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A SURVEY OF APA MEMBERS' ATTITUDES CONCERNING DUAL RELATIONSHIPS

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A Thesis Submitted to the Graduate Division in Partial Fulfillment of the Requirements for the Degree of Master of Science

By

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Abstract

The American Psychological Association (APA) has constructed the Ethical Standards of Psychologists to serve as a guideline for the therapeutic behavior of its members. Collective literary opinion suggests that a code of ethics be constructed from the attitudes and values of the associations members and the attitudes and values of the society in which these individuals practice.

The purpose of this study was twofold. First, it attempted to determine the attitudes of APA members concerning Section 6a of the 7th Draft of the Ethical Standards of Psychologists which deals with the practice of dual relationships. Second, this study attempted to describe the population of subjects whose responses deviated from those stated in Section 6a by correlating the responses received on each item with the subject's age, sex, years of experience and therapeutic setting.

An attitudinal survey questionnaire was constructed, validated and mailed to a nationwide random sample of 300 APA members registered with divisions 12 and 17. Of the 300 subjects sampled, 211 (70.3%) returned their questionnaires.

The results of this study indicate that for each of the 34 items, constructed from the concepts contained in Section 6a, both a deviant and non-deviant population exists. The non-deviant population is larger than the deviant population for the majority of the items. The results also indicate that age, sex, years of experience and therapeutic setting are associated with deviancy but only on individual, unrelated items and that these variables cannot be considered as descriptors associated with deviancy.

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CHAPTER I

BACKGROUND TO THE STUDY

Since the origins of psychotherapy, there has been some concern as to whom the therapist owed his allegiance. The question of whether the therapist expressed his loyalties to his client or to his profession generated much conflict (Wrenn, 1952).

In the early days of psychoanalysis, Freud (1919) expressed stronger loyalties to his professional society than to his clients. While others have expressed stronger loyalties to their clients rather than their professional society (Rogers, 1942). Because of this and other conflicts that had resulted from the performance of psychotherapy, the need for some guidelines or code of professional ethics was realized.

The first attempt to meet this need by the American Psychological Association came in 1952. The Hobbs Committee set out to codify the behavior of psychologists and utilized an empirical approach (Holtzman, 1960). The first APA code of ethics was published in 1953 and since that time it has been under constant revision. The most recent is the "Ethical Standards of Psychologists," Draft #7 approved July 20, 1975. Since this date, evidence of continued revision has shown up in the literature as late as January 1976 (Asher, 1976).

The literature contained a broad spectrum of definitions concerning what a code of ethics was, how it should have been compiled, and to what extent psychologists were expected to comply with it.

Daubner and Daubner (1970) referred to ethics as a normative rather than a factual discipline, concerned with norms that ought to govern human conduct rather than those that do govern it. This idea supporting the construction of an ethical code according to basic overall moralistic ideals was also supported by Livers (1974). Livers expanded this idea and explained that a code of ethics was subject to evolutionary change and interpretation. He felt that what was ethical or unethical was not clearly discernable.

Peterson (1970) viewed a code of ethics as a guideline for action based on commonly held values. He explained that the prerequisite for a meaningful code of ethics is that it should reflect both the agreed upon values of the profession and the values generally accepted by the society the profession serves.

Brammer and Shostrom (1968) supported the premises of both Peterson and Livers, but expressed some concern about its effectiveness. They explained that a code of ethics could only be descriptive of the shared social and professional values at one point in time. The values of society are affected by a continuous evolutionary source of change. They felt the definite need for constant revisions of published codes.

Another matter that has been a constant source of debate, is how closely the practitioner should adhere to a published code of ethics?

Many therapists supported the APA's opinion to strictly adhere to its ethical code when dealing with clients. Blocker (1974) referred to the ethics code as a set of ethical obligations that

governed the behavior of the therapist. Acceptance of this interpretation required the therapist to mold his/her behavior to conform with the APA code of ethics even if his/her personal values were in conflict with it. Schweber (1955) expressed this exact interpretation in somewhat stronger language by calling for rigid adherence to ethical codes.

Others have viewed this from a more liberal point of view. Livers (1974) suggested that ethical codes required individual interpretation. While Peterson (1970) described an ethical code as a guideline of therapeutic behavior.

Carkhuff and Berenson (1967) indicated that the therapist must be freed to utilize his/her own internalized code of conduct, even to the extent of acting in a way not concurrent with societies values. They also indicated that the ultimate concern of the therapist was for the client. Obligations to society or one's professional association were secondary.

One of the most controversial portions of the 1975 Draft is Principle 6 Section a. This portion deals with dual relationships between therapist and client. The APA (1975) stated its objection to the therapist involving oneself in dual relationships in Section a.

> Psychologists are continually cognizant both of their own needs and of their inherently powerful position vis á vis clients, in order to avoid exploiting the client's trusts and dependency. Psychologists make every effort to avoid dual relationships with clients and/or dual relationships which might impair their professional judgement or increase the risk of client exploitation. Examples of such dual relationships include treating an employee or supervisee, treating a close friend or family relative, and sexual relationships with clients (APA 1975, pp. 3).

According to the APA Committee of Scientific and Professional Ethics and Conduct's, arguments prohibiting dual relationships were based more on logic than empirical evidence (Gurel, Note 1).

The literature contained many differing opinions concerning the dual therapist/client relationship and how the therapist was expected to behave. Freud discussed the idea of dual relationships as far back as 1919. He felt that as far as his relationship with the client was concerned, the client must be left with unfulfilled wishes in abundance. The frustration caused by this practice was viewed as therapeutic (Freud, 1919).

Fromm (1956) and others differed in their approach to the psychotherapeutic relationship from Freud by supporting a warm, caring therapist/client relationship. This relationship was viewed as essential for positive growth in psychotherapy to occur (May, 1953; Rogers, 1961). Dolliver (1974) agreed with the idea of a warm, caring relationship and expanded this idea of relationship to allow the client to give to the therapist, i.e., to share with the therapist. He felt that denial to the client of the role of giver was particularly harsh since it implied the denial of such enviable characteristics in the client.

Other practitioners viewed the therapeutic relationship as a restrictive, regimented interaction. Black (1952) suggested that the therapeutic relationship be controlled and limited to one in that the therapist attempted to control the boundaries of the relationship. While Blocker (1974) and others, expressed similar opinions and explicitly stated that the client was limited in terms of time of

appointments, length of appointments, location where therapy could take place, and the nature of the interaction between therapist and client (Pepinsky and Pepinsky, 1954).

Another faction of the literature exposed a more liberal non-controlling school of thought. Menninger (1958) explained that a balance of giving and taking must be achieved between the client and therapist or the therapeutic process tends to break down prematurely. Carkhuff and Berenson (1969) expanded on this idea of non-control by suggesting that the client's welfare was their first priority. They explained that there were no boundaries that should limit the therapist's committment to the client. In addition, they suggested that the therapist do anything for the client that he would do for himself under similar circumstances.

The dual relationship has continued to be controversial since its inclusion in the first APA code of ethics in 1953. There are numerous suggestions that an empirical review was needed and that an objective solution was in order (Seemon, 1954; Morganbesser, 1957; Wiskoff, 1960). While others, suggested a normative sample of practitioners would provide the needed information to make a decision (Daubner and Daubner, 1970; Peterson, 1970). Still others, suggested that empirical evidence and normative opinions of both society and practitioners would provide a more realistic solution (Holtzman, 1960; Kuenzli, 1960; Farwell, 1974). Whichever mechanism is decided upon, it is apparent that some acceptable solution to the dual relationship controversy in regards to ethics needs to be found.

Approach to the Problem

This study was an attempt to determine the opinions and values of APA members concerning Section 6a (dual therapist/client relationships) of Draft #7 of the American Psychological Association's Ethical Standards of Psychologists. To measure these opinions and values, a computerized random sample of APA members of Divisions 12 (counseling) and 17 (clinical) were asked to complete a survey questionnaire consisting of 14 multiple response statements (see appendix A).

The survey statements were constructed to assess aspects mentioned in Section 6a concerning the dual relationship of therapists with clients. Validity and reliability were determined through two pilot surveys (see Chapter III for a complete discussion of methodology). The survey was mailed to a national random sample of APA members to determine their individual opinions governing their performance in therapy at that point in time. The decision to use APA members was supported by Peterson (1970) and others in that ethical statements should be based partially on commonly held professional values and attitudes of practitioners (Brammer and Shostrom, 1968).

The responses of each subject were examined both individually and cumulatively to determine if a population exists that expresses attitudes deviant from those described in Section 6a of the Ethical Standards of Psychologists. This deviant population was described by correlating both deviant and nondeviant populations with sex, age, years of counseling experience, and type of counseling setting as variables.

Definition of Terms

Dual Relationship: A relationship involving a therapist and a client engaged in both psychotherapy and some other relationship outside of the psychotherapeutic session.

Subjects: Members of the American Psychological Association Division 12 (counseling) and/or Division 17 (clinical).

Extra-therapeutic: Activities outside of the scheduled therapy session.

APA Ethical Standards of Psychologists, Section 6a, Draft #7:

> Psychologists are continually cognizant both of their own needs and of their inherently powerful position vis á vis clients, in order, to avoid exploiting the client's trust and dependency. Psychologists make every effort to avoid dual relationships which might impair their professional judgment or increase the risk of client exploitation. Examples of such dual relationships include treating and employee or supervisee, treating a close friend or family relative, and sexual relationships with clients (APA, 1975, pp. 3).

Survey Questionnaire: Instrument constructed and validated by the researcher to assess the subjects personal opinions and attitudes concerning an ethical issue (see Appendix A).

Attitudes: A predisposition to react negatively or positively, in some degree, towards a class of objects, ideas, or people (Nunnally, 1972).

Validity: The clarity (clearness) of the survey questionnaire.

Deviant: Not in agreement with the constructs of Section 6a of the Seventh Draft of the Ethical Standards of Psychologists.

Non-Deviant: In agreement with the constructs of Section 6a of the Seventh Draft of the Ethical Standards of Psychologists.

Treatment Conditions

Group One: Treatment condition and membership for the first group of individuals consisted of completion of the Pilot I form of the survey questionnaire (see Appendix B) and a personal interview to explain their responses. Group One consisted of Graduate Students at Kansas State College of Pittsburg in Psychology Seminar 840, Issues and Trends in Counseling attending class March 29, 1976.

Group Two: Treatment conditions and membership for the second group of individuals consisted of completion of the Pilot II form of the survey questionnaire (see Appendix C). Group Two consisted of professional counselors attending the "Choice Awareness: A new look at how you live" workshop at Kansas State College of Pittsburg on April 24, 1976.

Group Three: Treatment conditions and membership for the third group of individuals consisted of completion and return of the final survey questionnaire (see Appendix A). Group Three consisted of a computerized random sample of APA members registered with either Divisions 12 and/or 17.

Hypotheses of the Study

The objectives of this thesis were to verify the hypotheses as stated below.

Hypothesis One: The non-deviant population with attitudes synonymous with the constructs of Section 6a will be larger than the deviant population with attitudes that deviate from the constructs of Section 6a on all statements.

Hypothesis Two: Subjects in the deviant population will have significantly lower ages when correlated with the non-deviant population.

Hypothesis Three: Subjects in the deviant population will have significantly lower years of experience when correlated with the non-deviant population.

Hypothesis Four: Male subjects will show significantly more deviation when correlated with female subjects.

Hypothesis Five: Subjects practicing in private practice settings will be significantly more deviant when correlated with subjects in agency, hospital, school, and clinical settings.

These hypotheses will be accepted as correct if the probability of the results occuring by chance is less than .05.

Limitations of the Study

1. Only content and construct validity indices were measured with survey questionnaires.

2. Responses were tabulated by hand and some source of error may have been introduced.

3. The survey was limited to 300 subjects selected at random.

4. The results may have been biased by a limited number of survey questionnaires completed and returned.

5. The survey questionnaire returned only partially completed may have caused a bias in the results.

Delimitations of the Study

1. The survey was a static study and produced results for

only a point in time.

2. The results of this study can be generalized only to APA members of Division 12 and/or 17.

3. The format of this survey allowed only a regimented response not an explanation concerning why a certain response was chosen.

Value of the Study

The literature has led the researcher to realize the need for a normative attitudinal study involving the dual relationship and to what extent practitioners' personal opinions and attitudes coincide with the published code (Holtzman, 1960; Brammer and Shostrom, 1968; Daubner and Daubner, 1970; Peterson, 1970).

This study provides a national normative indication of APA practitioners' attitudes and opinions in regards to Section 6a of the APA Ethical Standards of Psychologists which is not presently available.

Information obtained from this study is valuable to the American Psychological Associations' Committee on Scientific and Professional Ethics and Conduct in their evaluation and future revisions of this portion of the code of ethics.

This study provides the practitioner with a national norm and an instrument to compare his/her attitudes and opinions with those representative of the majority of APA practitioners.

This study provides researchers with an indication of the evolutionary processes and trends occurring in the psychotherapeutic relationships of APA members.

CHAPTER II

REVIEW OF RELATED LITERATURE

Literature related to this study falls into three categories. They include: the therapeutic relationship; the ethics governing the therapeutic relationship; and the literature related to the dual relationship.

Literature describing the therapeutic relationship deals mainly with the idea of what constitutes the ideal therapeutic relationship. This included those who support a distant therapeutic relationship, those who support a close therapeutic relationship, and the degree of reciprocity that should be engaged in by the therapist and client. These areas related to this study mainly because they describe therapeutic relationships that either do or do not provide an environment for involvement in a dual relationship.

The second area deals with specific codes of ethics governing psychotherapy and counseling. Issues included in this treatment are how a code should be constructed, what should be influential on the content and construction of a code, and a discussion of practitioners' reactions to past and present code of ethics.

The final portion of this literature review deals with the dual relationship. This portion includes the American Psychological Association's views concerning dual relationships, those who support and those in opposition to an involvement in a dual relationship. Other relevant areas include the use of nonprofessionals, which tend to support the use of dual relationships, and sexual involvement with clients while engaged in therapy.

The Therapeutic Relationship

In this section, the researcher has attempted to present the diverse interpretations of a proper and effective therapeutic relationship contained in the literature.

Pepinsky and Pepinsky (1954) offered a definition of the therapeutic relationship as a "hypothetical construct to designate the inferred affective character of the observable interactions between individuals" (p. 171). In addition, this interaction was to take place between two individuals designated as counselor and client. The purpose of this interaction was viewed as a means of facilitating changes in the client.

The literature exposed three basic interpretations of the therapeutic relationship:

1. A distant relationship or veritcal relationship (Drasgow, 1960) where the therapist maintained a superior role in the relationship while the client assumed a subordinate role.

2. An equal, horizontal relationship (Drasgow, 1960) where both therapist and client assumed an equal role.

3. A reciprocal therapeutic relationship allowing a degree of involvement to the extent that there is a giving and taking between the client and therapist (Dolliver and Woodward, 1974).

Maintenance of a Distant Therapeutic Relationship

The distant or vertical relationship is characterized by the psychoanalytical approach to therapy (Freud, 1919; Fromm-Reichmann, 1950; French, 1955). Fromm-Reichmann (1950) suggested

the need for the therapist to maintain a colorless, inanimate appearance to the client. The proposed goal of this was to approach the ideal of serving the client as a recording machine. The therapist could record whatever was on the client's mind. This inanimate attitude also served as a safeguard against the therapist becoming emotionally involved with his clients, thus, retarding the risk of subjectivity and dependency.

French (1955) described a psychoanalytic therapy session as an attempt to create a totally controlled laboratory situation. The therapist was a more effective therapeutic agent by placing himself behind the client where the client could not see him and avoided any disclosure about himself. The consistent control of facial expressions, posture, and gestures allowed the therapist to avoid influencing the client (Fromm-Reichmann, 1950).

In an earlier paper Cohen (1947) supported views similar to both French and Fromm-Reichmann suggesting that anxiety either felt or defended by the therapist was the prime source of dependency and counter transference.

Both Winder (1962) and Caracenta (1965) provided empirical evidence to substantiate claims made by the psychoanalytical approach regarding dependency. Both of these studies independently found a significant correlation between comments approached or avoided by the therapist and the client's continuance or discontinuance of the topic or reaction. Their findings indicated that the client continued content related to dependency when approached and conversely, the client discontinued content expressions of dependency when avoided by the therapist.

Maintenance of a Close, Equal Therapeutic Relationship

The horizontal or equal therapeutic relationship is supported by a large number of individuals representing many different theoretical orientations. The two major orientations that subscribe to this form of therapeutic relationship are the Humanistic and the Ecclectic approaches.

The horizontal relationship is characterized by an acceptance of the client and self disclosure by the therapist. Many authors suggested that a warm, caring relationship should also be included in the therapeutic relationship (Sorokin, 1950; Montague, 1950; May, 1953; Fromm, 1956; Rogers, 1958, 1961).

