giving and politely refuse the gift. If gift-giving is a cultural norm for the offender, I would accept and make it clear that the gift is to the whole service, not to me personally. I would document the incident and discuss with my supervisor and seek advice from Professional Standards.

Please describe how you would respond if you derive great satisfaction from a client's praise or affection.

It's always nice be praised and to thank the person – when it is genuine it may be part of the therapeutic relationship when working on attachment issues for example – however, with offenders it is important to assess the motivation and any attempts at being manipulative at which point determining the offenders goal is important. What do they want etc.!

I would reflect on my practice, the way I am dealing with the offender and be realistic. Psychologists are in helping positions because they like helping people and therefore derive satisfaction from this. It depends on whether it is just a certain offender or if the psychologist says things specifically to elicit more praise. I think it is human to be complimented and to receive a compliment

graciously - but when your self-efficacy and worth about your practice is solely reliant on the (often empty as it is a manipulation) praise of inmates/offenders, this is where problems can arise.

We are human and it is human to feel satisfaction from another's praise or affection. However, I would deflect the praise and affection back to the client. The client has done the hard work and warrants the praise and affection from themselves for their achievement. My role has been that of guide and I am not deserving of praise beyond that role. I would discuss this with my supervisor and use self-reflection to assess if I am feeling too close to this particular client and if my satisfaction at their praise and affection is a warning sign.

Please describe how you would respond if you insulted a client as a reaction to his/her behaviour.

I am not sure I have ever insulted an offender – however an offender may object strongly to an intervention – in which case I would discuss what was said and how it was experienced and if appropriate apologise.

I would explore this and if needed apologise politely but I would not be entering into any discussions where the inmate/offender implies I have to "make up" for my behaviour.

I would apologise immediately and make it clear that the insult was unintended. I would then use this as an opportunity to explore the client's behaviour and whether other's have reacted as I had done and why that may have been the case. I would document the incident and discuss with my supervisor. I would

self-reflect on whether there are aspects to this client's presentation that evoke a negative counter-transference and whether I can continue to work effectively with the client. If the client wishes to make a complaint, I would provide them with the appropriate information about how to do so.

Please describe how you would respond if an offender shows you sympathy regarding the difficulty of your job or offers to help you with other offenders that you see.

This is an empathy question or an expression of manipulative behaviour. I would assess the context and motivation behind the offenders behaviour , especially if they were offering help with another offender – provide appropriate response or intervention and if they are genuine, being supportive and showing empathy I may acknowledge their comments positively, but making sure they are not left with the feeling they could be vulnerable, placing others in a vulnerable position, or that I was vulnerable in some way etc.

I would simply accept this, acknowledge it and move on. I would not continue to discuss issue with the offender. I would re-focus the conversation - eg "we are here to talk about you not me" kind of thing. If the offender has done a counselling course or something and wants to be like a psychologist, I would be quite particular in stating they cannot do this. I would clearly explain why.

I would thank them for their concern and then explore with them if they are more comfortable in helping others than helping themselves and why this should be so. I would document the session.

Please describe how you would respond if you found yourself feeling anxious to please a client.

I think this can be an issue on occasion, especially if there is difficulty engaging the client and you want to make the therapy work, so to speak. This is a process issue and requires self-monitoring and clinical discussion and a review of possible countertransference issues.

I would reflect on my own practice and seek supervision as to why this might be. It may be representative of a fear (ie psychologist may want to placate an offender who rises to anger very quickly)

I would see this as a warning sign and immediate concern for self-reflection. I would discuss these feelings with my supervisor and seriously consider alternative arrangements for the client.

Please describe how you would respond if an offender touched you during a therapy session (e.g. flicked a bit of dust off your clothing or placed his/her hand on your shoulder in a supportive manner).

I can't think of any incidence when this has happened. This would defiantly be a red light and strictly not tolerated – an immediate responses would include a

direction not to do that and if appropriate to inform custodial staff of the incident. Further contact with the offender may need to be monitored and likely a transfer of the case to another psychologist – the offenders mental illness or level of antisocialist may be a deciding factor in what course of action should occur.

If it was a one-off and genuine I would not make a big deal about it. If I felt that my personal physical boundaries were crossed, then I would make this known to the offender in a clear calm manner.

I would ask them not to touch me and explain that it is not appropriate to our relationship. I would explore why they felt the need to remove the dust (obsessive?) or attempt to physically support me. It is likely an attempt to "normalise" the therapeutic relationship but can be counter-productive. I would document the incident and discuss with my supervisor and if the client continued to attempt to touch me after my request not to do so, I would discuss with local managers as well as my supervisor to assess risk.