Rogers (1961) felt that the deeper involved the therapist gets in the client's world the less evaluative and judgemental he became. He also suggested that more understanding could be gained by a warm, genuine, accepting relationship with the client.

Thorne (1961) vehemently opposed this idea of total acceptance of the client. He questioned to what extent the therapist should accept asocial and completely improper attitudes of the client. He also raised the question of whether unconditional acceptance was at all necessary in therapy. Thorne noted that some very blunt, outspoken, critically evaluative persons have made excellent therapists and enjoyed great success with their clients.

The degree of involvement between client and therapist, appeared to be a topic of debate. Rogers (1942) suggested that from the therapist's point of view, the relationship was a controlled one. The therapist must control his identification in order to best serve the

client he is helping. Black (1952) agreed with this idea of a controlled relationship. He summarized that the therapeutic relationship, regardless of the system or method of therapy employed, possessed common factors: first, a feeling of rapport through which the client discovered that he was accepted as a person and found support in the therapist, and second, that the therapist sets limits on the relationship and controls his own involvement. Carkhuff and Berenson (1967) expressed agreement with the idea of a warm, accepting therapeutic relationship but suggested that the therapist is committed to do anything that will aid the client in his/her efforts to achieve actions which would enhance his/her personal emergence. They disagreed with the idea of a controlled relationship and suggested a commitment to personal and intimate involvement in a fully sharing relationship. They interpreted the terms "personal" and "intimate" to mean a unity of purpose, persuasive empathy, a giving up of roles and pretenses, and a healthy and productive identification.

Mullan and Sangialiano (1964) also supported a non-control relationship. They suggested that the therapist and client must relate to each other by going beyond the behavioral limits ascribed by their role as therapist and client to achieve successful results.

Seeman (1954) found in an empirical study of success factors of psychotherapy that success in psychotherapy was closely associated with a strong, growing, mutual liking and respect between the therapist and client.

In another empirical study designed to determine causality in early client termination, McNair, Callahan and Danial (1967) evaluated

incoming clients and divided them into two groups, terminators and remainders. Both groups entered therapy with therapists who expressed varying degrees of acceptance and warmth toward their clients. Their results indicated that therapists with a marked interest in the client's problems held a significantly higher proportion of both predicted terminators and remainders in treatment. They concluded that an increase in concern and involvement in the client's problems and feelings resulted in a more successful therapeutic relationship.

Fiedler (1950) attempted to determine any correlation between therapists of divergent theoretical views and therapeutic techniques on the concept of an ideal therapeutic relationship. He indicated that better trained therapists of different schools of theoretical orientation agreed more highly with each other on an ideal therapeutic relationship than did less well trained therapists of the same theoretical orientation. Behar and Altrocchis (1961) replicated the results of Fiedler and in addition determined that agreement with ideal concepts of therapeutic relationships increased significantly with an increase in years of experience. These empirical studies tend to substantiate the use of a close, accepting relationship.

The review of related literature indicated a general agreement with the concepts of a strong mutually accepting relationship (Sorokin, 1950; May, 1953; Fromm, 1958; Carkhuff and Berenson, 1967; et al.). The extent of therapist/client involvement and exact content of what was appropriate and what was not tended to be an issue of considerably less agreement (Rogers; 1955; Carkhuff and Berenson, 1967; Mullan, 1964; et al.).

Maintenance of a Reciprocal Therapeutic Relationship

The degree of giving and taking in the therapeutic relationship appeared to be another source of controversy in the literature.

The psychoanalytic orientation (Freud, 1919; Fromm-Reichmann, 1950; French, 1955) suggested limiting the client to the role of taker. Limitations on the therapists' role as giver were also suggested. Fordham (1974) expressed this theoretical approach by stating:

> The analyst should not make confessions or give information about himself; nor should he become excessively passive or feel guilty because of the pain and terror that the client claims the therapist causes. (pp. 198).

Thorne (1961) also suggested that there was no justification for allowing a close equal relationship with the client. Therapy can be maintained successfully without allowing the client to assume the role of giver. This, he suggested, should be reserved for the therapist.

In a paper presented by Reissman (1965), he expressed that it was debatable whether people receiving help are always benefited. However, it was more likely that individuals giving help were profiting from their role. An empirical study (Foa and Foa, 1971) supported this concept but suggested that each individual may gain or lose in a relationship. The role of giver definitely added satisfaction to the giver. If the therapist could see that there was no loss to the client, the therapist ought to be able to receive appreciation offered by the client. Foa and Foa suggested that usually the therapist would fend off compliments offered to him/her and deny the client the satisfaction of giving.

Sullivan suggested as early as 1954 that there was a necessity for both the therapist and client to be reciprocal for the best therapeutic relationship to occur.

Menninger (1958) agreed with this interpretation. He suggested that in any engagement between two individuals in which a transaction occurred that there was an exchange or giving and a gain of something by both parties with a consequent meeting of needs in a reciprocal, mutual way. He felt that this situation also applied to the therapeutic relationship and that when this balance was not achieved, either because one did not give what the other needed, or because one or the other had a feeling that the exchange was an unfair exchange, the contract tended to break down prematurely and the therapeutic relationship suffered.

Noel and DeChenne (1971) and Wyatt (1971) also supported the rationalization that there was an apparent need to alternately give to the therapist. Noel and DeChenne (1971) delineated that this produced a much closer, equal relationship. By disallowing the client the role of giver, the therapist created both a closeness and a distance in the relationship. The closeness developed through the therapist giving to the client, while the distance was created by restricting the client from giving to the therapist (Wyatt, 1971).

Dolliver and Woodward (1974) wrote:

> The role of giver carries with it the implications that the giver possesses various highly desirable characteristics. In psychotherapy, the role of giver carries with it the implication that the giver is wise, in good psychological health, is an expert in "relating," and is able to be more objective or subjective than most people. Denial to the client of the role of giver is particularly harsh

> since it implies that denial of such enviable characteristics in the client. (pp. 68).

In summary, the ideal therapeutic relationship continues to be an illusive theoretical idea. The ideal relationship for the psychoanalytical community appeared to be unacceptable to the majority who supported a closer Humanistic or Existential relationship. Even among this majority there was uncertainty regarding the degree of acceptance, warmth, and content of the relationship. The diversity of therapeutic philosophies adhered to by practitioners tended to decrease clarity and produce no clearcut, universally acceptable ideal therapeutic relationship.

Code of Ethics: Content, Construction and Interpretation

The first attempt by the American Psychological Association to codify the behavior of the therapist during psychotherapy came in 1953 (APA, 1953). Since that first draft was offered for inspection to members of the Association, many diverse opinions and attitudes regarding content, construction, and interpretation have appeared in the literature. Lucena (1972) pointed out that ethical problems arose from the constant evolutionary process that influenced the field of psychology and that one of the major functions of psychologists was to study the moral and ethical implications of his/her discipline.

The literature indicated that there were several different ways of constructing a code of ethics. Each with its own gallery of supporters. The first approach was to construct a code primarily upon empirical evidence (Wrenn, 1952; Morgenbesser, 1957, Holtzman,

1960; Wiskoff, 1960). Wrenn (1952) described a code of ethics as a crystallization of the value system of the therapist. He suggested that the therapist must distinguish between his own values and those held by his client in order to guard against a subtle imposition of his values and moral code upon his client. He supported the Hobbs Committee's reliance upon empirical evidence to construct an ethical guideline.

Likewise, Morgenbesser (1957) rejected the logical basis of ethical objectivity. He delineated that a statement in both science and ethics was considered objective if it was supported by empirical evidence gathered in certain standardized ways, and one which could be agreed on by almost anyone willing to review the evidence in an appropriate manner. This would seem to be a more appropriate approach for an association which considered itself to be empirically oriented. He noted that evidence for ethical sentences "consists of the probable agreement of the person addressed, subsequent to the interchange of ideas, views, and experiences" (pp. 185). These, he suggests, must be supported by evidence.

Wiskoff (1960) shared the same views regarding an empirical construction of the Ethical Standards of Psychologists (APA, 1959) as Morgenbesser. He attacked the later 1959 revision of the code as having inadequate ethical anchors, which he suggested, must be empirically based.

Holtzman (1960) praised the 1950 Hobbs Committee for their empirical approach to the codifying of therapeutic behavior. In addition, he suggested that the content of a code of ethics must be

close enough to the contemporary scene to win the genuine acceptance of the majority of practitioners who were most directly affected by its principles. Holtzman, in reference to content, also suggested that "the heart of the code must be based upon a lasting idealism that can serve as a model worthy of all psychologists for generations to come" (pp. 250). Kuenzli (1960) approached the idea of a lasting idealism and suggested that this term was analogous to what should be. He noted that this did not basically describe fact or what is.

Daugner and Daubner (1970) described the construction of ethics as normative rather than factual. They suggested that a code of ethics be representative of the principles or norms, held by practitioners, that ought to govern therapeutic conduct rather than those that do. Peterson (1970) added support to this idea of a normative approach to codify behavior in his description of a code of ethics:

> An ethical system or code of ethics is a guideline for action based upon commonly held values. To be meaningful, a code of ethics should reflect not only the agreed upon values of the profession but also the values generally accepted by the society the profession serves. An adopted code of ethics is then a guage of the most basic values agreed upon by the profession. (pp. 120).

Brammer and Shostrom (1968) shared similar views regarding the construction and content of the code of ethics. They advised that a code should reflect professional and social values. In addition, they noted that a code reflected values only at one particular point in time and that one would expect them to change as the consensus of social values undergo revision.

Brayfield (Note 2), in a paper presented at the XVIth International Congress of Applied Psychology, described the ethical issue.

he stated that the development and application of psychological knowledge was becoming more complex, more extensive, and more open to public scrutiny. He mentioned that the ethical question presently demanded more interest and attention compared to any other time in the history of the discipline.

The extreme complexity of ethics in therapy was also described by Livers (1974). He postulated that ethics were seen as a standard of conduct that constituted a basic moral code for the therapeutic treatment of clients. He also acknowledged that ethical standards were subject to interpretation and to evolutionary change. He noted "what is right or wrong is not clearly descernable" (pp. 181).

Sanford (1955) suggested that the idea of habeus mentum (right of a man to his own mind) be included onto the Ethical Standard of Psychologists. He felt both therapist and client should be allowed to practice according to their own set of morals and values. This idea of self interpretation was also supported by Kovac (1968) and Bugenthal (Note 3).

Kovac (1968) suggested that the Ethical Standards of Psychologists (APA, 1963) seemed to be a set of limits to protect the American Psychological Association. He felt that they had been designed to insure that no psychologist would behave in any way that might cause controversy or embarrassment to the professional community. Kovacs warned that several principles of the ethical code placed undue restrictions upon the practice of psychotherapy.

Bugenthal (Note 3) implied that a significant gap existed between the requirements of practice and the guidelines provided by

the Ethical Standards. He suggested that the code constituted a source of inauthenticity for the psychologist.

Farwell (1974) discussed this same idea of ethical interpretation in regard to both the American Psychological Association and the American Personnel and Guidance Association's code of ethics and suggested that behavior required more than merely checking the code to determine whether that behavior conformed or not. He delineated five additional statements to interpret therapeutic behavior:

1. Does the behavior help the counselor?
2. Is the behavior morally "right?"
3. Is the counselor's behavior fairly consistent?
4. Is the counselor's response basically rational?
5. Is the counselor's behavior properly motivated?

(pp. 198-199)

Farwell felt that these questions, when applied to the therapeutic behavior would determine ethical behavior.

To renumerate, collective professional opinion reflected the need to construct a code by utilizing attitudes and values representative of both practitioners and the society in which the therapist practiced and that these values be gathered in an empirical, controlled manner.

The literature also eluded to problems that a code of professional ethics generated. These included the idea that any code was only representative of one point in time due to the constant evolutionary process, influences in the field, and the interpretations by the practitioner of that code.

Dual Relationship

In this section, the researcher has accumulated relevant literature dealing with the dual relationship. A dual relationship is

defined as a relationship involving a therapist and a client engaged in both psychotherapy and some other relationship outside of the psychotherapeutic session.

The literature relating to the dual relationship appeared to be grouped into various categories; those opposed to the involvement in dual relationships and those supporting the involvement in dual relationships. Other aspects that were treated and that will be discussed in this section include: The APA's stance on the dual relationship, dependency caused by the dual relationship, the use of non-professionals in therapy, and sex in therapy.

APA's Stance on the Dual Relationship

The American Psychological Association has condemned the therapist's involvement in dual relationships since the first version of the Ethical Standards of Psychologists was published in 1953. This first attempt to deal with the problem of a dual relationship suggested:

> Care must be taken to ensure an appropriate time and place for clinical work to protect both client and clinician from actual or imputed harm, and the profession from censure. This implies an orderly arrangement for clinical work, generally within established hours and in an office, school or hospital setting. (APA, 1953, pp. 4).

This first statement, broad as it was, implicitly suggested that there be no relationship between the therapist and client outside of the therapeutic session and setting. Behaviors that were considered appropriate in therapy remained a question with this ethical statement.

In the next published code of ethics, the APA reflected the

influences of the society which the therapist served. The code suggested that the therapist show sensible regard for the social codes and moral expectations of the community in which he works. A violation of these societal morals and values may involve the client in damaging personal conflicts and impugn the therapists' own name and the reputation of his profession (APA, 1959).

This code also suggested that the therapist must insure an appropriate therapeutic setting, but also dealt with specific situations that were classified as dual relationships and unacceptable.

> Psychologists do not normally enter into a clinical relationship with members of their own family, intimate friends, close associates, or others whose welfare might be jeopardized by such a dual relationship (pp. 281).

This concept of dual relationship remained consistant in the Ethical Standards of Psychologists published in 1963. The code implicitly identified the individuals in which therapeutic involvement constituted a dual relationship but still made no attempt to identify behaviors which might violate the code.

An attempt was made to deal with specific therapeutic behavior in Draft #7 of the Ethical Standards of Psychologists, approved by the Committee on Scientific and Professional Ethics and Conduct on July 20, 1975.

> Psychologists are continually cognizant of both their own needs and of the inherently powerful position vis á vis clients, in order to avoid exploiting the clients trust and dependency. Psychologists make every effort to avoid dual relationships with clients and/or dual relationships which might impair their professional judgement or increase the risk of client exploitation. Examples of such dual relationships include treating an employee or supervisor, treating a close friend or family relative, and sexual relationships with clients. (pp. 3).

This was the first statement by APA dealing with specific therapist/client behaviors. In February of 1976, Asher described a new revision to the proposed code of ethics. Section 6a was revised and stronger language was used to describe sexual relations with a client.

> Psychologists make every effort to avoid dual relationships with clients and/or relationships which might impair their professional judgement or increased the risk of client exploitation. . . Sexual intimacies with clients are unethical. (pp. 11).

To summarize, the American Psychological Association explicitly stated that the therapist should not involve himself in therapy with family members, close friends, or individuals in which the therapist was involved in extra-therapeutic activities. The code failed to elaborate which activities constituted unethical behavior.

With this last revision of Section 6a of Draft #7, the association forcefully stated that sexual intimacies were unethical but neglected to define what a sexual intimacy consisted of. Interpretation of what is considered unethical comes, at present, from the Committee on Scientific and Professional Ethics and Conduct post facto.

Opposition to a Dual Relationship

The literature contained a large contingency of individuals who voiced an agreement with the American Psychological Association's stance to oppose the dual relationship in therapy. The general consensus of this group was that the therapeutic relationship needed to be controlled by the therapist (Bixter, 1949; Black, 1952; Rogers, 1955).

Black (1952) and Rogers (1955) agreed with this idea of a controlled relationship. Both suggested in separate publications that the therapeutic relationship, regardless of the system or method employed, was a controlled, limited interaction. These limits were set by the therapist to control both the behavior of the client in the relationship and his/her own involvement in it. This was viewed as most beneficial for the helping relationship.

Bixter (1949) suggested that an effective therapeutic relationship was a controlled relationship and added that differences in therapies were sufficiently stimulating and threatening to attract attention but in spite of the fact that problems were inherent to all therapies and that the problems could be resolved by setting limits on the relationship.

Freud opposed the dual relationship in an article published in 1919. He suggested that as far as the client's relations with the therapist are concerned, the client must be left with unfulfilled desires in abundance. He felt that it was expeditious to deny the client precisely those satisfactions which he desired most intensely and expressed as most important.

Fromm-Reichmann (1950) expressed agreement with this assertion and stated that a separation of interaction between the therapist and client allowed the therapist to reduce the client's dependence on him/her. He also recommended that one make it a rule not to see the client outside of the scheduled interviews, professionally or otherwise.

Pepinsky and Pepinsky (1954) and Blocker (1974) agreed with the practice of limiting interaction with the client to scheduled therapeutic sessions. Pepinsky and Pepinsky implicitly stated that there should be no extra-therapeutic contact with the client. Blocker also explained that the therapist's behavior was governed by a set of ethical standards. He stated that these limitations included limiting the client in terms of time of appointment, length of appointment, and the nature of the interaction with the therapist.

A study conducted by Snyder (1961) tended to illustrate the ineffectiveness of therapy when a dual relationship existed. One group of students received therapy with therapists who maintained dual roles as therapists and teacher. While another group received therapy in which the therapist was not involved in a dual relationship with them. The results indicated that although in some cases no harm seemed to result, in a number of cases the therapy was made considerably more difficulty by the extra-therapeutic contact. Establishing a successful therapeutic relationship was determined to be considerably more difficult when a dual relationship existed.

Ivey (1963), in a similar study, found that students showed no differences in satisfaction of therapy whether they were involved in the teacher/therapist relationship or not. However, he did find that students expressed a greater willingness to express psychological problems to individuals in which they were not involved with in dual roles. These two pieces of research tended to substantiate an anti-dual relationship policy.

Gurel (Note 1) suggested, in a letter, that the reason for APA's opposition depended more on logic than empirical evidence. She stated that the main reason for the objection was that it was the duty of the psychologist to remain objective in the therapeutic relationship. When a therapist was involved in a dual relationship the likelihood of sustaining this detachment was lessened.

Snyder (1963), in another article, suggested that dependency was a by-product of psychotherapy but when an extra-therapeutic relationship was also included the degree of dependency intensified significantly. Studies done by Winder and Ahmad (1963), Caracena (1965), and Schuldt (1966) showed definite client/therapist dependency relationships in all stages of therapy. These studies tend to substantiate Snyder's theory that dual relationships made the therapeutic process increasingly less effective.

Schwebel (1955) attributed the unethical practice of dual relationships to the overpowering self-interest of the therapist as expressed in personal profit, self-enhancement, and maintenance of security and status. He suggested that poor judgement was due, in part, to inexperience in problem solving in therapy and ignorance of technical knowledge of ones own values. In another article that same year (1955a) he suggested that where interpersonal relationships were essential to effective outcome, the therapist should beware of the inadequacies in his/her own personality. He felt that these inadequacies could bias his/her appraisal of clients or distract his/her relationship with them.

In summary, involvement in dual relationships in therapy was discouraged by therapists, researchers, and the American Psychological Association. Objections to such relationships grew out of two basic premises: the first suggested that the therapist could not maintain an objective perspective of the client and his/her problem in a dual relationship, and the second, suggested that dual relationships resulted in undue dependency relationships that tended to impair progress in therapy.

Berne (1966) strongly condemned those who maintained dual relationships. He wrote:

> To those who would forsake their clients needs in the pursuit of the gratification of their own needs (even openly acknowledge). If you want the patient to be your therapist, be sure first that you can afford to pay him your usual fee (pp. 358).

Supporters of the Dual Relationship

Several authors expressed their support of a totally open, unrestricted therapeutic relationship. The code of ethics was seen as an inhibiting agent that consequently robbed the therapeutic relationship of its possible effectiveness.

Cantoni and Cantoni (1961) suggested the use of friends as therapeutic agents, a practice which was in violation of the APA code. They felt that the friend-relationship provided an added ability to help. Their reasoning behind this conviction stemmed from the fact that a relationship already existed between the therapist and client thus allowing therapy to begin with a "head-start."

Mullan and Sangiuliano (1964) suggested that current practice of psychotherapy tended to sacrifice the spontaneous interaction between

the therapist and client. They felt that the therapeutic potential suffered when fixed procedures were practiced. In regard to the therapeutic relationship, they noted that as the therapist and client came together, the need arose to relate more closely to each other. This could be accomplished only by going beyond the behavioral limits ascribed to their roles as therapist and client. As the role of therapist and client became fixed, so too, the time and therapeutic setting became set. This in essence, retarded the effectiveness of the relationship.

Carkhuff and Berenson (1967) also agreed with the premise that a fixed therapeutic situation contributed to inefficiency in therapy. They strongly stated that:

> High levels of care conditions, insights, and confrontations do provide the counselor with the experience he needs to determine how he goes about implementing the goals of therapy; that is, the counselor is committed to do anything which will aid the client in his efforts to translate the fully honest "give" and "take" counseling into actions which will enhance personal emergence (pp. 182).

They also discussed the therapists' personal view of therapy. They postulated that the therapist must live his/her life independently of society. They agreed that at many points the therapists' view of life would be congruent with the ideals and values of society but at many points it would differ from the rules and regulations prescribed by his/her society. They supported a reliance on the therapist's own internalized code of conduct to determine whether or not to move the client toward or away from societies goals.

Carkhuff and Berenson (1969) also discussed the therapist's commitment to his/her client. They suggested that this commitment

was total and all encompassing. To an extent that if the client failed in his/her endeavor to develop, the therapist also failed. They suggested several axioms that aided in such a relationship. First, the therapist should view the client as he/she viewed him/herself with the same respect and cautions that he/she would apply to themself. The therapist was committed to do anything for the client that he/she would do for him/herself under similar circumstances. They suggested that no boundaries should limit the therapist's commitment to the client. These limits included the therapeutic setting and the degree of relationship. Finally, they suggested that the therapist was committed to extend him/herself totally into the life of the client. By extending the therapeutic relationship in all aspects of the life of the client and the abolition of boundaries prescribed by both society in general and the therapist's professional association, a more effective therapeutic environment was established.

The literature contained opinions of several prominent psychologists that suggested that the restrictive measures leveed on the therapist by his/her professional code of ethics and society in general, stripped the therapeutic endeavor of both spontaneity and effectiveness. Freedom to expand the association between the client and the therapist to various therapeutic settings and interactions between them increased the probability of effective development in therapy.

Use of Non-Professionals in Therapy

Research done on the effects of non-professionals appeared to

substantiate the practice of dual relationships (Zunker & Brown, 1966; Patterson & Brodsky, 1966; Goodman, 1967).

Patterson and Brodsky (1966) and Stoner and Gueney (1967) in two independent studies, used mothers as therapeutic agents dealing with their own children. Even though an obvious dual relationship was involved results indicated favorable therapeutic progress.

In studies using both professional and non-professionals in treatment with schizoid clients, clients treated by non-professionals who also assumed other dual roles showed, in most cases, significantly more improvement than clients treated by professionals (Zunker & Brown, 1966; Goodman, 1967).

Reiff and Reisman (1965) suggested that the success shared by non-professionals was attributed to their greater flexibility in appropriate and acceptable behaviors in therapy. College students, not being bound by a professional code of ethics, might take the client on an outing or attend a social gathering held by the client, whereas the professional's role prescription would not allow the indulgence in such activities.

Gruver's (1971) findings empirically indicated that non-professionals were more successful because of their flexibility. He described the flexible method as a fresh new uninhibited approach to therapy.

Poser (1966) also encouraged a more flexible approach to therapy. He stated that non-professional college girls used their femininity to attract, stimulate, and manipulate clients. Such techniques as "Drop the Hanky" (pp. 287), were used. Whereas the professional

therapist would not dare engage in such activities. The professional was again limited by his role prescription.

In each case, the flexibility of the non-professional role, the therapeutic setting, and the behaviors engaged in by non-professionals were thought to be responsible for a more effective therapeutic situation. Each of these authors inferred that possibly the role description and limits leveed on professional therapists were more of a hindrance than a help.

Sex in the Therapeutic Relationship

One of the most controversial issues that appeared in the literature was the idea of sexual intimacies with clients or while involved in therapy. The therapist's involvement in sexual intimacies with a client has been labeled unethical in recent revisions of Section 6a of the Ethical Standard of Psychologists (Asher, 1976).

In a survey conducted by Kardener, Fuller and Mensh (1973) of attitudes and practices of physicians including psychiatrists, they determined that from 5 to 13% of the 460 physicians surveyed admitted to past or present erotic behaviors with clients. The erotic behavior both included and excluded sexual intercourse with a limited number of clients. Of psychiatrists surveyed, 5 to 7% engaged in erotic behaviors with clients. The results also showed that 19% indicated a belief that erotic contact with clients was beneficial. Psychiatrists supporting erotic contact, suggested that this could be a mechanism to allow the clients to express their need to be loved and be accepted by an important individual. Several of the psychiatrists surveyed indicated that they viewed themselves as a parent surrogate and that

sexual involvement with their clients helped them mature psychosexually. They postulated that participation in "overt transference" of an erotic nature was definitely beneficial to some clients.

In another survey of psychologists, 25% of the survey sample reported that they felt sexual intimacies with clients was acceptable if there existed a genuineness of feelings between therapist and client (Wagner, Note 4).

The majority of authors indicated that sexual intimacies with clients were unacceptable. Szasz (1965) suggested that a denial of sexual relations was in order. He suggested that a denial of a sexual relationship was not a case of frustrating the client but an attempt to maintain the contractual nature of autonomous psychotherapy. Fromm-Reichmann (1950) also felt that sexual intimacies were inappropriate. She suggested that the therapist must safeguard against using the client, actually or in fantasy, for the pursuit of his/her own sexual gratification.

Kardener (1974) delineated that sexual intimacies between the therapist and client were not therapeutically beneficial. He also agreed that the therapist entered into the role of parent surrogate with the client. He suggested that sexual relations with a client was analagous to incest and left the client in a state of extreme mental trauma. Lustic, Dresser, and Spellman (1966) supported Kardener's theory that such relationships resulted in great harm to the client.

McConnell (1974) discussed the probable cause for the sexual intimacy controversy. He suggested that therapists' were trained to

function as if living in a Victorian society in terms of human sexuality. In most cases, practitioners pretended that sex did not exist. He postulated that the solution existed in competency and training in this area and in the therapists coming to grips with his/her own sexuality.

In summary, the majority of literature supported the avoidance of any sexual intimacies with clients. The reasoning for this stance was that sexual intimacies caused a loss of objectivity in the relationship. The client and therapist became involved in other roles that resulted in damage to both individuals psychologically.

Supporters of sexual intimacies in therapy felt that this situation added strength and support to the client. It allowed him/her to totally give to another important individual and be viewed as having value to this individual.

Summary of Related Literature

In every area discussed in this review, no clear-cut solutions were offered for the dual relationship controversy. In all cases, there appeared to be a faction that supported a concept while another faction opposed it. The psychoanalytical community supported a very distant therapeutic relationship while the Humanistic community supported close therapeutic relationships. Some individuals supported a code of ethics constructed totally of objective empirically supported concepts while others supported a subjective or logical content. Even when the most controversial issues were examined one portion of practitioners indicated that sexual intimacies with clients were viewed

as beneficial while others indicated that it was totally detrimental. This phenomena of one faction in support while another was in opposition permeated each issue that was discussed.

The majority of literature reviewed supported a close, reciprocal therapeutic relationship. This relationship was tempered by limits set by both the individual practitioner and the practitioners' professional association.

General consensus of opinion concerning the construction of a code of ethics supported a code derived from the collective attitudes and values of both members of the professional association and society in general. Most believed that these attitudes should be collected in a standardized manner and supported by empirical evidence.

The majority of authors reviewed suggested that dual relationships tended to impair progress in therapy rather than stimulate progress. Dual relationships, in most instances, were described as being responsible for causing undue client/therapist dependency, a subjective rather than an objective perspective of the client and generally detrimental to the therapeutic endeavor.

CHAPTER III

RESEARCH SETTING

Kansas State College of Pittsburg is an institution offering a liberal arts program as well as several other programs, such as engineering and business administration. It offers masters degrees on two levels, Specialist in Education and the Master's Degree, but does not offer doctoral degrees. Master degrees are available in the fields of Art, Science, and Music.

The student population at Kansas State College of Pittsburg is 5,688. These students can be classified as 285 in Vocational Technology, 3,688 in undergraduate studies, and 1,755 in graduate studies. Within the student population, 15% are from out of state and 30% are part-time students. The faculty consists of 285 full-time-equivalent personnel.

The Counseling and Testing Center of Kansas State College of Pittsburg serves the student population and the community at large. Services include a complete psychological testing program which involves entrance, advanced placement, achievement, aptitude, and psychodiagnostic examinations. The testing service is complimented by therapy programs which include individual, group, and marriage counseling. Topics dealt with by the Counseling and Testing Center include personal, academic, inter-personal relationships and occupational counseling.

Two pilot studies to determine the validity and reliability of the survey questionnaire were performed in this setting during the Spring Semester of 1976.

Subjects

The subjects used in this study were drawn from three settings. The first group consisted of graduate students enrolled in Psychology Seminar 840, Issues and Trends in Counseling attending class on March 29, 1976. These students were all part-time and/or full-time graduate students (MS and EdS programs). Their major fields of study included Psychology (Agency and Community Counseling) and Counseling.

The second group of subjects were professional counselors and graduate students participating in the "Choice Awareness: A new look at how to live" workshop at Kansas State College of Pittsburg on April 24, 1976. Subjects in this group ranged in age from 22 to 64. Subjects counseling experience ranged from 0 to 37 years. Subjects in this group were employed in a diverse array of counseling institutions including hospitals, schools, community agencies, clinics, and private practices.

The third group of subjects were therapists listed in either Division 12 and/or 17 of the APA register. The subjects were selected in a computerized random sample generated by the APA of approximately 6,000 members.

Description of Research Instrument

The research instrument utilized in this study was constructed and validated by the researcher. The instrument consists of a self reported mail-questionnaire containing 14 multi-version statements. The instrument contains a total of 34 statement-response questions.

Responses were made by a five item multipoint rating scale (see appendix A for mail-questionnaire) which described the subject's degree of agreement or disagreement with the statement. This form of an absolute response questionnaire was described by Nunnally (1972) as the simplest and most preferred method for the determination of attitudes.

Reliability

Reliability for the survey questionnaire was established through two pilot surveys. Instructions explaining the reliability process were placed below the directions on the survey questionnaire (see appendices D and E). A five item rating scale was used to determine the extent to which each subject was allowed to express his/her attitudes and feelings concerning each of the 34 statement-response items. The above mentioned five point scale was placed below each response.

Pilot I Survey. The Pilot I Form of the survey questionnaire was administered to a graduate class containing 16 subjects (see Chapter III, Subjects, Group One). Each subject rated every statement and responded according to how well he/she was allowed to express his/her attitudes. The mean for each of the 34 statements was computed from the ratings of the 16 subjects.

Each subject was interviewed to determine the following:

1. Did the subject understand the rating system and instructions?

2. Did the subject reverse the scale or rate a statement as a high indicator of their attitudes when they intended to indicate the opposite.

3. If he/she rated any statement response as one (1), was this an accurate measure?

Each statement-response was required to meet the following criteria before inclusion into the Pilot II Form (see appendix B) of the survey questionnaire.

1. Each statement-response was required to achieve a mean rating of 3.5 or higher.

2. Each statement-response was allowed no one (1) ratings after the interview.

All statements, with the exception of statement-response number 2 received a mean of 3.5 or higher (see Table I for results of Pilot I survey).

Pilot II Survey. The Pilot II Form of the survey questionnaire (see appendix C) was administered to a group of 27 professional counselors attending a workshop at Kansas State College of Pittsburg (see Chapter III, Subjects, Group Two). Subjects rated each statement-response as in the Pilot I survey. No interview was given to this group of subjects.

A mean for each statement-response was computed from the rating of the 27 subjects. The means for the Pilot II Form of the questionnaire are reported in Table II (see Table II).

Survey Questionnaire. The results from both the Pilot I Survey and the Pilot II Survey were used to determine the reliability and which of the statements were included in the final survey questionnaire. The average mean for the 43 subjects surveyed was computed for the reliability of each of the 34 statement-responses. Criteria for

TABLE I

MEAN RESULTS OF THE PILOT I SURVEY

Statement Response	$\bar{x}_1$	Statement Response	$\bar{x}_1$
1	4.19	9a	4.56
2	3.31	9b	3.88
3a	4.0	9c	3.94
3b	4.0	9d	3.75
4a	4.0	10a	3.75
4b	4.0	10b	3.81
5a	4.38	10c	3.88
5b	4.38	10d	3.88
6a	4.38	11a	3.69
6b	4.38	11b	3.75
6c	4.19	11c	4.06
6d	4.25	11d	4.13
6e	4.25	12a	3.88
6f	4.31	12b	3.94
7	4.13	12c	4.0
8	4.13	12d	4.06
		13	3.88

TABLE II

MEAN RESULTS OF THE PILOT II SURVEY

Statement Response	$\bar{x}_2$	Statement Response	$\bar{x}_2$
1	3.56	10a	3.93
2	3.70	10b	4.19
3	4.07	10c	3.74
4a	3.63	10d	3.78
4b	3.67	11a	3.70
5a	3.63	11b	3.85
5b	3.63	11c	3.93
6a	3.41	11d	3.67
6b	3.44	12a	4.11
7a	3.78	12b	4.0
7b	3.67	12c	4.15
7c	3.74	12d	4.30
7d	3.89	13a	4.0
7e	3.78	13b	3.96
7f	3.70	13c	4.04
8	3.78	13d	3.85
9	4.15	14	3.70

inclusion into the final survey questionnaire was determined to be an average reliability of 3.5 or higher for each statement-response (see Table III for average reliability). The reliability of statement-responses used on the survey questionnaire ranged from 3.67 to 4.23. The reliability for the final survey questionnaire was computed to be 3.91.

Validity

Both content and construction validity were determined for all three forms of the survey questionnaire.

Content validity was determined by the researcher's thesis advisor and two other faculty members with an expertise in test construction. Early drafts of the survey questionnaire were amended to sample all constructs contained in Section 6a of the Ethical Standard of Psychologists Draft #7.

Construct validity was determined on both Pilot I and Pilot II forms of the survey questionnaire. A section on the last page of each of these two forms was provided to allow subjects to identify any sources of ambiguity or confusion (see appendix F for instructions for face validity) and to suggest improvements. Major sources of ambiguity and confusion were corrected and/or eliminated.

Procedures

In order to facilitate replication, the procedures which were used in this study are given in a step by step sequence of events. Each step represents a distinct time frame and all events which occur simultaneously are contained within that step.

TABLE III

STATEMENT/RESPONSE RELIABILITIES

Statement Response	$\bar{x}_1$	$\bar{x}_2$	$\bar{x}_T$
1	4.19	3.56	3.79
2	3.31	3.70	3.70
3	*	4.07	4.07
4a	4.0	3.63	3.77
4b	4.0	3.67	3.79
5a	4.0	3.63	3.77
5b	4.0	3.63	3.77
6a	4.38	3.41	3.77
6b	4.38	3.44	3.79
7a	4.38	3.78	4.00
7b	4.38	3.67	3.93
7c	4.19	3.74	3.91
7d	4.25	3.89	4.02
7e	4.25	3.78	3.95
7f	4.31	3.70	3.93
8	4.13	3.78	3.91
9	4.13	4.15	4.14
10a	4.56	3.93	4.16
10b	3.88	4.19	4.07
10c	3.94	3.74	3.81
11a	3.75	3.70	3.72
11b	3.81	3.85	3.84
11c	3.88	3.93	3.91
11d	3.88	3.67	3.74
12a	3.69	4.11	3.98
12b	3.75	4.00	3.91
12c	4.06	4.15	4.12
12d	4.13	4.30	4.23
13a	3.88	4.00	3.95
13b	3.94	3.96	3.95
13c	4.00	4.04	4.02
13d	4.06	3.85	3.93
14	3.88	3.70	3.77
	$R_1 = 4.03$	$R_2 = 3.83$	$R_T = 3.91$

* Number 2 on Pilot I was later broken into numbers 2 and 3 on Pilot II
$\bar{x}_1$ mean of Pilot I
$\bar{x}_2$ mean of Pilot II
$\bar{x}_T$ Total mean
R_1 reliability of Pilot I
R_2 reliability of Pilot II
R_T reliability of Survey Questionnaire

Step 1. A survey questionnaire was constructed and validated. Reliability for the questionnaire was established. For replication of this study the survey questionnaire is contained in appendix A.

Step 2. A computerized random sample of APA members was purchased from the American Psychological Association. The sample contained 300 subjects with 200 subjects drawn from Division 12 (counseling) and 100 subjects drawn from Division 17 (clinical).

Step 3. The survey questionnaire was mailed to the 300 subjects. An addressed, stamped envelope and cover letter (see appendix G for cover letter) accompanied the survey questionnaire. The survey was returned to an individual other than the researcher to insure additional confidentiality.

Step 4. As the survey questionnaires were returned the name of the subject was crossed off the mailing list by the individual receiving the questionnaires.

Step 5. After a period of four weeks, a follow up letter along with another copy of the survey questionnaire was sent to the subjects who had not yet returned the survey questionnaire (see appendix H).

Step 6. Three weeks after the follow up letter had been sent the results of the survey were compolated, correlated, and analyzed by the following statistical methods.

Statistical Techniques

The following statistical techniques were employed to test the statistical significance of these hypotheses (see Chapter I).

In this study, two general analyses were made. The first was to report the collective responses of the deviant and non-deviant populations. The second analysis was to describe the deviant and non-deviant populations by correlating both populations with age, sex, years of counseling experience and counseling setting. The statistical procedures that were used are listed below.

1. The number of subjects in deviant population were compared to the number of subjects in the non-deviant population to determine which population was larger on each of the 34 items.

2. A Pearson's Product-moment Correlation (Klugh, 1970) was used to determine any significant correlation between the deviant and non-deviant populations and the ages of the survey subjects.

3. A Pearson's Product-moment Correlation (Klugh, 1970) was used to determine any significant correlation between deviant and non-deviant populations and the years of experience of the subjects surveyed.

4. A 2 x 2 chi square (Ostle, 1963) was used to determine any significant relationship between the deviant and non-deviant populations and the sex of the subjects surveyed.

5. A 2 x 5 chi square (Ostle, 1963) was used to determine any significant relationship between the deviant and non-deviant populations and five counseling settings; a private practice, an agency, a clinic, a hospital, and a school.

CHAPTER IV

RESULTS

The purpose of this study was twofold. First, this study sought to identify the attitudes of APA members concerning Section 6a of the 7th Draft of the Ethical Standards of Psychologists and compare their attitudes with the attitudes of the APA Ethics Committee contained in the 7th Draft of the Ethical Standards of Psychologists.

Secondly, this study sought to describe the deviant population or that population that did not share the APA attitudinal stance on each of the thirty-four statements by correlating both the deviant and the non-deviant populations with sex, age, years of experience and therapeutic setting.

The analysis that follows was based upon the results received from an attitudinal survey sent to 300 APA members. Of these 300 surveys, 211 (70.3%) were returned and 207 (69%) were completed properly and analyzed. When compared to other national and regional surveys that appeared in professional literature this study achieved the highest percentage of return of all the surveys reviewed. These returned surveys represented 164 males and 64 females. In the analysis of subjects' employment settings it was indicated that 31 were from clinical settings, 76 from private practice, 33 from hospitals, 48 from educational facilities, and 19 from agencies. The ages of the respondents ranged from 27 to 79 years with a mean age of 46 years. Experience ranged from 2 to 50 years with a mean of 21 years.

The statistical analysis of this data was performed by an IBM 370-125 computer operated by the Computer Center at Kansas State College of Pittsburg.

The response obtained from the survey subjects were collated and transformed for analysis. Subjects expressing an attitude on a statement congruent with the 7th Draft were scored either 4 or 5 (4 = D or A, 5 = SA or SD) to indicate membership in the non-deviant population. Subjects expressing an attitude that deviated from the draft were scored either 1 or 2 on that statement (1 = SA or SD, 2 = A or D) to indicate membership in the deviant population. Subjects responding with NO (no opinion) on a statement were scored as 3 on that particular statement. This population was considered neutral and subsequently not used in further analysis of hypotheses 1 through 5. The cumulative results of the survey are presented in Table IV.

Hypothesis One

"The non-deviant population with attitudes synonymous with the constructs of Section 6a will be larger than the deviant population with attitudes that deviate from the constructs of Section 6a on all statements" (p. 9).

The survey questionnaire was mailed to 300 APA members of which 207 practitioners returned the questionnaire with both the initial information and each statement completed. Each statement, when analyzed independently, contained two populations; a deviant (D) and a Non-deviant (ND).

TABLE IV

COLLATED RESULTS OF THE SURVEY QUESTIONNAIRE

Item	Statement	Response				
1	I feel that it is appropriate to extend myself into as close a relationship as possible with each client (i.e., warm, caring, friendly).	SA*	A*	NO	D**	SD**
		34	124	8	30	11 #
		16.4	59.9	3.9	14.5	5.3 %
2	I feel that it is appropriate to maintain a professional distance with each client by allowing no contact with the client outside of the therapeutic session.	SA*	A*	NO	D**	SD**
		25	95	13	61	13 #
		12.1	45.9	6.3	29.5	6.3 %
3	I feel that it is appropriate to maintain a professional distance with each client by not allowing myself to become emotionally involved with the client (i.e., keep my feelings and the client's separate).	SA*	A*	NO	D**	SD**
		60	92	7	43	5 #
		29.0	44.4	3.4	20.8	2.4 %
4	I feel that it is appropriate to involve myself in extratherapeutic social activities (i.e., cocktail and/or dinner parties, informal gatherings) with clients: of the same sex.	SA**	A**	NO	D*	SD*
		1	30	10	79	87 #
		.5	14.5	4.8	38.2	42.0 %
5	(same statement as 4): of the opposite sex.	SA**	A**	NO	D*	SD*
		1	29	10	77	90 #
		.5	14.0	4.8	37.2	43.5%
6	I feel that it is appropriate to involve myself in extratherapeutic recreational activities (i.e., tennis, bowling, outdoor sports) with clients: of the same sex.	SA**	A**	NO	D*	SD*
		0	34	15	85	73 #
		0	16.4	7.2	41.1	35.3%
7	(same statement as 6): of the opposite sex.	SA**	A**	NO	D*	SD*
		0	32	16	84	75 #
		0	15.5	7.7	40.6	36.2

TABLE IV (cont)

Item	Statement	Response					
8	I feel that it is appropriate, in my home, to entertain (i.e., cocktail and/or dinner parties, informal gatherings) with clients: of the same sex.	SA**	A**	NO	D*	SD*	
		2	15	12	87	91	#
		1.0	7.2	5.8	42.0	44.0	%
9	(same statement as 8): of the opposite sex.	SA**	A**	NO	D*	SD*	
		2	15	12	42	152	#
		1.0	7.2	5.8	41.1	44.9	%
10	I feel that it is appropriate to be involved in therapy with: a member of my family.	SA**	A**	NO	D*	SD*	
		1	9	3	42	152	#
		.5	4.3	1.4	20.3	73.4	%
11	(same statement as 10): a close friend.	SA**	A**	NO	D*	SD*	
		0	22	8	56	121	#
		0	10.6	3.9	27.1	58.5	%
12	(same statement as 10): a colleague.	SA**	A**	NO	D*	SD*	
		2	63	17	57	68	#
		1.0	30.4	8.2	27.5	32.9	%
13	(same statement as 10): a supervisor.	SA**	A**	NO	D*	SD*	
		0	29	14	64	100	#
		0	14.0	6.8	30.9	48.3	%
14	(same statement as 10): a supervisee.	SA**	A**	NO	D*	SD*	
		2	49	14	60	82	#
		1.0	23.7	6.8	29.0	39.6	%
15	(same statement as 10): one of my employees.	SA**	A**	NO	D*	SD*	
		0	26	13	71	97	#
		0	12.6	6.3	34.3	46.9	%

TABLE IV (cont)

Item	Statement	Response					
16	I feel that it is appropriate to become involved in formal business dealings (i.e., contractual dealings) with a client, including other interests in which the therapist is involved.	SA**	A**	NO	D*	SD*	
		2	8	22	77	98	#
		1.0	3.9	10.6	37.2	47.3	%
17	I feel that it is appropriate to become involved in informal business dealings (i.e., small loans, non-contractual dealings) with clients.	SA**	A**	NO	D*	SD*	
		0	8	15	77	107	#
		0	3.9	7.2	37.2	51.7	%
18	I feel that it is appropriate, inside of the therapeutic session, to share with the client: my professional expertise (i.e., psychological).	SA*	A*	NO	D**	SD**	
		81	102	6	15	3	#
		39.1	49.3	2.9	7.2	1.4	%
19	(same statement as 18): other expertise (i.e., financial, mechanical).	SA**	A**	NO	D*	SD*	
		7	85	27	67	21	#
		3.4	41.1	13.0	32.4	10.1	%
20	(same statement as 18): my general feelings (i.e., reactions to life, home life, world situation).	SA*	A*	NO	D**	SD**	
		15	114	25	45	8	#
		7.2	55.1	12.1	21.7	3.9	
21	(same statement as 18): my problems (i.e., family difficulties, sexual problems).	SA**	A**	NO	D*	SD*	
		0	31	15	69	92	#
		0	15.0	7.2	33.3	44.4	%
22	I feel that it is appropriate, outside of the therapeutic session, to share with the client: my professional expertise (i.e., psychological).	SA**	A**	NO	D*	SD*	
		21	69	20	60	37	#
		10.1	33.3	9.7	29.0	17.9	%
23	(same statement as 22): other expertise (i.e., financial, mechanical).	SA**	A**	NO	D*	SD*	
		8	60	26	65	48	#
		3.9	29.0	12.6	31.4	23.2	%

TABLE IV (cont)

Item	Statement	Response					
24	(same statement as 22): my general feelings (i.e., reactions to life, home life, world situations).	SA**	A**	NO	D*	SD*	
		5	79	18	61	44	#
		2.4	38.2	8.7	29.5	21.3	%
25	(same statement as 22): my problems (i.e., family difficulties, sexual problems.	SA**	A**	NO	D*	SD*	
		1	15	16	71	104	#
		.5	7.2	7.7	34.3	50.2	%
26	I feel that it is appropriate, inside of the therapeutic session, to allow the client to share with me: his/her professional expertise (i.e.,	SA*	A*	NO	D**	SD**	
		29	90	31	50	7	#
		14.0	43.5	15.0	24.2	3.4	%
27	(same statement as 26): other expertise (i.e., financial, mechanical).	SA*	A*	NO	D**	SD**	
		26	91	33	50	7	#
		12.6	44.0	15.9	24.2	3.4	%
28	(same statement as 26): general feelings (i.e., reactions to life, home life, world situations).	SA*	A*	NO	D**	SD**	
		115	86	4	1	1	#
		55.6	41.5	1.9	.5	.5	%
29	(same statement as 26): problems (i.e., family and/or sexual, financial difficulties).	SA*	A*	NO	D**	SD**	
		141	61	2	1	2	#
		68.1	29.5	1.0	.5	1.0	%
30	I feel that it is appropriate, outside of the therapeutic session, to allow the client to share with me: his/her professional expertise (i.e., managerial, accounting).	SA**	A**	NO	D*	SD*	
		14	75	25	54	39	#
		6.8	36.2	12.1	36.2	18.8	%
31	(same statement as 30); other expertise (i.e., financial, mechanical).	SA**	A**	NO	D*	SD*	
		14	78	24	51	40	#
		6.8	37.7	11.6	24.6	19.3	%

TABLE IV (cont)

Item	Statement	Response					
32	(same statement as 30): general feelings (i.e., reactions to life, home life, world situations).	SA**	A**	NO	D*	SD*	
		12	83	22	58	32	#
		5.8	40.1	10.6	28.0	15.5	%
33	(same statement as 30): problems (i.e., family and/or sexual, financial difficulties).	SA**	A**	NO	D*	SD*	
		10	49	21	85	42	#
		4.8	23.7	10.1	41.1	20.3	%
34	I feel that it is appropriate to involve myself in sexual relations with a client when it is evident that the client will benefit from this encounter.	SA**	A**	NO	D*	SD*	
		0	2	4	25	176	#
		0	1.0	1.9	12.1	85.0	%

* non-deviant population
** deviant population
\# number of individuals
% percentage of individuals

When the size of the deviant population was compared to the non-deviant population (see Table 5), the non-deviant population was larger on most statements with the exception of statements 19, 31, and 32 in which the deviant population was larger than the non-deviant population. The non-deviant population ranged from 42.5% (item 19) to 97.1% (items 28, 34) of the total population with a mean of 71.9%. The deviant population ranged from 1% (items 38, 34) to 45.9% (item 32) with a mean of 20.6% computed from the 34 statements.

Since the percentage of non-deviant subjects was larger than that of the deviant population for each statement with the exception of statements 19, 31, and 32 there is a basis for concluding that the hypothesis was upheld for each statement with the exception of statements 19, 31, and 32. In these cases, the non-deviant population was smaller than the deviant population and the hypothesis was not upheld for these three statements.

Hypothesis Two

"Subjects in the deviant population will have significantly lower ages when correlated with the non-deviant population" (p. 9).

The 207 returned questionnaires were correlated with age as a variable in an attempt to describe and/or isolate a variable which may have been associated with the deviant population. The Pearsons Product-moment Correlation (Klugh, 1970) was used to correlate age with deviancy on each of the 34 items.

TABLE V

FREQUENCY DISTRIBUTION OF DEVIANT VS.
NON-DEVIANT POPULATIONS

	D#	D%	ND#	ND%
1	41	19.8	158	76.3
2	74	35.9	120	57.0
3	48	23.2	152	73.4
4	31	15.0	166	80.2
5	30	14.5	167	80.7
6	34	16.4	158	76.4
7	32	15.5	159	76.8
8	17	8.2	178	86.0
9	17	8.2	178	86.0
10	10	4.8	194	93.7
11	22	10.6	177	85.6
12	65	31.5	125	60.4
13	29	14.0	164	79.2
14	51	24.7	142	68.6
15	26	12.6	168	81.2
16	10	4.9	175	84.5
17	8	3.9	184	88.9
18	18	8.6	183	88.4
19	92	44.5	88*	42.5*
20	53	25.6	129	62.3
21	31	15.0	161	77.7
22	90	43.4	97	46.9
23	68	32.9	113	54.6
24	84	40.6	105	50.8
25	16	7.7	175	84.5
26	57	27.6	119	57.5
27	57	27.6	117	56.6
28	2	1.0	201	97.1
29	3	1.5	202	97.6
30	89	43.0	93	44.9
31	92	44.5	91*	43.9*
32	95	45.9	90*	43.5*
33	39	28.5	127	61.4
34	2	1.0	201	97.1

NO or neutral population not included
* non-deviant population smaller than deviant population
D# number deviant
D% percentage deviant
ND# number non-deviant
ND% percentage non-deviant

The results of this analysis yielded an r value and an alpha level for each of the 34 items (see Table VI). The r values ranged from -.340 on item 18 to .145 on item 31. The hypothesis was supported with items 19, 21, 22, 24, 30, 31, and 32. In these cases the results indicated a positive correlation between a lower age of the practitioner and an increase in deviation with an alpha level less than .05. The hypothesis was rejected on the remainder of the items.

Hypothesis Three

"Subjects in the deviant population will have significantly lower years of experience when correlated with the non-deviant population" (p. 9).

The responses received from the 207 returned questionnaires were correlated with years of experience as a variable in an attempt to describe and/or isolate a variable which may have been associated with the deviant population. The Pearson's Product-moment Correlation (Klugh, 1970) was used to correlate years of experience with deviancy on each of the 34 items.

The results of the analysis yielded an r value and an alpha level for each of the 34 items (see Table VII). The r values range from -.216 on item 18 to .135 on item 21. The hypothesis was supported for only item 21. In this case the results indicated a correlation of .135 significant to the .05 level, indicating a positive correlation between practitioners with lower years of experience and increased deviation. The hypothesis was rejected for the remaining 33 items.

TABLE VI

CORRELATION OF AGE AND DEVIANCY

Item	r	Item	r
1	.017	18	-.34**
2	.032	19	.132*
3	.095	20	-.236**
4	.079	21	.142*
5	.081	22	.140*
6	.105	23	.102
7	.084	24	.138*
8	-.005	25	.117
9	.012	26	-.058
10	-.035	27	-.070
11	.059	28	-.021
12	.045	29	-.064
13	.002	30	.119*
14	-.007	31	.145*
15	.017	32	.119*
16	.055	33	.009
17	-.056	34	.009

* significant = $p < .05$
** significant = $p < .01$

TABLE VII

CORRELATION OF EXPERIENCE AND DEVIANCY

Item	r	Item	r
1	.037	18	-.217**
2	.024	19	.062
3	.097	20	-.181**
4	.070	21	.136*
5	.074	22	.034
6	.066	23	.028
7	.047	24	.087
8	.021	25	.090
9	.035	26	.037
10	.018	27	.029
11	.068	28	.068
12	.010	29	-.003
13	-.002	30	.087
14	-.015	31	.104
15	.020	32	.117
16	-.014	33	-.011
17	-.110	34	-.032

* = significant = $p < .05$
** = significant = $p < .01$

Hypothesis Four

"Male subjects will show significantly more deviation when correlated with female subjects" (p. 10).

Three hundred (300) APA members registered in division 12 and 17 were surveyed by mail to sample their attitudes concerning Section 6a of the 7th Draft of the Ethical Standards for Psychologists. Subjects were asked to designate their sex in the preliminary information portion of the survey questionnaire. Of the 207 subjects who returned the questionnaire properly completed 43 were female and 164 were male.

Data was punched for computer assisted data analysis using a 2 x 2 Chi Square ($\overline{x}^2$) (Ostle, 1963). Results included observed frequencies, expected frequencies, sectional values, Chi Square values and alpha levels for each of the 34 items (see Appendix I for computer analysis of sex vs. deviancy). Chi Square values ranged from .0002 on item 7 to 7.124 on item 3. In order for the hypothesis to be accepted each item needed to attain a Chi Square value of at least 3.84 or higher ($p < .05$). The hypothesis was supported for items 2, 3, 21 and 33. These items received a Chi Square value in excess of 3.84 which indicated that males were significantly more deviant than females. The hypothesis was rejected for all remaining items.

Hypothesis Five

"Subjects practicing in private practice settings will be significantly more deviant when correlated with subjects in agency, hospital, school, and clinical settings" (p. 11).

Three hundred (300) APA members registered in divisions 12 and 17 were used to provide data for this study. Each was asked to complete and return a mail questionnaire concerning ethical attitudes. Of the 300 subjects surveyed 207 surveys were returned and completed properly for analysis. Subjects were asked to designate the therapeutic work setting in which they worked. Cummulative results indicated that of the 207 subjects analyzed 31 worked in clinical settings, 76 in private practices, 33 in hospitals, 48 in educational facilities, and 19 in agencies.

Data was punched for computer assisted data analysis using a 2 x 5 Chi Square (Ostle, 1963) for analysis. Results included observed frequencies, expected frequencies, sectional values, Chi Square value and an alpha level for each of the 34 items (see appendix J for computer analysis of counseling setting vs. deviancy). Chi Square values ranged from .856 on item 21 to 12.345 on item 22. In order for the hypothesis to be accepted each item needed to attain a Chi Square value of 9.49 or higher ($p < .05$) with the private practice cell having the highest sectional value. Analysis indicated that no item attained the criteria necessary and the hypothesis was therefore rejected on all 34 items.

Disscusion

The purpose of this study was twofold, first to determine if practitioners actually did share attitudes congruent (non-deviant) and incongruent (deviant) with those expressed by the APA's Ethics Committee in Section 6a of the 7th Draft of the Ethical Standards

of Psychologists. Secondly, this study attempted to describe the deviant population by correlating age, sex, years of experience, and counseling setting of practitioners to establish any association between these variables and an increase in the occurrence of deviant responses. It becomes imperative in this section to discuss each research hypothesis for it's contribution to the global view of this study.

The first hypothesis stated that the non-deviant population with attitudes synonymous with constructs of Section 6a would be larger than the deviant populations with attitudes that deviated from the constructs of Section 6a on all statements. The hypothesis originated from the assumption that there would be a variation in subjects' attitudes concerning dual relationships associated with the psychotherapeutic process. On each item both deviant and non-deviant responses occurred. The hypothesis dealt with the prediction that in each of 34 statements the non-deviant population would be larger than the deviant population. The hypothesis was supported by the results of all but three of the items contained on the survey questionnaire (19, 31, 32). In these three cases the deviant population was larger than the non-deviant population therefore rejecting the hypothesis.

In order to view the results of this study in the proper perspective each statement must be considered as a measure of one construct of Section 6a. The degree of variation or size of the two populations gives some indication to the acceptance of the APA's attitudes concerning dual relationships associated with psychotherapy.

On three items the deviant population was greater than the non-deviant population. In each of these situations the deviant population consisted of at least 44% of the subjects analyzed. Analysis showed that 7 items had deviant populations of 1/3 or more, 15 items showed a deviant population of 1/5 of the subjects, or more indicating attitudes deviant from those expressed by APA's Ethics Committee on that particular construct.

The second hypothesis indicated that subjects in the deviant population would have significantly lower ages when correlated with the non-deviant population. The hypothesis originated from the idea that when age was used as a variable younger practitioners' responses would be deviant more often than older practitioners' responses.

Analysis of each of the 34 items indicated a positive correlation between lower ages and on increase in deviancy in 7 items (19, 21, 22, 24, 30, 31, and 32). The correlation of these 7 items ranged from .118 to .145 ($p < .05$). In all other items age was not associated with an increase in deviancy (no correlation) or a negative correlation existed. When the results of all 34 items are considered, age appeared not to be strongly associated with an increase or decrease in deviancy and can not be considered as a valid descriptor of the deviant population.

The third hypothesis stated that subjects in the deviant population would have significantly fewer years of experience when correlated with the non-deviant population. The hypothesis originated from the idea that when years of counseling experience is correlated with deviancy, a therapist with less experience will tend to be more

deviant than the more experienced therapist.

Analysis of the 34 items indicated a significant positive correlation between fewer years of experience and an increase in deviation on only 1 item (21). Analysis showed either no correlation or a negative correlation for the remaining 33 items. Analysis indicated that years of experience was associated with only one item contained on the survey questionnaire and for the entire study could not be considered as a descriptor of the deviant population.

The fourth hypothesis stated that male subjects would show significantly more deviation when correlated with female subjects. The hypothesis originated from the assumption that males tend to deviate in opinion from accepted standards more than females. A comparison of subjects' sex to deviancy would therefore indicate that males are significantly more deviant than females on all items of the survey questionnaire.

Analysis indicated a significantly greater incidence of deviant responses on 4 items (2, 3, 21, 33). On these items males were significantly more deviant than females ($p < .05$). On the remaining 30 items males were not significantly more deviant than females. Analysis also indicated that on no item were females significantly more deviant than males. A global view of the results generated from this hypothesis indicated that sex cannot be considered to be a descriptor of the deviant population.

The fifth hypothesis stated that subjects from private practice settings would be significantly more deviant when correlated with subjects from agency, hospital, school, or clinical settings. The

hypothesis originated from the assumption that subjects in private practice are subject to less stringent supervision and regulation, the results being an increase in deviancy.

Analysis indicated that the hypothesis was rejected on all 34 items. The private practice setting was not associated with an increase in deviancy. Analysis of the results indicated that the hospital setting was significantly more deviant than the other four counseling settings on items 13 and 22. The school setting was significantly more deviant on items 3, 7, and 30, the agency setting significantly more deviant on item 6, and the clinical setting not significantly associated with any item. The analysis indicated that the counseling setting was not an accurate descriptor of the deviant population in general and that the private practice setting was not associated with an increase in the occurrence of deviant responses.

Summary

From the analysis of this data it appears that there are differences in attitudes of subjects surveyed on all 34 of the items presented in this study. The attitudes of subjects appear to fall into three categories, those whose attitudes are synonymous with the APA's 7th Draft, those whose attitudes deviate from APA, and those who expressed no opinion. Hypotheses two through five examined the correlation between deviancy and four variables: age, sex, years of experience, and therapeutic setting. The results clearly indicate that these variables (age, sex, years of experience, and setting) are associated with only individual items and cannot be considered associated with deviancy for the results of the entire survey.

CHAPTER V

CONCLUSIONS

The American Psychological Association has attempted to provide psychologists with guidelines for acceptable therapeutic behavior via the Ethical Standards of Psychologists. Collective professional opinion reflected the need to construct this code of ethics by utilizing attitudes and values representative of both practitioners and the society in which the therapist practiced and that these attitudes be gathered in an empirical, controlled manner.

The purpose of this study was to determine the attitudes of APA members concerning Section 6a of the 7th Draft of the Ethical Standards of Psychologists (dual relationships). The results of this study can only be generalized to members registered in Divisions 12 and 17 of the American Psychological Association, these being the only divisions surveyed by this study.

The first conclusion suggested by this study is that subjects' responses can be classified into three populations: those who express attitudes synonymous with Section 6a, those who express attitudes deviant from Section 6a, and those who express no opinion. This pattern was present for all 34 items. This conclusion suggests that the results of the study (Tavle IV) can be generalized to describe the attitudes of the 6,000 APA members registered with Divisions 12 and 17.

On each item, with the exception of items 19, 31 and 32, the non-deviant population is larger than the deviant population. This conclusion indicates that the attitudes of APA members registered with

Divisions 12 and 17 are more in agreement with the 7th Draft than in disagreement.

The second conclusion suggested by this study is that Section 6a of the 7th Draft of the Ethical Standards of Psychologists is not providing practitioners with the necessary guidelines to provide a uniform explanation of acceptable therapeutic behavior for the therapist.

The appropriateness of therapist/client contact outside of the therapeutic session accounted for the largest overall degree and amount of deviation in this study. Thirty-five (35.8%) percent of subjects surveyed suggested that extratherapeutic contact with clients is appropriate (item 2). On items 22, 23, 24, 30, 31, 32, and 33, which dealt with therapist/client contact outside of therapy, the deviant population was comprised of 25.6% to 45.9% of the subjects responses indicating attitudes that such contact in both professional and other capacities (i.e., professional expertise, other expertise, general feelings, problems) is appropriate. When more specific examples of extratherapeutic behavior were applied, the amount of deviation dropped markedly. Extratherapeutic social activities with clients were reported to be appropriate by 15.0% and 14.5% (items 4 and 5) of the subjects surveyed, extratherapeutic recreational activities with clients 16.4% and 15.5% (items 6 and 7), extratherapeutic social activities in the therapist's home 8.2% (items 8 and 9), and extratherapeutic business involvement 4.8% and 3.9% (items 16 and 17).

When the behavior of the therapeutic session was considered, several items received a large percentage of responses that were deviant

from Section 6a. Twenty-three (23.2%) percent of the subjects surveyed expressed the attitude that it is appropriate to allow emotional involvement with the client (item 3; keep therapist/client feelings and emotions separate). On item 19, 44.5% of the subjects surveyed expressed the attitude that it is appropriate to share other expertise (i.e., financial, mechanical) with the client while involved in a therapeutic session. In another case (item 20), 25.6% of the subjects expressed the attitude that it is appropriate for the therapist to share his/her general feelings not pertaining to the therapy session (i.e., home life, work situation) with the client while involved in a therapeutic session.

Items 10, 11, 12, 13, 14, 15, and 34 were constructed from explicitly stated behaviors identified as inappropriate in Section 6a of Draft #7. These items dealt with individuals that the therapist should avoid becoming involved in therapy with (i.e., a close friend, a colleague, a supervisor, a supervisee, and an employer) because of the obvious existance of a dual relationship and sexual intimacies with clients while in therapy. The percentage of subjects expressing attitudes that deviated from Section 6a ranged from 4.8% on item 10 (therapy with a family member) to 31.5% on item 12 (therapy with a colleague). Involvement in therapy with a supervisor received 14.0% of the subjects responses, therapy with a supervisee 24.7%, and therapy with an employee 12.6% deviant responses. These results suggest the possibility of an evolutionary process effecting the attitudes of subjects concerning therapeutic behavior similar to the process described by Lucena (1972). However the researcher believes that alternative explanations of these results are also possible.

An analysis of the results of item 34, the appropriateness of the therapist becoming involved in sexual intimacies with the client while in therapy, indicated that 1% of the subjects surveyed expressed attitudes supporting sexual intimacies with their clients. These results were inconsistent with the findings of Kardener, Fuller and Marsh (1973) who suggested that in actual practice 13 to 15% of therapists become involved in sexual relationships with clients while in therapy. This inconsistency suggests the possibility that attitudes may not be directly associated with actual practice.

The third conclusion suggested by this study is that age is not associated with an increase or decrease in deviancy. The results indicate a significant correlation between age and deviancy on 9 of the 34 items. It appears that a difference in age is associated with several individual, unrelated items but no global association with deviancy.

The fourth conclusion suggested by this study is that subjects' sex is not associated with deviancy. The results indicate a significant correlation between subject sex and deviancy on 4 of the 34 items. Although a significant correlation between sex and deviancy was found on 4 items, sex cannot be considered a variable associated with deviancy and a descriptor of the deviant population.

The fifth conclusion suggested by this study is that years of experience is not associated with deviancy and therefore cannot be considered as a descriptor. As in the previous conclusion, years of experience correlated significantly with only individual, unrelated items (19, 20, and 21) and is not associated with the degree of deviancy of the deviant population.

The sixth conclusion suggested by this study is that the therapeutic setting is not associated with deviancy and therefore cannot be considered as a descriptor of the deviant population. The results of this study indicate that a significant association between deviancy and the five therapeutic settings occurred with 5 items. No individual setting was associated with more than 3 items. Although there is a significant association between a particular therapeutic setting and the degree of deviancy on 5 items, the therapeutic setting of the practitioner cannot be considered a descriptor or associated with the degree of deviancy when the entire study is considered.

Conclusions three through six suggest that the deviant population is a heterogeneous population in which the variables tested in this study have no global association with either an increase or a decrease in the degree of deviancy.

Suggestions for Future Research

Based upon the implications of this study, some specific recomendations will be made to guide future research.

1. The pilot study should be replicated with larger numbers of subjects to obtain additional data concerning the reliability and validity of the survey questionnaire.
2. The present study should be replicated with a larger random sample of APA members to validate the results of this study.
3. The present study should be replicated with other variables to replace age, sex, years of experience, and therapeutic setting in an attempt to describe the deviant populations.

4. The present study should be applied to all divisions of the American Psychological Association to account for any divisional variation in attitudes that might be present.
5. An instrument should be devised to determine the association between ethical attitudes and actual therapeutic behaviors.

APPENDIX A

SURVEY QUESTIONNAIRE

PRELIMINARY INFORMATION: Please fill in appropriate information.

age. . . . . ._____

sex. . . . . .M F

years of experience: counseling and/or therapy . . . ._____

type of institution presently practicing: (choose one)

clinic, private practice, hospital, school, agency . ._____

****

DIRECTIONS: Please read each statement thoroughly, applying it to yourself. Each statement may have several versions. Respond to each statement by marking (circle) the response to the right that most clearly describes your feelings and attitudes about the statement. The response should describe only your attitudes and feelings. Please answer all statements.

SA = strongly agree A = generally agree NO = no opinion D = generally disagree SD = strongly disagree

****

1. I feel that it is appropriate to extend myself into as close a relationship as possible with each client, (i.e., warm, caring, friendly). . . . . SA A NO D SD
2. I feel that it is appropriate to maintain a professional distance with each client by allowing no contact with the client outside of the therapeutic session . . . SA A NO D SD
3. I feel that it is appropriate to maintain a professional distance with each client by not allowing myself to become emotionally involved with the client, (i.e., keep my feelings and the client's separate). . . . . SA A NO D SD

4. I feel that it is appropriate to involve myself in extra-therapeutic social activities (i.e., cocktail and/or dinner parties, informal gatherings) with clients:

   a) of the same sex; . . . . . SA A NO D SD

   b) of the opposite sex. . . . . SA A NO D SD

5. I feel that it is appropriate to involve myself in extra-therapeutic recreational activities (i.e., tennis, bowling, outdoor sports) with clients:

   a) of the same sex; . . . . . SA A NO D SD

   b) of the opposite sex. . . . . SA A NO D SD

6. I feel that it is appropriate, in my home, to entertain (i.e., cocktail and/or dinner parties, informal gatherings) with clients:

   a) of the same sex; . . . . . SA A NO D SD

   b) of the opposite sex. . . . . SA A NO D SD

7. I feel that it is appropriate to be involved in therapy with:

   a) a member of my family; . . . . . SA A NO D SD

   b) a close friend; . . . . . SA A NO D SD

   c) a colleague; . . . . . SA A NO D SD

   d) a supervisor; . . . . . SA A NO D SD

   e) a supervisee; . . . . . SA A NO D SD

   f) one of my employees. . . . . SA A NO D SD

8. I feel that it is appropriate to become involved in formal business dealings (i.e., contractual dealings) with a client, including other interests in which the therapist is involved . . . . . SA A NO D SD

9. I feel that it is appropriate to become involved in informal business dealings (i.e., small loans, non-contractual dealings) with clients. . . . . SA A NO D SD

10. I feel that it is appropriate, inside of the therapeutic session, to share with the client:

    a) my professional expertise (i.e., psychological);. . . . . SA A NO D SD

    b) other expertise (i.e., financial, mechanical); . . . . . SA A NO D SD

    c) my general feelings (i.e., reactions to life, home life, world situation); . . . SA A NO D SD

    d) my problems (i.e., family difficulties, sexual problems) . . . . . SA A NO D SD

11. I feel that it is appropriate, outside of the therapeutic session, to share with the client:

    a) my professional expertise (i.e., psychological);. . . . . SA A NO D SD

    b) other expertise (i.e., financial, mechanical); . . . . . SA A NO D SD

    c) my general feelings (i.e., reactions to life, home life, world situations);. . . SA A NO D SD

    d) my problems (i.e., family difficulties, sexual problems) . . . . . SA A NO D SD

12. I feel that it is appropriate, inside of the therapeutic session, to allow the client to share with me:

    a) his/her professional expertise (i.e., managerial, accounting); . . . . . SA A NO D SD

    b) other expertise (i.e., financial, mechanical); . . . . . SA A NO D SD

    c) general feelings (i.e., reactions to life, home life, world situations);. . . . . SA A NO D SD

    d) problems (i.e., family and/or sexual, financial difficulties). . . . . SA A NO D SD

13. I feel that it is appropriate, outside of the therapeutic session, to allow the client to share with me:

    a) his/her professional expertise (i.e., managerial, accounting); . . . . . SA A NO D SD

    b) other expertise (i.e., financial, mechanical); . . . . . SA A NO D SD

    c) general feelings (i.e., reactions to life, home life, world situations);. . . . . SA A NO D SD

    d) problems (i.e., family and/or sexual, financial difficulties). . . . . SA A NO D SD

14. I feel that it is appropriate to involve myself in sexual relations with a client when it is evident that the client will benefit from this encounter . . . SA A NO D SD

Please check to see that all statements are answered and the Preliminary Information portion is filled in. My results deadline is June 5, 1976. I hope this will give you ample time to complete and return this questionnaire. Thank you for your participation.

APPENDIX B

PILOT I SURVEY

Preliminary Information:

age . . . . . _____

sex . . . . . M F

years of experience . . . . . _____

Type of institution: (choose one) clinic, private . _____

practice, hospital, school.

****

Directions: Please read each statement thoroughly, applying it to yourself. Each statement may have several versions. Respond to each statement by marking (circle) the response to the right that most clearly describes your feelings and attitudes about the statement. The response should describe only your attitudes and feelings.

SA = strongly agree A= generally agree NO = no opinion D = generally disagree SD = strongly disagree

Directions for reliability: Below each statement response (SA A NO D SD) is a range of numbers (1 to 5). These numbers are to rate how well this statement and response allowed you to express your attitudes and feelings. Circle the appropriate number for each statement/response before going on to the next statement. Example: This statement allowed me to accurately express my attitudes and feelings_____.

1 = not at all 2 = not very well 3 = somewhat 4 = fairly well 5 = exactly

1.	I feel that it is appropriate to extend myself into as close a relationship as possible with each client, (i.e., warm, caring, friendly).	SA 1	A 2	NO 3	D 4	SD 5
2.	I feel that it is appropriate to maintain a professional distance with each client, (i.e., no contact outside of therapy, indifferent feelings towards client).	SA 1	A 2	NO 3	D 4	SD 5

3. I feel that it is appropriate to involve myself in extra-therapeutic social activities (i.e., cocktail and/or dinner parties, informal gatherings) with clients:

a) of the same sex;.	SA	A	NO	D	SD
	1	2	3	4	5
b) of the opposite sex	SA	A	NO	D	SD
	1	2	3	4	5

4. I feel that it is appropriate to involve myself in extra-therapeutic recreational activities (i.e., tennis, bowling, outdoor sports) with clients:

a) of the same sex;.	SA	A	NO	D	SD
	1	2	3	4	5
b) of the opposite sex	SA	A	NO	D	SD
	1	2	3	4	5

5. I feel that it is appropriate, in my home, to entertain (i.e., cocktail and/or dinner parties, informal gathering) clinets:

a) of the same sex;.	SA	A	NO	D	SD
	1	2	3	4	5
b) of the opposite sex	SA	A	NO	D	SD
	1	2	3	4	5

6. I feel that it is appropriate to be involved in therapy with:

a) a member of my family;.	SA	A	NO	D	SD
	1	2	3	4	5
b) a close friend;	SA	A	NO	D	SD
	1	2	3	4	5
c) a colleague;.	SA	A	NO	D	SD
	1	2	3	4	5
d) a supervisor;	SA	A	NO	D	SD
	1	2	3	4	5
e) a supervisee;	SA	A	NO	D	SD
	1	2	3	4	5
f) one of my employees	SA	A	NO	D	SD
	1	2	3	4	5

7.	I feel that it is appropriate to become involved. . . in formal business dealings with a client, (i.e., contractual dealings) including other interests in which the therapist is involved.	SA 1	A 2	NO 3	D 4	SD 5
8.	I feel that it is appropriate to become involved. . . in informal business dealings (i.e., small loans, non-contractual dealings) with clients.	SA 1	A 2	NO 3	D 4	SD 5
9.	I feel that it is appropriate, inside of the therapeutic session, to give to the client:					
	a) my professional expertise (i.e.,. . . . . psychological);	SA 1	A 2	NO 3	D 4	SD 5
	b) other expertise (i.e., financial, ... mechanical);	SA 1	A 2	NO 3	D 4	SD 5
	c) my general feelings (i.e., reactions. . . to life, home life, world situations);	SA 1	A 2	NO 3	D 4	SD 5
	d) my problems (i.e., family and/or. . . . . sexual difficulties);	SA 1	A 2	NO 3	D 4	SD 5
10.	I feel that it is appropriate, outside of the therapeutic session, to give to the client:					
	a) my professional expertise (i.e.,. . . . . psychological);	SA 1	A 2	NO 3	D 4	SD 5
	b) other expertise (i.e., financial, ... mechanical);	SA 1	A 2	NO 3	D 4	SD 5
	c) my general feelings (i.e., reactions. . . to life, world situations);	SA 1	A 2	NO 3	D 4	SD 5
	d) my problem (i.e., family and/or . . . . . sexual difficulties).	SA 1	A 2	NO 3	D 4	SD 5

11. I feel that it is appropriate, inside of the therapeutic session, to allow the client to give to me:

a) his/her professional expertise	SA	A	NO	D	SD
(i.e., accounting, managerial):	1	2	3	4	5
b) other expertise (i.e., financial,. . . .	SA	A	NO	D	SD
mechanical);	1	2	3	4	5
c) general feelings (i.e., reactions. . . .	SA	A	NO	D	SD
to life, home life, world situations);	1	2	3	4	5
d) problems (i.e., family and/or sexual,. .	SA	A	NO	D	SD
financial difficulties).	1	2	3	4	5

12. I feel that it is appropriate, outside of the therapeutic session, to allow the client to give to me:

a) his/her professional expertise	SA	A	NO	D	SD
(i.e., accounting, managerial):	1	2	3	4	5
b) other expertise (i.e., financial,. . . .	SA	A	NO	D	SD
mechanical);	1	2	3	4	5
c) general feelings (i.e., reactions to . .	SA	A	NO	D	SD
life, home life, world situations);	1	2	3	4	5
d) problems (i.e., family and/or sexual,. .	SA	A	NO	D	SD
financial difficulties).	1	2	3	4	5

13. I feel that it is appropriate to involve myself. . . SA A NO D SD
in sexual relations with a client when it is 1 2 3 4 5
evident that the client will benefit from this encounter.

Suggestions for face validity: Please note any sources of confusion and/or ambiguity. Identify each statement by number (and initial when appropriate), note the problem, and give suggestions about how to clarify it.

APPENDIX C

PILOT II SURVEY

Preliminary Information:

age . . . . . _____

sex . . . . . M F

years of experience . . . . . _____

type of institution: (choose one) clinic, private . . . . _____

practice, hospital, school.

****

Directions: Please read each statement thoroughly, applying it to yourself. Each statement may have several versions. Respond to each statement by marking (circle) the response to the right that most clearly describes your feelings and attitudes about the statement. The response should describe only your attitudes and feelings. Please answer all statements.

SA = strongly agree A = generally agree NO = no opinion D = generally disagree SD = strongly disagree

Directions for reliability: Below each statement response (SA A NO D SD) is a range of numbers (1 to 5). These numbers are to rate how well this statement and response allowed you to express your feelings and attitudes. Circle the appropriate number for each statement/response before going on to the next statement. This rating is not to show how much you agreed or disagreed with the statement but only how well you were allowed to express your positive or negative feeling and attitudes.

1 = not at all 2 = not very well 3 = somewhat 4 = fairly well 5 = exactly

****

1. I feel that it is appropriate to extend myself . . . . SA A NO D SD
   into as close a relationship as possible with each
   client, (i.e., warm, caring, friendly).
   How well did this statement allow me to express my . . 1 2 3 4 5
   feelings?

6. I feel that it is appropriate, in my home, to entertain (i.e., cocktail and/or dinner parties, informal gatherings) clients:

a) of the same sex; . . . . . SA A NO D SD

How well did this statement allow me to express my feelings? 1 2 3 4 5

b) of the opposite sex. . . . . SA A NO D SD

How well did this statement allow me to express my . . feelings? 1 2 3 4 5

7. I feel that it is appropriate to be involved in therapy with:

a) a member of my family; . . . . . SA A NO D SD

How well did this statement allow me to express my . . feelings? 1 2 3 4 5

b) a close friend;. . . . . SA A NO D SD

How well did this statement allow me to express my feelings? 1 2 3 4 5

c) a colleague; . . . . . SA A NO D SD

How well did this statement allow me to express my feelings? 1 2 3 4 5

d) a supervisor;. . . . . SA A NO D SD

How well did this statement allow me to express my feelings? 1 2 3 4 5

e) a supervisee;. . . . . SA A NO D SD

How well did this statement allow me to express my feelings? 1 2 3 4 5

f) one of my employees. . . . . SA A NO D SD

How well did this statement allow me to express my feelings? 1 2 3 4 5

8. I feel that it is appropriate to become involved . . . SA A NO D SD
in formal business dealings with a client, (i.e.,
contractual dealings) including other interests in which
the therapist is involved.
How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

9. I feel that it is appropriate to become involved . . . SA A NO D SD
in informal business dealings (i.e., small loans,
non-contractual dealings) with clients.
How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

10. I feel that it is appropriate, inside of the thera-
peutic session, to share with the client:

a) my professional expertise (i.e.,. . . . . SA A NO D SD
psychological);

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

b) other expertise (i.e., financial, ... SA A NO D SD
mechanical);

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

c) my general feelings (i.e., reactions to . . . . SA A NO D SD
life, home life, world situations);

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

10. (cont.)

d) my problems (i.e., family difficulties, ... SA A NO D SD
sexual problems).

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

11. I feel that it is appropriate, outside of the therapeutic session, to share with the client:

a) my professional expertise (i.e.,. . . . . SA A NO D SD
psychological);

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

b) other expertise (i.e., financial, ... SA A NO D SD
mechanical);

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

c) my general feelings (i.e., reactions to . . . . SA A NO D SD
life, home life, world situations);

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

d) my problems (i.e., family difficulties, ... SA A NO D SD
sexual problems).

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

12. I feel that it is appropriate, inside of the therapeutic session, to allow the client to share with me:

a) his/her professional expertise (i.e., ... SA A NO D SD
accounting, managerial);

12. (cont.)

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

b) other expertise (i.e., financial, mechanical);. SA A NO D SD

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

c) general feelings (i.e., reactions to. . . . . SA A NO D SD
life, home life, world situations);

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

d) problems (i.e., family and/or or sexual,. . . . SA A NO D SD
financial difficulties).

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

13. I feel that it is appropriate, outside of the therapeutic session, to allow the client to share with me:

a) his/her professional expertise (i.e., ... SA A NO D SD
accounting, managerial);

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

b) other expertise (i.e., financial, ... SA A NO D SD
mechanical);

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

c) general feelings (i.e., reactions to life,. . . SA A NO D SD
home life, world situations);

How well did this statement allow me to express my . . 1 2 3 4 5
feelings?

13. (cont.)

d) problems (i.e., family and/or sexual, financial difficulties). . . . . SA A NO D SD

How well did this statement allow me to express my feelings? . . 1 2 3 4 5

14. I feel that it is appropriate to involve myself in sexual relations with a client when it is evident that the client will benefit from this encounter. . . . . SA A NO D SD

How well did this statement allow me to express my feelings? . . 1 2 3 4 5

****

Suggestions for face validity: Please note any sources of confusion and/or ambiguity. Identify each statement by number (and initial when appropriate), note the problem, and give suggestions about how to clarify it.

APPENDIX D

INSTRUCTIONS TO PILOT I RELIABILITY STUDY

INSTRUCTIONS TO PILOT I RELIABILITY STUDY

Directions for reliability: Below each statement response (SA A NO D SD) is a range of numbers (1 to 5). These numbers are to rate how well this statement and response allowed you to express your attitudes and feelings. Circle the appropriate number for each statement/response before going on to the next statement.

Example: This statement allowed me to accurately express my attitudes and feelings _____.

1 = not at all 2 = not very well 3 = somewhat 4 = fairly well

5 = exactly

APPENDIX E

INSTRUCTIONS TO PILOT II RELIABILITY STUDY

INSTRUCTIONS TO PILOT II RELIABILITY STUDY

Directions for reliability: Below each statement response (SA A NO D SD) is a range of numbers (1 to 5). These numbers are to rate how well this statement and response allowed you to express your feelings and attitudes. Circle the appropriate number for each statement/response before going on to the next statement. This rating is not to show how much you agreed or disagreed with the statement but only how well you were allowed to express your positive or negative feeling and attitudes.

1 = not at all 2 = not very well 3 = somewhat 4 = fairly well

5 = exactly

APPENDIX F

INSTRUCTIONS TO PILOT I & II VALIDITY STUDIES

INSTRUCTIONS TO PILOT I & II VALIDITY STUDIES

Suggestions for face validity: Please note any sources of confusion and/or ambiguity. Identify each statement by number (and initial when appropriate), note the problem, and give suggestions about how to clarify it.

APPENDIX G

COVER LETTER

KANSAS STATE COLLEGE of PITTSBURG

66762

April 28, 1976

Dear APA Member:

This letter is a request for your cooperation to determine the attitudes of APA practitioners concerning Section 6a of the seventh draft of the Ethical Standards of Psychologists. I am concerned with whether or not this code is representative of the collective attitudes and feelings of APA members.

The American Psychological Association has provided me with your name through a random sample of its members. The APA has also expressed a desire for the results of this survey.

All that is required of you is to read and follow the directions of the questionnaire. Once you have completed the Preliminary Information and all the items, return the questionnaire in the addressed stamped envelope by dropping it in the nearest mailbox. Your responses on this questionnaire will be kept in the strictest confidence. Your questionnaire is being returned to another APA member so there will be no way to determine to whom each questionnaire belongs. Please indicate on the return envelope if the results are desired.

Thank you for your cooperation in this important endeavor.

Sincerely yours,

Gary P. Sazama

Gary P. Sazama
Counseling Center/Russ Hall
Kansas State College of Pittsburg
Pittsburg, KS 66762

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APPENDIX H

FOLLOW-UP LETTER

KANSAS STATE COLLEGE of PITTSBURG

66762

June 9, 1976

Dear APA Members:

This letter is a follow up to my earlier request for your cooperation to determine the attitudes of APA practitioners concerning Section 6a of the seventh draft of the Ethical Standards of Psychologists. Thus far, I have received the full cooperation of a large number of members who were selected to participate in this survey. Ethical research is an endeavor that directly effects us all. Your opinions are far too important not to be included in this survey.

I am asking you to take the time to fill out this survey and return it today. After all sections of this questinnaire have been completed, use the enclosed mailing lable and return it to:

Dr. Calvin H. Merrifield
Counseling Center/ Russ Hall
Kansas State College of Pittsburg
Pittsburg, KS. 66762

Due to a very low budget it is impossible to provide another stamped, addressed envolope at this time.

Please do this today. Your attitudes are too important not to be included in this research.

Thank you for your cooperation in this important endeavor.

Sincerely yours,

Gary P. Sazama

Gary P. Sazama
Counseling Center/ Russ Hall
Kansas State College of Pittsburg
Pittsburg, KS. 66762

APPENDIX I

COMPUTER ANALYSIS OF SEX VS. DEVIANCY

Item 1

		♂	♀
D	OF	34	7
	EF	32.55	8.45
	SV	.027	.106
ND	OF	124	34
	EF	125.45	32.55
	SV	.72E-02	.028

$\bar{x}^2 = .169$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 2

		♂	♀
D	OF	66	8
	EF	58.36	15.64
	SV	.873	3.259
ND	OF	87	33
	EF	94.64	25.36
	SV	.539	2.009

$\bar{x}^2 = 6.681^{**}$

OF = observed frequency
EF = expected frequency
SV = sectional value
** = $p < .01$

Item 3

		♂	♀
D	OF	45	3
	EF	37.92	10.08
	SV	1.142	4.295
ND	OF	113	39
	EF	120.08	31.92
	SV	.361	1.356

$\bar{x}^2 = 7.154^{**}$

OF = observed frequency
EF = expected frequency
SV = sectional value
** = $p < .01$

Item 4

		♂	♀
D	OF	26	5
	EF	24.39	6.61
	SV	.050	.186
ND	OF	129	37
	EF	130.61	35.39
	SV	.94E-02	.035

$\bar{x}^2 = .281$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 5

		♂	♀
D	OF	25	5
	EF	23.60	6.40
	SV	.034	.126
ND	OF	130	37
	EF	131.40	35.60
	SV	.61E-02	.023

$\bar{x}^2 = .188$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 6

		♂	♀
D	OF	28	6
	EF	27.09	6.91
	SV	.61E-02	.024
ND	OF	125	33
	EF	125.91	32.09
	SV	.13E-02	.51E-02

$\bar{x}^2 = .036$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 7

		♂	♀
D	OF	26	6
	EF	25.47	6.53
	SV	.46E-04	.18E-03
ND	OF	126	33
	EF	126.53	32.47
	SV	.92E-05	.36E-04

$\bar{x}^2$ = .27E-03

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 8

		♂	♀
D	OF	15	2
	EF	13.34	3.66
	SV	.101	.369
ND	OF	138	40
	EF	139.66	38.34
	SV	.97E-02	.035

$\bar{x}^2$ = .514

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 9

		♂	♀
D	OF	15	2
	EF	13.34	3.66
	SV	.101	.369
ND	OF	138	40
	EF	139.66	38.34
	SV	.97E-02	.035

$\bar{x}^2 = .515$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 10

		♂	♀
D	OF	10	0
	EF	7.94	2.06
	SV	.306	1.180
ND	OF	152	42
	EF	154.06	39.94
	SV	.016	.061

$\bar{x}^2 = 1.563$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 11

		♂	♀
D	OF	21	1
	EF	17.36	4.64
	SV	.569	2.128
ND	OF	136	41
	EF	139.64	37.36
	SV	.071	.265

$\bar{x}^2 = 3.032$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 12

		♂	♀
D	OF	56	9
	EF	51.32	13.68
	SV	.341	1.279
ND	OF	94	31
	EF	98.68	26.32
	SV	.177	.665

$\bar{x}^2 = 2.463$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 13

		♂	♀
D	OF	24	5
	EF	22.99	6.01
	SV	.011	.043
ND	OF	129	35
	EF	130.01	33.99
	SV	.20E-02	.77E-02

$\bar{x}^2 = .064$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 14

		♂	♀
D	OF	43	8
	EF	39.90	11.10
	SV	.169	.608
ND	OF	108	34
	EF	111.10	30.90
	SV	.061	.219

$\bar{x}^2 = 1.057$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 15

		♂	♀
D	OF	22	4
	EF	20.88	5.12
	SV	.018	.075
MD	OF	133	34
	EF	134.92	32.88
	SV	.29E-02	.012

$\bar{x}^2 = .108$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 16

		♂	♀
D	OF	8	2
	EF	7.95	2.05
	SV	.025	.097
MD	OF	139	36
	EF	139.05	35.95
	SV	.14E-02	.55E-02

$\bar{x}^2 = .129$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 17

		♂	♀
D	OF	5	3
	EF	6.42	1.58
	SV	.131	.531
ND	OF	149	35
	EF	147.58	36.42
	SV	.57E-02	.023

$\bar{x}^2 = .690$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 18

		♂	♀
D	OF	12	6
	EF	14.51	3.49
	SV	.278	1.154
ND	OF	150	33
	EF	147.49	35.51
	SV	.027	.114

$\bar{x}^2 = 1.573$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 19

		♂	♀
D	OF	75	17
	EF	72.07	19.93
	SV	.082	.297
ND	OF	66	22
	EF	68.93	19.07
	SV	.086	.311

$\bar{x}^2 = .776$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 20

		♂	♀
D	OF	39	14
	EF	42.52	10.48
	SV	.214	.868
ND	OF	107	22
	EF	103.48	25.52
	SV	.088	.357

$\bar{x}^2 = 1.527$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 21

		♂	♀
D	OF	30	1
	EF	24.70	6.30
	SV	.932	3.654
ND	OF	123	38
	EF	128.30	32.70
	SV	.179	.704

$\tilde{x}^2 = 5.469^*$

OF = observed frequency
EF = expected frequency
SV = sectional value
* = $p < .05$

Item 22

		♂	♀
D	OF	75	15
	EF	70.75	19.25
	SV	.199	.731
ND	OF	72	25
	EF	76.25	20.75
	SV	.185	.678

$\tilde{x}^2 = 1.793$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 23

		♂	♀
D	OF	56	12
	EF	52.97	15.03
	SV	.121	.425
ND	OF	85	28
	EF	88.03	24.97
	SV	.073	.256

$\bar{x}^2 = .874$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 24

		♂	♀
D	OF	72	12
	EF	66.22	17.78
	SV	.421	1.567
ND	OF	77	28
	EF	82.78	22.22
	SV	.337	1.254

$\bar{x}^2 = 3.577$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 25

		♂	♀
D	OF	16	0
	EF	12.65	3.35
	SV	.643	2.424
ND	OF	135	40
	EF	138.35	36.65
	SV	.059	.222

$\bar{x}^2 =$ 3.348

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 26

		♂	♀
D	OF	47	10
	EF	44.37	12.63
	SV	.102	.359
ND	OF	90	29
	EF	92.63	26.37
	SV	.049	.172

$\bar{x}^2 =$ .683

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 27

		♂	♀
D	OF	47	10
	EF	44.55	12.45
	SV	.085	.305
MD	OF	89	28
	EF	91.45	25.55
	SV	.042	.149

$\bar{x}^2 = .580$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 28

		♂	♀
D	OF	2	0
	EF	1.59	.41
	SV	.47E-02	.018
MD	OF	159	42
	EF	159.41	41.59
	SV	.47E-04	.18E-03

$\bar{x}^2 = .023$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 29

		♂	♀
D	OF	3	0
	EF	2.39	.615
	SV	.55E-02	.021
ND	OF	160	42
	EF	160.62	41.39
	SV	.82E-04	.32E-03

$\tilde{x}^2 = .027$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 30

		♂	♀
D	OF	70	19
	EF	68.46	20.54
	SV	.016	.053
ND	OF	70	23
	EF	71.54	21.46
	SV	.015	.050

$\tilde{x}^2 = .134$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 31

		♂	♀
D	OF	73	19
	EF	70.89	21.12
	SV	.037	.124
ND	OF	68	23
	EF	70.12	20.89
	SV	.037	.125

$\tilde{x}^2 = .322$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 32

		♂	♀
D	OF	79	16
	EF	73.95	21.05
	SV	.281	.985
ND	OF	65	25
	EF	70.05	19.95
	SV	.296	1.040

$\tilde{x}^2 = 2.601$

OF = observed frequency
EF = expected frequency
SV = sectional value

Item 33

		♂	♀
D	OF	53	6
	EF	46.0	13.01
	SV	.920	3.254
ND	OF	92	35
	EF	99.01	28.0
	SV	.428	1.512

$\bar{x}^2 = 6.113^*$

OF = observed frequency
EF = expected frequency
SV = sectional value
* = $p < .05$

Item 34

		♂	♀
D	OF	2	0
	EF	1.59	.41
	SV	.47E-02	.018
ND	OF	159	42
	EF	159.41	41.59
	SV	.47E-04	.18E-03

$\bar{x}^2 = .023$

OF = observed frequency
EF = expected frequency
SV = sectional value

APPENDIX J

COMPUTER ANALYSIS OF THERAPEUTIC SETTING VS. DEVIANCY

Item 1		C	PP	H	S	A
D	OF	6	18	3	10	4
	EF	6.39	15.25	5.98	9.48	3.92
	SV	.023	.497	1.481	.029	.19E-02
ND	OF	25	56	26	36	15
	EF	24.61	58.75	23.03	36.52	15.09
	SV	.61E-02	.129	.384	.75E-02	.48E-03

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 2.560$

Item 2		C	PP	H	S	A
D	OF	12	22	10	24	6
	EF	11.44	27.46	11.44	16.78	6.87
	SV	.027	1.087	.182	3.103	.109
ND	OF	18	50	20	20	12
	EF	18.56	44.54	18.56	27.22	11.13
	SV	.017	.670	.112	1.914	.067

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 7.288$

Item 3		C	PP	H	S	A
D	OF	5	15	5	19	4
	EF	7.20	17.52	7.68	11.04	4.56
	SV	.672	.363	.935	5.739	.069
ND	OF	25	58	27	27	15
	EF	22.80	55.48	24.32	34.96	14.44
	SV	.212	.115	.295	1.812	.022

OF = observed frequency
EF = expected frequency
SV = sectional value
* = $p < .05$

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 10.233$ *

Item 4		C	PP	H	S	A
D	OF	3	8	5	12	3
	EF	4.72	11.33	5.19	6.92	2.83
	SV	.627	.979	.72E-02	3.722	.99E-02
ND	OF	27	64	28	32	15
	EF	25.28	60.67	27.81	37.08	15.17
	SV	.117	.183	.13E-02	.695	.19E-02

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 6.343$

Item 5		C	PP	H	S	A
D	OF	2	8	5	12	3
	EF	4.57	10.97	5.03	6.70	2.74
	SV	1.444	.802	.13E-03	4.191	.025
ND	OF	28	64	28	32	15
	EF	25.43	61.04	27.98	37.30	15.26
	SV	.259	.144	.23E-04	.753	.44E-02

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 7.622$

Item 6		C	PP	H	S	A
D	OF	2	7	7	12	6
	EF	5.14	12.57	5.67	7.79	2.83
	SV	1.914	2.470	.314	2.273	3.539
ND	OF	27	64	25	32	10
	EF	23.87	58.43	26.33	36.21	13.17
	SV	.412	.532	.068	.489	.762

OF = observed frequency
EF = expected frequency
SV = sectional value
* = $p < .05$

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 12.772$ *

Item 7		C	PP	H	S	A
D	OF	2	6	7	12	5
	EF	4.86	11.73	5.36	7.37	2.68
	SV	1.682	2.797	.501	2.906	2.007
ND	OF	27	64	25	32	11
	EF	24.14	58.27	26.64	36.64	13.32
	SV	.339	.563	.101	.585	.404

OF = observed frequency
EF = expected frequency
SV = sectional value
* = $p < .05$

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\tilde{x}^2 = 11.884$ *

Item 8		C	PP	H	S	A
D	OF	2	3	3	8	1
	EF	2.62	6.28	2.79	3.84	1.48
	SV	.145	1.711	.016	4.520	.157
ND	OF	28	69	29	36	16
	EF	27.39	65.72	29.21	40.16	15.52
	SV	.014	.163	.15E-02	.432	.015

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\tilde{x}^2 = 7.174$

Item 9		C	PP	H	S	A
D	OF	2	3	3	8	1
	EF	2.62	6.28	2.79	3.84	1.48
	SV	.145	1.711	.016	4.520	.157
ND	OF	28	69	29	36	16
	EF	27.39	65.75	29.21	40.16	15.52
	SV	.014	.163	.15E-02	.432	.015

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 7.174$

Item 10		C	PP	H	S	A
D	OF	3	3	1	3	0
	EF	1.47	3.63	1.62	2.35	.93
	SV	1.591	.109	.236	.178	.931
ND	OF	27	71	32	45	19
	EF	28.53	70.37	31.38	45.65	18.07
	SV	.082	.56E-02	.012	.92E-02	.048

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 3.201$

Item 11		C	PP	H	S	A
D	OF	4	8	5	3	2
	EF	3.32	8.07	3.54	4.98	2.10
	SV	.141	.61E-03	.605	.784	.48E-02
ND	OF	26	65	27	42	17
	EF	26.68	64.93	28.46	40.03	16.90
	SV	.018	.76E-03	.075	.097	.60E-03

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 1.725$

Item 12		C	PP	H	S	A
D	OF	10	25	11	16	3
	EF	9.92	23.95	10.61	15.05	5.47
	SV	.63E-03	.046	.015	.060	1.118
ND	OF	19	45	20	28	13
	EF	19.08	46.05	20.40	28.95	10.53
	SV	.33E-03	.024	.76E-02	.031	.581

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 1.883$

Item 13		C	PP	H	S	A
D	OF	2	7	10	8	2
	EF	4.36	10.37	4.81	6.76	2.71
	SV	1.276	1.094	5.606	.227	.184
ND	OF	27	62	22	37	16
	EF	24.64	58.63	27.19	38.24	15.30
	SV	.226	.194	.991	.040	.033

OF = observed frequency
EF = expected frequency
SV = sectional value
* = $p < .05$

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 9.868$ *

Item 14		C	PP	H	S	A
D	OF	5	15	10	18	3
	EF	8.19	17.97	8.19	12.16	4.49
	SV	1.244	.491	.399	2.810	.496
ND	OF	26	53	21	28	14
	EF	20.81	50.03	22.81	33.85	12.51
	SV	.447	.176	.143	1.009	.178

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 7.393$

Item 15		C	PP	H	S	A
D	OF	3	6	8	7	2
	EF	4.02	9.52	4.29	5.63	2.55
	SV	.259	1.299	3.212	.334	.117
ND	OF	27	65	24	35	17
	EF	25.98	61.49	27.71	36.37	16.45
	SV	.040	.201	.497	.052	.018

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 6.029$

Item 16		C	PP	H	S	A
D	OF	0	5	2	2	1
	EF	1.46	3.89	1.68	1.95	1.03
	SV	1.460	.316	.063	.15E-02	.71E-03
ND	OF	27	67	29	34	18
	EF	25.54	68.11	29.32	34.05	17.97
	SV	.083	.018	.36E-02	.86E-04	.41E-04

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 1.945$

Item 17		C	PP	H	S	A
D	OF	2	2	1	2	1
	EF	1.21	3.08	1.29	1.63	.79
	SV	.519	.381	.066	.087	.055
ND	OF	27	72	30	37	18
	EF	27.79	70.92	29.71	37.38	18.21
	SV	.023	.017	.29E-02	.38E-02	.24E-02

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 1.155$

Item 18		C	PP	H	S	A
D	OF	0	7	1	7	3
	EF	2.60	6.63	2.96	4.21	1.62
	SV	2.597	.021	1.294	1.851	1.195
ND	OF	29	67	32	40	15
	EF	26.40	67.37	30.05	42.79	16.39
	SV	.255	.21E-02	.127	.182	.118

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 7.642$

Item 19		C	PP	H	S	A
D	OF	14	30	17	22	9
	EF	12.78	35.27	14.82	20.44	8.69
	SV	.117	.787	.320	.118	.011
ND	OF	11	39	12	18	8
	EF	12.22	33.73	14.18	19.56	8.31
	SV	.122	.822	.335	.124	.012

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 2.767$

Item 20		C	PP	H	S	A
D	OF	6	24	9	9	5
	EF	7.86	19.22	8.15	12.81	4.95
	SV	.441	1.189	.088	1.135	.49E-03
ND	OF	21	42	19	35	12
	EF	19.14	46.78	19.85	31.19	12.05
	SV	.181	.489	.036	.466	.20E-03

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 4.026$

Item 21		C	PP	H	S	A
	OF	5	12	4	8	2
D	EF	4.36	12.11	5.01	6.78	2.75
	SV	.094	.99E-03	.202	.219	.202
	OF	22	63	27	34	15
ND	EF	22.64	62.89	26.00	35.22	14.26
	SV	.018	.19E-03	.039	.042	.039

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = .856$

Item 22		C	PP	H	S	A
	OF	15	28	21	20	6
D	EF	13.96	34.65	13.48	19.25	8.66
	SV	.078	1.277	4.201	.029	.819
	OF	14	44	7	20	12
ND	EF	15.04	37.35	14.52	20.75	9.34
	SV	.072	1.185	3.898	.027	.760

OF = observed frequency
EF = expected frequency
SV = sectional value
* = $p < .05$

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 12.345$ *

Item 23		C	PP	H	S	A
D	OF	8	20	12	22	5
	EF	8.93	25.68	10.79	15.63	5.96
	SV	.098	1.258	.135	2.593	.153
ND	OF	16	49	17	20	11
	EF	15.07	43.32	18.21	26.37	10.04
	SV	.058	.746	.080	1.537	.091

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 6.748$

Item 24		C	PP	H	S	A
D	OF	11	27	13	25	8
	EF	12.89	30.67	13.78	18.67	8.0
	SV	.277	.438	.044	2.149	0
ND	OF	18	42	18	17	10
	EF	16.11	38.33	17.22	23.33	10.0
	SV	.222	.351	.035	1.719	0

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 5.234$

Item 25		C	PP	H	S	A
D	OF	2	4	4	5	1
	EF	2.26	6.12	2.68	3.44	1.51
	SV	.030	.732	.649	.714	.171
ND	OF	25	69	28	36	17
	EF	24.74	66.89	29.32	37.57	16.49
	SV	.28E-02	.067	.059	.065	.016

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 2.506$

Item 26		C	PP	H	S	A
D	OF	10	25	8	10	4
	EF	7.45	21.38	9.39	13.28	5.51
	SV	.874	.615	.206	.809	.412
ND	OF	13	41	21	31	13
	EF	15.55	44.63	19.61	27.72	11.49
	SV	.419	.295	.099	.388	.197

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 4.313$

Item 27		C	PP	H	S	A
D	OF	10	26	7	10	4
	EF	7.86	21.62	9.50	12.45	5.57
	SV	.581	.887	.658	.482	.442
ND	OF	14	40	22	28	13
	EF	16.14	44.38	19.50	25.55	11.43
	SV	.283	.432	.321	.235	.215

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 4.536$

Item 28		C	PP	H	S	A
D	OF	1	0	0	0	1
	EF	.31	.74	.33	.45	.18
	SV	1.580	.739	.325	.453	3.816
ND	OF	30	75	33	46	17
	EF	30.70	74.26	32.68	45.55	17.82
	SV	.016	.74E-02	.32E-02	.45E-02	.038

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 6.982$

Item 29		C	PP	H	S	A
D	OF	1	1	0	0	1
	EF	.45	1.11	.48	.69	.26
	SV	.658	.011	.483	.688	2.060
ND	OF	30	75	33	47	17
	EF	30.55	74.89	32.52	46.31	17.74
	SV	.98E-02	.17E-03	.72E-02	.010	.031

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 3.958$

Item 30		C	PP	H	S	A
D	OF	9	29	13	28	10
	EF	12.71	34.23	13.20	20.54	8.31
	SV	1.085	.799	.31E-02	2.719	.342
ND	OF	17	41	14	14	7
	EF	13.29	35.77	13.80	21.46	8.69
	SV	1.038	.765	.30E-02	2.594	.328

OF = observed frequency
EF = expected frequency
SV = sectional value
* = $p < .05$

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 9.669$ *

Item 31		C	PP	H	S	A
	OF	10	30	14	28	10
D	EF	13.07	35.19	13.57	21.62	8.55
	SV	.722	.766	.013	1.884	.247
	OF	16	40	13	15	7
ND	EF	12.93	34.81	13.34	21.38	8.45
	SV	.730	.774	.014	1.905	.250

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 7.305$

Item 32		C	PP	H	S	A
	OF	13	32	17	25	8
D	EF	13.87	34.92	15.41	22.08	8.73
	SV	.054	.244	.165	.386	.061
	OF	14	36	13	18	9
ND	EF	13.14	33.08	14.60	20.92	8.27
	SV	.057	.258	.174	.407	.064

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 1.870$

Item 33		C	PP	H	S	A
	OF	9	22	14	11	3
D	EF	8.25	22.84	9.52	13.32	5.08
	SV	.069	.031	2.113	.405	.849
	OF	17	50	16	31	13
ND	EF	17.75	49.16	20.48	28.68	10.93
	SV	.032	.014	.982	.188	.394

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 5.076$

Item 34		C	PP	H	S	A
	OF	1	0	1	0	0
D	EF	.31	.73	.33	.45	.19
	SV	1.580	.729	1.401	.453	.187
	OF	30	74	32	46	19
ND	EF	30.70	73.27	32.68	45.55	18.81
	SV	.016	.73E-02	.014	.45E-02	.19E-02

OF = observed frequency
EF = expected frequency
SV = sectional value

C = clinic
PP = private practice
H = hospital
S = school
A = agency

$\bar{x}^2 = 4.393$

REFERENCES

REFERENCES

American Psychological Association. Ethical Standards of Psychologists. American Psychologist, 1959, 14, 279-282.

American Psychological Association. Standards of Psychologists. American Psychological Association, 1953

American Psychological Association. Ethical Standards of Psychologists. Draft #7, Approved by Committee on Scientific and Profession Ethics and Conduct, July 20, 1975, 1-4.

Asher, J. Confusion reigns in the american psychological association malpractice plan. American Psychological Association Monitor, 1976, 7, (3), 11.

Behar, L., & Altrocehi, J. Agreement on the concept of the ideal therapist as a function of experience. Journal of Clinical Psychology, 1961, 17 (1), 65-69.

Berne, E. Principles of Group Treatment. New York: Oxford University Press, 1966.

Bixler, R.H. Limits are therapy. Journal of Counseling Psychology, 1949, 3, 1.

Black, J.D. Common factors of the patient therapist relationship. Journal of Clinical Psychology, 1952, 8, 302-306.

Blocher, D.L. Developmental Counseling. New York: The Ronald Press, 1974.

Brammer, L.M., & Shostrom, E.L. Therapeutic Psychology: Fundamentals of Actualization Counseling and Psychotherapy (2nd ed.). Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1968.

Cantoni, L.J. & Cantoni, L. Counseling Your Friends. New York: William-Fredrick Press, 1961

Caracena, P.F. Eliciatations of dependency expressions in the initial stage of psychotherapy. Journal of Counseling Psychology, 1965, 12, 268-274.

Carkhuff, R.R. & Berenson, B.G. Beyond Counseling and Therapy. New York: Rineholt & Winston, Inc., 1967

Carkhuff, R.R. & Berenson, B.G. The nature, structure, and functioning of counselor commitment. Journal of Rehabilitation, 1969, 35, 13-14.

Cohen, R.C. Military group psychotherapy. Mental Hygiene, 1947, 31, 94-103.

Daubner, E.V. & Daubner, E.S. Ethics and counseling decisions. Personnel and Guidance Journal, 1970, 49 (6), 433-442.

Dolliver, R.H. & Woodward, B.T. Giving and taking in psychotherapy. Psychotherapy: Theory, Research and Practice, 1974, 11 (1), 66-70.

Drasgow, J. & Walker, R.J. A graphic description of counseling relationships. Journal of Counseling Psychology, 1960, 7 (1), 51-55.

Farwell, G.F., Garmsky, N.R. & Malthieu-Coughlam, P. The Counselors Handbook. New York: International Educational Publishers, 1974, 196-199.

Fiedler, F.E. The concept of an ideal therapeutic relationship. Journal of Consulting Psychology, 1950, 14, 239-245.

Foa, U.G. & Goa, E.B. Resource exchange: toward a structural theory of interpersonal communication. In Siegman, A.W. & Pope, B. (Eds), Studies in Dydadic Communication. Long Island City, New York; Pergammon, 1971, 293-304.

Fordham, M. Defences of the self. Journal of Analytical Psychology, 1974 (Jul), 19 (2), 192-199.

French, T.M. The transference phenomenon. In Thompsons, C., Mazer, M. & Witenbergs, E. (Eds.). An Outline of Psychoanalysis. New York: Random House, 1955, 503-526.

Freud, S. Lines of advance in psycho-analytic therapy (1919). In The Standard Edition of the Complete Psychological Works of Sigmund Freud XVII. London: Hogarth Press, 1955, 163-164.

Fromm, E. The Art of Loving. New York: Harper, 1956.

Fromm-Reichmann, F. Principles of Intensive Psychotherapy. Chicago: The University of Chicago Press, 1950, 9-38.

Goodman, G. An experiment with companionship therapy: college students and troubled boys - assumptions, selection, and design. American Journal of Public Health, 1967, 57, 1772-1777.

Gruver, G.G. College students as therapeutic agents. Psychological Bulletin, 1971, 76 (2), 111-127.

Holtzman, W.H. Some problems of defining ethical behavior. American Psychologist, 1960, 15, 247-255.

Ivey, A.E. Role conflict in counseling. Journal of Counseling Psychology, 1962, 9 (2), 139-143.

Kardener, S.H. Sex and the physician-patient relationship. American Journal of Psychiatry, 1974, 131 (10), 1134-1136.

Kardener, S.H., Fuller, M. & Mensh, I.N. A survey of physician's attitudes and practices regarding erotic and nonerotic contact with patients. American Journal of Psychiatry, 1973, 130, 1077-1081.

Klugh, H. Statistics: The Essential for Research. New York: John Wiley & Sons, Inc., 1970, 70-74.

Kovacs, A. Editorial. California State Psychiatrist, 1968, 9, 15-18.

Kuenzli, A.E. An objective basis for ethics. The Humanist, 1960, 20 (3), 154-160.

Livers, D.L. Theoretical, professional, and ethical issues in counselor education. In Farwill, G.F., Garnsky, N.R. & Mathiew-Coughan, P. The Counselors Handbook. New York: Intext Educational Publishers, 1974, 180-194.

Lucena, I. Limits of the psychiatrist's function. Journal Brasileiro de Psiquiatrio, 1972 (Jan.) 21 (1), 33-53.

Lustig, N., Dresser, J.W., Spellman, S.W., et al. Incest: a family group survival pattern. Archives of General Psychiatry, 1966, 14, 314-331.

McConnell, L.G. The counselor and his asexual client. Canadian Counselor, 1974 (Jun), 8 (3), 207-210.

McNair, D., Callahan, M. & Danial, M. Patients and therapists influences on quitting psychotherapy. Journal of Consulting Psychology, 1967, 27 (1), 10-17.

May, R. Man's Search for Himself. New York: Norton, 1953.

Menninger, K. Theory of Psychoanalytic Technique. New York: Basic Books, Inc., 1958.

Montague, A. On Being Human. New York: H. Schuman, 1950.

Morgenbesser, S. Approaches to ethical objectivity. Education Theory, 1957, 7, 180-186.

Mullan, H. & Sangiuliana, I. The Therapist's Contribution to the Treatment Process. Springfield, Illinois: Charles C. Thomas Publishers, 1964, 24-29.

Noel, J.R & DeChenne, T.K. I - We - Thou - Multi-centered counseling in psychotherapy. Psychotherapy: Theory, Research and Practice, 1971, 8 (4), 282-284.

Nunnally, J.C. Educational Measurement and Evaluation (2nd ed.). New York: McGraw-Hill Book Company, 1972, 105-130.

Ostle, B. Statistics in Research (2nd ed.). Ames, Iowa: The Iowa State University Press, 1963, 81-86.

Patterson, G.R. & Brodsky, G.A. A behavior modification programme for a child with problem behavior. Journal of Child Psychology, 1966, 7, 277-295.

Pepinsky, H.B. & Pepinsky, P.H. Counseling Theory and Practice. New York: The Ronald Press Co., 1954, 171-181.

Peterson, J.A. Counseling and Values. Scranton, Pennsylvania: International Textbook Company, 1970, 120.

Poser, E.G. The effect of therapist's training on group therapeutic outcome. Journal of Counseling Psychology, 1966, 30, 283-289.

Reiff, R. & Riessman, F. The indigenous nonprofessional: a strategy of change in community action and community mental health programs. Community Mental Health Journal, 1965, Monograph 1.

Riessman, F. The helper therapy principle. Social Work, 1965, 10 (2), 27-32.

Rogers, C.R. Counseling and Psychotherapy. Boston: Houghton Mifflin, 1942.

Rogers, C.R. The characteristic of a helping relationship. Personnel and Guidance Journal, 1958, 37, 6-16.

Rogers, C.R. On Becoming a Person. Boston: Houghton Mifflin, 1961.

Sanford, F.H. Creative health and the principle of Habeus Mentem. American Psychologist, 1955, 10, 829-835.

Schuldt, W.S. Psychotherapists approach - avoidance responses and clients expressions of dependency. Journal of Counseling Psychology, 1966, 13, 178-183.

Schwebal, M. Some ethical problems in counseling. Personnel and Guidance Journal, 1955, 33 (5), 254-259.

Schwebel, M. Why? unethical practice. Journal of Counseling Psychology, 1955, 2 (2), 122-128.

Seeman, J. Counselors judgements of therapeutic process and outcome. In Rogers, C.R., Dymond, R.F. (eds). Psychotherapy and Personality Change. Chicago: University of Chicago Press, 1954, Chapter 7.

Snyder, W.U. The Psychotherapy Relationship. New York: Macmillan Co., 1961.

Snyder, W.U. Dependency in Psychotherapy. New York: Macmillan Co., 1963.

Sorokin, P.A. Exploration in Altruistic Love and Behavior. Boston: Beacon, 1950.

Stover, L. & Buerney, B.G., Jr. The efficacy of training procedures for mothers in filial therapy. Psychotherapy: Theory, Research, and Practice, 1967, 4, 110-115.

Sullivan, H.S. The Psychiatric Interview. New York: W.W. Norton, 1954.

Szasz, T.S. The Ethics of Psychoanalysis. New York: Basic Books, Inc., 1965.

Thorne, F.C. Towards more realistic expectations of psychotherapists. Journal of Clinical Psychology, 1961, 17 (1), 101-102.

Winder, C.L.; Ahmad, F.Z.; Bandura, A. & Rau, L.C. Dependency of patients, psychotherapists' responses, and aspects of psychotherapy. Journal of Counseling Psychology, 1962, 26, 129-134.

Wiskoff, M. Ethical standards and divided loyalties. American Psychologist, 1960, 15, 656-660.

Wrenn, C.G. The ethics of counseling. Educational and Psychological Measurements, 1952, 12 (2), 161-172.

Wyatt, F. Person into therapist. In Mahrer, A. & Pearson, L. (eds). Creative Developments in Psychotherapy. Cleveland, Ohio: Case Western Reserve Press, 1971, 299-306.

Zunker, V.G. & Brown, W.F. Comparative effectiveness of students and professional counselors. Personnel and Guidance Journal, 1966, 44, 738-743.

REFERENCE NOTES

1. Gurel, B. Personal communication, February 24, 1976, to Committee of Scientific and Professional Ethics and Conduct.
2. Brayfield, A.H. Ethical Problems of the Applications of Psychology. Address presented at the meeting of the XVIth International Congress of Applied Psychology, Amsterdam, The Netherlands, August, 1968.
3. Bugenthal, J.F.T. The Practice of Psychotherapy and Inauthenticity. Paper presented to the American Psychiatric Association, Los Angeles, California, October, 1967.
4. Wagner, N. Ethical Concerns of Medical Students. Paper read at the 1972 Western Workshop of the Center for the Study of Sex Education in Medicine, Santa Barbara, California.